APPENDIX

Presidential Documents

Executive Order 14168 of January 20, 2025

Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government

By the authority vested in me as President by the Constitution and the laws of the United States of America, including section 7301 of title 5, United States Code, it is hereby ordered:

Section 1. *Purpose.* Across the country, ideologues who deny the biological reality of sex have increasingly used legal and other socially coercive means to permit men to self-identify as women and gain access to intimate single-sex spaces and activities designed for women, from women's domestic abuse shelters to women's workplace showers. This is wrong. Efforts to eradicate the biological reality of sex fundamentally attack women by depriving them of their dignity, safety, and well-being. The erasure of sex in language and policy has a corrosive impact not just on women but on the validity of the entire American system. Basing Federal policy on truth is critical to scientific inquiry, public safety, morale, and trust in government itself.

This unhealthy road is paved by an ongoing and purposeful attack against the ordinary and longstanding use and understanding of biological and scientific terms, replacing the immutable biological reality of sex with an internal, fluid, and subjective sense of self unmoored from biological facts. Invalidating the true and biological category of ''woman'' improperly transforms laws and policies designed to protect sex-based opportunities into laws and policies that undermine them, replacing longstanding, cherished legal rights and values with an identity-based, inchoate social concept.

Accordingly, my Administration will defend women's rights and protect freedom of conscience by using clear and accurate language and policies that recognize women are biologically female, and men are biologically male.

Sec. 2. *Policy and Definitions.* It is the policy of the United States to recognize two sexes, male and female. These sexes are not changeable and are grounded in fundamental and incontrovertible reality. Under my direction, the Executive Branch will enforce all sex-protective laws to promote this reality, and the following definitions shall govern all Executive interpretation of and application of Federal law and administration policy:

(a) ''Sex'' shall refer to an individual's immutable biological classification as either male or female. ''Sex'' is not a synonym for and does not include the concept of ''gender identity.''

(b) ''Women'' or ''woman'' and ''girls'' or ''girl'' shall mean adult and juvenile human females, respectively.

(c) ''Men'' or ''man'' and ''boys'' or ''boy'' shall mean adult and juvenile human males, respectively.

(d) ''Female'' means a person belonging, at conception, to the sex that produces the large reproductive cell.

(e) ''Male'' means a person belonging, at conception, to the sex that produces the small reproductive cell.

(f) ''Gender ideology'' replaces the biological category of sex with an ever-shifting concept of self-assessed gender identity, permitting the false claim that males can identify as and thus become women and vice versa, and requiring all institutions of society to regard this false claim as true.

Gender ideology includes the idea that there is a vast spectrum of genders that are disconnected from one's sex. Gender ideology is internally inconsistent, in that it diminishes sex as an identifiable or useful category but nevertheless maintains that it is possible for a person to be born in the wrong sexed body.

(g) ''Gender identity'' reflects a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex.

Sec. 3. *Recognizing Women Are Biologically Distinct From Men.* (a) Within 30 days of the date of this order, the Secretary of Health and Human Services shall provide to the U.S. Government, external partners, and the public clear guidance expanding on the sex-based definitions set forth in this order.

(b) Each agency and all Federal employees shall enforce laws governing sex-based rights, protections, opportunities, and accommodations to protect men and women as biologically distinct sexes. Each agency should therefore give the terms ''sex'', ''male'', ''female'', ''men'', ''women'', ''boys'' and ''girls'' the meanings set forth in section 2 of this order when interpreting or applying statutes, regulations, or guidance and in all other official agency business, documents, and communications.

(c) When administering or enforcing sex-based distinctions, every agency and all Federal employees acting in an official capacity on behalf of their agency shall use the term ''sex'' and not ''gender'' in all applicable Federal policies and documents.

(d) The Secretaries of State and Homeland Security, and the Director of the Office of Personnel Management, shall implement changes to require that government-issued identification documents, including passports, visas, and Global Entry cards, accurately reflect the holder's sex, as defined under section 2 of this order; and the Director of the Office of Personnel Management shall ensure that applicable personnel records accurately report Federal employees' sex, as defined by section 2 of this order.

(e) Agencies shall remove all statements, policies, regulations, forms, communications, or other internal and external messages that promote or otherwise inculcate gender ideology, and shall cease issuing such statements, policies, regulations, forms, communications or other messages. Agency forms that require an individual's sex shall list male or female, and shall not request gender identity. Agencies shall take all necessary steps, as permitted by law, to end the Federal funding of gender ideology.

(f) The prior Administration argued that the Supreme Court's decision in *Bostock* v. *Clayton County* (2020), which addressed Title VII of the Civil Rights Act of 1964, requires gender identity-based access to single-sex spaces under, for example, Title IX of the Educational Amendments Act. This position is legally untenable and has harmed women. The Attorney General shall therefore immediately issue guidance to agencies to correct the misapplication of the Supreme Court's decision in *Bostock* v. *Clayton County* (2020) to sex-based distinctions in agency activities. In addition, the Attorney General shall issue guidance and assist agencies in protecting sex-based distinctions, which are explicitly permitted under Constitutional and statutory precedent.

(g) Federal funds shall not be used to promote gender ideology. Each agency shall assess grant conditions and grantee preferences and ensure grant funds do not promote gender ideology.

Sec. 4. *Privacy in Intimate Spaces.* (a) The Attorney General and Secretary of Homeland Security shall ensure that males are not detained in women's prisons or housed in women's detention centers, including through amendment, as necessary, of Part 115.41 of title 28, Code of Federal Regulations and interpretation guidance regarding the Americans with Disabilities Act.

(b) The Secretary of Housing and Urban Development shall prepare and submit for notice and comment rulemaking a policy to rescind the final rule entitled ''Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs'' of September 21, 2016, 81 FR 64763, and shall submit for public comment a policy protecting women seeking single-sex rape shelters.

(c) The Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with this order, and shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.

(d) Agencies shall effectuate this policy by taking appropriate action to ensure that intimate spaces designated for women, girls, or females (or for men, boys, or males) are designated by sex and not identity.

Sec. 5. *Protecting Rights.* The Attorney General shall issue guidance to ensure the freedom to express the binary nature of sex and the right to single-sex spaces in workplaces and federally funded entities covered by the Civil Rights Act of 1964. In accordance with that guidance, the Attorney General, the Secretary of Labor, the General Counsel and Chair of the Equal Employment Opportunity Commission, and each other agency head with enforcement responsibilities under the Civil Rights Act shall prioritize investigations and litigation to enforce the rights and freedoms identified.

Sec. 6. *Bill Text.* Within 30 days of the date of this order, the Assistant to the President for Legislative Affairs shall present to the President proposed bill text to codify the definitions in this order.

Sec. 7. *Agency Implementation and Reporting.* (a) Within 120 days of the date of this order, each agency head shall submit an update on implementation of this order to the President, through the Director of the Office of Management and Budget. That update shall address:

(i) changes to agency documents, including regulations, guidance, forms, and communications, made to comply with this order; and

(ii) agency-imposed requirements on federally funded entities, including contractors, to achieve the policy of this order.

(b) The requirements of this order supersede conflicting provisions in any previous Executive Orders or Presidential Memoranda, including but not limited to Executive Orders 13988 of January 20, 2021, 14004 of January 25, 2021, 14020 and 14021 of March 8, 2021, and 14075 of June 15, 2022. These Executive Orders are hereby rescinded, and the White House Gender Policy Council established by Executive Order 14020 is dissolved.

(c) Each agency head shall promptly rescind all guidance documents inconsistent with the requirements of this order or the Attorney General's guidance issued pursuant to this order, or rescind such parts of such documents that are inconsistent in such manner. Such documents include, but are not limited to:

(i) ''The White House Toolkit on Transgender Equality'';

(ii) the Department of Education's guidance documents including:

(A) ''2024 Title IX Regulations: Pointers for Implementation'' (July 2024);

(B) ''U.S. Department of Education Toolkit: Creating Inclusive and Nondiscriminatory School Environments for LGBTQI+ Students'';

(C) ''U.S. Department of Education Supporting LGBTQI+ Youth and Families in School'' (June 21, 2023);

(D) ''Departamento de Educación de EE.UU. Apoyar a los jóvenes y familias LGBTQI+ en la escuela'' (June 21, 2023);

(E) ''Supporting Intersex Students: A Resource for Students, Families, and Educators'' (October 2021);

(F) ''Supporting Transgender Youth in School'' (June 2021);

(G) ''Letter to Educators on Title IX's 49th Anniversary'' (June 23, 2021);

(H) ''Confronting Anti-LGBTQI+ Harassment in Schools: A Resource for Students and Families'' (June 2021);

(I) ''Enforcement of Title IX of the Education Amendments of 1972 With Respect to Discrimination Based on Sexual Orientation and Gender Identity in Light of Bostock v. Clayton County'' (June 22, 2021);

(J) ''Education in a Pandemic: The Disparate Impacts of COVID–19 on America's Students'' (June 9, 2021); and

(K) ''Back-to-School Message for Transgender Students from the U.S. Depts of Justice, Education, and HHS'' (Aug. 17, 2021);

(iii) the Attorney General's Memorandum of March 26, 2021 entitled ''Application of *Bostock* v. *Clayton County* to Title IX of the Education Amendments of 1972''; and

(iv) the Equal Employment Opportunity Commission's ''Enforcement Guidance on Harassment in the Workplace'' (April 29, 2024).

Sec. 8. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

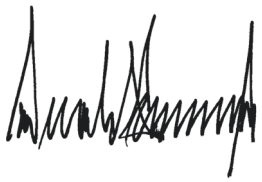
(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(d) If any provision of this order, or the application of any provision to any person or circumstance, is held to be invalid, the remainder of this order and the application of its provisions to any other persons or circumstances shall not be affected thereby.



THE WHITE HOUSE,
January 20, 2025.

[FR Doc. 2025–02090
Filed 1–29–25; 11:15 am]
Billing code 3395–F4–P

U.S. Department of Justice
Federal Bureau of Prisons

Reentry Services Division *Washington, D.C. 20534*

February 21, 2025

MEMORANDUM FOR ALL CHIEF EXECUTIVE OFFICERS

FROM: **DANA R. DIGIACOMO, ACTING ASSISTANT DIRECTOR**
REENTRY SERVICES DIVISION

S. SALEM, ASSISTANT DIRECTOR
CORRECTIONAL PROGRAMS DIVISON

SUBJECT: **Compliance with Executive Order "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government"**

Executive Order (EO) 14166, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, was issued on January 20, 2025. On February 4, 2025, a nation-wide restraining order was issued which temporarily prohibits Bureau of Prisons (BOP) from implementing portions of the EO. Accordingly, the BOP will continue to provide medical and mental health care, as provided prior to the executive order, to the transgender population. Additionally, the EO does not supersede or change BOP's obligation to comply with Federal laws and regulations, including Prison Rape Elimination Act (PREA) and corresponding regulations.

Except as described above, BOP will comply with the executive order. Accordingly, the following guidance is provided:

Preferred Pronouns
Staff must refer to individuals by their legal name or pronouns corresponding to their biological sex. It is important that staff communicate effectively and professionally with ALL inmates.

Purchases of Accommodations
No appropriated funds should be utilized to purchase any items that align with transgender ideology (e.g., binders, stand-to-pee devices, hair removal devices, etc.).

Suspension of Clothing Accommodations

Requests for clothing accommodations, (e.g., issuance of smocks for male inmates and undergarments that do not align with an inmate's biological sex) will not be issued. Additionally, items previously purchased commissary items by inmates may remain in their possession.

Staff Annual Training

Annual Training for Fiscal Year 2025 has been updated. Updated training materials, including the revised PowerPoint, will be provided to your institutions shortly. Please ensure only the updated training is presented.

Suspend all Transgender-Specific Programming

Institutions must also halt all programs (Stronger Together Emerging Proud, Transition Acceptance, Resource Tools for Reentry for Transgender Individuals, Emerging Identity) specifically offered for self-identifying transgender individuals.

Suspension of Pat Search Accommodations

Pat search accommodations (i.e., permitting male inmates to be pat searched by female staff) are no longer authorized.

Suspension of Transgender Executive Council

The Transgender Executive Council has been renamed the Special Populations Oversight Committee (SPOC), and the associated mailbox previously utilized by the transgender population has been taken offline. This name change reflects our continued commitment to ensuring appropriate oversight and individualized assessments to serve special populations in the BOP. The SPOC will review designations and conduct case-by-case assessments, in consideration of and adherence to PREA. However, as per the EO, individuals will not be referred for gender affirming surgeries. Our focus remains on ensuring appropriate housing determinations and meeting the individual needs of those in our custody within the framework of existing statutes and policies.

Please ensure these directives are communicated to all relevant staff and implemented immediately. The safety and mental health of the individuals affected remain a top priority, and it is critical that these changes are carried out with the utmost care and sensitivity. If there are any concerns or additional needs identified during this process, please direct them through the appropriate channels.

Thank you for your attention and cooperation.

U.S. Department of Justice
Federal Bureau of Prisons

Health Services Division *Washington, D.C. 20534*

February 28, 2025

MEMORANDUM FOR CHIEF EXECUTIVE OFFICERS

Digitally signed by CHRISTOPHER BINA
Date: 2025.02.28 14:19:08 -05'00'

FROM: RADM Chris A. Bina, Assistant Director
Health Services Division

SUBJECT: Executive Order 14168 Compliance

Consistent with Executive Order (EO) 14168, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.

This policy is to be implemented in a manner consistent with applicable law including the Eighth Amendment.

cc: BOP Executive Team
Health Services Division Employees
Clinical Directors
Health Services Administrators

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

Let this be Ordered.
Eric C. Tostrud
U.S.D.J.
2/19/26

PROGRAM STATEMENT
Management of Inmates with Gender Dysphoria

Approved by	William K. Marshall III Director, Federal Bureau of Prisons
DPI	RSD
Number	5260.01
Date	February 19, 2026

1. PURPOSE AND SCOPE

To establish professional guidelines for the mental health evaluation and treatment of inmates meeting the diagnostic criteria[1] for Gender Dysphoria[2] (GD) to assist their progress toward recovery, while reducing or eliminating the frequency and severity of symptoms and associated negative outcomes.

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

- To ensure inmates diagnosed with GD receive timely, appropriate mental health services and individualized treatment programming, as clinically indicated. Treatment shall target psychological distress/dysphoria as well as any co-occurring mental health disorders and be tailored to the unique needs of the inmate.
- To allocate sufficient staff and resources to deliver appropriate services to such inmates.
- To enhance staff's understanding of the mental health issues associated with individuals diagnosed with GD and the appropriate treatment that accounts for the evolving scientific understanding.

b. **Institution Supplement**. None required.

[1] As defined by the Diagnostic and Statistical Manual of Mental Disorders- 5th Edition, Text Revision (DSM-5-TR); American Psychiatric Association, 2022).
[2] *Id.* at 511-520.

2. DEFINITIONS

Clinical Group Psychotherapy: a cognitive behavioral process by which a group of persons is led by a psychologist, licensed mental health professional, or qualified treatment specialist to guide interpersonal and intrapersonal growth through an examination of the persons' thoughts, feelings, experiences, and skills.

Gender Dysphoria (GD): a mental health diagnosis currently defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5 TR), or its replacement. It is a psychological disorder caused by clinically significant distress or impairment due to the perceived discrepancy between a person's expressed/experienced gender identity and his or her biological sex.

Gender Identity: a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex.

Individual Therapy: a collaborative treatment based on the therapeutic relationship between the patient and psychologist, licensed mental health professional, or qualified treatment specialist, including, but not limited to, cognitive behavioral and dialectical behavioral therapy.

Multidisciplinary Review Team (MRT): a multidisciplinary group of staff representing different disciplines, which has the responsibility for ensuring access to necessary assessment, treatment, continuity of care, and services to inmates in accordance with their identified mental health needs, and which collaboratively develops, implements, reviews, and revises the treatment plan. Additionally, institutions may request a review by the MRT of individual inmates based on treatment concerns or clinical consultation needs. The MRT is coordinated by the Psychology Services Branch (PSB), which is responsible for scheduling meetings, maintaining records, and documenting official notes. The MRT will consist of the following members (or their designee): (1) Psychology Services Branch (PSB) Administrator; (2) PSB, Chief of Mental Health; (3) Health Services Division (HSD) Chief Psychiatrist; (4) HSD Chief of Health Programs; (5) HSD Chief Pharmacist; (6) HSD Chief Social Worker; and (7) Women and Special Populations Branch (WASP) Administrator.

Psychoeducational Group Intervention: a didactic form of group therapeutic services designed to teach patients about their disorder and help them learn how to manage the related symptoms, behaviors, and consequences. These services may include workbook or homework activities, medication management, stress/anger management, prosocial skills training, coping skills exercises, and managing activities of daily living in a carceral setting.

Sex Trait Modification Surgeries: surgical procedures that seek to modify the person's physical characteristics to appear to align with the person's "gender identity" rather than the person's sex.

Examples of these surgeries include vaginoplasty, phalloplasty, orchiectomy, vulvoplasty, hysterectomy, oophorectomy, mastectomy, metoidioplasty, chest reconstruction, breast augmentation, hair removal, facial feminization surgery, and voice modification. These surgeries are also called "cross-sex," "sex reassignment," or "sex rejection" surgeries.

Social Accommodations: items, including cosmetics and clothing, used to alter the person's appearance to align with the person's "gender identity." Examples of "social accommodations" include buttock padding, breast padding, binders, undergarments, makeup, and wigs.
Social Transition: the process by which a person begins to try to live and present in a way that aligns with their "gender identity" rather than the person's sex. This typically involves various non-medical actions, such as the use of "social accommodations" to alter the person's appearance to align with the person's "gender identity."

3. STAFF RESPONSIBILITIES

The following Bureau of Prisons (Bureau) components are responsible for ensuring consistent establishment of the programs, services, and resource allocations necessary for inmates diagnosed with GD.

a. Central Office

The Psychology Services Branch (PSB), Reentry Services Division, provides oversight and consultation regarding services as they apply to inmates with a diagnosis of GD, including consultation, assessment, and the provision of advice and guidance related to the identification, evaluation, and recommendations for treatment needs of inmates with GD. Therapy will focus on reducing distress associated with GD, or any other mental health concerns that may be present. Mental health care is provided in the context of a collaborative therapeutic relationship with the inmate. Crisis intervention services are offered to inmates who may be experiencing acute distress or acute symptoms of mental illness to prevent self-directed harm (in accordance with Program Statement PS 5324.08, Suicide Prevention Program) or to provide relief from symptoms of mental illness and to prevent further decompensation.

The Health Services Division (HSD) oversees the treatment of inmates for all medical and psychiatric diagnoses. Services are offered to inmates in response to referrals by staff, inmate requests, or situational factors. Clinical guidance derived from the current body of research will be provided at the direction of the Medical Director and will be used to inform the clinical medical and psychiatric care of inmates.

The Women and Special Populations Branch (WASP) oversees the provision of non-medical services to meet the needs of federally incarcerated women and other federally incarcerated populations, including those individuals diagnosed with GD.

b. **Regional Offices**

Regional Offices provide oversight and consultation to institutions regarding services and care provided to inmates, including those diagnosed with GD.

c. **Wardens**

Wardens will establish a local multi-disciplinary approach for the management of inmates diagnosed with GD. The Chief Psychologist is the primary point of contact in the institution for issues related to this population and will consult, as needed, with the Executive Team, Captain, Clinical Director, Unit Manager, or other individuals, as appropriate. Institutions will consult with the Region, Central Office, and the MRT as necessary to ensure inmates diagnosed with GD receive clinically necessary mental health programming and medical services.

4. SCREENING AND EVALUATION

a. **Screening**

Diagnostic screening and evaluation of GD can occur at any time throughout an inmate's incarceration. All diagnostic evaluations are documented in the electronic health record as a *Diagnostic and Care Level Formulation* note. If primary care medical providers are diagnosing GD, the diagnosis will be documented in the electronic health record as a *Clinical Encounter* note.

If an inmate reports or presents a documented history of GD before incarceration, Psychology staff will request the inmate to complete a BP-A0171 Record of Information Release form to authorize the Bureau to obtain the inmate's prior mental health records from community providers who diagnosed or treated the inmate. Similarly, Health Services staff will request completion of a BP-A0621, Authorization for Release of Medical Information form, to obtain prior medical records relevant to the inmate's care. Signed documents will be added to the electronic health record. These signed documents will be added to the electronic health record and Psychology staff will enter as a *General Administrative Note*. If the inmate refuses to sign the records release form, this refusal will also be documented in the electronic health record as a *General Administrative Note*.

As appropriate, a diagnosis of GD will be made by a mental health clinician or primary care medical provider. The diagnosis will be added to the electronic health record. At a minimum, the inmate will be classified and maintained as a Mental Health Care Level 2.

If referral to medical or psychiatric staff is needed, the mental health clinician will complete an electronic referral to Health Services and document that request in the electronic health record as part of a *Clinical Contact or Consultation* note.

b. **Evaluation**

A diagnosis of GD can encompass a diverse array of conditions, with widely differing characteristics depending on the patient's age of onset, mental health, intelligence, environment, and motivation for identifying as the opposite sex. Like many DSM-V psychiatric conditions, GD is complex and often accompanied by other psychiatric comorbidities.

All inmates diagnosed with GD will be individually evaluated. Anxiety, depressive, personality, and posttraumatic stress disorders are mental health disorders that may coexist in those with GD. Because any co-occurring medical or psychiatric disorders may complicate the treatment of GD, a complete diagnostic and psychiatric/medical assessment of those with GD will be performed by Psychology Services clinicians and Health Services, respectively. Documentation of this evaluation will be entered into the electronic medical record.

Mental health clinicians or primary care medical providers will conduct a detailed clinical interview, and consider the use of the following instruments (as applicable) to evaluate the inmate:

- Clinical interview
- Beck Depression Inventory-II (BDI-II)
- Beck Anxiety Inventory (BAI)
- Wechsler Adult Intelligence Scale, 5th Edition
- Kaufman Brief Intelligence Test- 2nd Edition (KBIT-2)
- Montreal Cognitive Assessment (MoCA)
- Personality Assessment Inventory (PAI)
- Columbia Suicide Severity-Rating Scale Lifetime Recent (C-SSRS)
- Beck Scale for Suicidal Ideation (BSS)
- Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)
- Utrecht Gender Dysphoria Scale- Gender Spectrum (UGDS-GS)
- If diagnosed with an autism spectrum disorder (ASD), the inmate may be additionally assessed with the Adaptive Behavior Assessment System 3rd edition (ABAS-3)

The evaluation and testing results will be documented in the electronic health records as *Psychological Testing* with results summarized in the *Diagnostic Care Level Formulation* note. Primary care medical providers may document their diagnosis and evaluation of additional medical concerns or treatment needs as a *Clinical Encounter* note.

5. TREATMENT

Executive Order 14,168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8,615 (Jan. 30, 2025), prohibits the Bureau from expending federal funds for "any medical procedure, treatment, or drug for the

purpose of conforming an inmate's appearance to that of the opposite sex" "to the extent consistent with applicable law." *Id.* at 8,617-18. The Bureau will comply with this Executive Order unless compliance with the Executive Order is prohibited by a court injunction or court order. Though Executive Order 14,168 supports this policy, the Bureau also adopts this policy independently of Executive Order 14,168.

a. **Individualized Treatment Plan**

If treatment for GD is likely to be necessary based on the results of the foregoing evaluation, the following treatment protocol should be followed:

All clinicians will review available documentation in combination with clinical interview(s) to determine the appropriate treatments addressing all identified medical and psychiatric concerns. Because treatment is individualized, treatment plans are tailored to the specific clinical needs of the inmate.

In general, identified medical and psychiatric comorbidities should be addressed before treatment for GD proceeds. As appropriate, medical and psychiatric comorbidities should be addressed through psychotherapy, psychotropic medication, or other appropriate medically accepted interventions. When comorbidities are addressed before GD, further treatment for GD may be necessary and may proceed once these medical and psychiatric comorbidities are resolved or ruled out as the potential cause of GD.

Psychotherapy should be prioritized. Treatment should include, at a minimum, therapy in accordance with their mental health care level as outlined in Program Statement PS 5310.16, **Treatment and Care of Inmates with Mental Illness**. Additionally, other treatments, such as psychoeducational group interventions, may be added as clinically indicated. Treatment interventions will focus on managing the psychological distress/dysphoria, assisting with adjustment to incarceration, community re-entry, and strengthening resilience. Follow-up mental health care should target any associated emotional or behavioral problems and should emphasize supportive treatment modalities.

All clinicians will ensure individuals with GD are not experiencing acute distress during any clinical contact. If the individual is experiencing suicidal ideation, a suicide risk assessment and appropriate protocols related to decreasing distress will be prioritized (in accordance with Program Statement PS 5324.08, **Suicide Prevention Program**). The psychologist may deem it appropriate to refer the individual for trauma treatment, if clinically indicated. Additional areas of focus may include adjustment to incarceration, other mental health diagnoses, community re-entry, and strengthening resilience. Follow-up mental health care should target any associated emotional or behavioral problems and should emphasize supportive treatment modalities.

Psychotropic medication should be considered to determine if its use may alleviate the symptoms of GD.

Diagnosis and treatment of GD will be discontinued if it is determined by a mental or medical health professional that the inmate no longer meets the criteria for the diagnosis based on clinical outcomes. The treatment plan will be updated, and a *Diagnostic Care Level Formulation* note will be entered into the electronic health record to reflect the diagnosis as "Resolved."

All clinicians shall ensure that individuals with GD receive informed care. The medical provider is responsible for ensuring that the inmate understands and signs the informed consent form, before any medication orders. Consent must be voluntary, and the inmate must be able to understand and appreciate the risks and potential side effects of the prescription. If the required documented evidence is insufficient, or if the inmate fails to sign the consent form, the clinician shall not prescribe medication or provide the procedure.

b. **Availability of Sex Trait Modification Surgeries to Address Gender Dysphoria**

In instances when an inmate is diagnosed with GD, the Bureau will not provide sex trait modification surgeries to address GD and the inmate will not receive sex trait modification surgeries to address GD.

For inmates who have had sex trait modification surgery, medical care will be provided as necessary to address any complications or resulting conditions, such as urethral stricture and pelvic infections.

c. **Availability of Hormones to Address Gender Dysphoria**

i. **Inmates Not Currently Receiving Hormones to Address Gender Dysphoria**

In instances when an inmate is diagnosed with GD but is not currently receiving hormones to address GD, the Bureau will not provide hormones to address GD and the inmate will not receive hormones to address GD. Such inmates will continue to have an individualized treatment plan to meet the inmate's needs. The individualized treatment plan may include psychotherapy, group counseling, psychiatric services, and psychotropic medications.

ii. **Inmates Currently Receiving Hormones to Address Gender Dysphoria**

In instances when an inmate is previously and currently diagnosed with GD and is currently receiving hormones to address GD, the MRT shall review and approve or disapprove the tapering plan submitted by the Primary Care Provider for all such inmates. Each tapering plan shall consider the appropriate factors, such as the duration the inmate

has been receiving hormones to address GD, the initial rationale for receiving the hormone intervention, the response by the inmate to the intervention, and whether the inmate has undergone sex trait modification surgery.

For inmates that have recently begun receiving hormones to address GD, the Primary Care Provider shall develop a tapering plan that includes a rapid discontinuation of the hormone intervention.

For inmates that have been receiving hormones to address GD for an extended period of time, the Primary Care Provider shall develop a tapering plan that includes an appropriately paced discontinuation of the hormone intervention.

For inmates who (1) are post sex trait modification surgery or (2) have been receiving hormones to address GD for an extended period of time and develop severe physiological and psychological withdrawal effects from tapering, it may not be appropriate in all cases for the initial tapering plan to include cessation of hormones. But tapering plans should be reevaluated regularly with respect to cessation of hormones, including during the inmate's chronic care clinic appointments.

Medical and mental health professionals shall evaluate the inmate before beginning tapering. Based on that evaluation and patient-specific needs, medical and mental health professionals shall develop a monitoring and follow-up evaluation plan. All inmates who are tapering and were receiving mental health treatment before tapering shall continue to receive counseling and pharmacological treatment as appropriate as part of the inmate's individualized treatment plan. Tapering plans may be adjusted as necessary based on monitoring and follow-up evaluations, but the adjusted tapering plans must still be consistent with the purpose of this policy and based on all relevant factors, including security and prison-administration concerns.

Patients may submit a request for additional medical or mental health care or evaluation if they have acute concerns during the tapering process. All requests shall be considered in a reasonable amount of time in accordance with standard procedure, and decisions concerning such requests shall be based on all relevant factors, including security and prison-administration concerns.

d. **Social Accommodations**

The Bureau will not provide social accommodations, including to inmates diagnosed with GD, and the inmate will not receive social accommodations. If the inmate currently has social accommodations, the Bureau shall no longer provide the social accommodations and, when practicable, remove or confiscate the social accommodations. When appropriate, and in accordance with standard procedure, inmates may still have access to purchase items on the standardized list of Commissary items available to inmates in their facility.

6. DOCUMENTATION AND TRACKING OF MEDICAL AND MENTAL HEALTH INFORMATION

Medical and mental health information for this population will be maintained in the current electronic recordkeeping system or health record system in accordance with PS 6090.04, **Health Information Management** and PS 5310.17, **Psychology Services Manual**. Medical and mental health information is considered confidential and may only be released in accordance with appropriate laws, rules, and regulations.

7. ADMINISTRATIVE REMEDIES

Inmates who wish to seek formal review of any issue relating to this policy may use the procedures in PS 1330.18, **Administrative Remedy Program**.

8. SEVERABILITY, APPLICATION OF THIS POLICY AND NO PRIVATE RIGHT OF ACTION

If any provision of this policy, or the application of any provision of this policy to any individual or circumstance, is held to be invalid, the remainder of this policy and the application of its provisions to any other individuals or circumstances shall not be affected. The intent of this policy is for federal funds to not be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex to the maximum extent permitted by law, including the Eighth Amendment to the U.S. Constitution.

Nothing in this policy shall prevent a prison official from providing care required by federal law, including the Eighth Amendment to the U.S. Constitution. The Bureau shall ensure that all inmates diagnosed with GD receive care in accordance with federal law, including the Eighth Amendment to the U.S. Constitution.

Nothing in this policy is intended, nor shall it be construed, to create a private cause of action.

REFERENCES

Program Statements

1330.18	Administrative Remedy Program (1/6/2014)
5310.17	Psychology Services Manual (8/25/2016)
5310.16	Treatment and Care of Inmates with Mental Illness (2/18/2025)
5324.08	Suicide Prevention Program (4/5/2007)
6031.04	Patient Care (3/14/2025)
6090.04	Health Information Management (3/2/2015)

Additional Resources for Clinicians

Diagnostic and Statistical Manual of Mental Disorders (DSM), most current version.

Performance-Based Standards and Expected Practices for Adult Correctional Institutions, 5th Edition: *5-ACI-1C-09, 5-ACI-1D-12, 5-ACI-1D-13, 5-ACI-2C-02, 5-ACI-1D-08, 5-ACI-3D-05, 5-ACI-3D-08(M), 5-ACI-3D-09, 5-ACI-3D-10, 5-ACI-3D-11, 5-ACI-3D-12, 5-ACI-3D-13, 5-ACI-3D-14, 5-ACI-3D-15, 5-ACI-3D-16, 5-ACI-6A-21(M), 5-ACI-6A-32(M), 5-ACI-6C-14(M).*

Performance-Based Standards and Expected Practices for Adult Local Detention Facilities, 5th Edition: *5-ALDF-2A-27, 5-ALDF-2A-30, 5-ALDF-2A-32, 5-ALDF-6B-03, 5-ALDF-2C-03, 5-ALDF-4C-23M, 5-ALDF-4C-29M, 5-ALDF-4D-22, 5-ALDF-4D-23, 5-ALDF-4D-24, 5-ALDF-4D-25, 5-ALDF-4D-26, 5-ALDF-4D-27M, 5-ALDF-4D-28, 5-ALDF-4D-29, 5-ALDF-7B-08, 5-ALDF-7B-10, 5-ALDF-7B-11.*

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.

I, Dr. Elizabete Stahl, as Medical Director of the Federal Bureau of Prisons, certify under penalty of perjury that the enclosed documents are originals, or copies thereof, from the records of the U.S. Federal Bureau of Prisons. The enclosed index and documents constitute the administrative record to be filed in *Kingdom v. Trump, et al.*, U.S. District Court for the District of Columbia, Case No. 1:25-cv-00691 (D.D.C.)

The attached index is a true and accurate list of the contents of the administrative record for the development of the February 19, 2026, policy implemented by the Federal Bureau of Prisons to comply with the following:

(i) Section 4(c) of Executive Order 14168, "Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government" (the "Executive Order"), signed by President Trump on January 20, 2025, which directed the Federal Bureau of Prisons to revise its policies concerning medical care to be consistent with the Executive Order and ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.

Sincerely,

ELIZABETE STAHL Digitally signed by ELIZABETE STAHL
Date: 2026.03.12 15:22:41 -04'00'

Federal Bureau of Prisons

Dated: 03/12/2026

Index of Administrative Record
Kingdom v. Trump, et al.,
Civil Action No. 1:25-cv-00691-RCL
U.S. District Court for the District of Columbia

A. Compliance with Section 4(c) of Executive Order 14168

Date	Document Type	Description	Bates Number
		Administrative Record Summary	AR-000001-AR-000004
		Memorandum on Program Statement 5260.01, Management of Inmates with Gender Dysphoria (Feb. 19, 2026)	AR-000005-AR-000047
04/10/2024	Study	The Cass Review, Independent Review of Gender Identity Services for Children and Young People	AR-000048 - AR-000435
9/1/2009	Clinical Guideline	The Endocrine Society's Clinical Guidelines. Endocrine Treatment of Transsexual Persons.	AR-000436-AR-000468
8/27/2012	Standards of Care	World Professional Association for Transgender Health: Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People.	AR-000469-AR-000588
3/17/2025	Exhibit	Declaration of Dr. Cathy Thompson	AR-000589-AR-000683
6/17/2017	Clinical Guidelines	University of California, San Francisco Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.	AR-000684-AR-000882
8/24/2017	Clinical Guidelines	Endocrine Society Clinical Practice Guideline: Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons.	AR-000883-AR-000917
12/1/2016	Clinical Guidance	Federal Bureau of Prisons Medical Management of Transgender Inmates. Clinical Guidance	AR-000918-AR-000957

Date	Document Type	Description	Bates Number
5/17/2024	Journal Article	World Professional Association for Transgender Health, WPATH and USPATH Comment on the Cass Review.	AR-000958-AR-000960
06//27/2024	Journal Article	The Economist: Research into trans medicine has been manipulated. https://www.economist.com/united-states/2024/06/27/research-into-trans-medicine-has-been-manipulated	AR-000961 AR-000964
11/12/2025	Medical Resource	Coalition of Correctional Healthcare Authorities (CCHA), Correctional Health Policy Priorities.	AR-000965
6/11/2024	Journal Article	Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery.	AR-000966 AR-000974
11/28/2024	Journal Article	Defining a danger zone for iatrogenic long thoracic nerve injury in gender-affirming mastectomy.	AR-000975-AR-000986
2/4/2025	Study	Examining gender-specific mental health risks after gender-affirming surgery: a national database study.	AR-000987-AR-000993
9/10/2021	Study	Thematic Analysis of Lived Experience in Patients With Adult Acquired Buried Penis.	AR-000994 AR-000995
9/6/2023	Study	Gender-affirming treatment and mental health diagnoses in Danish transgender persons: a nationwide register-based cohort study.	AR-000996-AR-001006
11/13/2017	Study	Cohort profile: Study of Transition, Outcomes and Gender (STRONG) to assess health status of transgender people.	AR-001007-AR-001019
11/19/2025	Study	Treatment for pediatric gender dysphoria: Review of evidence and best practices. U.S. Department of Health and Human Services.	AR-001020-AR-001429
4/1/2017	Study	Varied reports of adult transgender suicidality: Synthesizing and describing the peer-reviewed and gray literature.	AR-001430-AR-001445

Date	Document Type	Description	Bates Number
6/1/2023	Journal Article	Gender-affirming care, incarceration, and the Eighth Amendment.	AR-001446-AR-001452
5/1/2025	New Article	AAP speaks out against HHS report on gender dysphoria, medical organizations' statements	AR-001453-AR-001454
9/1/2025	Medical Manual	Diagnostic and statistical manual of mental disorders (5-TR).	AR-001455-AR-001464
12/1/2015	Clinical Guidelines	Guidelines for psychological practice with transgender and gender nonconforming people.	AR-001465-AR-001497
1/1/2017	Code of Conduct	Ethical principles of psychologists and code of conduct	AR-001498-AR-001539
2/1/2024	Policy Statement	APA policy statement on affirming evidence-based inclusive care for transgender, gender-diverse, and nonbinary individuals, addressing misinformation, and the role of psychological practice and science.	AR-001540-AR-001543
9/23/2022	Journal Article	Gender dysphoria and its non-surgical and surgical treatments.	AR-001544-AR-001551
4/1/2021	Study	Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review.	AR-001552-AR-001567
11/6/2023	Study	Gender differences in risks of suicide and suicidal behaviors in the USA: A Narrative Review.	AR-001568-AR-001586
9/15/2022	Standard of Care	Standards of care for the health of transgender and gender diverse people, version 8.	AR-001587-AR-001844
11/26/2014	BOP Policy	Transgender Clinical Care Consultant Team	AR-001845-AR-001846

Date	Document Type	Description	Bates Number
11/01/2014	BOP Policy	BOP Transgender resource guide	AR-001847-AR-001856
12/1/2016	BOP Policy	BOP Medical Management of Transgender Inmates	AR-001857-AR-001896
5/3/2018	Journal Article	Suicidal ideation and suicide attempts in persons with gender dysphoria.	AR-001897-AR-001902
9/1/2021	Study	Fact Sheet: Suicide Risk and Prevention for Transgender People: Summary of Research Findings.	AR-001903-AR-001905
9/20/2019	Journal Article	Deficiencies in scientific evidence for medical management of gender dysphoria.	AR-001906-AR-001914
3/20/2023	Study	Suicide-related outcomes following gender-affirming treatment: A review.	AR-001915-AR-001930
5/2/2025	News Article	Researchers slam HHS report on gender-affirming care for youth.	AR-001931-AR-001936
8/19/2024	Study	Discontinuing hormonal gender reassignment: A nationwide register study.	AR-001937-AR-001945
8/5/2023	Journal Article	Prevalence of suicidal thoughts and attempts in the transgender population of the world: A systematic review and meta-analysis.	AR-001946-AR-001959
10/03/2002	Report	World report on violence and health. World Health Organization.	AR-001960-AR-002319
7/1/2022	Study	Health care experiences of patients discontinuing or reversing prior gender-affirming treatments.	AR-002320-AR-002330

Date	Document Type	Description	Bates Number
11/1/2022	Report	SB 132 the Transgender Respect, Agency, and Dignity Act implementation review report.	AR-002331-AR-002367
10/1/2022	Resource Guide	Resource guide to improve safety in carceral housing for transgender people.	AR-002368-AR-002501
9/1/2020	Report	OIG special report: The California Department of Corrections and Rehabilitation has taken thoughtful and important steps to address the difficult conditions of confinement for incarcerated transgender, nonbinary, and intersex individuals.	AR-002502-AR-002588
2/1/2024	Journal Article	The public health crisis state of transgender health care and policy.	AR-002589-AR-002591
8/18/2022	Journal Article	Continuation of gender-affirming hormones among transgender adolescents and adults.	AR-002592-AR-002598
9/19/2025	Declaration	Declaration of Kristopher E. Kaliebe, M.D.	AR-002599-AR-002673
6/4/2024	Journal Article	The present state of housing and treatment of transgender incarcerated persons.	AR-002674-AR-002683
3/12/2020	Journal Article	Trends in suicide death risk in transgender people: Results from the Amsterdam Cohort of Gender Dysphoria study	AR-002684-AR-002689
11/19/2025	Study	HHS Releases Peer-Reviewed Report Discrediting Pediatric Sex-Rejecting Procedures	AR-002690-AR-002693
7/16/2016	Journal Article	A case report of first-onset psychosis in transgendered female, Gynecological Endocrinology	AR-002694-AR-002697

Date	Document Type	Description	Bates Number
5/1/2010	Journal Article	Tapering vs. Cold Turkey: Symptoms vs. Successful Discontinuation of Menopausal Hormone Therapy.	AR-002698-AR-0026700
8/1/2018	Journal Article	The Perioperative Care of the Transgender Patient	AR-002701-AR-002718
8/4/2016	Journal Article	The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review	AR-002719-AR-002732
5/1/2021	News Article	Reducing Transgender Surgery Side Effects, Endocrine Society	AR-002733-AR-002736
7/26/2005	Journal Article	Patient-Reported Complications and Functional Outcomes of Male-to-Female Sex Reassignment Surgery	AR-002737-AR-002748
10/7/2015	Journal Article	Treatment of Symptoms of the Menopause: An Endocrine Society Clinical Practice Guideline, The Journal of Clinical Endocrinology & Metabolism	AR-002749-AR-002785
1/17/2023	Journal Article	Timing of testosterone discontinuation and assisted reproductive technology outcomes in transgender patients: a cohort study	AR-002786-AR-002791
10/30/2024	Journal Article	Dispute arises over World Professional Association for Transgender health's involvement in WHO's trans health guideline	AR-002792-AR-002795
3/7/2002	Journal Article	Hierarchy of evidence: a framework for ranking evidence evaluating healthcare interventions.	AR-002796-AR-002803
1/1/2015	Journal Article	Gender Dysphoria: Definition and Evolution Through the Years.	AR-002804-AR-002816
9/15/2023	News Article	Randomized controlled trials are the 'gold standard' of research—but a difficult fit for trans care	AR-002817-AR-002821

Date	Document Type	Description	Bates Number
12/13/2024	News Article	Several countries have restricted the use of puberty blockers, citing insufficient evidence on their benefits for gender-questioning youth and potential long-term effects.	AR-002822-AR-002828
8/29/2016	Journal Article	Cross-sex hormone therapy in transgender persons affects total body weight, body fat and lean body mass: a meta-analysis.	AR-002829-AR-002839
6/1/2003	Journal Article	Weighing risks and benefits in treating the individual patient. Clinics in Perinatology	AR-002840-AR-002851
3/19/2021	Journal Article	Standardization vs customization: finding the right balance. Annals of Family Medicine	AR-002852-AR-002858
3/15/2020	Medical Study	Effects of gender-affirming hormone therapy on insulin resistance and body composition in transgender individuals: A systematic review.	AR-002859-AR-002871
1/9/2024	Medical Study	Hormone therapy and cancer risks in transgender people: a systematic review.	AR-002872-AR-002884
2/8/2023	Journal Article	The effect of gender-affirming hormones on gender dysphoria, quality of life, and psychological functioning in transgender individuals:	AR-002885-AR-002900
2/1/2024	Medical Study	Cardiovascular disease in transgender people: a systematic review and meta-analysis.	AR-002901-AR-002912
1/13/2016	Medical Study	A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals.	AR-002913-AR-2923
2/1/2011	Article	Self-directed violence surveillance: Uniform definitions and recommended data elements, version 1.0.	AR-002924-AR-003019
4/1/2018	Article	Correctional Policy and Attempted Suicide Among Transgender Individuals	AR-003020-AR-003031

Date	Document Type	Description	Bates Number
2/22/2011	Article	Long-term Follow-up of Persons Undergoing Sex Reassignment Surgery	AR-003032-AR-003039
5/1/2015	Care Guide	California Correctional Health Services Care Guide Gender Dysphoria	AR-003040 AR-003051
10/1/2025	Care Guide	California Correctional Health Care Services Care Guide on Transgender	AR-003052-AR-003091
1/31/2023	Policy	Minnesota Department of Corrections Management and Placement of Incarcerated People Who Are Transgender, Gender Diverse, Intersex, or Nonbinary	AR-003092-AR-003100
5/20/2020	Policy	Kentucky Corrections Policies and Procedures: Lesbian, Gay, Bisexual, Transgender, and Intersex	AR-003101-AR-003110
12/21/2022	Policy	Oklahoma Department of Corrections Determination and Management of Inmates with Gender Dysphoria	AR-003111-AR-003117
09/30/2024	Policy	Florida Department of Corrections Office of Health Services. Bulletin 15.05.23. Mental Health Treatment for Gender Dysphoria	AR-003118-AR-003125
2/18/2025	Policy	BOP Policy: Sexually Abusive Behavior Prevention	AR-003126-AR-003190
6/1/2023	Policy	California Correctional Health Care Services Referral for Consideration of Gender Affirming Surgery	AR-003191-AR-003193
3/17/2025	Exhibit	Declaration of Dr. Dan H. Karasic	AR-003194-AR-003244
4/4/2025	Exhibit	Second Declaration of Dr. Dan H. Karasic	AR-003245-AR-003251

ADMINISTRATIVE RECORD

The goal of the Bureau of Prisons (BOP) is to deliver medically necessary health care to inmates effectively in accordance with proven standards of care without compromising public safety concerns inherent to BOP's overall mission. *See* Program Statement 6010.05.

BOP's clinical guidance is aimed to reflect the evolving nature of treatment, based on what is considered the "community standard," while translating it to a carceral environment. No single source is used in writing clinical guidance. Robust clinical guidance is ideally built on high-quality research, such as randomized controlled trials, systematic reviews, and well-designed observational studies. But not every diagnostic tool, condition, or treatment plan is well understood. Medical providers are therefore reliant on expert opinions, peer reviewed sources, and medical societies or organizations. As this administrative record will show, treatment of gender dysphoria is an evolving science; involves a field of medicine that is continuously shaped by advances in psychology, ethics, and public health; and implicates sensitive safety, security, and prison-administration concerns.

BOP is tasked with providing essential medical, dental, and mental health (psychiatric) services in a manner consistent with accepted community standards that are supported by reliable evidence for a correctional environment. Providing medically necessary care, which is informed by the community standard of care as translated into the carceral setting, is an important tenet of correctional health care and must be viewed in light of the correctional environment's unique safety, security, and administration concerns. But within this context, challenges exist in defining appropriate clinical guidance for patients who are diagnosed with gender dysphoria in a carceral setting.

On January 20, 2025, President Trump issued Executive Order 14,168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8, 615 (Jan. 30, 2025). Section 4(c) of the Executive Order provided, "The Attorney General shall ensure that the Bureau of Prisons (BOP) revises its policies concerning medical care to be consistent with this order and shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex." "This Order shall be implemented consistent with applicable law[.]" *Id.* § 8(b).

In evaluating its medical policies, BOP considered the relevant issues, factors, information, and sources, including conducting extensive reviews of existing research, medical expert opinions, medical journals, national media reports, recent medical studies, state correctional policies, BOP's prior policies, and pertinent case law.

As a result of this research and as further explained in the accompanying memorandum to the Administrative Record, BOP has revised its policy to reflect treatment for gender dysphoria that is more aligned with the latest scientific information and consistent with BOP's longstanding policy of providing medical care that is tailored to the unique needs of the inmate. *See* Program Statement 5260.01, *Management of Inmates with Gender Dysphoria*, Federal Bureau of Prisons (Feb. 19, 2026). For example, BOP's reviews found, based on the best reliance evidence, that

providing hormones to inmates diagnosed with gender dysphoria is generally not medically necessary to address gender dysphoria. The reliable evidence base for the care of gender dysphoria with hormone interventions is limited. Existing studies are small in sample size, short in duration, observational rather than randomized, and focused on narrowly defined populations. For all these reasons, it is not possible to draw evidence-based conclusions about long-term outcomes of hormone use in persons diagnosed with gender dysphoria while there is well documented side effects and downsides flowing from hormone use. Providing hormone interventions in a carceral setting is further complicated because of heightened security risks and other prison-administration concerns. It is therefore appropriate to focus treatment for gender dysphoria in a carceral setting on non-hormone modalities that generally are available to those in the custody of the BOP, such as psychotherapy. Further, the tapering of hormones for inmates currently receiving hormone therapy is feasible if performed through the appropriate process and closely monitored by health and mental health providers, as required by Program Statement 5260.01.

Providing inmates with hormones to address gender dysphoria creates safety, security, and prison-administration concerns for both the inmate receiving hormones and for correctional staff. For example, the physical changes that may occur as a result of cross-sex hormones, such as the growth of breasts and the feminization of their faces and voices, increases the risk of victimization by other inmates. BOP incarcerates sexual predators and other violent individuals who have a tendency to prey upon inmates who appear feminine, including due to hormones or social accommodations, requiring BOP staff to devote more attention and time to keeping these inmates safe. For instance, BOP staff spend a significant amount of time ensuring these inmates have appropriate cellmates and often use additional resources managing these inmates in protective custody. Staff members' personal safety is also at an increased risk when they must intervene to stop fights between inmates or predatory behavior.

Similarly, providing or allowing access to social accommodations to some inmates and not to others causes animosity between inmates, which creates additional safety, security, and prison-administration concerns. Inmates who do not receive social accommodations may feel resentful for not being able to receive additional items from the commissary. Historically, providing certain items to one group of inmates and not another creates conflict within BOP facilities. Further, allowing inmates to use social accommodations, such as wearing makeup and feminine undergarments, increases the risk that those inmates will be targeted. Allowing inmates to have these social accommodations also requires BOP staff to spend more time and resources ensuring the safety of these inmates. Finally, providing social accommodations increases the risk of inmates concealing contraband and escaping from facilities and can hinder investigation of intra-prison incidents.

Finally, inmates have also threatened self-harm and suicide to obtain sex trait modification interventions, such as hormones and social accommodations. The availability of cross-sex hormones and social accommodations can create improper incentives for inmates to harm themselves.

Providing sex trait modification surgeries also jeopardizes the safety, security, and administration of BOP facilities because inmates receiving these surgeries are at higher risk of harassment due to their appearance. This increased risk results in BOP expending additional time and resources to

ensure the protection of these inmates. Transferring such inmates to opposite-sex facilities is not an acceptable way to mitigate these safety, security, and prison-administration concerns as it would then create security, safety, and privacy issues for the inmates of the opposite sex. For example, the presence of a male in close quarters with female inmates may harm the emotional and physical well-being of some female inmates, particularly those who have suffered from sexual abuse.

Based on a review of the practice of housing males in female facilities, BOP has decided to discontinue this practice. The previous practice potentially increases the risk of violence and sexual assault for women housed in the female facilities. Housing female inmates with men also compromises the female inmates' privacy. This is especially true when women are forced to sleep and shower in spaces with men.

Research of State Policies

Florida
Florida Department of Corrections Office of Health Services, Bulletin No. 15.05.23 titled Mental Health Treatment of Inmates with Gender Dysphoria.

California
- California Correctional Health Care Services, Care Guide on Gender Dysphoria. (2015)
- California Correctional Health Care Services Referral for Consideration of Gender Affirming Surgery. (2023)
- California Correctional Health Care Services, Care Guide on Transgender (2025)

Kentucky
Kentucky Corrections Policies and Procedures on Lesbian, Gay, Bisexual, Transgender and Intersex Offenders.

Oklahoma
Oklahoma Department of Corrections Policies on Determination and Management of Inmates with Gender Dysphoria.

Minnesota
Department of Corrections Management and Placement of Incarcerated People Who are Transgender, Gender Diverse, Intersex, or Nonbinary

Review of Case Studies

As further explained in the accompanying memorandum to the Administrative Record, the study of gender dysphoria in the carceral community is relatively new, which hampers the ability to reference a community standard of care. Compared with other illnesses or conditions, Gender dysphoria has had a newer, more rapidly evolving clinical landscape (Fraser, L., 2015). A recent and swift evolution of community clinical guidance makes it more difficult to determine where the standard of care currently lies. For example, the World Professional Association for Transgender Health's (WPATH) initial guidance recommended as recently as 1990 a treatment model for gender dysphoria with strict eligibility requirements for diagnosis, evaluations from separate mental

health providers, and required psychotherapy. This stands in contrast with later versions of the WPATH guidance, which reduced or eliminated these requirements (Fraser, L., 2015 & Coleman, E., et al., 2022).

Moreover, recent investigations have called into question WPATH's current recommendations, making determining the community standard even more challenging (Block, J., 2024). Other nations such as Sweden, Denmark, France, and the United Kingdom have distanced themselves from the stance of U.S. organizations such as WPATH, particularly related to care of minors and young adults, due to concerns about the body of research and potential research bias, among other things (Galvin, G., 2024). The recent divergence in global recommendations on proper care for this population leads to challenges in determining a set community standard, especially in the carceral setting. Other leading community organizations are similarly reevaluating their clinical guidance for patients diagnosed with gender dysphoria, in light of recent information. For example, the University of California at San Francisco, long known for its clinical guidance in this area, is currently undergoing a revision of its recommendations for this population (UCSF, n.d.).

A 2020 systematic review of available studies "found insufficient evidence to determine the efficacy or safety of hormonal treatment approaches for transgender women in transition"—it concluded that "[t]he evidence is very incomplete, demonstrating a gap between current clinical practice and clinical research." Haupt et al., *Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women*, 11 Cochrane Database of Systematic Reviews, Art. No. CD013138, at 2, 11 (2020). Another systematic review of studies concluded that it was "impossible to draw conclusions about the effects of hormone therapy on death by suicide" because of the "low" "strength of evidence." Kellan E. Baker, et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5 J. Endocrine Soc. 1, 12-13 (2021).

BOP reviewed recent studies that indicated that there are significant risks accompanying hormone interventions used to address gender dysphoria. For example, evidence showed that males who are treated with estrogen have twenty-two times the likelihood to develop breast cancer. *See* Rakesh R. Gurrala et al., *The Impact of Exogenous Testosterone on Breast Cancer Risk in Transmasculine Individuals*, 90(1) Annals of Plastic Surgery 96 (2023).

BOP also concluded that hormone-based interventions for gender dysphoria are fraught with serious risks. There are non-surgical, non-hormone related interventions that have been shown to address gender dysphoria effectively—specifically, "[s]ocial support and psychotherapy are widely recognized approaches." *K.C. v. Individual Members of the Med. Licensing Bd. of Ind.*, 121 F.4th 604, 610-11 (7th Cir. 2024) (citing Danyon Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical Treatments*, 10 Health Psych. Rsch., 4 (2022)).

For additional details and cites, please see attached memorandum.

Memorandum on Program Statement 5260.01, Management of Inmates with Gender Dysphoria (Feb. 19, 2026)

I. Introduction

On January 20, 2025, the President issued Executive Order 14,168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8,615 (Jan. 30, 2025), which prohibited the Bureau of Prisons (BOP) from expending federal funds for "any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex" "to the extent consistent with applicable law." *Id.* at 8,617-18. In light of Executive Order 14,168 and BOP's own independent judgment, BOP has reevaluated its policies regarding inmates and gender dysphoria.

BOP's general policy is to "deliver medically necessary health care to inmates effectively in accordance with proven standards of care without compromising public safety concerns inherent to the Bureau's overall mission." BOP Program Statement (PS) 6010.05 §1, Health Services Administration. Though BOP considers community standards of care, BOP must consider such standards in light of the unique nature of the carceral environment. In evaluating its policies on gender dysphoria, BOP considered the relevant issues, factors, information, and sources, including conducting extensive reviews of existing research, medical expert opinions, medical journals, national media reports, recent medical studies, state correctional policies, BOP's prior policies, and pertinent case law.

For example, BOP has considered the standards of care issued by the World Professional Association for Transgender Health (WPATH) and other organizations, such as the Endocrine Society. BOP has determined that WPATH's standards of care and other guidelines issued by similar organizations are not reliable or at a minimum, show that medical interventions to address gender dysphoria are highly controversial, medically disputed, and insufficiently proven by appropriate evidence. In addition, the recent debate regarding WPATH's standards and other organizations' guidelines support reevaluation of policies regarding gender dysphoria, particularly in the correctional context.

WPATH has recently been characterized as not "political neutral," *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019), and as an "advocacy organization," whose "lodestar is ideology, not science," *Eknes-Tucker v. Governor of Alabama*, 114 F.4th 1241, 1261 (11th Cir. 2024) (Lagoa, J., concurring); *see, e.g.*, *United States v. Skrmetti*, 605 U.S. 495, 543 (2025) (Thomas, J., concurring) ("Recent revelations suggest that WPATH, long considered a standard bearer in treating pediatric gender dysphoria, bases its guidance on insufficient evidence and allows politics to influence its medical conclusions." (citation omitted)); *Edmo v. Corizon, Inc.*, 949 F.3d 489, 497 (9th Cir. 2020) (O'Scannlain, J., opinion respecting the denial of reh'g en banc) ("The WPATH Standards are merely criteria promulgated by a controversial private organization with a declared point of view."); Expert Report of Kristopher E. Kaliebe, M.D., ¶63 (Sept. 19, 2025) (hereinafter "Kaliebe Decl.") ("WPATH's internal documents clearly show that WPATH is an advocacy organization and not a scientific one."); *Nondiscrimination in Health & Health Education Programs or Activities*, 85 Fed. Reg. 37,160, 37,186-98 (June 19, 2020) (calling WPATH "an advocacy group" and explaining that the U.S. Department of Health and Human

Services did not consider WPATH's guidelines to be based on "independent scientific fact-finding"); *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*, U.S. Dep't Health and Human Services, 170 (Nov. 19, 2025) ("This combination of poorly managed COIs [conflicts of interests] and restrictive membership practices significantly undermines the credibility and scientific integrity of SOC-8 as a clinical practice guideline. The GDG's [guideline development group's] handling of … evidence WPATH commissioned for development of SOC-8 further highlights the serious threat to clinical integrity that plagued the guideline development process."); Executive Order 14,187, *Protecting Children from Chemical and Surgical Mutilation*, 90 Fed. Reg. 8,771, 8,771 (Feb. 3, 2025) (finding that WPATH "lacks scientific integrity"). And WPATH's standards have been described as being based on "self-referencing consensus rather than evidence-based research" and "built … on concededly weak evidence." *See, e.g.*, *Skrmetti*, 605 U.S. at 544 (Thomas, J., concurring) ("WPATH appears to rest [its conclusions] on self-referencing consensus rather than evidence-based research."); *id.* at 547 (WPATH and other "prominent medical professionals … have built their medical determinations on concededly weak evidence" and "have surreptitiously compromised their medical recommendations to achieve political ends."); *K.C. v. Individual Members of Med. Licensing Bd. of Indiana*, 121 F.4th 604, 611 (7th Cir. 2024) ("Some have expressed doubt about whether WPATH's guidelines actually reflect medical consensus as to treatments for gender dysphoria."); Kaliebe Decl. ¶¶60-82.

An expert has persuasively opined that "WPATH has violated many principles underpinning medical ethics and research and contributed to widespread publication bias in gender medicine," Kaliebe Decl. ¶63, and that "WPATH openly engages in ideologically-based political advocacy, systematically misrepresents evidence, and often bases its recommendations, no matter how impactful for the patient, on low-quality supporting evidence," Kaliebe Decl. ¶60. Countries that once looked to WPATH and other organizations in the United States have begun to backtrack and distance themselves from WPATH and these other organizations. *See, e.g.*, Gabriela Galvin, *The UK is the latest country to ban puberty blockers for trans kids. Why is Europe restricting them?*, Euro News (Dec. 13, 2024); *Skrmetti*, 605 U.S. at 537-38 (Thomas, J., concurring). Other organizations are similarly reevaluating their clinical guidance for patients suffering from gender dysphoria, in light of recent debate. For example, the University of California at San Francisco, known for its clinical guidance in this area, is currently undergoing a revision of its recommendations for this population. *See Gender Affirming Health Program*, University of California San Francisco, https://transcare.ucsf.edu/guidelines.

WPATH's standards are particularly unreliable when it comes to prisoners. *See, e.g.*, Kaliebe Decl. ¶60. WPATH recommended that sex-trait-modification interventions, including surgery, hormones, and social accommodations, should be provided to inmates in correctional facilities before a meaningful number of inmates had such interventions. *See, e.g.*, *Edmo*, 949 F.3d at 497-98 (O'Scannlain, J., opinion respecting the denial of reh'g en banc). In fact, when WPATH published the current version of the standards, a small number of inmates in the United States had ever received sex-trait-modification interventions, there were no reliable studies on such interventions in the correctional context, and WPATH failed to adequately consider or address the

special challenges of the inmate population. *See, e.g.*, *id.* (O'Scannlain, J., opinion respecting the denial of reh'g en banc); Kaliebe Decl. ¶79.

Guidelines from other organizations are similarly unpersuasive as WPATH's. The Endocrine Society, for example, has received similar criticism to WPATH. *See, e.g.*, *K.C.*, 121 F.4th at 611 ("But the most influential voices in this group have been two professional organizations—the Endocrine Society and the World Professional Association for Transgender Health…. But these organizations have not evaded criticism."); *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices*, U.S. Dep't Health and Human Services, 14 (Nov. 19, 2025). This is unsurprising given that WPATH and the Endocrine Society collaborated on their guidelines. *See* Kaliebe Decl. ¶74 ("the WPATH and Endocrine Society collaborated, meaning a very small, interconnected group of WPATH members led to the creation of multiple guidelines among multiple medical organizations"). And WPATH's guidelines have also influenced other organization guidelines, making those guidelines similarly unpersuasive. *See* Kaliebe Decl. ¶75 ("WPATH's unreliable and low-quality recommendations have infected other guidelines, causing a systematic distortion of clinical guidance.").

In sum, BOP does not find WPATH's or other organizations' similar standards or guidelines persuasive. *See* Kaliebe Decl. ¶60 ("WPATH and other affirmative guidelines regarding the care of people with Gender Dysphoria should neither be treated as authoritative nor be used to determine care for Gender Dysphoria."). If anything, recent discussions show that the appropriateness of sex-trait-modification interventions to address gender dysphoria is subject to "fierce scientific and policy debates about the[ir] safety, efficacy, and propriety," and filled with "sincere concerns" with "profound" implications, *Skrmetti*, 605 U.S. at 525; *see, e.g.*, *Gibson*, 920 F.3d at 221 ("the WPATH Standards of Care [and the guidelines of other organizations] reflect not consensus, but merely one side in a sharply contested medical debate"); *Haverkamp v. Linthicum*, 152 F.4th 618, 625 n.7 (5th Cir. 2025) (same); *Clark v. Valletta*, 157 F.4th 201, 206 (2d Cir. 2025) ("how to treat that disorder [*i.e.*, gender dysphoria] is not settled in the scientific and medical community"); *id.* at 216 ("as the record reflects, medical experts disagree about how to treat gender dysphoria").

For at least these reasons and the others discussed in this memorandum, it was prudent for BOP to reevaluate its policies regarding gender dysphoria, as those policies unreasonably relied on these organizations, these organizations' guidelines, and other biased sources regarding interventions to address gender dysphoria. After considering the relevant issues and factors and weighing the relevant considerations, BOP has revised its policy to reflect treatment for gender dysphoria that is more aligned with the latest scientific information, that is consistent with BOP's longstanding policy of providing medical care that is tailored to the unique needs of the inmate, and that accounts for the complex security and administration concerns in the correctional environment. *See* Program Statement 5260.01, *Management of Inmates with Gender Dysphoria*, Federal Bureau of Prisons (Feb. 19, 2026).

As further explained below, BOP has adopted Program Statement 5260.01. That policy requires an individualized treatment plan for each inmate that is diagnosed with gender dysphoria.

The individualized treatment plan may include psychotherapy, group counseling, psychiatric services, and psychotropic medications.

BOP will not provide sex trait modification surgeries to address gender dysphoria, but BOP will provide care necessary to address any complications or resulting conditions from such surgeries, such as urethral stricture and pelvic infections.

BOP will not provide social accommodations to address gender dysphoria and when practicable, will remove or confiscate social accommodations.

If an inmate is diagnosed with gender dysphoria but is not currently receiving hormones to address gender dysphoria, BOP will not provide hormones to address the inmate's gender dysphoria. If an inmate is previously and currently diagnosed with gender dysphoria and is currently receiving hormones to address gender dysphoria, BOP will develop a tapering plan for each inmate after consideration of appropriate factors. For inmates that have recently begun receiving hormones to address gender dysphoria, the tapering plan will include a rapid discontinuation of the hormone intervention. For inmates that have been receiving hormones to address gender dysphoria for an extended period of time, the tapering plan will generally include an appropriately paced discontinuation of the hormone intervention. For inmates who (1) are post sex trait modification surgery or (2) have been receiving hormones to address gender dysphoria for an extended period of time and develop severe physiological and psychological withdrawal effects from tapering, it may not be appropriate in all cases for the initial tapering plan to include cessation of hormones.

Nothing in Program Statement 5260.01 prevents a prison official from providing care required by federal law, including the Eighth Amendment to the U.S. Constitution. And under Program Statement 5260.01 and other BOP policies, BOP will ensure that all inmates diagnosed with gender dysphoria receive care in accordance with federal law, including the Eighth Amendment to the U.S. Constitution.

II. Program Statement 5260.01, Management of Inmates with Gender Dysphoria (Feb. 19, 2026)

A. Sex Trait Modification Surgeries

After considering the relevant issues and factors and weighing the relevant considerations, BOP adopts a policy prohibiting sex trait modification surgeries to address gender dysphoria, but for inmates who have had sex trait modification surgery, medical care will be provided as necessary to address any complications or resulting conditions, such as urethral stricture and pelvic infections. Sex trait modification surgeries are not medically necessary to address gender dysphoria. Sex trait modification surgeries are highly controversial, medically disputed, and unproven by appropriate evidence; or at the very least, there is reasonable debate about the efficacy of sex trait modification surgeries to address gender dysphoria. To the extent there is uncertainty about the efficacy of sex trait modification surgeries to address gender dysphoria, that uncertainty counsels against providing such controversial interventions when there are other more established treatments, such as psychotherapy, available. Even assuming sex trait modification surgeries are

medically necessary or appropriate to address gender dysphoria, BOP concludes that sex trait modification surgeries in the secure prison environment raise numerous security and prison-administration concerns, and each concern, whether considered separately, cumulatively, or in any combination, outweighs any costs from Program Statement 5260.01, any reliance interests, and any benefits from providing sex trait modification surgeries. In BOP's judgment, and after considering the relevant issues and factors and weighing the relevant considerations, prohibiting sex trait modification surgeries is reasonable and appropriate to provide adequate care to inmates diagnosed with gender dysphoria; is reasonable and appropriate to maintain internal order, discipline, and institutional security of the correctional environment; and outweighs any asserted benefit, costs, or interests from allowing sex trait modification surgeries.

1. Sex trait modification surgeries are not medically necessary to address gender dysphoria.

BOP's general policy is to "deliver medically necessary health care to inmates effectively in accordance with proven standards of care without compromising public safety concerns inherent to the Bureau's overall mission." PS 6010.05 §1, Health Services Administration. BOP also provides inmates with gender dysphoria care to address the condition, including individualized treatment plans that may include psychotherapy, group counseling, psychiatric services, and psychotropic medications.

After considering the relevant issues and factors and weighing the relevant considerations, BOP concludes that sex trait modification surgeries are not medically necessary to address gender dysphoria, especially in the correctional context. Sex trait modification surgeries are highly controversial, medically disputed, and unproven by appropriate evidence. Medical professionals, at the very least, reasonably disagree on the efficacy of sex trait modification surgeries to address gender dysphoria, particularly in the correctional context. Sex trait modification surgeries are not "medically necessary" or "in accordance with proven standards of care." PS 6010.05 §1, Health Services Administration. It is reasonable for BOP to not provide medically disputed or insufficiently proven interventions to inmates, especially when those interventions may result in irreversible effects or harms.

Medical professionals have persuasively explained that sex trait modification surgeries are not medically necessary. *See, e.g.*, Kaliebe Decl. ¶21 ("Cross-sex surgeries are not medically necessary and should not be made available in correctional environments."); *id.* ¶155 (same); *id.* ¶118 ("Cross-sex surgeries have not been shown to be medically necessary."). At the very least, sex trait modification surgeries are highly controversial and subject to reasonable medical disagreement. *See, e.g.*, *Gibson*, 920 F.3d at 216 ("For it is indisputable that the necessity and efficacy of sex reassignment surgery is a matter of significant disagreement within the medical community."); *id.* at 221 ("sex reassignment surgery is medically controversial"); *id.* at 226 ("sex reassignment surgery remains an issue of deep division among medical experts"); *id.* ("the undisputed medical controversy over sex reassignment surgery"); *Haverkamp*, 152 F.4th at 625 ("there remains 'significant disagreement within the medical community' about whether sex-reassignment surgery is an 'effective treatment for gender dysphoria'"); *Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014) (en banc). There is little (if any) reliable evidence showing that sex trait

modification surgeries treat gender dysphoria. *See, e.g.*, Kaliebe Decl. ¶¶118-30. In any event, there is no reliable evidence showing that sex trait modification surgeries treat gender dysphoria in the correctional environment. *See, e.g.*, Kaliebe Decl. ¶118 ("These surgeries have substantial risks, and there is little, if any, reliable data supporting that such surgeries cause meaningful long-term benefits in improving mental health or reducing suicide risks. This is particularly true in prison settings. Indeed, there are no controlled studies, high-quality evidence, or reliable evidence on sex-trait modification, such as through cross-sex surgery, of inmates with Gender Dysphoria in the carceral setting."). Sex trait modification surgery can prolong symptoms of gender dysphoria, undermine other treatments to address gender dysphoria, worsen symptoms of gender dysphoria, and cause other physical and psychological harms. *See, e.g.*, Kaliebe Decl. ¶¶118-30; *id.* ¶129 ("Cross-sex surgeries can have serious complications, some of which are lifelong…."); *id.* ¶130 ("As such, with the known harms to healthy tissue, potential increased risk of psychiatric decompensation, technical issues such as wound care, potential surgical complications, potential life-long health complications, and unclear mental health benefits, cross-sex surgeries within the correctional environment are not medical necessary."). To the extent that sex trait modification surgeries might have short-term benefits to addressing gender dysphoria in the correctional context, they are outweighed by the potential long-term harm. *See, e.g.*, Kaliebe Decl. ¶¶118-30. In any event, BOP determines that it is reasonable to not provide sex trait modification surgeries given the uncertainty in long-term benefit and its potential irreversibility.

Even if there is some reliable evidence that sex trait modification surgeries address gender dysphoria when the individual is in society at large, the evidence does not sufficiently support that sex trait modification surgeries address gender dysphoria in the correctional environment. What a person may want or need to address gender dysphoria outside prison says little (if anything) about what that person should have access to in a secure prison environment. *See, e.g.*, Kaliebe Decl. ¶142 ("The concept of social transitioning through social accommodations, hormones, or surgery is out of place in the correctional context because an inmate does not live in society at large but a secure prison environment."); *id.* ¶118. That is especially true given that inmates often present unique backgrounds not readily present in individuals in society at large. *See, e.g.*, Kaliebe Decl. ¶¶127, 141-43.

Again, BOP provides inmates with gender dysphoria with individualized treatment plans with well-established treatment methods for gender dysphoria, such as psychotherapy, group counseling, psychiatric services, and psychotropic medications. Sex trait modification surgeries are not medically necessary or at a minimum, there is reasonable disagreement as to their efficacy, such that it is reasonable for BOP to not provide the intervention. In BOP's judgment, it is reasonable and appropriate to provide these individual treatment plans without the prospect of providing or allowing access to sex trait modification surgeries to address gender dysphoria.

2. Security and prison-administration concerns support Program Statement 5260.01's prohibition on sex trait modification surgeries.

BOP's general policy is to "deliver medically necessary health care to inmates effectively in accordance with proven standards of care *without compromising public safety concerns inherent to the Bureau's overall mission*." PS 6010.05 §1, Health Services Administration (emphasis

added). BOP is responsible for "the safekeeping, care, and subsistence of all persons charged with or convicted of offenses against the United States." 18 U.S.C. §4042(a). Providing sex trait modification surgeries to inmates, including to address gender dysphoria, raises serious security and prison-administration concerns. These security and prison-administration concerns independently support BOP's adoption of a prohibition on providing inmates sex trait modification surgeries to address gender dysphoria. The security and prison-administration concerns, when considered separately, cumulatively, or in any combination, outweigh the benefits (medical or otherwise) from providing sex trait modification surgeries. Thus, even if sex trait modification surgeries address gender dysphoria, BOP, after considering the relevant issues and factors and weighing the relevant considerations, determines that it is reasonable and appropriate to not provide or allow access to sex trait modification surgeries to address gender dysphoria.

Sex trait modification surgeries jeopardize the security, safety, and prison administration of correctional facilities in at least three ways. First, the inmate receiving sex trait modification surgery will experience increased risk of the inmate becoming a target for attacks, which increases harm to the targeted inmate and the prison officials tasked with protecting the inmate. Second, special treatments, such as providing or allowing access to sex trait modification surgeries to address gender dysphoria, raise fairness concerns and can breed resentment among other inmates, which can lead to violence. Third, granting sex trait modification surgeries conflicts with a reasonable practice of refusing to reward threats of self-harm and may even increase self-harm. Each of BOP's security and prison-administration concerns, whether considered cumulatively, separately, or in any combination, outweighs any asserted benefits from providing or allowing access to sex trait modification surgeries to address gender dysphoria.

First, prohibiting sex trait modification surgeries reduces the chance of an inmate being targeted by other inmates. "Recognizing that reasonable concerns would arise regarding a post-operative, male-to-female transsexual being housed with male prisoners takes no great stretch of the imagination." *Kosilek*, 774 F.3d at 93. The inmate would inevitably become a target for abuse in the male facility. *Cf., e.g.*, *Keohane v. Fla. Dep't of Corr. Sec'y*, 952 F.3d 1257, 1275 (11th Cir. 2020) (noting the "obvious[]" consequence of permitting a male inmate to dress and be groomed as a female "would inevitably become a target for abuse in an all-male prison"). And based on BOP's experience and expertise, these same concerns also apply to women's correctional facilities, which also experience meaningful amounts of harassment and violence. *See, e.g.*, Emily Buehler, *Substantiated Incidents of Sexual Victimization Reported by Adult Correctional Authorities*, 2016-2018, U.S. Dep't of Justice, 18 (2023) (noting that 31% of the recorded incidents of inmate-on-inmate sexual harassment occurred in female correctional facilities).

Sex trait modification surgeries not only put the inmate at additional risk of assault or harassment but also endanger "the prison employees who would have to step in to protect" the inmate and will require expending already limited resources to address these risks. *Keohane*, 952 F.3d at 1263. Preventing such attacks would require prison officials to be more vigilant in protecting the inmates from assault or harassment, despite BOP's limited resources.

It is insufficient to point to transfer to mitigate these security and prison-administration complications from sex trait modification surgeries. For example, a transfer of a post-operative

male to a female facility will increase the risk of harm of female inmates. *See* Kaliebe Decl. ¶139 ("[H]ighly relevant is the fact that the presence of a biological male in close quarters in a female prison could significantly harm the emotional and physical well-being of certain female prisoners, such as female victims of sexual abuse. This concern is particularly acute since female prisoners suffer from extremely high rates of sexual trauma. Placing these vulnerable female inmates with biological males could have meaningful negative effects on female inmates."); *see also, e.g.*, *Cruel and Unusual Punishment: Stopping the Dangerous Policies Putting Men in Women's Prisons*, Independent Women's Forum (Dec. 20, 2024). And based on BOP's experience and expertise, similar concerns exist for transfer of a female inmate to a male facility, as the female inmate would be a target by other male prisoners and implicate the privacy interests of male inmates.

Second, based on BOP's experience and expertise, fairness concerns counsel against providing or allowing access to sex trait modification surgeries. When inmates receive special treatment within a correctional environment, other inmates may begin to resent those receiving special treatment, which can increase the risk of retaliation against the inmate receiving special treatment and cause ripple effects throughout the correctional institution and disrupting the delicate prison environment. Fairness concerns are particularly present if such special treatment is provided to one type of facilities (*e.g.*, female facilities) and not another (*e.g.*, male facilities).

Finally, BOP has considered the issue of self-harm and has determined that a policy prohibiting sex trait modification surgeries avoids rewarding threats of self-harm and may reduce overall self-harm. Inmates frequently use threats of self-harm and suicide to try to obtain concessions from prison officials. *See, e.g.*, Kaliebe Decl. ¶148 ("In my experience working in correctional facilities and treating adult and juvenile inmates, including those diagnosed with Gender Dysphoria, inmates frequently use threats of self-harm and suicide to try to obtain concessions from prison officials."); *Kosilek*, 774 F.3d at 94 ("Such threats are not uncommon in prison settings …."). But providing sex trait modification surgeries, especially in response to threats of self-harm or suicide, could increase self-harm. *See, e.g.*, Kaliebe Decl. ¶149 ("In corrections, rewarding self-injury or threats of self-injury tends to increase overall self-harm, both for the individual patient and also within the system."). Granting such requests may establish an "unacceptable precedent," forcing "prison authorities to comply with the prisoners' particular demands." *Kosilek*, 774 F.3d at 94. Consequently, it is reasonable for prison administrators to have rules against providing inmates benefits in response to self-harm or suicide to discourage threats. *See* Kaliebe Decl. ¶150 ("Simple and clear institutional policies, such as no social transitions or no initiation of new hormone treatments, are likely to lead to the lowest level of self-harm and the least overall harm to inmates because when prisoners know the interventions they desire are not available, they are less likely to self-harm to obtain them. In other words, it is reasonable for prison administrators to have outright prohibitions of providing inmates benefits, such as unproven surgeries, special-order items, and housing placements, in response to self-harm or suicide threats to discourage false threats."); *Kosilek*, 774 F.3d at 94 (noting that such threats must be "firm[ly] reject[ed] by the authorities, who must be given ample discretion in the dealing with such situations"). BOP determines that a clear rule against sex trait modification surgeries is the most reasonable way to handle this complex issue. BOP takes threats of self-harm seriously and has protocols in place to handle these complex situations.

After considering the relevant issues and factors and weighing the relevant considerations, BOP determines that each of its security and prison-administration concerns, whether considered separately, cumulatively, or in any combination, outweighs any asserted benefits of providing sex trait modification surgeries. In addition, after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that the medical concerns discussed above when considered with any of its security or prison-administration concerns—separately, cumulatively, or in any combination—outweighs any asserted benefits of providing sex trait modification surgeries.

3. Other considerations do not outweigh the benefits from Program Statement 5260.01.

a. Reliance Interests and Costs

BOP has also considered potential reliance interests, but the potential reliance interests are either illegitimate or outweighed by the benefits of Program Statement 5260.01. Indeed, after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that each of its medical, security, and prison-administration concerns, whether considered separately, cumulatively, or in any combination, outweighs the asserted benefits, interests, or costs of providing or allowing access to sex trait modification surgeries.

As an initial matter, the policy prohibits future sex trait modification surgeries, and an inmate has no reasonable reliance interest in the future possibility of obtaining such surgeries. That is all the more true if sex trait modification surgeries are not medically necessary or in accordance with proven standards of care.

Even if an inmate has a currently scheduled sex trait modification surgery, the inmate still does not have legitimate reliance interests. Sex trait modification surgeries are not medically necessary or in accordance with proven standards of care. An inmate has no legitimate reliance interest in an unproven surgical intervention. Nor does an inmate have a legitimate reliance interest in a surgical intervention that is, at a minimum, subject to reasonable debate in the medical community.

In any event, even if the prospect of sex trait modification surgeries created legitimate reliance interests, the interests are not weighty. Providing sex trait modification surgeries has not been a longstanding, formal policy of BOP, and access to medical interventions has always been subject to security concerns. *See, e.g.*, PS 6010.05 §1, Health Services Administration; PS 5538.08, Escorted Trips. Further, the policy has always been subject to change, including based on security and prison-administration concerns. And the reliance interests are even smaller given, again, that sex trait modification surgeries are not medically necessary, unproven, or medically disputed.

Moreover, implementing Program Statement 5260.01 will incur, at most, *de minimis* costs and will likely lead to savings. Program Statement 5260.01 will mitigate security and prison-administration concerns, which will reduce costs. Program Statement 5260.01 will also reduce expenditures on medical interventions that are not medically necessary or are medically disputed and on medical procedures to address potential complications from sex trait modification surgeries.

Expenditures on care for inmates diagnosed with gender dysphoria are unlikely to meaningfully increase. In general, BOP officials would monitor an inmate diagnosed with gender dysphoria and provide the patient with an individualized treatment plan, which would generally have care in addition to the provision of surgery. To the extent that Program Statement 5260.01 would result in increased costs, it is outweighed by other considerations or the savings from the unavailability of sex trait modification surgeries.

In sum, after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that each of its medical, security, and prison-administration concerns, whether considered separately, cumulatively, or in any combination, significantly outweigh any costs, any reliance interests created by a former policy of providing or allowing access to sex trait modification surgeries, and any benefits from providing or allowing access to sex trait modification surgeries. In BOP's judgment and after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that prohibiting sex trait modification surgeries is reasonable and in the best interest of the agency, its officials, and those in its custody.

b. Alternatives

BOP has considered alternatives and has determined that Program Statement 5260.01 is more reasonable than and preferable to potential alternatives.

For example, BOP has considered the option of allowing sex trait modification surgeries only for inmates that have already undergone a different sex trait modification surgery. Although Program Statement 5260.01 permits procedures to address complications with past sex trait modification surgeries, BOP does not think it is prudent to allow further surgeries that do not address complications of past surgeries. Sex trait modification surgeries are not medically necessary, are unproven, or are medically controversial; can harm the inmate; and can have long-term irreversible effects. BOP does not find it prudent to provide additional potentially harmful interventions because the inmate has already had an intervention. Even if sex trait modification surgeries are medically beneficial to address gender dysphoria, further surgeries still raise the above security and prison-administration concerns, and each of these concerns outweighs the benefits of providing or allowing access to sex trait modification surgeries in this context. In BOP's judgment, Program Statement 5260.01's handling of sex trait modification surgeries is more reasonable than and preferable to this alternative approach.

BOP has considered the option of allowing sex trait modification surgeries only for inmates that have undergone hormones to address gender dysphoria. But sex trait modification surgeries are not medically necessary, are unproven, or are medically controversial; can harm the inmate; and can have long-term irreversible effects. BOP does not find it prudent to provide this medically disputed and potentially harmful intervention because the inmate is undergoing hormones, even if the inmate has received hormones for an extended period of time. Even if sex trait modification surgeries are medically beneficial to address gender dysphoria, such surgeries still raise the above security and prison-administration concerns, including those in addition to the security and prison-administration concerns that hormones may raise. The security and prison-administration concerns outweigh the benefits of providing sex trait modification surgeries in this circumstance. In BOP's

judgment, Program Statement 5260.01's handling of sex trait modification surgeries is more reasonable than and preferable to this alternative approach.

BOP has considered a policy that would allow sex trait modification surgeries based on an inmate's individual security profile. But the inmate's security profile does not change that sex trait modification surgeries are not medically necessary, unproven, or medically controversial; can harm the inmate; and can have long-term irreversible effects. BOP does not find it prudent to provide this medically disputed and potentially harmful intervention when the inmate's security profile may be low risk. Even if sex trait modification surgeries are medically beneficial to address gender dysphoria, surgeries still raise security and prison-administration concerns: An inmate with a low-risk security profile does not sufficiently mitigate that sex trait modification surgeries increase the risk that the inmate will become a target from attacks, which increases the risk of harm to the targeted inmate and prison officials tasked with protecting the inmate. Nor does it mitigate the fairness or self-harm concerns. In BOP's judgment, Program Statement 5260.01's handling of sex trait modification surgeries is more reasonable than and preferable to this alternative approach.

BOP has considered allowing sex trait modification surgeries based on the type of custody the inmate is in. But this alternative does not change that sex trait modification surgeries are not medically necessary or at the very least, controversial and disputed. Even if sex trait modification surgeries are medically beneficial to address gender dysphoria, the above prison-administration and safety concerns persist regardless of the type of custody the inmate is in. For example, providing sex trait modification surgeries to inmates in administrative segregations or protective custody does not negate all the above security and prison-administration concerns. And even if the inmate is in more limited custody now, such as administrative segregation, the inmate likely will not always be in such custody. In BOP's judgment, Program Statement 5260.01's handling of sex trait modification surgeries is more reasonable than and preferable this alternative approach.

BOP has also considered and rejected an alternative that allows inmates to pay for sex trait modification surgeries. Such an alternative does not sufficiently mitigate the medical, security, or prison-administration concerns of allowing sex trait modification surgeries. In BOP's judgment, Program Statement 5260.01's handling of sex trait modification surgeries is more reasonable than and preferable to this alternative approach.

Finally, BOP has considered other alternatives, including a combination of the above alternatives, but BOP has determined that Program Statement 5260.01's handling of sex trait modification surgeries is better than alternative approaches and is the most reasonable approach for addressing this issue.

* * *

In sum, BOP issues Program Statement 5260.01 independent of Executive Order 14,168 and after considering the relevant issues and factors and weighing the relevant considerations. Program Statement 5260.01's handling of sex trait modification surgeries is justified by the medical concerns of the intervention alone. Security and prison-administration concerns bolster that determination. Further, even assuming there are medical benefits to inmates from sex trait modification surgery, Program Statement 5260.01's handling of sex trait modification surgeries is justified by security and prison-administration concerns, as each of those concerns, whether

considered separately, cumulatively, or in any combination, outweigh any costs of Program Statement 5260.01, any reliance interests, and any benefits sex trait modification surgeries provide. BOP also concludes that Program Statement 5260.01's handling of sex trait modification surgeries is more reasonable than and preferable to potential alternatives. After considering the relevant issues and factors and weighing the relevant considerations, BOP determines that Program Statement 5260.01's handling of sex trait modification surgeries is reasonable and appropriate.

B. Social Accommodations

After considering the relevant issues and factors and weighing the relevant considerations, BOP adopts a policy prohibiting social accommodations, including to address gender dysphoria. Social accommodations are not medically necessary to address gender dysphoria. Social accommodations are highly controversial, medically disputed, and unproven by appropriate evidence; or at the very least, there is reasonable debate about the efficacy of social accommodations to address gender dysphoria. Even assuming social accommodations are medically necessary or beneficial to treat gender dysphoria, BOP concludes that social accommodations in the secure prison environment raise numerous security and prison-administration concerns that separately, cumulatively, or in a combination outweigh any medical benefits to an inmate. In BOP's judgment, and after considering the relevant issues and factors and weighing the relevant considerations, prohibiting access to social accommodations is reasonable and appropriate to provide adequate care to inmates diagnosed with gender dysphoria; to maintain internal order, discipline, and institutional security of the correctional environment; and outweighs any asserted benefit from allowing social accommodations.

1. Social accommodations are not medically necessary to address gender dysphoria.

BOP's general policy is to "deliver medically necessary health care to inmates effectively in accordance with proven standards of care without compromising public safety concerns inherent to the Bureau's overall mission." PS 6010.05 §1, Health Services Administration. BOP also provides inmates with gender dysphoria care to address the condition, including individualized treatment plans that may include psychotherapy, group counseling, psychiatric services, and psychotropic medications.

Based on BOP's review of the record and after considering the relevant issues and factors and weighing the relevant considerations, BOP concludes that social accommodations are not medically necessary to address gender dysphoria, especially in the correctional context. Social accommodations are highly controversial, medically disputed, and unproven by appropriate evidence. Medical professionals, at the very least, reasonably disagree on the efficacy of social accommodations to address gender dysphoria, particularly in the correctional context. Social accommodations are not "medically necessary" or "in accordance with proven standards of care." PS 6010.05 §1, Health Services Administration. It is reasonable for BOP to not provide medically disputed or insufficiently proven accommodations to inmates.

Medical professionals have persuasively explained that social accommodations are at most psychologically pleasing, not medically necessary. *See, e.g.*, Kaliebe Decl. ¶22 ("'Social

accommodation' is not medically necessary in the correctional setting."); *id.* ¶156 (same); *id.* ¶136 ("The fact that some social-transitioning items are psychologically pleasing to inmates with Gender Dysphoria does not mean that such interventions are medically necessary."); *Keohane*, 952 F.3d at 1274; *Bayse v. Ward*, 147 F.4th 1304, 1313 (11th Cir. 2025); *cf., e.g.*, *Fisher v. Fed. Bureau of Prisons*, 484 F. Supp. 3d 521, 534 (N.D. Ohio 2020) ("cosmetic products are not among the minimal civilized measures of life's necessities" (brackets omitted)). There is limited to no reliable evidence showing that access to social accommodations treats gender dysphoria. *See, e.g.*, Kaliebe Decl. ¶136 ("There is limited evidence suggesting that allowing cosmetic and clothing items, such binders, undergarments, makeup, wigs, and other accessories and items stereotypically associated with the opposite sex, would improve or resolve symptoms associated with Gender Dysphoria. And there is no evidence-based study or reliable evidence showing that access to such items improves or resolves symptoms in inmates with Gender Dysphoria, regardless of whether the inmate is in a facility that aligns with the inmate's biological sex or gender identity."). Social accommodations "can prolong the symptoms [of gender dysphoria] and undermine psychotherapy, and there is no clear evidence of medical benefit." Kaliebe Decl. ¶136. To the extent that social accommodations might have short-term benefits to addressing gender dysphoria in the correctional context, they are outweighed by the potential long-term harm. *See, e.g.*, Kaliebe Decl. ¶140 ("[W]hile social transition might decrease inmate-patients' discomfort in the short term, it ultimately may cause long-term harm, such as continuation of Gender Dysphoria."). In any event, BOP determines that it is reasonable to no longer provide access to social accommodations given the uncertainty in long-term benefit.

Even if there is some reliable evidence that social accommodations address gender dysphoria when the individual is in society at large, the evidence does not support that social accommodations address gender dysphoria in the correctional environment. The concept of access to social accommodations is out of place in the correctional context because an inmate does not live in society at large but rather a secure prison environment. What a person may want or need to socially transition outside prison says little (if anything) about what that person should have access to in a secure prison environment. *See, e.g.*, Kaliebe Decl. ¶142 ("The concept of social transitioning through social accommodations, hormones, or surgery is out of place in the correctional context because an inmate does not live in society at large but a secure prison environment.").

Again, BOP provides inmates with gender dysphoria with individualized treatment plans with well-established treatment methods for gender dysphoria, such as psychotherapy, group counseling, psychiatric services, and psychotropic medications. Social accommodations are not medically necessary or at a minimum, there is reasonable disagreement as to their efficacy, such that it is reasonable for BOP to not provide social accommodations. In BOP's judgment, it is reasonable and appropriate to provide these individual treatment plans without the prospect of providing or allowing access to social accommodations to address gender dysphoria.

2. Security and prison-administration concerns support Program Statement 5260.01's prohibition on social accommodations.

BOP's general policy is to "deliver medically necessary health care to inmates effectively in accordance with proven standards of care *without compromising public safety concerns inherent to the Bureau's overall mission*." PS 6010.05 §1, Health Services Administration (emphasis added). BOP is responsible for "the safekeeping, care, and subsistence of all persons charged with or convicted of offenses against the United States." 18 U.S.C. §4042(a). Providing social accommodations to inmates, including to address gender dysphoria, raises serious security and prison-administration concerns. These security and prison-administration concerns not only support the medical concerns for BOP's adoption of a prohibition on providing inmates social accommodations but also independently support BOP's adoption of such a prohibition. At a minimum, the security and prison-administration concerns, when considered separately or cumulatively or in any combination, outweigh the benefits (medical or otherwise) from providing social accommodations. Thus, even if social accommodations address gender dysphoria, BOP, after considering the relevant issues and factors and weighing the relevant considerations, determines that it is reasonable and appropriate to not provide or allow access to social accommodations, including to address gender dysphoria.

Social accommodations jeopardize the security, safety, and prison administration of correctional facilities in at least four ways. First, providing social accommodations heightens the risk of inmates concealing dangerous contraband or escaping and may hinder the prison's ability to investigate intra-prison crimes. Second, providing social accommodations disrupts the uniform appearance among inmates, increasing the risk the accommodated inmate becomes a target for attacks, which increases the risk of harm to the targeted inmate and prison officials tasked with protecting the inmate. Third, special accommodations designed to change an inmate's outward appearance raise fairness concerns and can breed resentment among other inmates, which can lead to violence. Fourth, granting social accommodations conflicts with a reasonable practice of refusing to reward threats of self-harm and may even increase self-harm.

First, certain social accommodations, such as wigs, breast pads, buttock pads, and chest binders, can enable an inmate to hide contraband or other items without easy detection. *See, e.g.*, *Keohane*, 952 F.3d at 1263 ("the [Florida Department of Corrections] FDC concluded that there are clear advantages to maintaining uniformity in a prison setting, including the ability to more readily detect contraband"); *Keohane v. Fla. Dep't of Corr. Sec'y*, 981 F.3d 994, 998 (11th Cir. 2020) (Newsom, J., concurring in denial of reh'g en banc); *cf. Green v. Polunsky*, 229 F.3d 486, 490 (5th Cir. 2000) ("contraband such as drugs and weapons can be hidden in long hair"). A uniform dress code enables prison officials to more readily detect contraband. *See Keohane*, 952 F.3d at 1263. In addition to the harm from contraband going undetected, BOP would have to expend additional time and expense to administer the facility and ensure its security and safety.

Providing access to certain social accommodations also increases risk of escape by the inmate and may hinder the prison's ability to investigate intra-prison crimes because these items can be used to obfuscate or conceal an inmate's identity. Inmates would be able to change their appearances with ease by removing their social accommodations, such as wigs, chest binders, or

breast padding. *See, e.g.*, *Green*, 229 F.3d at 490. By prohibiting these items, Program Statement 5260.01 decreases the risk of fleeing inmates from avoiding detection or delaying detection and helps ensure the prison can adequately investigate intra-prison crimes.

Second, prohibiting social accommodations reduces the chance of an inmate being targeted by other inmates. For example, allowing a male inmate to obtain items designed to make him appear more feminine may entice other male inmates to disturb the orderly operation of the facility and can lead to increased incidents of assault or harassment on the accommodated inmate. Indeed, an inmate dressed or groomed as a female, such as via social accommodations, would increase the risk of the inmate becoming a target for abuse in a male prison. *See, e.g.*, *Keohane*, 952 F.3d at 1275 (noting the "obvious[]" consequence of permitting a male inmate to dress and be groomed as a female "would inevitably become a target for abuse in an all-male prison"); *Keohane*, 981 F.3d at 997-98 (Newsom, J., concurring in denial of reh'g en banc). And based on BOP's experience and expertise, these same concerns apply to both male and female correctional facilities, as female facilities also experience meaningful amounts of harassment and violence. *See, e.g.*, Emily Buehler, *Substantiated Incidents of Sexual Victimization Reported by Adult Correctional Authorities*, 2016-2018, U.S. Dep't of Justice, 18 (2023) (noting that 31% of the recorded incidents of inmate-on-inmate sexual harassment occurred in female correctional facilities).

Social accommodations not only put the inmate at additional risk of assault or harassment but also endanger "the prison employees who would have to step in to protect" the inmate and will require expending already limited resources to address these risks. *Keohane*, 952 F.3d at 1263. Preventing such attacks would require prison officials to be more vigilant in protecting the accommodated inmates from assault or harassment, despite BOP's limited resources.

And obviously, transfer to an opposite-sex facility is not an appropriate recourse in an attempt to mitigate these security and prison-administration complications from social-accommodations. Transfer would not sufficiently mitigate all the security and prison-administration concerns from providing social accommodations; in fact, transfer would create new grave security and prison-administration concerns. *See, e.g.*, Kaliebe Decl. ¶139 ("[H]ighly relevant is the fact that the presence of a biological male in close quarters in a female prison could significantly harm the emotional and physical well-being of certain female prisoners, such as female victims of sexual abuse. This concern is particularly acute since female prisoners suffer from extremely high rates of sexual trauma. Placing these vulnerable female inmates with biological males could have meaningful negative effects on female inmates."); *Cruel and Unusual Punishment: Stopping the Dangerous Policies Putting Men in Women's Prisons*, Independent Women's Forum (Dec. 20, 2024). And transfer is not medically necessary or appropriate to address gender dysphoria. *See, e.g.*, Kaliebe Decl. ¶¶23, 157. Transfer to address gender dysphoria is unproven, medically disputed, and controversial. *See* Kaliebe Decl. ¶139 ("There is no reliable study or high-quality evidence suggesting that an inmate being housed in a facility in line with the inmate's gender identity rather than the inmate's biological sex has any meaningful benefits (let alone long-term benefits) to the inmate's Gender Dysphoria symptoms."). It is reasonable for BOP to not provide a transfer to an inmate diagnosed with gender dysphoria, given the security, prison-administration, and medical issues.

Third, based on BOP's experience and expertise, fairness concerns counsel against providing access to social accommodations. When inmates receive special treatment within a correctional environment, other inmates may begin to resent those receiving special treatment, which can increase the risk of retaliation against the inmate receiving special treatment and cause ripple effects throughout the correctional institution and disrupting the delicate prison environment. Moreover, in general, correctional environments aim to be uniform in their approach to access to items because once a facility grants access to one thing for an inmate, it often makes it difficult to refuse granting special items to everyone else. Fairness concerns are particularly present if such special treatment is provided to one type of facilities (*e.g.*, female facilities) and not another (*e.g.*, male facilities).

Finally, BOP has considered the issue of self-harm and has determined that a policy prohibiting social accommodations avoids rewarding threats of self-harm and may reduce overall self-harm. Inmates frequently use threats of self-harm and suicide to try to obtain concessions from prison officials. *See, e.g.*, Kaliebe Decl. ¶148 ("In my experience working in correctional facilities and treating adult and juvenile inmates, including those diagnosed with Gender Dysphoria, inmates frequently use threats of self-harm and suicide to try to obtain concessions from prison officials."); *Kosilek*, 774 F.3d at 94 ("Such threats are not uncommon in prison settings …."). But providing access to social accommodations, especially in response to threats of self-harm or suicide, could increase self-harm. *See, e.g.*, Kaliebe Decl. ¶149 ("In corrections, rewarding self-injury or threats of self-injury tends to increase overall self-harm, both for the individual patient and also within the system."). Granting such requests may establish an "unacceptable precedent," forcing "prison authorities to comply with the prisoners' particular demands." *Kosilek*, 774 F.3d at 94. Consequently, it is reasonable for prison administrators to have rules against providing inmates benefits in response to self-harm or suicide to discourage threats. *See* Kaliebe Decl. ¶150 ("Simple and clear institutional policies, such as no social transitions or no initiation of new hormone treatments, are likely to lead to the lowest level of self-harm and the least overall harm to inmates because when prisoners know the interventions they desire are not available, they are less likely to self-harm to obtain them. In other words, it is reasonable for prison administrators to have outright prohibitions of providing inmates benefits, such as unproven surgeries, special-order items, and housing placements, in response to self-harm or suicide threats to discourage false threats."); *Kosilek*, 774 F.3d at 94 (noting that such threats must be "firm[ly] reject[ed] by the authorities, who must be given ample discretion in the dealing with such situations"). BOP determines that a clear rule against social accommodations is the most reasonable way to handle this complex issue. BOP takes threats of self-harm seriously and has protocols in place to handle these complex situations.

After considering the relevant issues and factors and weighing the relevant considerations, BOP determines that each of its security and prison-administration concerns, whether considered separately, cumulatively, or in any combination, outweighs any asserted benefits of providing social accommodations. In addition, after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that the medical concerns discussed above when considered with any of its security and prison-administration concerns—separately, cumulatively, or in any combination—outweighs any asserted benefits of providing social accommodations.

3. Other considerations do not outweigh the benefits from Program Statement 5260.01.

a. Reliance Interests and Costs

BOP has also considered potential reliance interests, but the potential reliance interests are either illegitimate or outweighed by the benefits of the policy. Indeed, after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that each of its medical, security, and prison-administration concerns, whether considered separately, cumulatively, or in any combination, outweighs the asserted benefits, interests, or costs of providing or allowing access to social accommodations.

As an initial matter, an inmate that currently does not have social accommodations has no legitimate reliance interest in the future possibility of obtaining access to social accommodations. That is especially true because social accommodations are not medically necessary or in accordance with proven standards of care.

Inmates currently in possession of social accommodations do not have legitimate reliance interests either. Social accommodations are not medically necessary or in accordance with proven standards of care. A policy that produces, at most, psychologically pleasing effects does not create legitimate reliance interests. That is all the more true given that social accommodations can prolong symptoms of gender dysphoria, may lead to long-term harm, and can undermine psychotherapy.

In any event, even if social accommodations create legitimate reliance interests, the interests are not weighty. Providing social accommodations has not been a longstanding, formal policy of BOP, and access to social accommodations has always been subject to security concerns. *See, e.g.*, PS 6010.05 §1, Health Services Administration; PS 5521.06, Housing Units, Inmates, and Inmate Work Areas; PS 5580.08, Inmate Personal Property ("Staff may not allow an inmate to accumulate materials to the point where the materials become a fire, sanitation, security, or housekeeping hazard."). Moreover, BOP policy has always been subject to change, including based on security and prison-administration concerns. Further, inmates that have had social accommodations for a short period of time have limited reliance interests. And the weight of this reliance varies among inmates due to, in part, the length of their prison sentence, among other things. Inmates that are in possession of social accommodations with little time left have a smaller interest than those with a longer remaining prison sentence.

Moreover, implementing Program Statement 5260.01 will incur, at most, *de minimis* costs and will likely lead to savings. Program Statement 5260.01 will mitigate security and prison-administration concerns, which will reduce costs. Program Statement 5260.01 will also reduce expenditures on interventions that are not medically necessary or medically disputed. Expenditures on care for inmates diagnosed with gender dysphoria are unlikely to meaningfully increase. In general, BOP officials would monitor an inmate diagnosed with gender dysphoria and provide the inmate with an individualized treatment plan, which would generally have care in addition to the provision of social accommodations. To the extent that Program Statement 5260.01 would result

in increased costs, it is outweighed by other considerations or the savings from reduced availability of social accommodations.

In sum, after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that each of its medical, security, and prison-administration concerns, whether considered separately, cumulatively, or in any combination, significantly outweigh any costs of Program Statement 5260.01, any reliance interests created by a former policy of providing access to social accommodations, and any benefits from providing social accommodations. In BOP's judgment, prohibiting social accommodations is reasonable, appropriate, and in the best interest of the agency, its officials, and those in its custody.

b. Alternatives

BOP has considered alternatives and has determined that Program Statement 5260.01 is more reasonable than and preferable to potential alternatives.

For example, BOP has considered the option of denying future requests for social accommodations but allowing inmates who were previously given social accommodations to maintain access to social accommodations. Such an approach is not warranted because of BOP's medical concerns. Even if there are benefits to the more limited course as to social accommodations, BOP has determined that such a limitation would not adequately minimize the above security and prison-administration concerns to justify the alternative. In BOP's judgment, Program Statement 5260.01's handling of social accommodations is more reasonable than and preferable to this alternative approach.

BOP has considered a policy that would allow social accommodations based on an inmate's individual security profile. Such an approach is not warranted because of BOP's medical concerns. Even if there are benefits to this alternative approach to social accommodations, case-by-case determinations would not sufficiently mitigate the increased security and prison-administration concerns from social accommodations. For example, it would not sufficiently minimize the risks associated with the inmate becoming a target by other inmates, the risk to prison officials to deal with the increased risk of the inmate becoming a target, the risk from non-uniformity in the prison environment, or the risks related to threats of self-harm. Moreover, BOP's security profile is predictive, so the risk associated with contraband, escape, and intra-prison crime is still increased. In BOP's judgment, Program Statement 5260.01's handling of social accommodations is more reasonable than and preferable to this alternative approach.

BOP has considered allowing social accommodations based on the type of custody the inmate is in. Such an approach is not warranted because of BOP's medical concerns. Even if there are benefits to this alternative approach to social accommodations, the above prison-administration and safety concerns persist regardless of the type of custody the inmate is in, such as administrative segregations or general population. For example, providing social accommodations to inmates in administrative segregation still raises contraband-detection concerns, increases the risk of the inmate being targeted by other inmates, and raises the risk related to threats of self-harm. In any event, even if the inmate is in more limited custody now, such as administrative segregation, the inmate likely will not always be in such custody. Providing access to the items to inmates in such

custody to only take it away when the inmate leaves that custody is not prudent and risks further disruptions in the prison environment and potentially further self-harm threats by the inmate. In BOP's judgment, Program Statement 5260.01's handling of social accommodations is more reasonable than and preferable to this alternative approach.

BOP has considered and rejected a policy that removes all gendered clothing and hygiene products individually marketed to a particular sex. Though this option would foster uniformity for inmate dresswear, it also has significant drawbacks that render it a less desirable policy than the one selected. Implementing such a policy would be significantly costly and disruptive as it would require BOP to redesign its longstanding dress-code policy. This alternative policy would also entail the prison staff to remove newly classified contraband from all inmates, requiring BOP to expend even more resources than the selected policy as the latter involves removing contraband from a small percentage of the prison population. Moreover, this option would not be considered satisfactory by those who seek social accommodations to address gender dysphoria. In short, this alternative's defects significantly outweigh any purported advantages; in BOP's judgment, Program Statement 5260.01's handling of social accommodations is more reasonable than and preferable to this alternative approach.

BOP has also considered and rejected an alternative that allows inmates to pay for social accommodations to address gender dysphoria. Such an alternative does not sufficiently mitigate the medical, security, or prison-administration concerns of allowing social accommodations. In BOP's judgment, Program Statement 5260.01's approach to social accommodations is more reasonable than and preferable to this alternative approach.

Finally, BOP has considered other alternatives, including a combination of the above alternatives, but BOP has determined that Program Statement 5260.01's handling of social accommodations is better than and preferable to alternative approaches and is the most reasonable approach for addressing this issue.

* * *

In sum, BOP issues Program Statement 5260.01 independent of Executive Order 14,168 and after considering the relevant issues and factors and weighing the relevant considerations. Program Statement 5260.01's handling of social accommodations is justified by the medical concerns of the intervention. Security and prison-administration concerns bolster that determination. Further, even assuming there are medical benefits to inmates from providing social accommodations, Program Statement 5260.01's handling of social accommodations is justified by security and prison-administration concerns, as each of those interests, whether considered separately, cumulatively, or in any combination, outweighs any costs of Program Statement 5260.01, any reliance interests, and any benefits with respect to social accommodations. BOP also concludes that Program Statement 5260.01's handling of social accommodations is more reasonable than and preferable to potential alternatives. After considering the relevant issues and factors and weighing the relevant considerations, BOP determines that Program Statement 5260.01's handling of social accommodations is reasonable.

C. Hormones

After considering the relevant issues and factors and weighing the relevant considerations, BOP adopts Program Statement 5260.01's approach regarding hormones to address gender dysphoria. Under Program Statement 5260.01, if an inmate is diagnosed with gender dysphoria but is not currently receiving hormones to address gender dysphoria, BOP will not provide hormones to address the inmate's gender dysphoria. Hormonal interventions for inmates who are not currently receiving hormones to address gender dysphoria are not medically necessary or at a minimum, are highly controversial, medically disputed, and unproven by appropriate evidence. To the extent there is uncertainty about the efficacy of hormones to address gender dysphoria, that uncertainty counsels against providing such controversial interventions to inmates who are not currently receiving hormones when there are other more established treatments, such as psychotherapy, available. Even assuming hormones are beneficial to address gender dysphoria, BOP concludes that hormones in the secure prison environment raise numerous security and prison-administration concerns, and each concern, whether considered separately, cumulatively, or in any combination, outweigh any costs from Program Statement 5260.01, any reliance interests, and any benefits from providing hormones to inmates diagnosed with gender dysphoria who are not currently receiving hormones.

Under Program Statement 5260.01, if an inmate is previously and currently diagnosed with gender dysphoria and is currently receiving hormones to address gender dysphoria, BOP will develop a tapering plan for each inmate after consideration of appropriate factors. For inmates that have recently begun receiving hormones to address gender dysphoria, the tapering plan will include a rapid discontinuation of the hormone intervention. For inmates that have been receiving hormones to address gender dysphoria for an extended period of time, the tapering plan will generally include an appropriately paced discontinuation of the hormone intervention. For inmates who (1) are post sex trait modification surgery or (2) have been receiving hormones to address gender dysphoria for an extended period of time and develop severe physiological and psychological withdrawal effects from tapering, it may not be appropriate in all cases for the initial tapering plan to include cessation of hormones.

Even for inmates currently receiving hormones to address gender dysphoria, such hormonal interventions are medically controversial and disputed. There are little (if any) reliable evidence on the benefits of hormonal interventions to address gender dysphoria, especially in the correctional environment. There are also indications that hormonal interventions can prolong symptoms of gender dysphoria, undermine other treatments to address gender dysphoria, worsen symptoms of gender dysphoria, and cause physical and psychological harm. But given that inmates currently receiving hormones involve a more complex case in light of the reality that removing medical interventions can cause stress or other side effects, BOP determines that it is reasonable to take the above approach with respect to inmates who are currently receiving hormones to address gender dysphoria, which balances the medical, security, and prison-administration concerns to deal with this more complex situation.

In BOP's judgment, and after considering the relevant issues and factors and weighing the relevant considerations, Program Statement 5260.01's approach as to hormones is reasonable, and

appropriate to provide adequate care to inmates diagnosed with gender dysphoria; is reasonable and appropriate to maintain internal order, discipline, and institutional security of the correctional environment; and outweighs any asserted benefit from alternative policies regarding hormones to address gender dysphoria.

1. In general, hormones are not medically necessary to address gender dysphoria.

a. Inmates Not Currently Receiving Hormones to Address Gender Dysphoria

After considering the relevant issues and factors and weighing the relevant considerations, BOP concludes that hormones are not medically necessary to address gender dysphoria for individuals not currently receiving hormones to address gender dysphoria, especially in the correctional context. Hormonal interventions to address gender dysphoria are highly controversial, medically disputed, and unproven by appropriate evidence. Medical professionals, at the very least, reasonably disagree on the efficacy of hormones to address gender dysphoria for individuals not currently receiving hormones to address gender dysphoria, particularly in the correctional context. Hormones are not "medically necessary" or "in accordance with proven standards of care" for inmates not currently receiving hormones to address gender dysphoria. PS 6010.05 §1, Health Services Administration. It is reasonable for BOP to not provide medically disputed or insufficiently proven interventions to inmates who are not currently receiving the intervention.

An expert has persuasively explained that hormones are not medically necessary to address gender dysphoria when that inmate is not currently receiving hormones to address gender dysphoria. *See, e.g.*, Kaliebe Decl. ¶20 ("it is not medically necessary to provide hormone therapy to inmates who are diagnosed with Gender Dysphoria but not currently receiving hormone therapy"); *id.* ¶154 (same); *id.* ¶112 ("it is appropriate to not initiate hormone therapy on inmates who are not currently subject to hormonal therapy"). At the very least, providing hormones to address gender dysphoria is highly controversial, insufficiently proven, or subject to reasonable medical disagreement. Indeed, hormones to address gender dysphoria "is unproven" and "experimental." *See, e.g.*, Kaliebe Decl. ¶20 ("Hormone therapy is unproven and experimental treatment for Gender Dysphoria that generally should not be available to those in the custody of the Federal Bureau of Prisons."); *id.* ¶154 (same). Providing hormonal interventions to address gender dysphoria "is not based on guidelines using best practice or systematic reviews of evidence." Kaliebe Decl. ¶83. There is little (if any) reliable evidence showing that hormones address gender dysphoria. *See, e.g.*, Kaliebe Decl. ¶83; Haupt et al., *Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women*, 11 Cochrane Database of Systematic Reviews, Art. No. CD013138, at 2, 11 (2020); Kellan E. Baker, et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5 J. Endocrine Soc. 1, 12-13 (2021); *Marcum v. Crews*, No. 5:25-CV-00238-GFVT, 2025 WL 2630922, at *7 (E.D. Ky. Sept. 12, 2025) ("The problem in making this analogy is that the Plaintiff is assuming that HRT is a well-settled area of medicine. When, in fact, the record indicates that there remains significant disagreement about whether the side effects and the negative consequences of HRT outweigh the positive benefits. And, further, there is medical evidence

suggesting that even if HRT is not provided, there are other ways to care for an individual diagnosed with Gender Dysphoria, absent using HRT."); *Marcum v. Crews*, No. 25-5840, Dkt. 26 at 6 (6th Cir. Oct. 23, 2025) ("The existing record thus suggests that the medical community has not reached a consensus on the role hormone therapy should play in treating gender dysphoria."). In any event, there is no reliable evidence showing that hormones address gender dysphoria in the correctional environment. To the contrary, recent research has raised significant concerns on the safety, efficacy, and prudence of hormonal interventions to address gender dysphoria. *See, e.g.*, Kaliebe Decl. ¶86 ("Recent large reviews and research into harms from hormone treatment for Gender Dysphoria raise increased concerns regarding the safety, efficacy, and prudence of this practice.").

There are also indications that hormonal interventions can prolong symptoms of gender dysphoria, undermine other treatments to address gender dysphoria, worsen symptoms of gender dysphoria, and cause "[s]ubstantial [h]ealth risks" and "[m]edical harms." *See, e.g.*, Kaliebe Decl. ¶¶96-111; Rakesh R. Gurrala et al., *The Impact of Exogenous Testosterone on Breast Cancer Risk in Transmasculine Individuals*, 90(1) Annals of Plastic Surgery 96 (2023) (explaining that evidence showed that males who are treated with estrogen have twenty-two times the likelihood to develop breast cancer). Some of the effects of hormonal interventions also might not be reversible. *See, e.g.*, Kaliebe Decl. ¶109. To the extent that hormonal interventions might have short-term benefits to addressing gender dysphoria in the correctional context, they may be placebo effects, *see, e.g.*, Kaliebe Decl. ¶¶90-91, or in any event, outweighed by the potential long-term risks or harms. At any rate, BOP determines that it is reasonable to not provide hormones to inmates not currently receiving hormones given the uncertainty in benefits, the potential harms, and the potential irreversibility of some effects of the intervention.

Again, BOP provides inmates with gender dysphoria with individualized treatment plans with well-established treatment methods for gender dysphoria, such as psychotherapy, group counseling, psychiatric services, and psychotropic medications. Hormonal interventions for inmates not currently receiving the intervention to address gender dysphoria are not medically necessary or at a minimum, there is reasonable disagreement as to their efficacy, such that it is reasonable for BOP to not provide the intervention. In BOP's judgment, it is reasonable and necessary and appropriate to provide these individual treatment plans to inmates who are not currently hormones without the prospect of receiving hormones to address gender dysphoria.

b. Inmates Currently Receiving Hormones to Address Gender Dysphoria

Though the medical concerns explained above are still present for inmates currently receiving hormones, BOP has determined that a different approach is warranted as to inmates that are already receiving hormones to address gender dysphoria. These inmates involve a more complex situation, reflecting the reality that removing medical interventions can cause stress or other side effects. *See* Kaliebe Decl. ¶114.

Under Program Statement 5260.01, inmates who are previously and currently diagnosed with gender dysphoria and are currently receiving hormones to address gender dysphoria will receive tapering plans based on the appropriate factors, such as the duration the inmate has been

receiving hormones to address gender dysphoria, the initial rationale for receiving the hormone intervention, the response by the inmate to the intervention, and whether the inmate has undergone sex trait modification surgery. But BOP determines that it is appropriate to generally divide these inmates based on the length of time the inmate has received hormones to address gender dysphoria. *See* Kaliebe Decl. ¶114 ("it is reasonable for dysphoric patients to be divided into different patient populations with different clinical approaches").

For inmates that recently started receiving hormones to address gender dysphoria, BOP determines that such inmates will receive a tapering plan that includes a rapid discontinuation of hormones. *See* Kaliebe Decl. ¶114 ("A rapid discontinuation is appropriate for those who recently started treatment."). Given the medical concerns with respect to hormones, the short-term side-effects to discontinuing hormones when hormones have only been recently provided to the inmate, and the other measures BOP has in place to monitor and receive requests from inmate patients, among other relevant considerations, BOP determines that a tapering plan that includes a rapid discontinuation of hormones is reasonable for inmates who have only recently begun receiving hormones to address gender dysphoria.

For inmates that have been receiving hormones to address gender dysphoria for an extended period of time, the inmates will receive a tapering plan based on the appropriate factors. In general, the tapering plan will include an appropriately paced discontinuation of the hormone intervention. *See* Kaliebe Decl. ¶114 ("A rapid discontinuation is appropriate for those who recently started treatment, but a slow withdrawal could be appropriate for others ….). For inmates who (1) are post sex trait modification surgery or (2) have been receiving hormones to address gender dysphoria for an extended period of time and develop severe physiological and psychological withdrawal effects from tapering, it may not be appropriate in all cases for the initial tapering plan to include cessation of hormones. But given "the unproven medical benefits of continued hormone[s]," "the potential negative effects of hormone[s]," and that "it is likely rare that an inmate should continue hormone therapy indefinitely," Kaliebe Decl. ¶116, tapering plans should be reevaluated regularly with respect to cessation of hormones, including during the inmate's chronic care clinic appointments.

All inmates who are tapering and were receiving mental health treatment before tapering will continue to receive counseling and pharmacological treatment as appropriate as part of the inmate's individualized treatment plan. Tapering plans may be adjusted as necessary based on monitoring and follow-up evaluations, but the adjusted tapering plans must still be consistent with the purpose of Program Statement 5260.01 and based on all relevant factors, including security and prison-administration concerns. And inmate patients may submit a request for additional medical or mental health care or evaluation if they have acute concerns during the tapering process.

In BOP's judgment, the above approach reasonably balances the medical concerns presented by hormones for inmates that are currently receiving hormones to address gender dysphoria.

2. Security and prison-administration concerns support Program Statement 5260.01's approach to hormones to address gender dysphoria.

BOP's general policy is to "deliver medically necessary health care to inmates effectively in accordance with proven standards of care *without compromising public safety concerns inherent to the Bureau's overall mission*." PS 6010.05 §1, Health Services Administration (emphasis added). BOP is responsible for "the safekeeping, care, and subsistence of all persons charged with or convicted of offenses against the United States." 18 U.S.C. §4042(a). Providing hormonal interventions to inmates to address gender dysphoria raises serious security and prison-administration concerns. These security and prison-administration concerns independently support Program Statement 5260.01's handling of hormones. At a minimum, the security and prison-administration concerns, when considered separately, cumulatively, or in any combination, outweigh the benefits from a policy handling hormones differently, such as allowing more access to hormones to address gender dysphoria. Thus, after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that it is reasonable and appropriate to adopt Program Statement 5260.01's approach to hormonal interventions to address gender dysphoria.

Using hormonal interventions to address gender dysphoria jeopardizes the security, safety, and prison administration of correctional facilities in at least three ways. First, the inmate receiving hormones will have increased risk of the inmate becoming a target for attacks, which increases harm to the targeted inmate and prison officials tasked with protecting the inmate. Second, special treatments raise fairness concerns and can breed resentment among other inmates, which can lead to violence. Third, granting hormones conflicts with a reasonable practice of refusing to reward threats of self-harm and may even increase self-harm. Each of BOP's security and prison-administration concerns, whether considered cumulatively, separately, or in any combination, outweighs any asserted benefits from a different approach to hormones than the one adopted in Program Statement 5260.01.

First, limiting the availability of hormonal interventions to address gender dysphoria reduces the chance of an inmate being targeted by other inmates. The inmate would inevitably become a target for abuse in the male facility. *Cf., e.g.*, *Keohane*, 952 F.3d at 1275 (noting the "obvious[]" consequence of permitting an inmate to dress and be groomed as a female "would inevitably become a target for abuse in an all-male prison"); *Kosilek*, 774 F.3d at 93 ("Recognizing that reasonable concerns would arise regarding a post-operative, male-to-female transsexual being housed with male prisoners takes no great stretch of the imagination."). And based on BOP's experience and expertise, these same concerns also apply to women's correctional facilities, which also experience meaningful amounts of harassment and violence. *See, e.g.*, Emily Buehler, *Substantiated Incidents of Sexual Victimization Reported by Adult Correctional Authorities*, 2016-2018, U.S. Dep't of Justice, 18 (2023) (noting that 31% of the recorded incidents of inmate-on-inmate sexual harassment occurred in female correctional facilities).

Hormonal interventions not only put the inmate at additional risk of assault or harassment but also endanger "the prison employees who would have to step in to protect" the inmate and will require expending already limited resources to address these risks. *Keohane*, 952 F.3d at 1263.

Preventing such attacks would require prison officials to be more vigilant in protecting the inmates from assault or harassment, despite BOP's limited resources.

It is insufficient to point to transfer to mitigate these security and prison-administration complications from providing hormones to address gender dysphoria. For example, a transfer of a male (who is receiving hormones to address gender dysphoria) to a female facility will increase the risk of harm of female inmates. *See* Kaliebe Decl. ¶139 ("[H]ighly relevant is the fact that the presence of a biological male in close quarters in a female prison could significantly harm the emotional and physical well-being of certain female prisoners, such as female victims of sexual abuse. This concern is particularly acute since female prisoners suffer from extremely high rates of sexual trauma. Placing these vulnerable female inmates with biological males could have meaningful negative effects on female inmates."); *see also, e.g.*, *Cruel and Unusual Punishment: Stopping the Dangerous Policies Putting Men in Women's Prisons*, Independent Women's Forum (Dec. 20, 2024). And based on BOP's experience and expertise, similar concerns exist for transfer of a female inmate to a male facility, as the female inmate would be a target by other male prisoners. Moreover, transfer is not medically necessary to address gender dysphoria. *See, e.g.*, Kaliebe Decl. ¶¶23, 157. Transfer to address gender dysphoria is unproven, medically disputed, and controversial. *See* Kaliebe Decl. ¶139 ("There is no reliable study or high-quality evidence suggesting that an inmate being housed in a facility in line with the inmate's gender identity rather than the inmate's biological sex has any meaningful benefits (let alone long-term benefits) to the inmate's Gender Dysphoria symptoms."). It is reasonable for BOP to not provide a transfer to an inmate diagnosed with gender dysphoria (including those receiving hormones), given the security, prison-administration, and medical concerns.

Second, based on BOP's experience and expertise, fairness concerns counsel against broader availability of hormones to address gender dysphoria. When inmates receive special treatment within a correctional environment, other inmates may begin to resent those receiving special treatment, which can increase the risk of retaliation against the inmate receiving special treatment and cause ripple effects throughout the correctional institution and disrupting the delicate prison environment. Fairness concerns are particularly present if such special treatment is provided to one type of facilities (*e.g.*, female facilities) and not another (*e.g.*, male facilities).

Finally, BOP has considered the issue of self-harm and has determined that Program Statement 5260.01's handling of hormones to address gender dysphoria reduces rewarding threats of self-harm and may reduce overall self-harm. Inmates frequently use threats of self-harm and suicide to try to obtain concessions from prison officials. *See, e.g.*, Kaliebe Decl. ¶148 ("In my experience working in correctional facilities and treating adult and juvenile inmates, including those diagnosed with Gender Dysphoria, inmates frequently use threats of self-harm and suicide to try to obtain concessions from prison officials."); *Kosilek*, 774 F.3d at 94 ("Such threats are not uncommon in prison settings …."). But providing more access to hormones, especially in response to threats of self-harm or suicide, could increase self-harm. *See, e.g.*, Kaliebe Decl. ¶149 ("In corrections, rewarding self-injury or threats of self-injury tends to increase overall self-harm, both for the individual patient and also within the system."). Granting such requests may establish an "unacceptable precedent," forcing "prison authorities to comply with the prisoners' particular demands." *Kosilek*, 774 F.3d at 94. Consequently, it is reasonable for prison administrators to have

rules against providing inmates benefits in response to self-harm or suicide to discourage threats. *See* Kaliebe Decl. ¶150 ("Simple and clear institutional policies, such as no social transitions or no initiation of new hormone treatments, are likely to lead to the lowest level of self-harm and the least overall harm to inmates because when prisoners know the interventions they desire are not available, they are less likely to self-harm to obtain them. In other words, it is reasonable for prison administrators to have outright prohibitions of providing inmates benefits, such as unproven surgeries, special-order items, and housing placements, in response to self-harm or suicide threats to discourage false threats."); *Kosilek*, 774 F.3d at 94 (noting that such threats must be "firm[ly] reject[ed] by the authorities, who must be given ample discretion in the dealing with such situations"). BOP determines that Program Statement 5260.01's approach as to hormones is the most reasonable way to handle this complex issue. BOP takes threats of self-harm seriously and has protocols in place to handle these complex situations.

After considering the relevant issues and factors and weighing the relevant considerations, BOP determines that each of its security and prison-administration concerns, whether considered separately, cumulatively, or in any combination, outweighs any asserted benefits of providing hormones in a broader way that differs from the approach adopted by Program Statement 5260.01. Specifically, each of the above security and prison-administration concerns, whether considered separately, cumulatively, or in any combination, support not providing hormones to address gender dysphoria to an inmate who is not currently receiving hormones. Each of the above security and prison-administration concerns, whether considered separately, cumulatively, or in any combination, also support providing tapering plans that include a rapid discontinuation of hormones for inmates who recently begun receiving hormones to address gender dysphoria. These concerns further support providing tapering plans that include an appropriately paced discontinuation of hormones for inmates who have been receiving hormones to address gender dysphoria for an extended period of time. And these concerns support the approach with respect to inmates who are post sex trait modification surgery or have been receiving hormones to address gender dysphoria for an extended period of time and develop severe physiological and psychological withdrawal effects from tapering. BOP has determined that it is reasonable to tolerate some of these security and prison-administration concerns for inmates that present the complex situation described above in the way that Program Statement 5260.01 handles hormones for these inmates. In addition, after considering the relevant issues and factors and weighing the relevant considerations, BOP determines that the medical concerns discussed above when considered with any of its security and prison-administration concerns—separately, cumulatively, or in any combination—outweighs any asserted benefits of providing hormones in a way that differs from the approach adopted by Program Statement 5260.01.

3. Other considerations do not outweigh the benefits from Program Statement 5260.01.

a. Reliance Interests and Costs

BOP has also considered potential reliance interests, but the potential reliance interests are either illegitimate or outweighed by the benefits of Program Statement 5260.01. Indeed, after considering the relevant issues and factors and weighing the relevant considerations, BOP

determines that each of its medical, security, and prison-administration concerns, whether considered separately, cumulatively, or in any combination, outweighs the asserted benefits, interests, or costs of providing hormones to address gender dysphoria in a way that differs from the approach adopted in Program Statement 5260.01.

As an initial matter, Program Statement 5260.01 prohibits providing hormones to inmates who are not currently receiving hormones to address gender dysphoria, and an inmate has no reasonable reliance interest in the future possibility of obtaining hormones. That is especially true because hormones are not medically necessary or at a minimum, controversial or medically disputed. It is reasonable for BOP to not provide medically disputed or insufficiently proven interventions to inmates who are not currently receiving the medically disputed intervention.

As for inmates currently receiving hormones to address gender dysphoria, these inmates' reliance interests are at best in the provision of "medically necessary health care to inmates effectively in accordance with proven standards of care without compromising public safety concerns inherent to the Bureau's overall mission." PS 6010.05 §1, Health Services Administration. In BOP's judgment, Program Statement 5260.01 is designed to provide such care.

In any event, even if the availability of hormones to address gender dysphoria create legitimate reliance interests, the interests are not sufficiently weighty to outweigh the benefits of Program Statement 5260.01. Access to hormones has always been subject to security concerns. *See, e.g.*, PS 6010.05 § 1, Health Services Administration. Moreover, BOP policies have always been subject to change, including based on new medical studies, security concerns, and prison-administration concerns.

Moreover, implementing Program Statement 5260.01 will incur, at most, *de minimis* costs and will likely lead to savings. Program Statement 5260.01 will mitigate security and prison-administration concerns, which will reduce costs. Program Statement 5260.01 will also reduce expenditures on medical interventions that are not medically necessary or medically disputed. Expenditures on care for inmates diagnosed with gender dysphoria are unlikely to meaningfully increase. In general, even if an inmate is receiving hormones, BOP officials would monitor the inmate patient and provide the inmate patient with an individualized treatment plan, which would generally have care in addition to the provision of hormones. To the extent that Program Statement 5260.01 would result in increased costs, it is outweighed by other considerations or the savings from reduced availability of hormones.

In sum, after considering the relevant issues and factors and weighing the relevant considerations, each of BOP's medical, security, and prison-administration concerns, whether considered separately, cumulatively, or in any combination, significantly outweigh any reliance interests created by a former policy that provided more access to hormones than the approach adopted in Program Statement 5260.01. In BOP's judgment, Program Statement 5260.01's handling of hormones to address gender dysphoria is reasonable and in the best interest of the agency, its officials, and those in its custody.

b. Alternatives

BOP has considered alternatives and has determined that Program Statement 5260.01 is more reasonable than and preferable to potential alternatives.

For example, BOP has considered a policy allowing hormones to inmates diagnosed with gender dysphoria but are not currently receiving hormones to address gender dysphoria, such as on a case-by-case basis. Such an approach is not warranted because of BOP's medical concerns. Even if there are benefits to the alternative approach as to hormones for inmates currently not receiving hormones, BOP has determined that the alternative approach would not adequately minimize the above security and prison-administration concerns to justify the alternative. In BOP's judgment, Program Statement 5260.01's approach to hormones for inmates not currently receiving hormones is preferable to this alternative approach.

BOP has considered a policy allowing case-by-case determinations on whether to adopt tapering plans for inmates who have recently begun receiving hormones. Such an approach is not warranted because of BOP's medical concerns. In BOP's judgment, any effects from tapering, including a rapid discontinuation of hormones, for inmates who recently began receiving hormones are outweighed by the benefits of not providing a medically disputed medical intervention that can prolong symptoms of gender dysphoria, undermine other treatments to address gender dysphoria, worsen symptoms of gender dysphoria, and cause physical and psychological harm, including harm that is potentially irreversible. Even if there are benefits to the alternative approach as to hormones for inmates who recently began receiving hormones, BOP has determined that the alternative approach would not adequately minimize the above security and prison-administration concerns to justify the alternative. In BOP's judgment, Program Statement 5260.01's approach to hormones for inmates who recently begun receiving hormones is preferable to this alternative approach.

BOP has considered an alternative that allows case-by-case determinations on whether to adopt tapering plans for inmates who have been receiving hormones for an extended period of time. Such an approach is not warranted because of BOP's medical concerns. In BOP's judgment, any effects from tapering for inmates have been receiving hormones for an extended period of time are outweighed by the benefits of not continuing to provide a medically disputed medical intervention that can prolong symptoms of gender dysphoria, undermine other treatments to address gender dysphoria, worsen symptoms of gender dysphoria, and cause physical and psychological harm, including harm that is potentially irreversible. The potential harm is further minimized by Program Statement 5260.01's approach to cessation of hormones for inmates who (1) are post sex trait modification surgery or (2) have been receiving hormones to address gender dysphoria for an extended period of time and develop severe physiological and psychological withdrawal effects from tapering. And the potential harm is even further minimized by the ability of inmate patients under Program Statement 5260.01 to request additional medical or mental health care or evaluation if they have acute concerns during the tapering process. Moreover, even if there are benefits to the alternative approach as to hormones for inmates who have been receiving hormones for an extended period of time, BOP has determined that this alternative approach would not adequately minimize the above concerns to justify the alternative. In BOP's judgment, Program

Statement 5260.01's approach to hormones for inmates who have been receiving hormones more an extended period of time is preferable to this alternative approach.

BOP has also considered and rejected an alternative that allows inmates to pay for hormones to address gender dysphoria when BOP would not provide such hormones. Such an alternative does not sufficiently mitigate the medical, security, or prison-administration concerns of allowing hormones when BOP would not provide such hormones. In BOP's judgment, Program Statement 5260.01's approach to hormones is preferable to this alternative approach.

Finally, BOP has considered other alternatives, including a combination of the above alternatives, but BOP has determined that Program Statement 5260.01's approach to hormones is preferable to alternative approaches and is the most reasonable approach for addressing this issue.

* * *

In sum, BOP issues Program Statement 5260.01 independent of Executive Order 14,168 and after considering the relevant issues and factors and weighing the relevant considerations. Program Statement 5260.01's approach to hormones is justified by the medical concerns of the intervention. Security and prison-administration concerns bolster that determination. Further, even assuming there are medical benefits to inmates from hormones, Program Statement 5260.01's handling of hormones is justified by security and prison-administration concerns, as each of those interests, whether considered separately, cumulatively, or in any combination, outweigh any costs of Program Statement 5260.01, any reliance interests, and any benefits from broader availability of hormones. BOP also concludes that Program Statement 5260.01's handling of hormones is preferable to and more reasonable than potential alternatives. After considering the relevant issues and factors and weighing the relevant considerations, BOP determines that Program Statement 5260.01's approach to hormones is reasonable.

D. Other Aspects of Program Statement 5260.01

After considering the relevant issues and factors and weighing the relevant considerations, including reliance interests, costs, and potential alternatives, BOP adopts the other aspects of Program Statement 5260.01.

For example, under Program Statement 5260.01, identified medical and psychiatric comorbidities, which can complicate treatment for gender dysphoria, should generally be addressed before treatment for gender dysphoria proceeds. *See, e.g.*, Kaliebe Decl. ¶¶55-57; Florida Dep't of Corrections, Policy 15.05.23, 3-4 (Sept. 30, 2024) ("All medical and psychiatric comorbidities must be identified as these comorbidities can complicate the treatment of Gender Dysphoria."). As appropriate, medical and psychiatric comorbidities should be addressed through psychotherapy, psychotropic medication, or other appropriate medically accepted interventions. *See, e.g.*, Kaliebe Decl. ¶¶55-59. When comorbidities are addressed before gender dysphoria, further treatment for gender dysphoria may be necessary and may proceed once these medical and psychiatric comorbidities are resolved or ruled out as the potential cause of gender dysphoria.

Moreover, psychotherapy should be prioritized. Psychotherapy is a well-known and well-established treatment for gender dysphoria and helps patients while avoiding the use of potentially

irreversible medical interventions. *See, e.g.*, Kaliebe Decl. at page 14 ("Psychotherapy is the preferred treatment approach for Gender Dysphoria, particularly within correctional environments."); *see also, e.g.*, Kaliebe Decl. ¶¶43-59; *K.C.*, 121 F.4th at 610-11 ("Social support and psychotherapy are widely recognized approaches" to treating gender dysphoria. (citing Danyon Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical Treatments*, 10 Health Psych. Rsch., at 4 (2022))).

Again, BOP provides individualized treatment plans to address gender dysphoria, which may include psychotherapy, group counseling, psychiatric services, and psychotropic medications. Nothing in Program Statement 5260.01 prevents a prison official from providing care required by federal law, including the Eighth Amendment to the U.S. Constitution. And Program Statement 5260.01 requires BOP to ensure that all inmates diagnosed with gender dysphoria receive care in accordance with federal law, including the Eighth Amendment to the U.S. Constitution. In BOP's judgment, the other aspects of Program Statement 5260.01 are preferable to potential alternatives and reasonable in light of the relevant issues and factors. The costs for these other aspects of Program Statement 5260.01 are *de minimis* and outweighed by their benefits. Any reliance interests are outweighed by the benefits of these other aspects of Program Statement 5260.01 and Program Statement 5260.01 as a whole. After considering the relevant issues and factors and weighing the relevant considerations, BOP determines that the other aspects of Program Statement 5260.01 is reasonable.

III. Severability

Each of the provisions of Program Statement 5260.01 serve an important, related, but distinct purpose. BOP also confirms that each of the provisions in Program Statement 5260.01 is intended to operate independently of each other and that the potential invalidity of one provision should not affect the other provisions. Accordingly, if any provision of Program Statement 5260.01, or the application of any provision of Program Statement 5260.01 to any individual or circumstance, is held to be invalid, the remainder of Program Statement 5260.01 and the application of its provisions to any other individuals or circumstances shall not be affected.

For example, if a court concludes that the aspect or any aspect of Program Statement 5260.01 regarding hormones or social accommodations is unlawful, BOP would still prohibit sex trait modification surgeries. Program Statement 5260.01's prohibition on sex trait modification surgeries, even without the provisions on hormones or social accommodations, would still reasonably address the applicable medical, security, and prison-administration concerns; outweigh any costs, reliance interests, and countervailing benefits; and be more reasonable than and preferable to potential alternatives.

If a court concludes that the aspect of Program Statement 5260.01 regarding hormones or sex trait modification surgeries is unlawful, BOP would still prohibit social accommodations. Program Statement 5260.01's prohibition on social accommodations, even without the provisions on hormones or sex trait modification surgeries, would still reasonably address the applicable medical, security, and prison-administration concerns; outweigh any costs, reliance interests, and countervailing benefits; and be more reasonable than and preferable to potential alternatives.

If a court concludes that the aspect of Program Statement 5260.01 regarding hormones is unlawful, BOP would still prohibit sex trait modification surgeries and social accommodations. Program Statement 5260.01's prohibition on sex trait modification surgeries and social accommodations, even without the provisions on hormones, would still reasonably address the applicable medical, security, and prison-administration concerns; outweigh any costs, reliance interests, and countervailing benefits; and be more reasonable than and preferable to potential alternatives.

If a court concludes that any part of Program Statement 5260.01 regarding hormones is unlawful, BOP would still adopt the other aspects of Program Statement 5260.01 with respect to hormones. For instance, Program Statement 5260.01's prohibition on hormones for inmates with gender dysphoria who are not current receiving hormones, even without the other provisions on hormones, would still reasonably address the applicable medical, security, and prison-administration concerns; outweigh any costs, reliance interests, and countervailing benefits; and be more reasonable than and preferable to potential alternatives. Program Statement 5260.01's provision on hormones for inmates with gender dysphoria who recently begun receiving hormones, even without the provisions on hormones for inmates who have been receiving hormones for an extended period of time, would still reasonably address the applicable medical, security, and prison-administration concerns; outweigh any costs, reliance interests, and countervailing benefits; and be more reasonable than and preferable to potential alternatives.

To give another example, if a court concludes that Program Statement 5260.01 cannot be retroactive to remove already issued social accommodations, then BOP would apply that aspect of Program Statement 5260.01 prospectively, such that no social accommodations will be provided in the future. Although continuing to allow accommodations already granted may lead to medical, security, and prison-administration harms that Program Statement 5260.01 seeks to avoid, the benefits from a prohibition on future social accommodations would still outweigh any costs, reliance interests, and countervailing benefits and be preferable to a policy allowing more access to social accommodations.

To be sure, BOP has determined that every provision of Program Statement 5260.01 is legally supportable, individually and in the aggregate, but include this discussion to remove any doubt that it would have adopted the remaining provisions of Program Statement 5260.01 without any of the other provisions, should any of them or any application of them be deemed unlawful by a court. The intent of Program Statement 5260.01 is for federal funds to not be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex to the maximum extent permitted by law, including the Eighth Amendment to the U.S. Constitution. Nothing in Program Statement 5260.01 shall prevent a prison official from providing care required by federal law, including the Eighth Amendment to the U.S. Constitution. BOP shall ensure that all inmates diagnosed with gender dysphoria receive care in accordance with federal law, including the Eighth Amendment to the U.S. Constitution. And nothing in Program Statement 5260.01 is intended, nor shall it be construed, to create a private cause of action.

IV. Non-Exhaustive List of References

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D. Bureau of Prisons and Department of Justice Correspondence

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E. Executive Orders

- Executive Order 14,168 of January 20, 2025, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8,615 (Jan. 30, 2025)
- Executive Order 14,187 of January 28, 2025, *Protecting Children from Chemical and Surgical Mutilation*, 90 Fed. Reg. 8,771 (Feb. 3, 2025)

F. State Laws and Policies

- Florida
    - Florida Department of Corrections, Office of Health Services, Bulletin No. 15.05.23 titled Mental Health Treatment of Inmates with Gender Dysphoria.
    - Fla. Stat. Ann. §286.311, *et seq.*
- California
    - California Correctional Health Care Services, Care Guide on Gender Dysphoria. (2015)

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- California Correctional Health Care Services, Care Guide on Transgender (2025)

- Georgia
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- Idaho
  - Idaho Code §18-8901, *et seq.*
- Indiana
  - Ind. Code Ann. §11-10-3-3.5, *et seq.*
- Kentucky
  - Kentucky Corrections Policies and Procedures on Lesbian, Gay, Bisexual, Transgender and Intersex Offenders.
  - Ky. Rev. Stat. Ann. §197.280, *et seq.*
- Oklahoma
  - Oklahoma Department of Corrections Policies on Determination and Management of Inmates with Gender Dysphoria.
- Minnesota
  - Department of Corrections Management and Placement of Incarcerated People Who are Transgender, Gender Diverse, Intersex, or Nonbinary

DECLARATION OF KRISTOPHER E. KALIEBE, M.D.

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EXPERIENCE AND QUALIFICATIONS

1. I have been retained by Defendants in the above-captioned lawsuit to provide an expert opinion concerning mental health care, including care of Gender Dysphoria, within correctional environments. My opinion is based primarily on my own experience as a physician, psychiatrist, and professor in the field of psychiatry, as well as the relevant literature in this area. I have also reviewed documents and court filings in this case. I may wish to supplement my opinions or the basis for them as new evidence emerges or new research is published.

2. I am over the age of 18, am qualified to give this declaration, and have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion. I am being compensated at a rate of $450 dollars per hour. Testimony and depositions are billed in 4-hour increments. Any compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony that I provide.

3. I am Board Certified in Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry. My clinical work has been primarily in university-based clinics, community clinics, and correctional facilities.

4. I am a professor at the University of South Florida in Tampa, Florida, United States. I was promoted to the position on August 1, 2023. From 2016 to August 2023, I served as an Associate Professor at the University of South Florida, where my clinical roles included working in university clinics, providing consultative services at Tampa General Hospital, assessing and treating juveniles within correctional facilities, and supporting primary care physicians through the Florida Medicaid Psychiatric Medication hotline. From 2005 to 2016, I served as an Assistant Professor at the Louisiana State University (LSU) Health Science Center – New Orleans. I served as the training director of the LSU Child Psychiatry Fellowship for two years.

5. I received my medical degree in 1999 and subsequently completed general psychiatry, child and adolescent psychiatry, and forensic psychiatry training. This training included education in human biology, human sexuality, development, brain functioning, normal development, and psychopathology. Gender Dysphoria (then labeled "gender identity disorder") and Gender Dysphoria treatment were part of my professional training.

6. I have extensive teaching experience, including teaching medical students, general psychiatry residents, child and adolescent psychiatry fellows, and forensic psychiatry fellows. I have had years of extensive positive feedback from medical students and psychiatric residents. I have been awarded four resident teaching awards, including from the general University of South Florida residents in June 2023 and as the Forensic Psychiatry Fellowship Educator of the Year in June 2025.

7. I practice forensic psychiatry, working on both child and adult cases in both criminal and civil courts. I teach forensic psychiatry, and specifically I annually lecture forensic fellows on correctional psychiatry and on a biannual basis I lecture child and adolescent psychiatry fellows on correctional psychiatry.

8. I volunteer with direct patient care and resident supervision at University of South Florida's refugee clinic. I am also on call for nights, holidays, and weekends at Tampa General Hospital's consult service.

9. I work in two university-based training clinics. As a supervising physician at the University of South Florida's Silver Child Development Center, my role is to function as a clinical supervisor and instructor. Psychiatry residents and child psychiatry residents serve as primary patient evaluators and clinicians. I also evaluate new patients directly and then see patients as needed. I oversee the residents' work product and function as the physician of record. In this clinic, I evaluate

and treat pediatric patients with Gender Dysphoria. In addition to these direct clinical experiences, my duties at the Silver Child Development Center include training residents regarding the treatment of patients, including those with Gender Dysphoria.

10. Additionally, I am a supervising physician at the University of South Florida's general (adult) psychiatry clinic, the Outpatient Psychiatry Center. My duties at the Outpatient Psychiatry Center include supervising and instructing psychiatry residents. At this clinic, general psychiatry residents serve as primary patient evaluators and clinicians. I evaluate new patients directly and see them as needed afterward. I oversee the residents' work product and function as the physician of record. As part of my role in this clinic, I evaluate and treat adult patients with Gender Dysphoria.

11. I have experience working in adult corrections as part of my forensics training. In addition, I have experience working in Orleans Parish Prison and at the Elayn Hunt Correctional Center.

12. I have worked in juvenile corrections at various facilities since I graduated from the Forensics Fellowship in 2005. I also treat patients with Gender Dysphoria at the seven juvenile correctional centers I actively cover. I have also been consulted to provide a second opinion and coordinate care regarding a patient with Gender Dysphoria in the Louisiana juvenile correctional system.

13. I practice and support conventional medicine, and I have advocated for the expansion of Federally Qualified Health Centers, along with improved collaboration of mental health with primary care (Kaliebe 2016; Kaliebe 2017). I've presented at the Preventing Overdiagnosis conference in Oxford, England, in 2014, and at the National Institutes of Health in Bethesda, Maryland, in 2015. The Preventing Overdiagnosis conferences examine how physicians,

researchers, and patients can implement solutions to the problems of overdiagnosis and overuse in the healthcare system.

14. I am a member of the American Academy of Child and Adolescent Psychiatry, the American Academy of Psychiatry and the Law, and the American Psychiatric Association. I am also a member of the Open Therapy Institute, Therapy First, and Heterodox Academy. I co-chair the Heterodox Academy Campus Community at the University of South Florida.

15. I have been very active in the American Academy of Child and Adolescent Psychiatry (AACAP) since I joined in 2000 and have presented at its annual conference 26 times. I was awarded the status of a Distinguished Fellow at AACAP in 2016. I served as co-chair of AACAP Media Committee from 2013 to 2021 and was an author on AACAP's clinical practice guidelines for telepsychiatry. In addition, I served as the liaison between AACAP and the American Academy of Pediatrics from 2016 to 2022. I have also served AACAP through its state affiliates, acting as secretary-treasurer of the Louisiana Council for Child Psychiatry for four years and as president for two years. I was also a member of the Association for Behavioral and Cognitive Therapies from 2004 to 2016.

16. I have extensive experience in psychotherapy and have received additional training in Cognitive Behavioral Therapy and trauma-focused therapies. Throughout my career, I have provided psychotherapy and taught psychotherapy to psychiatry trainees. I currently routinely supervise psychiatry residents at the University of South Florida regarding psychotherapy. From 2007 to 2016, I created and taught a Cognitive Behavioral Therapy practicum for LSU residents.

17. My presentations related to Gender Dysphoria include:

- Psychotherapeutic Processes with Young People Experiencing Gender Dysphoria, Tampere, Finland, June 16, 2023. During this event, I presented and moderated a panel: "Working Psychotherapeutically in a Contested Space: Overcoming Challenges."

- Society for Evidence Based Gender Medicine Conference, New York, New York, October 9-12, 2023; Panelist: "The Etiology of Gender Dysphoria, The role of social and cultural context"; "Current Gender Dysphoria Guidelines, Assessing the Quality"; "Question and Answers, Next Steps."

- "Compassionate Care for Gender Non-conforming Youth" at Safe Children Coalition Conference, Sarasota, Florida, April 26, 2024.

- Society for Evidence Based Gender Medicine, Psychotherapeutic Approaches to Youth Gender Dysphoria, Athens, Greece, October 3, 2024; Panel Discussion, "The transgender zeitgeist: Exploring gender as a youth social movement."

- "The Chain of Trust is Broken in Gender Medicine," Heterodox Academy Conference, Chicago, Illinois, June 7, 2024.

- "When Perfect Storms Collide: The Ecological Origins of Youth Gender Medicine," Genspect, The Bigger Picture Conference, Lisbon, Portugal, September 27, 2024.

- "The Cass Review and its Implications for Approaching Youth with Gender Distress," Grand Rounds, University of South Florida, Department of Pediatrics, Tampa, Florida, November 14, 2024.

- "Power, Responsibility, and Truth: Increasing Open Expression Regarding Race and Gender in Medicine," as part of "The Battle to Remove Political Intentions from the Road to Scientific Truth: Three Physician Perspectives," Heterodox Academy Conference, New York, New York, June 23, 2024.

18. I have been a co-author on publications related to working with incarcerated populations:

- *Prescribing Psychotropic Medications for Justice-Involved Juveniles*, Journal of Correctional Health Care, Tamburello, A., Penn, J., Negron-Muñoz, R., & Kaliebe, K. (2023).

- *Telepsychiatry in Juvenile Justice Settings*, Child and Adolescent Clinics of North America, Kaliebe, K., Heneghan, J., Kim, T. (2011).

- *Clinical Update: Telepsychiatry With Children and Adolescents*, AACAP, Committee on Telepsychiatry and AACAP Committee on Quality Issues, Journal of American Academy of Child and Adolescent Psychiatry (Oct. 2017).

19. My recent publications related to Gender Dysphoria include:

- *Adolescent Onset Gender Dysphoria, Our Perspective*, AACAP News, with David Atkinson, MD (Nov/Dec 2023).
- *A Reply to Legal, Mental Health, and Societal Considerations Related to Gender Identity and Transsexualism*, Letter to the Editor, Journal of the American Academy of Psychiatry and the Law, Vol. 51 (2023).
- Letter to the Editor, in response to "*A reply to "The present state of housing and treatment of transgender incarcerated persons*," Journal of the American Academy of Psychiatry and the Law, Vol. 52 (2024).
- *Obstacles to progress in pediatric gender medicine*, European Journal of Developmental Psychology, Kozlowska, K., Hunter, P., Clayton, A., Kaliebe, K., & Scher, S. (2025).

OPINIONS

20. Hormone therapy is unproven and experimental treatment for Gender Dysphoria that generally should not be available to those in the custody of the Federal Bureau of Prisons ("BOP"). Though it is not medically necessary to provide hormone therapy to inmates who are diagnosed with Gender Dysphoria but not currently receiving hormone therapy, inmates currently receiving hormone therapy may be a more complex situation. In most circumstances, it is appropriate, after individual assessment, to discontinue hormone therapy for inmates currently receiving hormone therapy through an appropriate withdrawal process. In a limited set of circumstances, it may be appropriate, after individual assessment, to continue hormone therapy for inmates already being treated with hormones.

21. Cross-sex surgeries are not medically necessary and should not be made available in correctional environments.

22. "Social accommodation" is not medically necessary in the correctional setting.

23. It is not medically necessary to house inmates with Gender Dysphoria according to their asserted gender identity.

BACKGROUND

Definitions

24. Definitions and description of nomenclature in this report.

- "Social transition" is the process of changing one's sex-associated name, presenting oneself as a member of the other sex, and being referred to with third-person pronouns for the other sex.
- "Gender medicine" will be used for the clinical field that treats Gender Dysphoria, sometimes with medical interventions.
- The term "medical transition" will be used, as it is more accurate and clearer than the term "gender-affirming care."
- The term "cross-sex hormones" will be used, as it is more neutral and informative than the term "gender-affirming hormones."
- The term "medical necessity" refers to health care services that a physician and/or health care professional, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or their symptoms. I use the term "medical necessity" as that term is used in the medical field, without regard to how that term may be used as applied to the Eighth Amendment or otherwise.

Sex and Gender

25. The basic biology of human beings is as a sexually dimorphic species. Biological sex is well-defined in all biological sciences, including medicine (Bhargava 2021). Sex is important in human development and throughout the lifecycle (Archer 2019). Sex is binary and determined at conception. Biological sex is programmed into every cell in the human body.

26. The term "gender identity" was introduced in the 1960s and meant the sense of knowing to which sex one belongs, the awareness of being male or female (Byrne 2023). More recently, however, the phrase "gender identity" is used differently by The World Professional Association for Transgender Health (WPATH), Standards of Care (SOC) 8, which defines "gender identity" as:

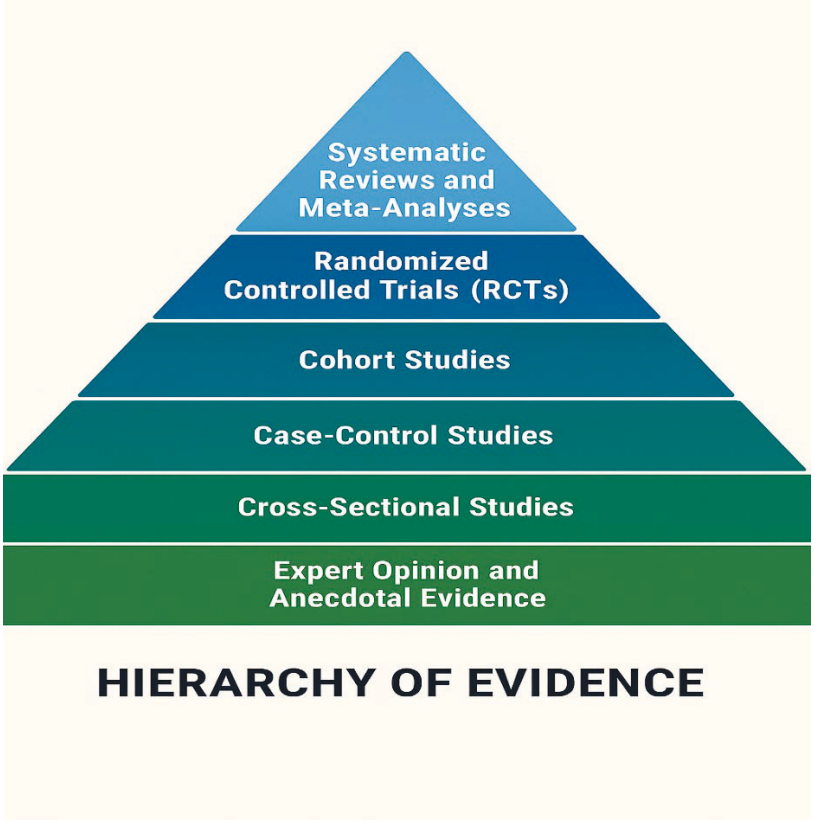
"A person's deeply felt, internal, intrinsic sense of their own gender." This definition is opaque because it refers to the amorphous term of "gender."

27. The term "transgender" is typically explained in terms of gender identity, i.e., that transgender people are those whose gender identities do not align with their sex.

28. This lack of clear definitions and shifting trends related to self-identified gender contribute to confusion about claims of medical necessity for the treatment of individuals with Gender Dysphoria, particularly in the correctional environment. While there are different uses of the term "gender" (Stock 2022 at 37-40), in this report, I will not use "gender" to refer to the distinction between men and women but will use the terms sex, biological sex, or natal sex for clarity.

Hierarchies of Evidence

29. In medicine, hierarchies of evidence are structured frameworks used to rank the reliability and validity of different types of research studies, guiding clinical decision-making, and evidence-based practice (Guyatt 1995, Evans 2003). Typically depicted as a pyramid, the hierarchy places systematic reviews and meta-analyses of randomized controlled trials (RCTs) at the top, as they synthesize high-quality data across multiple studies. Just below are RCTs, valued for their ability to minimize bias through randomization and control groups. Further down are cohort studies, case-control studies, and cross-sectional studies, which offer observational insights but are more susceptible to confounding factors. At the base lie expert opinions and anecdotal evidence, which, while sometimes useful, lack the rigorous methodology needed for strong clinical recommendations. This hierarchy helps clinicians prioritize the most trustworthy evidence when evaluating treatments, diagnostics, or prognostic tools.



30. In evidence-based medicine, grades like "low quality" or "high quality" evidence refer to how confident we can be that the research findings reflect the true effect of an intervention. These grades are part of the GRADE system (Grading of Recommendations Assessment, Development and Evaluation), which evaluates factors such as study design, risk of bias, consistency of results, directness of evidence, and precision of estimates. High-quality evidence typically comes from well-conducted randomized controlled trials and suggests that further research is unlikely to change our confidence in the results. In contrast, low-quality evidence—often from observational studies or flawed trials—means that future studies may significantly alter our understanding of the effect. These ratings help clinicians and policymakers make informed decisions by weighing the strength and reliability of the available data (Guyatt 2008).

Treatment Approaches for Gender Dysphoria

31. Gender Dysphoria is like depression, anxiety, and other mental disorders and is not among the most severe and persistent illnesses, such as schizophrenia, Level 3 autism, or bipolar disorder. The condition should not be assumed to be lifelong (Jorgenson 2024, Levine 2021). The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) provides that the diagnostic criteria for Gender Dysphoria in adolescents and adults are (1) a "marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least six months, as manifested by at least two of the [identified symptoms]," and (2) "clinically significant distress or impairment in social, occupational, or other important areas of functioning." DSM-5 (Gender Dysphoria). While Gender Dysphoria is viewed by some as a serious medical or psychiatric illness, others have also viewed it as a developmental adaptation to psychological problems, or an issue of sexual minority rights (Levine 2016, Castro-Peraza 2019). These beliefs about the nature of Gender Dysphoria will affect clinicians' treatment approach and the expectations of individuals experiencing Gender Dysphoria.

32. There are at least three different treatment models: (1) psychiatric comorbidities, (2) psychotherapeutic, and (3) affirmative.

33. The first clinical model is supportive and directly treats psychiatric comorbidities, such as depression and anxiety that frequently co-occur with gender dysphoria. This is a cautious approach based on the principle that not all human suffering should be a target of psychological or medical intervention. With any treatment, there is a potential for medical and psychological harm, wasted resources, and undermining patient independence and self-sufficiency. As gender non-conformity is not pathological, it is beyond the capacity and understanding of professionals to create interventions that are clearly beneficial and a reasonable use of resources. This approach treats

Gender Dysphoria as just another type of body-related distress that need not be over-emphasized or become a direct focus of treatment.

34. The second clinical approach is psychotherapeutic, aimed at alleviating distress by applying long-standing and evidence-informed tools of psychotherapy for patients suffering from Gender Dysphoria. Proper psychotherapy for gender distress does not impose the ideas of the clinician but can empower patients "to develop creative solutions to their difficulties and promotes agency and autonomy" (DeAngelo 2023).

35. The third treatment approach is the affirmation model (Coleman 2022), which promotes affirmation of the transgender identity immediately and decisively. Under this approach, social transition, i.e., living as the opposite sex, including changing the individual's name, preferred pronouns, and appearance, is encouraged. This approach considers the body parts and physical features that are associated with dysphoria as targets for treatment. Under this model, social transition, hormones, and surgeries would be provided without regard, or with minimal regard, toward factors associated with transgender identities, such as trauma, disorders of personality development, internalized or externalized homophobia, and neurocognitive disorders (e.g., autism).

A. <u>The affirmation model has many weaknesses and risks.</u>

36. In the community, the gender-affirming treatment options have become more common recently and are typically available for adults, and in some states, for minors. Yet affirmative treatment has significant known and unknown risks as discussed below and is based on low-quality evidence. These risks are amplified when applied to the correctional populations because such populations are highly unique and vulnerable due to higher rates of trauma, neurodevelopmental disorders, personality disorders, and psychopathy (Levine 2016, Liu 2021).

37. First, because the affirmative treatment paradigm emphasizes patient autonomy and the patient's desire to be treated as if they are the opposite sex, questions about the patients' self-identification are viewed as hostile and potentially harmful to the patient. This approach often overly credits patients' "rights", thus circumventing the scientific debate of evidence. It also tends to minimize discussion of harms and trade-offs, and risks patients harming themselves due to impaired decision-making, desperation, and/or exposure to misinformation that distorts informed consent of risk and benefit. Within the affirmation model, hormones or surgical interventions are provided despite that these treatments would not meet the usual clinical standards of providing treatments that improve health.

38. Second, the affirmation model treats Gender Dysphoria as a permanent disorder when it is better considered a temporary disorder like bulimia or depression. While some cases of depression or bulimia are long-lasting, most are not. The same is true with Gender Dysphoria. But once Gender Dysphoria is medicalized, it is more likely to become a long-lasting aspect of the individual, in part because patients are forever physically changed, and also due to patient self-justification, as will be detailed later in the report.

39. Third, much of the justification for affirmative treatment, such as cross-sex hormones and surgical treatments, comes from surveys indicating patient satisfaction. Although patient satisfaction is often used as an outcome measure in medical care, patient satisfaction can be influenced by factors unrelated to the quality of care (Richman & Schulman 2022), and prioritizing patient happiness and satisfaction may lead to inappropriate overtreatment (Mandell 2016, Lemke 2016), and undermine the importance of clinical outcomes and evidence-based practices, which are crucial for ensuring high-quality care (Fenton 2012).

40. As noted by Sirvoch (2012) at 412, "Fenton and colleagues followed more than 50000 adult participants in the National Center for Health Statistics' Medical Expenditure Panel Survey over a 2-year period (longer for mortality). Judging from patients' reported satisfaction with their physicians after year one, the authors found that, compared with patients in the lowest quartile of satisfaction, patients in the highest quartile were subsequently less likely to be seen in an emergency department, but more likely to be hospitalized, were responsible for more prescription drug and total health care expenditures, and were more likely to die." Sirvoch (at 413) goes on to note that: "Satisfaction with seemingly adverse outcomes of potentially excessive medical care appears to be the norm" and that "[m]ore aggressive practice, therefore, improves not only patients' perceived outcomes, but also those of physicians (reimbursement, performance ratings, protection against lawsuits), and the positive feedback loop of health care utilization is fueled at two ends."

41. Concerns about relying on patient satisfaction are especially acute when using affirmative treatments for Gender Dysphoria. There is sparse data to track in a controlled manner those who have embarked on these treatments and what their outcome has been. Retrospective recall is unreliable (Coleman 2024, Mazzoni 2003) and recall among patients expressing Gender Dysphoria may be particularly distorted by their current emotional state and beliefs (Kulatunga 2024). There is also a survivorship bias in surveys of those who remain transgender-identified, and large numbers of dropouts are frequently seen in studies purported to show long-term benefits (Shelemy 2023). And patients who have embarked on irreversible medical treatment would have the most self-justification, considering they have altered the trajectory of their lives, and for many, there is no return to their previous bodily state. This cohort would have the least propensity to factor in regret and look soberly at the outcome.

42. In sum, under the affirmation model, medical sex trait modification is patient-driven, voluntary, and sought-out treatment, but is supported only by low-quality evidence, is promoted by a field that has created publication bias, lacks a strong research foundation, and has failed to adhere to typical standards for clinical practice (Kozlowska 2025). The unknowns and risks, especially in carceral settings where practically no direct research evidence exists, are accompanied by an unreliable evidence base, ideological influences over care recommendations, and unknown long-term effects.

B. Psychotherapy is the preferred treatment approach for Gender Dysphoria, particularly within correctional environments.

43. While patient-driven medicine characteristic of the affirmation model carries significant risks because humans have immense powers to deceive themselves and because patients may be susceptible to clinicians' suggestions of affirmative treatment, both primary psychotherapeutic schools within mental health, Psychodynamic Therapy and Cognitive Behavioral Therapy, focus largely on identifying self-deception. A major target of treatment is helping patients identify how they deceive themselves.

44. In my opinion, the psychotherapeutic model is the most appropriate treatment model. That approach provides treatment aimed at alleviating distress by applying long-standing and evidence-based tools of psychotherapy. It enables the exploration of causative factors, enhances self-awareness and self-efficacy, and facilitates patients' coping with comorbidities.

45. The approach also provides support to reduce suicidality and self-harm and decrease symptoms of comorbidities, such as depression and anxiety. Psychotherapy practitioners do not directly challenge a claimed transgender identity, nor do they affirm the patient's narrative or theories. Instead, they permit the patient to continue to express a transgender identity (Hakeem 2012, DeAngelo 2021), while engaging in a dialogue with the patient regarding these matters

without providing the answer. Therapists (including psychologists, psychiatrists and a range of other mental health professionals) are all trained to appreciate that an individual is shaped by his or her upbringing, socialization, and life events. Therapists and patients work together to help the patient identify and address why the patient is uncomfortable with his or her sense of self, just as the therapist can help put the patient's other identities (such as racial and ethnic backgrounds, religious or spiritual affiliations, or professions) in perspective.

46. The dialogue in psychotherapy would look for adversity, abuse, and other traumas as potential contributors (Withers 2020). Therapy explores the influence of exposure to images, ideologies, and modeling, including online. This paradigm also considers fantasy, parental attachment, and psychosexual influences. Any of these factors can intermix with temperament, psychiatric symptoms, and neurocognitive disorders such as ADHD and autism, which are more common in those with Gender Dysphoria (Thrower 2020). Practitioners inquire about potential influences and encourage self-exploration, especially considering the increased rate of Gender Dysphoria and neurocognitive disorders.

47. This broad focus allows a full range of established treatments for the comorbidities typically present in correctional populations diagnosed with Gender Dysphoria. This approach avoids what Hillary Cass described as diagnostic over-shadowing (Cass 2024), or what is sometimes called gender exceptionalism, i.e., the focus on the gender-related distress deflects treatment away from other conditions.

48. While few studies have explored standard psychotherapy techniques in the context of Gender Dysphoria, psychotherapy is a longstanding mental health tradition with decades of accumulated wisdom regarding what works, how to approach and align with patients, goal setting, instilling hope, and establishing rapport. These and other common elements in various types of

psychotherapy are acknowledged to be healing, regardless of whether the orientation is psychodynamic, cognitive behavioral, or any other school of therapy (Feinstein 2015, Cuijpers 2019, Laska 2014).

49. Longstanding frameworks such as Psychodynamic Psychotherapy and Cognitive Behavioral Therapy have been used to treat an extremely wide range of mental health problems (David 2018, Hoffman 2012, Sanai 2024) and can be used to treat Gender Dysphoria. Psychodynamic Psychotherapy is a form of talk therapy that focuses on how unconscious processes and past experiences influence a person's current thoughts, feelings, and behaviors. Cognitive Behavioral Therapy is a type of talk therapy that helps individuals become aware of inaccurate or negative thinking patterns, enabling them to view challenging situations more clearly, take action to overcome symptoms, and respond to stressors more effectively.

50. Cognitive Behavioral Therapy, for example, is an effective treatment for Body Dysmorphic Disorder (Harrison 2016), which shares similar features as Gender Dysphoria, including body-related distress, a focus on appearance, increase in younger generations spending more time online (Gupta 2023), and significant comorbidities such as increased rates of self-harm, anxiety, and depression. Cognitive Behavioral Therapy's success in ameliorating Body Dysmorphic Disorder indicates applying similar approaches would be an effective treatment for Gender Dysphoria.

51. Cognitive Behavioral Therapy is also commonly used as a psychotherapy for eating disorders, such as Anorexia (Öst 2024). Eating disorders share features with Gender Dysphoria, as both are influenced by socio-cultural concepts of appearance (Choukas-Bradley 2022). Both disorders also have shown a potential for social contagion, i.e., the phenomenon where mental health symptoms, attitudes, or behaviors spread through a social network or population (Giedinghagen 2023, Alho 2023, Agostino 2021, Hacking 2006). This social contagion can happen

through various mechanisms, including peer influence, social learning, emotional mimicry, and the normalization of certain behaviors. In both Anorexia and Gender Dysphoria, patients seek to transform their bodies to align with the internalized image. Psychotherapy for Anorexia often includes Dialectical Behavior Therapy. Dialectical Behavior Therapy is a modified type of Cognitive Behavioral Therapy that focuses on teaching skills in four key areas: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness (Cogodi 2024, Monteloeone 2024). In Anorexia, the distorted body image is never affirmed, and patients are not encouraged to alter their bodies to fit their embodiment goals (Korte 2023).

52. Because cross-sex identification can arise after trauma (Cosentino 1993), and gender dysphoric patients have experienced a higher incidence of trauma than the general population (Brewerton 2022, Gehring 2005), many effective psychotherapy treatments for post-traumatic stress symptoms can also be used to treat Gender Dysphoria. Cognitive Processing Therapy helps people challenge and modify unhelpful beliefs and thoughts that developed after the trauma. Prolonged Exposure Therapy is a specific type of Cognitive Behavioral Therapy that helps people with post-traumatic stress disorder by gradually and repeatedly exposing them to memories, feelings, and situations they have been avoiding since the traumatic event. Eye movement desensitization and reprocessing is a psychotherapy technique that helps people process and heal from trauma by using bilateral stimulation, often in the form of guided eye movements, while the individual recalls distressing memories.

53. These various treatments all use components of Cognitive Behavioral Therapy, which helps patients reconceptualize their experiences and tolerate body sensations associated with the stress response. Trauma-focused treatments, such as Cognitive Behavioral Therapy, can also ameliorate co-occurring depressive, anxiety, and grief symptoms.

54. Dialectical Behavior Therapy has the strongest evidence for reducing self-harm, but cognitive behavioral therapy and other approaches also show promise to reduce self-harm—a potential problem co-occurring with Gender Dysphoria. Dialectical Behavior Therapy has been shown to be the gold standard treatment for Borderline Personality Disorder, the criteria of which include changes in gender identity and along with frequent self-harm, emptiness, and unstable interpersonal relationships. Dialectical Behavior Therapy teaches patients to be present in the moment and aware of their thoughts and feelings without judgment. Patients learn distress tolerance techniques and strategies to manage intense emotions that often lead to self-harm.

55. There are higher rates of personality disorders among the patient cohort with Gender Dysphoria (Rodriguez-Seijas 2024, Kaila-Vanhatalo 2025), and higher levels of personality disorders in correctional populations (Levine 2016, Liu 2021). Psychotherapy is the treatment of choice for personality disorders, and there has been significant progress in developing approaches for this population (Stoffers-Winterling 2022, Emmelkamp 2025).

56. Because of the high levels of comorbidity of psychiatric disorders in patients with Gender Dysphoria, Cognitive Behavioral Therapy could be extremely helpful as the same approach and techniques have proven effective with so many problems including anxiety, depression, and in reducing self-harm. For instance, those with Gender Dysphoria may also suffer from anxiety. Cognitive Behavioral Therapy has been demonstrated to be helpful for the full range of anxiety disorders, and teaches patients to build on small successes, increase distress tolerance, and learn coping skills and self-regulation. Patient in Cognitive Behavioral Therapy face their fears and experiment with new experiences. Targets in Cognitive Behavioral Therapy for anxiety can include: (1) fears of the future; (2) feelings of tension, restlessness, and arousal; (3) social anxiety;

(4) thoughts focused on worry, impending danger, or panic; and (5) concentrating or thinking about anything other than the present worry.

57. Cognitive Behavioral Therapy, Interpersonal Therapy, Psychodynamic Psychotherapy, and mind-body therapies have all shown success in reducing depression, another comorbidity of Gender Dysphoria. These therapies can target (1) negative body sensations, (2) negative self-perception, (3) social struggles and isolation, (4) over-focus of the negative via persistent rigid or unrealistic thinking thoughts, (5) catastrophizing (expecting the worst possible outcome), and (6) overgeneralization (making broad conclusions from a single or few data points). Cognitive Behavioral Therapy has strong evidence for reducing depression, with a recent meta-analysis covering over 400 randomized controlled trials and 50,000 patients (Cuijpers 2023).

58. Psychotherapy can be combined with mind-body therapies that show promise to foster self-regulation and reduce body-related distress (Nejadghaderi, 2024, Brinsley, 2021, Deveci, 2023).

59. A significant benefit of psychotherapy is its ability to help patients without irreversible medical interventions. Patients with Gender Dysphoria may disfavor the cautious approach of psychotherapy in the short term and the effort involved, but the skills built and the perspective gained in psychotherapy can provide long-term benefits to the patients. Some patients will reassume the gender identity of their natal sex.

Regarding WPATH

60. WPATH and other affirmative guidelines regarding the care of people with Gender Dysphoria should neither be treated as authoritative nor be used to determine care for Gender Dysphoria. WPATH openly engages in ideologically-based political advocacy, systematically misrepresents evidence, and often bases its recommendations, no matter how impactful for the patient, on low-quality supporting evidence. WPATH's standards are even more unreliable when it comes to prisoners. "Inmates who seek treatment for Gender Dysphoria typically display little

resemblance to the patients who present for treatment in the community, and prison life bears little resemblance to life in the community. The SOC [WPATH Standards of Care] were not developed with the complexities, vulnerabilities, and life circumstances of incarcerated persons in mind" (Osborne 2016 at 1651).

61. Since its beginnings in 1979, WPATH—then known as the Harry Benjamin International Gender Dysphoria Association—has struggled to reconcile its goals of being both a scientific, clinical organization studying Gender Dysphoria and an advocacy organization. WPATH has made clear its desire to change policy toward gender identity and away from biological sex. For example, it endorses The Yogyakarta Principles, which urge the overhaul of sex- and gender-related legal frameworks to advance the human rights of gender-nonconforming individuals. *See* WPATH Statement on Yogyakarta Principles plus 10 and Healthcare Delivery (July 29, 2019), https://wpath.org/wp-content/uploads/2024/11/WPATH-Statement-on-Yogykarta-Principles-Plus-10.pdf

62. Some recent articles expose what has occurred at WPATH (Kozlowska 2025). This comes after the release of documents in a legal case in Alabama (*Boe v. Marshall*).

- Pamela Paul, New York Times, *Why is the US still pretending we know gender-affirming care works?* (July 12, 2024): "Recently released emails show the WPATH leaders told researchers that their work should 'not negatively affect the provision of transgender health care in the broadest sense.'"

- The Economist, *Research into trans medicine has been manipulated* (June 27, 2024):

  - "Court documents recently released as part of the discovery process in a case involving youth gender medicine in Alabama reveal that wpath's claim was built on shaky foundations. The documents show that the organisation's leaders interfered with the production of systematic reviews that it had commissioned from the Johns Hopkins University Evidence-Based Practice Centre (epc) in 2018."

  - "After wpath leaders saw two manuscripts submitted for review in July 2020, however, the parties' disagreements flared up again. In August the wpath executive committee wrote to Ms. Robinson [Associate Professor at Johns Hopkins] that wpath had 'many

concerns' about these papers, and that it was implementing a new policy in which wpath would have authority to influence the epc team's output—including the power to nip papers in the bud on the basis of their conclusions."

- "Ms. Robinson protested that the new policy did not reflect the contract she had signed and violated basic principles of unfettered scientific inquiry she had emphasised repeatedly in her dealings with wpath. The Hopkins team published only one paper after wpath implemented its new policy: a 2021 meta-analysis on the effects of hormone therapy on transgender people. Among the recently released court documents is a wpath checklist confirming that an individual from wpath was involved 'in the design, drafting of the article and final approval of [that] article'. (The article itself explicitly claims the opposite.) Now, more than six years after signing the agreement, the epc team does not appear to have published anything else, despite having provided wpath with the material for six systematic reviews, according to the documents."

- Benjamin Ryan, NY Sun, '*Damning' Information About Trans Medical Group Expected to Reach Supreme Court, as Justices Consider Challenge to Ban on Gender Treatments for Minors* (July 10, 2024):

  - "The unsealed documents indicate Wpath leadership caved to political pressure from outside groups and quietly crafted its pediatric guidelines with the intent of influencing public policy. Wpath leadership also balked at the potential publication of research findings the organization had commissioned that its leadership believed might negatively impact access to gender-transition treatment."

  - "Erica Anderson, a psychologist, transgender woman, and former head of WPATH's American branch USPATH, characterized the recent disclosures as 'damaging' to the organization. 'The backroom discussions cement the picture of ideological and political capture,' she told the Sun of how she saw her former colleagues as woefully compromised. She said their exposed communications 'hardly' portrayed them as 'scientists using evidence to develop best practices.' Many Wpath leaders, she added, 'clearly have lost their way.'"

  - "According to unsealed internal communications, WPATH also wielded a heavy hand after it in 2018 commissioned from evidence-based medicine experts at Johns Hopkins University a series of systematic literature reviews—the gold standard of scientific evidence—regarding various facets of trans medical care. After some of the Hopkins teams' findings raised concerns among WPATH leadership that they might 'negatively affect the provision of transgender health care,' WPATH compromised the independence of the Hopkins researchers. This included asserting the final say on the publication of any systematic reviews. To date, just two reviews have been published."

  - "The Cantor report [an expert report submitted in the Alabama litigation] further found that WPATH leaders crafted the language of its medical guidelines for the express purpose of influencing insurance coverage, policy, and litigation, which, according to Dr. Cantor, in at least some points, came 'even at the expense of scientific accuracy.'

> He also found that Wpath coordinated on the draft with the ACLU, which is behind many of the suits against state bans of such treatment."

63. These portrayals align with my review of the WPATH documents disclosed in the Alabama case (*Boe v. Marshall*, Kaliebe report; *Boe v. Marshall*, Cantor report). WPATH's internal documents clearly show that WPATH is an advocacy organization and not a scientific one. Scientific organizations do not pressure scholars to distort or suppress evidence that does not fit their narrative or systematically mislead the professional community and public regarding the treatments they support. WPATH has violated many principles underpinning medical ethics and research and contributed to widespread publication bias in gender medicine. Publication bias is the tendency for studies with positive or significant results to be published more frequently and rapidly than those with negative or inconclusive findings, leading to a distorted understanding of the evidence base. As noted in Murad at 85 (2018) publication bias is "one of the worst threats to the validity of scientific research."

64. Additionally, the recently released "WPATH files" are leaked internal discussions between WPATH members published by the think tank Environmental Progress (https://environmentalprogress.org/big-news/wpath-files). The site reports: "the WPATH Files reveal that the organization does not meet the standards of evidence-based medicine, and members frequently discuss improvising treatments as they go along." My review of the lightly redacted text and the video confirms this analysis. These files display that the internal discussions at WPATH do not match the simplistic affirmative guidelines WPATH produces.

65. The WPATH files further showed that there was minimal discussion of the tradeoffs involved in gender care, and prudent clinical caution is frequently derided as "gatekeeping." Activist members speak freely regarding their disdain for "cis normativity" and the

"gender binary" and their belief in patient self-determination regarding surgical body-modification.

66. Members of WPATH, and other advocates, which in total comprise a small number of physicians, have been able to leverage moralized claims and low-quality evidence to promote medical interventions for Gender Dysphoria. There has simultaneously been silencing, stigmatization, and censorship of more balanced and mainstream viewpoints (Bailey 2023, Ciszek 2021, Clark 2023, Clark 2024, Dreggor 2008, Gliske 2021, Soh 2021, Stevens 2020, Stevenson 2023), creating a mirage of general support for positions contrary to good medicine.

67. Public policy, including prison policy, based on the theories promoted by WPATH is unlikely to be good policy, as it arises from ideology more than evidence.

68. Dahlen reviewed WPATH's prior guidelines, SOC-7, as part of a systematic review and quality assessment of international clinical practice guidelines for gender minority/trans-identifying people. They noted that WPATH SOC-7 contained no auditable quality standards and scored poorly on editorial independence, applicability, and rigor of development. The reviewers noted that WPATH prioritized stakeholder involvement rather than methodological rigor. Among the principal findings was that WPATH SOC-7 "cannot be considered [the] 'gold standard'" (Dahlen 2021).

69. Yet despite the well-known methodological weakness of SOC-7, WPATH created SOC-8 with many of the same problems, only selectively using the conventions that are necessary to create a trustworthy clinical practice guideline. "It appears WPATH expects readers to faithfully accept potentially biased judgments of the literature rather than confidently submitting SoCv8 to open scientific scrutiny. SoCv8 could have been much better: its evidence base and recommendations cannot yet be relied upon" (Dahlen 2022).

70. WPATH's approach is contrary to the recommendation of the Institute of Medicine—the health arm of the National Academy of Sciences—that clinical practice guidelines should be informed by systematic reviews of evidence, which can help minimize potential harm created through guidelines supported mainly by the consensus of expert impression (Institute of Medicine 2011).

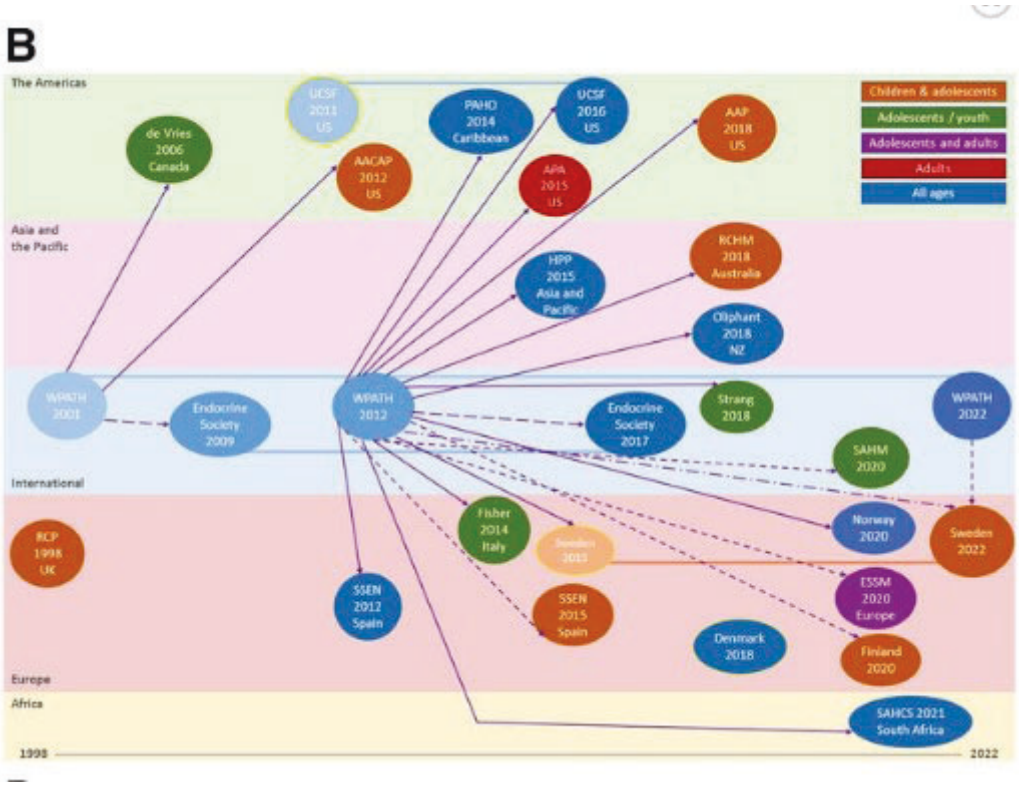
71. With recently unsealed court documents, we now know that WPATH SOC-8 did submit for likely more than a dozen systematic reviews of evidence but interfered with the researchers conducting the reviews, disallowed publication of most reviews, and undermined the publication of the available data (Kozlowska 2025, Economist 2024, Selin-Davis 2024, Ryan 2024). WPATH did what should be unthinkable; it has hidden, to this day, what systematic reviews were attempted, then stopped or buried them due to unfavorable results. (Kozlowska 2025, Economist 2024, *Boe v. Marshall* Cantor Report).

72. WPATH SOC-8 intentionally obscured the most important element required for a trustworthy clinical practice guideline: the assessment of the strength of the evidence used to make recommendations. Hiding the strength of evidence hides critical data from readers trying to evaluate the evidence base for an organization's recommendations (Murad 2017). This is especially concerning due to the lifelong implication and irreversible nature of the treatments WPATH advocates.

73. The British National Health Service's Cass Review of youth gender medicine, published in 2024, echoed these concerns. Dr. Hillary Cass conducted a systematic review of available clinical guidelines for children and adolescents experiencing Gender Dysphoria or incongruence. She reviewed 23 guidelines published from 1998 to 2022. "The findings from this review . . . raise questions about the credibility of currently available guidance, despite the majority being

published in the last 5 years. Most guidelines have not followed international standards for guideline development set out by the [Appraisal of Guidelines for Research and Evaluation II] initiative and/or provide insufficient information about their development. Because of this, the review team only recommended two guidelines for practice—the Finnish guideline published in 2020 and the Swedish guideline published in 2022" (Taylor 2024).

74. The Cass systematic review noted how the other guidelines cross-reference other guidelines to justify their recommendations, rather than citing actual evidence (see figure label B – below). Furthermore, the WPATH and Endocrine Society collaborated, meaning a very small, interconnected group of WPATH members led to the creation of multiple guidelines among multiple medical organizations. "The WPATH and Endocrine Society international guidelines, which like other guidance lack developmental rigour and transparency have, until recently, dominated the development of other guidelines. Healthcare professionals should consider the lack of quality and independence of available guidance when utilising this for practice" (Taylor 2024).



75. The above graphic from the Cass systematic review (Taylor 2024) shows that WPATH's unreliable and low-quality recommendations have infected other guidelines, causing a systematic distortion of clinical guidance.

76. While a complete review of WPATH's SOC-8 is beyond the scope of this report, I note a few concerns below:

77. First, SOC-8 does not analyze why it prioritizes affirmation of gender identity over affirmation and acceptance of the physical, sexed body. For all other mental health disorders, clinicians aim to help patients accept and feel comfortable in their body. Nowhere else do mental health professionals recommend changing the body to fit the mind's impression. SOC-8 treats the question as though it had a clear answer supported by the evidence: affirm self-reported gender identity. That unproven theory runs through the SOC-8 guidelines and underpins much of the assessment and treatment recommendations in the SOC-8, therefore making it untrustworthy.

78. Second, WPATH associates comorbidities, such as suicidality and depression, as being caused by society rather than individual psychopathology. This is often called the "minority stress" theory, the supporters of which advocate that it is the role of medical and mental health care to relieve that stress by affirming the patient's preferred gender. This unfortunate therapeutic stance is in tension with evidence that the victim mindset undermines the patients' mental health and impedes their healing (Kaufman 2025). Narratives that encourage those with Gender Dysphoria to develop a victim mindset may be especially detrimental in prison populations.

79. Third, SOC guidelines consistently recommend changes to institutions, such as prisons, without a review of the tradeoffs and harm involved. The SOC-8 suggestions regarding institutional care neglect the honest appraisals, stakeholder input, and nuance required to create a trustworthy recommendation regarding gender transition in carceral settings. WPATH overstates the benefit of an affirming and medicalized approach and does not adequately review the risks, particularly those associated with carceral settings.

80. Fourth, SOC-8 normalizes self-mutilation by devoting a chapter to "Eunuchs" (a castrated man) and treating it as just another non-binary category. It did so without the necessary warning that mental health assessments are needed before any consideration of chemical or surgical procedures and without acknowledging the damage associated with such self-harm.

81. Fifth, SOC-8 downplays concerns related to detransitioning, repeatedly using the term "rare" without definition or the methodology they used to determine that term is appropriate. Evidence suggests the more recently transitioned cohort with less-restrictive access to hormones and surgeries has a much higher rate of detransition, although the precise detransition rate is unknown (Cohn 2023, Jorgensen 2023).

82. As reflected in the WPATH SOC 8, within gender medicine, there has been a failure of "maintaining terminological and conceptual clarity" (Kozlowska 2025). This accompanies a failure to engage in appropriate scholarly discourse, a failure to publish research results in a timely manner, and a failure to frame outcomes and strength of evidence with accuracy. Reliance on WPATH has caused professional societies and government health authorities to break the "chain of trust" afforded to those who relied on WPATH (Kozlowska 2025).

CROSS-SEX HORMONES GENERALLY ARE NOT MEDICALLY NECESSARY

Weaknesses of Past Studies and Recommendations Related to Cross-Sex Hormones

83. Although used in affirming clinical practice, hormone therapy for Gender Dysphoria is not based on guidelines using best practice or systematic reviews of evidence. There are no controlled studies or high-quality evidence in the carceral setting that would lead to the recommendation of sex-trait modification, such as through cross-sex hormones, of inmates with Gender Dysphoria.

84. In 2012, the American Psychiatric Association (APA), along with members of WPATH within APA, decided to support affirmative treatments. At the time, the APA task force admitted, "The quality of evidence pertaining to most aspects of [hormone] treatment was determined to be low" (Byne 2012 at 759). Nonetheless, the APA used clinical consensus to support new recommendations for affirming treatment "[w]ith subjective improvement as the primary outcome measure" (Byne 2012 at 759). As such, the APA's recommendation is not based on established standards for creating quality treatment guidelines, but rather on clinical consensus that is based primarily on subjective self-report.

85. Similarly, WPATH's SOC-7 and SOC-8 guidelines regarding hormone therapy did not follow best practice and lack developmental rigor (Dalen 2021).

86. Recent large reviews and research into harms from hormone treatment for Gender Dysphoria raise increased concerns regarding the safety, efficacy, and prudence of this practice. A recent Danish review, for example, indicated that using cross-sex hormones to treat Gender Dysphoria yields mixed results, and a worsening of psychiatric diagnosis one year after initiation of hormones. Although the patient stabilizes thereafter, the patient at all times has increased mental health problems when compared to the general population, especially for males prescribed feminizing hormones (Glintborg 2025 at 336).

87. In 2020, the United States Department of Health and Human Services ("HHS") declined to "take a definitive view on any of the medical questions raised" "about treatments for Gender Dysphoria" because there was a "lack of high-quality scientific evidence supporting" the interventions. HHS characterized WPATH as "an advocacy group" and did not consider WPATH's guidelines as being based on "independent scientific fact-finding." Nondiscrimination in Health & Health Education Programs or Activities, 85 Fed. Reg. 37,160, 37, 186-98 (June 19, 2020).

88. A recent a systematic review and meta-analysis regarding patients up to age 26 noted the uncertain effects of cross-sex hormones across multiple domains. Specifically, the effects cross-sex hormones on Gender Dysphoria itself are noted to be "very uncertain," as are the effects on global functioning and depression. The authors conclude: "The best available evidence reporting on the effects of GAHT [cross-sex hormones] in individuals with [Gender Dysphoria] ranged from moderate to high certainty for cardiovascular events and low to very low certainty for the outcomes of [Gender Dysphoria], global function, depression, sexual dysfunction, BMD [bone mineral density] and death by suicide" (Miroshnychenko 2025 at 444).

89. Shelemy's review (2023) found 14 studies that met their inclusion criteria, showing a trend toward reduced depression and anxiety during hormone treatment. Yet this review specifically

excluded non-affirmative approaches and as such, sheds no light on whether the outcome would be the same, better, or worse with psychotherapy treatment alone. Furthermore, several of the 14 studies did not report dropout rates, while 31% reported *high* dropout (over 40%), and 28% of studies were assessed to have a *high* level of selection bias (less than 60% of the participants registered or approached completed the pretest measure). Moreover, the authors noted, "There is potential for authorship bias throughout much of the research literature as several studies were authored by clinical staff in which interventions are routinely offered." This noted bias highlights a major problem in the research on cross-sex hormones, which is that those involved in gender medicine research are already favorably inclined toward using affirmative treatment (Scott 2013, West 2012). Best practice to create reliable research regarding medical transitions would be to have neutral scholars design and conduct the research, thus correcting the authorship bias noted by Shelemy.

90. In any event, the noted reduction in anxiety or improvements in mood may be placebo effects (Clayton 2022). Placebo effects are positive changes based on expectations. Missing from the discussion of reviews like Shelemy is a discussion of what percentage of the improvement is placebo effects, which are broadly considered across other disorders. (Bschor 2024, Wager & Atlas 2015). Placebo effects are highest for internalizing disorders like depression and anxiety, which share similar symptoms as Gender Dysphoria. Furthermore, as placebo effects are bolstered by expectations, these placebo effects may be enhanced by clinicians' positive statements regarding the effectiveness of medical transition, just as patients with stronger belief in antidepressant medications' effectiveness receive a stronger placebo effect in anti-depressant studies.

91. Placebo effects also could arise from psychosocial support, which would be expected within affirming-gender clinics, and from allies in the community (Clayton 2023). That is, the

improvement noted in mood or anxiety could arise—not from the hormone treatment itself—but from the psychosocial support the patient receives in connection with the hormone treatment. This in turn would suggest that hormonal treatment within correctional settings cannot be expected to produce the same placebo effects because any psychosocial support will be significantly limited due to inherent restrictions in activities, movement, and self-association.

92. Until recently, medical transition for adults with Gender Dysphoria has been rare, and tracking long-term outcomes has been sparse; therefore, nominal long-term data exists. What long-term data does exist is mixed, with some of the most powerful data being unfavorable (Anckarsäter & Gillberg 2020, Dhejne 2011). Based on long-term data in Sweden, cross-sex interventions have not been shown to reduce self-harm; nor do they clearly reduce mental health problems (Bränström 2020).

93. The initiation of sex-trait modification through cross-sex hormones remains an experimental treatment that has been pursued at the expense of more cautious, holistic, and measured approaches. The rapid spread of these untested treatments has been called "runaway diffusion": sex-trait modification and affirmation entered clinical practice worldwide without rigorous research confirming the underlying hypothetical benefits (Abbruzzese 2023).

94. WPATH's commissioned systematic review reveals a high risk of bias in the available studies, and it appears to have been manipulated to frame the unimpressive results as supporting affirmative treatments. Even so, WPATH's own systematic review indicates hormone therapy has not been shown to reduce suicide risks (Baker 2021). This conclusion that there is a lack of evidence regarding any reduction in the risk of suicide is particularly pronounced in carceral settings, where no substantial research exists and no claim can be made whether hormone treatments increase, decrease, or do not change suicide risk.

95. Overstating the benefits of hormone therapy is particularly problematic in prison settings, with both vulnerable and potentially belligerent populations that have higher degrees of psychopathologies, such as trauma disorders, neurocognitive disorders, and personality disorders. The forced intimacy of a prison setting creates many risks and challenges not seen in the general community, and as such, the provision of hormone treatment has more profound effects on the prison community milieu.

Substantial Health Risks of Cross-Sex Hormone Therapy

96. Sex-trait modification through hormone therapy has substantial health risks and is one of the few instances, and the only psychiatric disorder, in which doctors intentionally harm healthy tissue. For years, there has been little data collection and scholarly discussion regarding the harms of cross-sex hormone therapy, yet this is changing.

97. A recent review analyzed 290 adverse drug reactions in the U.S. Food and Drug Administration Adverse Event Reporting System (FAERS) (Gomez-Lumbreras & Villa-Zapata 2024 at 1089). "For individuals assigned female at birth undergoing gender transition to male (transgender men), 82 reports (230 [Adverse Drug Reactions]) were analyzed, with an average age of 29.5 years. Transgender hormonal therapy was cited in 72% of reports, predominantly from the United States (67.1%). A striking 88% were categorized as serious [Adverse Drug Reactions], primarily SOC [System Organ Class] injury, poisoning, and procedural complications (26.5%), followed by psychiatric disorders (14.8%) and nervous system disorders (12.2%). Among those assigned sex male at birth transitioning to female (transgender women) (81 reports, 237 [Adverse Drug Reactions]), mean age was 33.3 years, with 58% indicating use for Gender Dysphoria. A significant proportion (53.6%) were serious [Adverse Drug Reactions], primarily SOC: injury, poisoning, and procedural complications (26.6%)." This included 2 deaths, 25 hospitalizations, and 4 categorized as life threatening. A significant number of these adverse reactions were

Psychiatric Disorders (14.8% in natal females and 8.9% in natal males), and most commonly included depression and anxiety, but also included a wide range of psychiatric complications including aggression, suicidal behavior, suicidal ideation, and suicide attempts. This raises the possibility that cross-sex hormones are associated with increased self-harm, a concern reflected by the two completed suicides in a small but well-controlled study of cross-sex hormones in young people (Chen 2023, Biggs 2023).

98. This FAERS data included adverse effects classified as Neoplasms benign, malignant and unspecified (10.9% in natal females and 9.7% in natal males), and adverse effects classified as Nervous System Disorders (12.2% in natal females and 7.2% in natal males) along with a range of cardiovascular complications such as pulmonary embolisms, cerebrovascular accidents, transient ischemic attacks, laboratory abnormalities of glucose, and atherosclerotic plaque ruptures, among others. For all these adverse reactions, the relative youthfulness of the cohort, mean age 29.5 for the natal males and 33.3 for the natal females, is especially concerning as young people will tend to be in better health, and their younger age limits the amount of time they could have been prescribed cross-sex hormones.

99. Beyond these concerns are the longstanding and well-known psychological and psychiatric complications from supraphysiologic amounts of sex hormones. Data about androgens from tumors that produce abnormally high amounts of androgens and from anabolic steroid use has shown psychiatric effects including mania, irritability, aggressiveness, and reckless behavior, which are more common and more severe with higher doses (Hall 2005, Laidlaw & Jorgensen 2024).

100. Regarding the cardiovascular risk from hormone therapy, much remains unknown and to be studied due to limited follow-up data and the complexities of the cardiovascular system and its interactions with cross-sex hormones (Getahun 2018, Aranda 2021, Nota, 2020, Dutra 2019).

101. Estrogen therapy (natal males): Estrogen, often combined with anti-androgens, increases the risk of venous thromboembolism, including deep vein thrombosis and pulmonary embolism. Studies indicate a 2- to 5-fold increased venous thromboembolism risk, particularly with oral estrogens like ethinyl estradiol, due to hepatic metabolism and prothrombotic effects. Transdermal estrogen may pose a lower risk. Estrogen can also elevate triglycerides and reduce HDL [High-Density Lipoprotein] cholesterol, potentially increasing the risk of atherosclerosis and coronary artery disease. Hypertension is another concern, as estrogen can cause fluid retention and blood pressure elevation. Limited data suggests a slight increase in stroke risk, though evidence is less conclusive.

102. Testosterone therapy (natal females): Testosterone use is associated with increased red blood cell mass (erythrocytosis), which can elevate blood viscosity and the risk of thromboembolism. Studies show mixed results, but some report a 1.5- to 2-fold increase in cardiovascular events like myocardial infarction, particularly in older individuals or those with pre-existing conditions. Testosterone can lower HDL cholesterol and raise LDL cholesterol, potentially contributing to atherosclerosis. Hypertension is also a concern, as testosterone may increase blood pressure.

103. There is also concerning data for females using masculinizing hormones, especially across the lifespan (Gosiker 2024). A meta-analysis of 35 studies reported that masculinizing hormone therapy "was associated with significant changes in serum lipids from baseline up through the 60-month timepoint with meta-difference of means (95% CI) estimates of 26.2mg/dL (23.3,29.0) for

LDL-C, 26.1mg/dL (22.8,29.4) for total cholesterol, 30.7mg/dL (6.9,54.6) for triglycerides and –9.4mg/dL (–12.1, –6.7) for HDL-C." They noted studies evaluating the effects of feminizing hormones on balance demonstrated no notable changes in HDL-C or triglycerides while the results for LDL-C and total cholesterol were inconsistent." This data was reassuring regarding natal males on feminizing hormones, but not for females using masculinizing hormones. This was largely consistent with Leemaqz's longitudinal study (2023).

104. Also consistent is Allgayer's systematic review of the effects of cross-sex hormones on subclinical atherosclerosis, which concluded that androgens are associated with an increased risk of subclinical atherosclerosis in natal females. In contrast, natal males may experience either neutral or beneficial effects regarding atherosclerosis from estrogenic agents, even though many unknowns remain.

105. For natal females taking androgens, there is also a substantial risk of Pelvic Floor Dysfunction (PFD) (Da Silva 2024). PFD encompasses a range of symptoms including urinary incontinence, bowel dysfunction, sexual dysfunction, and pelvic pain, all of which can significantly impact quality of life. In natal females undergoing cross-sex hormone therapy with testosterone, research indicates a notably high incidence of PFD. A cross-sectional study conducted between September 2022 and March 2023 involving 68 females administered cross-sex testosterone therapy found that 94.1% experienced at least one PFD symptom.

106. Specifically, the study reported: 86.7% of participants had urinary issues, with 69.1% experiencing storage symptoms such as urinary incontinence, frequent urination, or bed-wetting. Among those with urinary incontinence, symptoms were reported as moderate in severity, impacting quality of life. Urinary control complications have more profound impacts within the forced intimacy and restricted movements of correctional environments. Among all participants,

74% reported bowel-related issues, including constipation, anorectal symptoms (45.6%), and flatal incontinence (39.7%). As for sexual dysfunction, defined by criteria such as reduced sexual interest, arousal difficulties, or orgasmic disorders, with some reporting pain during sexual intercourse, it was experienced by 52.9% of the participants.

107. The high incidence of PFD in this population is hypothesized to result from testosterone-induced changes, such as vaginal mucosa atrophy, which mimics a hypoestrogenic state similar to postpartum or postmenopausal conditions, potentially weakening pelvic floor muscles. The implications of PFD in females taking androgens are multifaceted, affecting physical, psychological, and social domains, including: anxiety, embarrassment, or reduced self-esteem, especially in younger individuals (average age 28 in the referenced study), who may face symptoms typically associated with older populations. However, the extent to which testosterone affects pelvic floor muscles remain understudied, and long-term effects on pelvic organs are not fully understood.

108. Marks (2018) found that 45% of females on masculinizing hormone therapy experienced hair loss. Testosterone is associated with hair loss (alopecia), and a percentage of natal females taking androgens will experience significant hair loss, which is often associated with significant distress and may prompt the desire for further medical procedures and medications. This hair loss can be especially distressing in younger populations (Gao 2023).

109. While incarcerated individuals rarely have access to procreative sex, most are not housed throughout their reproductive spans. As such, risks related to infertility from hormone therapy may be overlooked while incarcerated. After discharge, those who wish to procreate may have difficulty if they have been prescribed cross-sex hormones (De Roo 2025). For males taking estrogens, some patients only retain limited sperm production, while many no longer have sperm production and

exhibit testicular atrophy, hyalinization, and fibrosis. These histological changes may lead to an elevated risk of cancer. Taking estrogen alongside testosterone blockers was linked to sperm abnormalities and azoospermia (complete loss of sperm). These effects may or may not be reversible, and tissue studies following surgical removal of the testis show widespread damage (Schwartz 2025).

110. Schwartz highlights potential cognitive risks, including memory loss and early-onset cognitive impairment. Longer-term research on older natal females taking hormones has found poorer performance on tasks involving memory and processing speed. Again, it will likely be decades before firmer data emerges regarding these risks.

111. Medical harms occur from cross-sex hormone therapy. At the same time, there is little reliable data supporting that hormone therapy produces meaningful long-term mental health benefits. Accordingly, hormone therapy should not be available to those in BOP's custody, unless an exception is determined to be appropriate especially in the short term as discussed below.

A Reasonable Approach for Those Already Receiving Hormones Is to Assess Them Individually on Whether and How to Discontinue Therapy

112. While it is appropriate to not initiate hormone therapy on inmates who are not currently subject to hormonal therapy, there are complex questions about whether to continue these treatments for inmates already receiving hormones.

113. Some inmates arrive at BOP with prescribed hormone treatment from the community, and others start on these treatments while in custody. These cases can be individually assessed, with allowance for exceptions under certain circumstances.

114. This clinical approach reflects the reality that once a treatment has been provided, its removal can, but does not necessarily, cause physiological and psychological stress. And the benefits of ending treatment—through an appropriate way—could outweigh the short-term

physiological and psychological stress from ending the treatment. The amount of this stress can be estimated clinically and individually, taking into account factors such as the duration of treatment, the initial rationale for treatment, and the treatment response. Accordingly, under this approach, it is reasonable for dysphoric patients to be divided into different patient populations with different clinical approaches. A rapid discontinuation is appropriate for those who recently started treatment, but a slow withdrawal could be appropriate for others, and still others may be allowed to continue treatment indefinitely.

115. Standard psychiatric medications have withdrawal effects, and their abrupt cessation causes both physiological and psychological effects. The cessation of cross-sex hormones will have a similar impact. Just as the length of treatment predicts difficulties stopping a Selective Serotonin Reuptake Inhibitors, it can be expected that the duration of cross-sex hormones would be a pertinent clinical factor in assessing whether and how to cease hormone therapy (Kalfas 2025, Gøtzsche 2024).

116. Moreover, it is likely rare that an inmate should continue hormone therapy indefinitely. It could be reasonable for prison officials to adopt a strong presumption in favor of ending hormone therapy for all inmates (through the appropriate method of withdrawal), given the unproven medical benefits of continued hormone therapy and the potential negative effects of hormone therapy. This strong presumption would only be rebutted by exceptional cases.

117. Based on the above, there are multiple reasonable approaches to determining whether and how to discontinue hormone therapy for inmates diagnosed with Gender Dysphoria.

CROSS-SEX SURGERIES ARE NOT MEDICALLY NECESSARY

118. Cross-sex surgeries have not been shown to be medically necessary. There is widespread uncertainty with regards to whether cross-sex surgeries provide mental health benefits or, on the

whole, worsen mental health. These surgeries have substantial risks, and there is little, if any, reliable data supporting that such surgeries cause meaningful long-term benefits in improving mental health or reducing suicide risks. This is particularly true in prison settings. Indeed, there are no controlled studies, high-quality evidence, or reliable evidence on sex-trait modification, such as through cross-sex surgery, of inmates with Gender Dysphoria in the carceral setting.

119. Much of the research regarding cross-sex surgery shares weaknesses with hormone therapy data, in that short-term individual studies are insufficient to support the hypothesis of benefit, and longer-term population studies show mixed results and raise concerns about long-term outcomes.

120. A recent a systematic review and meta-analysis regarding Mastectomy for individuals younger than 26 years with Gender Dysphoria (Miroshnychenko 2025) "found limited evidence about aesthetic satisfaction and surgical complications (i.e., nipple necrosis, hematoma, and hypertrophic scarring)" and noted that "evidence regarding psychological outcomes is missing." This review highlights the sparse and "very low-certainty evidence on mastectomy effects."

121. A recent national database study (Lewis 2025), involving 107,583 patients and using matched cohorts, examined mental health risks after cross-sex surgery and found that those undergoing surgery were at significantly higher risk for depression, anxiety, suicidal ideation, and substance use disorders than those patients with Gender Dysphoria who did not have without surgery. Males with surgery showed a higher prevalence of depression (25.4% vs. 11.5%, RR 2.203, $P < 0.0001$) and anxiety (12.8% vs. 2.6%, RR 4.882, $P < 0.0001$). Females exhibited similar trends, with elevated depression (22.9% vs. 14.6%, RR 1.563, $P < 0.0001$) and anxiety (10.5% vs. 7.1%, RR 1.478, $P < 0.0001$). Feminizing individuals demonstrated particularly high risk for depression (RR 1.783, $P = 0.0298$) and substance use disorders (RR 1.284, $P < 0.0001$).

122. Another large retrospective patient data analysis with over 90 million patients compared cross-sex surgeries and concluded, "Patients who have undergone gender-affirming surgery are associated with a significantly elevated risk of suicide," and "patients who have undergone gender affirmation surgery are associated with significantly higher risks of suicide, self-harm, and PTSD compared to general population control groups in this real-world database" (Straub 2024).

123. A 2020 review of Swedish data showed that there was no significant benefit following cross-sex surgery, and in fact raised concerns of increased suicidality in the year after surgery (Bränström & Pachankis 2020). This study published in the American Journal of Psychiatry initially suggested that surgery was associated with improved mental health outcomes. But a later re-analysis and correction of the data indicated that there was "no advantage of surgery" compared to a control group of transgender people who had not had surgery. There were at least 9 MDs or PhDs who responded to the significant flaws when this article was initially published and erroneously claimed that the data supported cross-sex surgery. The references to these letters can be found listed under the original article in PubMed or in the August 2020 American Journal of Psychiatry.

124. As noted by Wold, "among the individuals examined in the study, the risk of being hospitalized for a suicide attempt was 2.4 times higher if they had undergone gender-corrective surgery than if they had not" (Wold 2020). Ring and Malone noted that the data suggested "that sex reassignment surgery is in fact associated with increased mental health treatment" (Ring & Malone 2020).

125. The Bränström and Pachankis study confirms the strong association between psychiatric morbidity and Gender Dysphoria. It does not demonstrate that either hormonal treatment or surgery has any effect on this morbidity. One caution that can be taken is that the incidence of mental health

problems and suicide attempts are especially high in the year after the completion of gender-affirming surgery.

126. The Dhejne review of long-term follow-up of medical transition surgeries in Sweden (Dhejne 2011) "found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalisations in sex-reassigned transsexual individuals compared to a healthy control population."

127. These concerns are especially elevated in a carceral setting. As noted by Levine, "The request for SRS [sex reassignment surgery] is fraught with legal, safety, clinical, political, and policy concerns." "Most inmates requesting SRS through litigation are serving very long or life sentences. Their backgrounds are quite unlike most transgendered individuals encountered in the community" (Levine 2016 at 236)

128. For example, as Elizabete Stahl, the BOP Medical Director recently stated, "Inmates have higher rates of certain chronic conditions and infectious diseases compared to people living within the community. They have higher rates of hypertension, asthma, arthritis, and tuberculosis. They also suffer from higher rates of mental illness" (Stahl Decl.).

129. Cross-sex surgeries can have serious complications, some of which are lifelong. Complications are especially prevalent in populations with poor general health status. Vaginoplasties require dilation protocols which, even when strictly followed, may not prevent stenosis, and may require follow-up surgeries, or lead to long-term wound care due to fistulas or infection. Vaginoplasties can also result in chronic pain and altered or absent sensations due to nerve damage or scarring. Phalloplasty can result in chronic pain, loss of sensation, scarring, infections, and urethral complications, such as strictures and fistulas. Similarly, metoidioplasty can also have urethral complications, limited size or function, chronic pain, and sensory changes.

Cross-sex mastectomies use techniques to create a chest that is made to appear more like the other sex, and the lateral chest contour involves increased risk of iatrogenic injury (Ferrin 2025).

130. With newer data, the utility of cross-sex surgeries and long-term outcomes has become more doubtful, which in any event is based on low-quality evidence base. As such, with the known harms to healthy tissue, potential increased risk of psychiatric decompensation, technical issues such as wound care, potential surgical complications, potential life-long health complications, and unclear mental health benefits, cross-sex surgeries within the correctional environment are not medical necessary.

SOCIAL ACCOMMODATIONS ARE NOT MEDICALLY NECESSARY

131. Social transition is understood as the process by which a person begins to live and present in a way that aligns with their internal gender identity, rather than their sex. This typically involves various non-medical actions, such as:

- Changing one's name and/or pronouns: Using a name and pronouns (e.g., she/her, he/him, they/them) that reflect their gender identity.
- Altering appearance and expression: This can include changing clothing, hairstyles, or other elements of their outward presentation to align with their gender identity.
- Coming out to others: Sharing their transgender or nonbinary identity with family, friends, and their community.
- Engaging in gendered activities: Participating in social activities or using facilities (like restrooms) that correspond to their affirmed gender.

132. Social transition is theorized to be helpful as it appears empathetic to gender distressed individuals by allowing them to live in the role of the other sex. But social transition is not medically necessary, particularly in correctional facilities. As can be seen from the list of activities related to social transition, none are related to healing medical illness or disease. Moreover, there

are no reliable study or high-quality evidence showing any benefits of social accommodations for individuals with Gender Dysphoria who are currently incarcerated.

133. The only systematic review of evidence regarding social transition is in children and adolescents, revealing minimal evidence to guide practice (Hall 2024). The evidence is overall low quality, and "[t]his review has shown that we have little evidence of the benefits or harms of social transition for children and adolescents." Concerningly, in children and adolescents, social transition appears to prolong transgender identification and continue Gender Dysphoria (Steensma 2013, Olson 2022, Rae 2019, Zucker 2020). Social transition is thus not associated with better outcomes but is related to future harms and risks due to the increased likelihood of later sex-trait modification. As noted by Zucker regarding social transition in children: "if one conceptualizes gender social transition as a type of psychosocial treatment, it should come as no surprise that the rate of Gender Dysphoria persistence will be much higher as these children are followed into their adolescence and young adulthood. If this is, in fact, the case, one might ask why would one recommend a first-line treatment that is, in effect, iatrogenic [illness cause by treatment]" (Zucker 2020 at 37).

134. Based on this data, we should consider the risk that social transition may increase the desire for cosmetic medical interventions to appear as the other sex, and these treatments harm healthy tissue and pose significant risks, without clear benefit.

135. Social transition may also undermine an individual's desire to participate in psychotherapy to explore why they have their body-related distress, thereby undermining the process of exploration and self-reflection that can lead to relief of the gender-related distress. Inmates with Gender Dysphoria tend to have significant trauma-related experiences and may have been treated poorly by family, peers, primary caretakers, and others, due to their gender non-conformity.

Sometimes incarcerated males identifying as transgender females have assaulted women and may be searching for an escape from their masculinity. All of these are important topics that require exploration in psychotherapy. It has been my experience that inmates (adults and juveniles) of both sexes with Gender Dysphoria often do not want psychotherapy because they are convinced that affirmation and medical interventions are the best and only treatment for their Gender Dysphoria. This misinformation has created an unfortunate "nocebo effect" in gender medicine, undermining psychotherapy (Clayton 2022). The nocebo effect is a phenomenon where negative expectations about a treatment or experience led to worse outcomes. The nocebo effect does occur in psychotherapy (Locher 2019). The nocebo effect in patients with Gender Dysphoria is created through promotion of affirmative treatments and derogatory proclamations, such as the claim that psychotherapy is "conversion therapy", creating the conditions that many patients with gender dysphoria have expectations that the psychotherapy is useless, inappropriate, or harmful.

136. There is limited evidence suggesting that allowing cosmetic and clothing items, such binders, undergarments, makeup, wigs, and other accessories and items stereotypically associated with the opposite sex, would improve or resolve symptoms associated with Gender Dysphoria. And there is no evidence-based study or reliable evidence showing that access to such items improves or resolves symptoms in inmates with Gender Dysphoria, regardless of whether the inmate is in a facility that aligns with the inmate's biological sex or gender identity. The fact that some social-transitioning items are psychologically pleasing to inmates with Gender Dysphoria does not mean that such interventions are medically necessary. Such social-transitioning items are not medically necessary, as they can prolong the symptoms and undermine psychotherapy, and there is no clear evidence of medical benefit.

137. In the correctional context, making social transition items available can work against the patients' overall mental health because having such items likely will prolong the symptoms of Gender Dysphoria for the already vulnerable inmate-patient population with significant co-morbidities, and because they may enhance the patients' reluctance to receive psychotherapy, when such treatment could have long-lasting benefits.

138. "Concept creep" is the principle that psychological and psychosocial concept start with a valid narrow idea that can arise out of a desire to help but, applied in new contexts and with less extreme forms, it can enfeeble those it is intended to assist (Haslam 2016). Those who advocate for social transition functionally lowers the bar for what is expected of individuals with gender dysphoria, such that we are led to believe they cannot handle routine experiences such as wearing clothing consistent with their sex, accepting their appearance, and being addressed by their biological sex. Medical necessity now is claimed by advocates of gender affirmation to include assisting with a preoccupation with appearance and avoidance of accurate but distress-provoking words. The psychological over-protection of social transition sends an institutional-wide message that inmates with gender dysphoria are unable to cope with knowing their own sex or appearing as they appear. There is no clear evidence that social transition does, in fact, lead to functional or mental health improvement in inmates. It may more often contribute to distress by prioritizing accommodating the distress rather than engaging the process of overcoming the distress.

139. The same is true with male inmates' requests to be housed in female facilities as part of the male inmates' social transition. To the extent that transfer to a prison facility matching the inmate's gender identity rather than the inmate's biological sex is asserted to be a treatment for Gender Dysphoria, transfer is not medically necessary. There is no reliable study or high-quality evidence suggesting that an inmate being housed in a facility in line with the inmate's gender identity rather

than the inmate's biological sex has any meaningful benefits (let alone long-term benefits) to the inmate's Gender Dysphoria symptoms. Even if there were evidence suggesting social transitioning in society at large treats Gender Dysphoria, the secure prison environment is fundamentally different. There may also be other concerns, such as security and prison administration concerns, with such transfers that could outweigh the speculative medical or mental health benefits of transfer for inmates with Gender Dysphoria. For example, highly relevant is the fact that the presence of a biological male in close quarters in a female prison could significantly harm the emotional and physical well-being of certain female prisoners, such as female victims of sexual abuse. This concern is particularly acute since female prisoners suffer from extremely high rates of sexual trauma. Placing these vulnerable female inmates with biological males could have meaningful negative effects on female inmates.

140. Unlike many other mental health treatments, where the focus is on the patients themselves, requiring prison officials to allow social transition as "treatment" for Gender Dysphoria is asking the administration, staff, and other inmates to validate the inmate's gender preference without any proven benefits. Again, while social transition might decrease inmate-patients' discomfort in the short term, it ultimately may cause long-term harm, such as continuation of Gender Dysphoria. Having correctional policies along the lines of biological sex can help set inmate-patients' expectations such that they may be amenable to proven mental health treatments discussed above. That is, maintaining neutral stances, rather than stances that validate the inmate-patient's preferred gender, can reasonably be expected to benefit the inmate-patient in the long term, as prison officials seek to balance competing interests in safeguarding the inmate's welfare.

PRISON RELATED SPECIAL TOPICS

141. Incarcerated people tend to have histories, characteristics, and vulnerabilities that differ substantially from community-dwelling people with Gender Dysphoria. Thus, different considerations apply when assessing the appropriate medical treatment for inmates. "Inmates who seek treatment for [Gender Dysphoria] typically display little resemblance to the patients who present for treatment in the community, and prison life bears little resemblance to life in the community. The [WPATH] SOC were not developed with the complexities, vulnerabilities, and life circumstances of incarcerated persons in mind" (Osborne & Lawerence 2016 at 1651).

142. The concept of social transitioning through social accommodations, hormones, or surgery is out of place in the correctional context because an inmate does not live in society at large but a secure prison environment.

143. And as noted above, the inmate population generally also has poorer health status. "These factors coupled with the safety and security concerns found in a carceral setting, provide challenges to BOP medical providers that are not present to medical providers who provide treatment outside of a prison setting" (Stahl Decl.).

Unavailability of Certain Treatment in Prison

144. Simply because a treatment may be available in the community does not mean that it should be provided in a prison setting. This situation is not exceptional. Prisons and correctional systems have formularies, lists of approved medications and supplies that determine what will be available for medical providers to use. For instance, the medication quetiapine (brand name Seroquel) is "off formulary" in many prisons, despite being routinely available in the community. This is because quetiapine has abuse potential and is often traded and sold in correctional environment, thus increasing risks to the inmate population. When quetiapine or other sedating medications are

prescribed, clinicians get excessive requests for them, with prisoners exaggerating or malingering illness to obtain them. Their availability also alters the social milieu because inmates, especially those with actual mental illness, will be enticed, or even "strongarmed" to obtain sedating medications like quetiapine for distribution. As such, even if some patients may benefit from them, it is safer and better for the prison population when these medications are off formulary and unavailable and alternative medications or treatments are pursued.

145. Another example is ketamine for depression, which is offered in the community, but to my knowledge, is not available through BOP. Transcranial Magnetic Stimulation (TMS) is also a community option for depression treatment, but to my knowledge, TMS is not available through BOP.

146. Thus, although cross-sex hormones and surgeries and items for social transition may be available in the community, it is reasonable that they are not provided in the prison setting. Mental health care for Gender Dysphoria in the prison setting must be adequate and appropriate but should not involve exceptional means that may have long-term negative effect on the prison's vulnerable population. The medical and social transition approach to Gender Dysphoria is exceptional within medicine and mental health care (Amos 2024), because it provides unclear benefits, impedes other proven therapeutic approaches, and calls for changing and harming healthy tissues to treat a mental disorder.

147. The prisoner population necessarily includes vulnerable inmates. Such inmates need added protections to provide them, including those with Gender Dysphoria, the right care, including to guard against over-treatment. For those reasons and the others explained in this declaration, sex-trait modification, such as through cross-sex surgery, in prison settings should not be considered

the standard of care or medically necessary. More conservative and cautious treatments appear much more appropriate.

Self-Injury

148. Self-injurious behavior and threats of self-harm are serious matters within correctional institutions. Correctional psychiatrists and other mental health professionals make difficult decisions to balance risks. Prisoners may have limited regard for their own bodies and may be willing to injure themselves for a constellation of reasons, including sometimes due to a wish to die, but more often as an expression of psychic distress or as a means of avoidance or gain (Carli 2011, Dixon-Gordon 2012). In my experience working in correctional facilities and treating adult and juvenile inmates, including those diagnosed with Gender Dysphoria, inmates frequently use threats of self-harm and suicide to try to obtain concessions from prison officials.

149. Self-harm and threats of self-harm must be met with nuanced responses, yet any response that provides either tangible or psychological rewards, may increase expressions of self-harm. When prisoners' expressions of self-harm or threats of self-harm are rewarded, the institution can be said to "shape up" patterns of thinking and behaving, which can mold chronic, dysfunctional self-harming behaviors and may even end tragically. This can be characterized as an iatrogenic harm. That is, correctional policies, institutional environments, and responses to inmates can and do increase threats of self-harm, suicide, or self-injurious behavior. If prisoners believe that threats of self-harm or actual self-harm will lead to receiving certain items or treatments they prefer, such as hormone therapy, surgeries, or movement to favorable settings, like women's prison, this can lead to more self-harm. In corrections, rewarding self-injury or threats of self-injury tends to increase overall self-harm, both for the individual patient and also within the system. In prisons,

there is always a difficult balance of short- and long-term safety concerns, and each patient must be considered as part of the system.

150. Simple and clear institutional policies, such as no social transitions or no initiation of new hormone treatments, are likely to lead to the lowest level of self-harm and the least overall harm to inmates because when prisoners know the interventions they desire are not available, they are less likely to self-harm to obtain them. In other words, it is reasonable for prison administrators to have outright prohibitions of providing inmates benefits, such as unproven surgeries, special-order items, and housing placements, in response to self-harm or suicide threats to discourage false threats.

151. Malingering is another difficult and common issue in correctional facilities. Gender identity is a declared internal state. But prisoners can easily recite the criteria for Gender Dysphoria to qualify for the special treatments available for those diagnosed with the medical condition. These tangible benefits can include restrictions about who can search you; choice regarding housing and cellmates; more time with therapists, nurses, and medical staff; and other special privileges. Considering the generally powerless position of inmates, it should not be underestimated how psychologically rewarding it can be for some inmates to have power over even minor aspects of the conditions of their confinement.

152. Saying no to patients can seem unkind and unjust. Yet the refusal to provide certain treatments is underpinned by medical ethics, including the prevention of iatrogenic harms from unwarranted, risky, and ineffective treatments. It is, therefore, important that malingering—which can be pronounced in the correctional setting as discussed—is properly addressed without causing harm to the inmate.

153. Finally, medical providers have a duty to protect scarce medical resources and to "apprise their patients of their conditions and the treatment options in language that is accurate, ethically neutral, and in no way misleading" (HHS 2025 at 29). In dealing with the special and vulnerable population of inmates with Gender Dysphoria, medical and mental health providers can serve this population best by straightforward and honest discussion of clinical issues. Neutral policy and a neutral clinical stance that neither affirms nor denies patient claims about themselves appear to represent the most compassionate and medically beneficial approach.

CONCLUSIONS

154. Hormone therapy is unproven and experimental treatment for Gender Dysphoria that generally should not be available to those in the custody of the BOP. Though it is not medically necessary to provide hormone therapy to inmates who are diagnosed with Gender Dysphoria but not currently receiving hormone therapy, inmates currently receiving hormone therapy may be a more complex situation. In most circumstances, it is appropriate, after individual assessment, to discontinue hormone therapy for inmates currently receiving hormone therapy through an appropriate withdrawal process. In a limited set of circumstances, it may be appropriate, after individual assessment, to continue hormone therapy for inmates already being treated with hormones.

155. Cross-sex surgeries are not medically necessary and should not be available in correctional environments.

156. "Social accommodation" is not medically necessary in the correctional setting.

157. It is not medically necessary to house inmates with Gender Dysphoria according to their asserted gender identity.

I verify, under the penalties for perjury the foregoing representations are true.

Executed this 19th day of September, 2025.

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Kristopher E. Kaliebe, M.D.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*, Plaintiffs, v. DONALD J. TRUMP, *et al.*, Defendants.	Civ. A. No. 25-691 (RCL)

DECLARATION OF ELIZABETE M. STAHL
MEDICAL DIRECTOR OF THE FEDERAL BUREAU OF PRISONS

I, Elizabete M. Stahl, pursuant to 28 U.S.C. § 1746, and based upon my personal knowledge and information made known to me during the course of my official duties, hereby declare as follows:

1. I have served as the Medical Director for the Federal Bureau of Prisons (BOP) in the Health Services Division since February 28, 2021. Prior to serving as Medical Director, I served as the Clinical Director at the Federal Correctional Complex in Allenwood, Pennsylvania (FCI Allenwood), from August of 2009, until February of 2021.

2. The Health Services Division is responsible for the medical, dental, and mental health (psychiatric) services provided to BOP inmates, including healthcare delivery, infectious disease management, and medical designations. Our mission is to deliver medically necessary health care to inmates effectively in accordance with proven standards of care without compromising safety and security concerns inherent to the Bureau's overall mission. The BOP Medical Director is responsible for updating the BOP clinical guidance and protocols based on guidelines from experts in the field. My duties and responsibilities include interpreting and issuing guidance on a multitude of diseases and medical conditions for implementation in our prison setting. I am responsible for ensuring that the BOP can provide care for any diagnosis, including gender dysphoria. Part of my duties include reviewing medical literature and information from medical organizations regarding developments

within the medical community. The BOP has a team of physicians, pharmacists, and mental health professionals who also review medical literature and advise me on how best to apply new diagnostic methodologies, treatment plans and procedures. In my role as Medical Director, I was actively involved in BOP's formulation of the 2026 Policy (Program Statement 5260.01, issued on February 19, 2026), and formulation of BOP's prior clinical guidance on medical care for inmates with gender dysphoria.

3. BOP previously had a Transgender Clinical Care Team (TCCT), composed of psychiatrists, pharmacists, social workers, psychologists, and physicians. The team was established to provide consultation and training to BOP primary care providers who provide treatment to trans-identifying patients. I was the appointed Chair of TCCT beginning in 2014 and served in that collateral duty until my selection as the Medical Director in February of 2021.

4. I submit this declaration to respond to certain factual assertions Plaintiffs made in their motion for updated preliminary injunction.

5. First, Plaintiffs state on page 27 of their motion for updated preliminary injunction that "Defendants plainly know the medical necessity of gender-affirming care for Plaintiffs and other Class Members: BOP doctors prescribed it to them [under the old policy], after deeming them to have a clinical need for it."

6. The above statement misleads the court into believing BOP providers no longer believe in the medical necessity of treating inmates with gender dysphoria. In fact, the new policy intensifies psychotherapy, and the utilization of psychotropic medications, which have been validated as appropriate treatment modalities for all the co-existing mental health problems accompanying gender dysphoria, e.g., anxiety, depression, bipolar, personality and posttraumatic stress disorders, etc. The "standard of care" for treating individuals with gender dysphoria and related disorders with cross-sex hormones and surgery is under a cloud of doubt and uncertainty, especially in carceral environments. After examining the issue, it is my opinion that the medical necessity and long-term benefit of cross-sex surgeries are currently in question and cross-sex hormones only appropriate in a very small subset number of incarcerated individuals with gender dysphoria until tapering can

appropriately be considered. The care that BOP previously provided therefore is not indicative of what is currently validated as medically necessary, but what had been propagated and accepted as validated scientific evidence by WPATH and like entities.

7. All of BOP's clinical guidance, including guidance on treatment for gender dysphoria, has aimed to reflect the evolving nature of treatment, based on what is considered the "community standard," while translating it to a carceral environment. Such translation is necessary because inmates have higher rates of certain chronic conditions and infectious diseases compared to people living in the community. They have higher rates of hypertension, asthma, arthritis, tuberculosis and others. They also suffer from higher rates of mental illness. These factors, coupled with the safety and security concerns found in a carceral setting, provide challenges to BOP medical providers that are not present to medical providers who provide treatment outside of a prison setting.

8. In 2017, BOP issued the Transgender Offender Manual to provide guidance about transgender inmates. The last Transgender Care Clinical Guidance adopted by BOP was in June 2023. Several sources were utilized by BOP in writing the Transgender Care Clinical Guidance, including WPATH. The 2023 guidance noted that significant changes were made "to more closely align with community standards and the [WPATH] Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 published in 2022," referred to as WPATH SOC 8.

9. I, in my role as Medical Director, along with the medical community, and BOP colleagues relied heavily on WPATH SOC 8 and trusted that the guidance was based on the best evidence to date. I also firmly believed WPATH's written guidance was reflective of all published evidence. I no longer believe that to be the case.

10. I became aware of information regarding WPATH studies and data that brings into question the validity of their recommendations. WPATH's leaders have admitted to "gaps" in evidence, and I have determined that WPATH has not been careful, conscientious, or rigorous in reporting systematic reviews of all available evidence when it comes to cross-sex surgeries. Also concerning is that WPATH has not been transparent; it failed to publish all relevant evidence or at the very least "caution" the target audience and well-intended providers about the gaps in knowledge

on potential long-term harms of "gender-affirming" care.

11. The medical associations that have published medical guidelines for purposes of guiding providers, clinicians and patients, followed WPATH's written ideological guidance and effectively abandoned the rigorous scientific review steps required in all other areas of medicine. As primary care providers and consumers of such published guidelines, BOP providers cannot trust the reliability of the WPATH guidance, when it has been so broadly questioned for lack of sound evidence and for being free from bias.

12. Medical evidence demonstrating the long-term benefits of cross-sex surgeries and hormones is scant and even more so if the individual is in a prison setting and has a greater number of co-morbidities. For example, as I explained in my attached declaration of August 19, 2025, that I submitted in the case of *JJS v. Pliler* concerning cross-sex surgeries, in examining the available evidence regarding cross-sex surgeries, I found that published evidence surrounding the long-term effects of cross-sex surgeries is very limited, typically from observational studies with short-term follow-up and highly variable outcomes. The majority of the studies involve small groups comparing before and after cross-sex surgery reports of the impacts from the surgical outcome. And most studies of the long-term effects of cross-sex surgeries reveal a complex picture. Some studies focus on patient reports of satisfaction with the reassignment procedure, which generally is rated highly by the patient. Some studies demonstrate improved quality of life and sexual satisfaction in the short term. Some studies, however, demonstrate worsened urinary tract functioning, and increased risk for cardiovascular disease, HIV, and hepatitis C among those who have undergone cross-sex surgery. And, there are a number of studies that found poor mental health outcomes including worsening depression, anxiety, and increased suicidal ideation, making it impossible to determine the precise effects on mental health outcomes among these patients.

13. While serving as a BOP primary care physician, before serving in my current role as Medical Director, I provided direct patient care to inmates with gender dysphoria and followed WAPTH's guidance in prescribing cross-sex hormones, even when I rarely saw any sustained mental health improvement in my patients. I trusted that even if the small number of patients I treated lacked

the benefits promoted by WPATH and other self-proclaimed experts, I was doing the right thing. However, in light of more recent thorough reviews of published data, it has been challenging to link the use of cross-sex hormones to improvements in gender dysphoria symptoms. To the extent possible, medical and mental health providers often rely on objective measures to follow disease progression or control. For example, when we treat hypertension, we rely on serial blood pressure measurements to adjust our treatment. Similarly, for depression, we rely on validated assessment tools that measure response to treatment and use it to increase or decrease antidepressants. For gender dysphoria, however, one of the many obstacles for medical providers is that there is no universally accepted, fully validated clinical instrument that can isolate and quantify the causal relationship between cross-sex hormone treatment and outcomes in people diagnosed with gender dysphoria receiving such treatment. Cross-sex hormone doses are adjusted based on patient preference and to avoid unsafe physiological hormone ranges, but historically speaking, providers do not have objective or standardized means to determine what is successful treatment for gender dysphoria. In the last year, some attempts have been made to create tools to assess "gender preoccupation", or measure various aspects of gender dysphoria over time, but there is no evidence to show that these assessment tools can reliably assess the outcome with cross-sex hormone use. Many studies rely on self-reports and measure anxiety/depression, or satisfaction with treatment, none of which measure cross-sex hormone response in gender dysphoric patients. It is this lack of evidence that brings us to question the medical necessity of cross-sex hormones in individuals with gender dysphoria. On the other hand, the downside risks of cross-hormone use and its long-term effects are substantial, which contributes to BOP's decision to limit cross-sex hormone use and ensure medical providers meet their medical and ethical obligation to first do no harm.

14. As the Medical Director, and after examining available evidence or lack thereof, and in consultation with others of the BOP clinical team, I have concluded that due to the high variability in study design and outcomes reported, lack of long-term follow-up and small study size, the long-term effects of cross-sex surgery and hormones in incarcerated patients who are diagnosed with gender dysphoria cannot be determined and is insufficient to deem these treatment modalities as "medically

necessary."

15. Plaintiffs state on page 37 of their brief that BOP "failed to consider critical, particularly relevant evidence: its own experience providing gender-affirming care to individuals with gender dysphoria for many years under its prior policy." This is not accurate.

16. As the Medical Director, I am not aware of any "critical, particularly relevant evidence" that would justify the prior policy. As already mentioned in this declaration, there is not a vetted, or validated clinical instrument that measures the success or failure of gender dysphoria treatment. The BOP has several quality metrics (National Performance Measures) broadly applied to different disease states e.g. Hypertension, DM, Cardiovascular Disease, Hepatitis C, HIV, etc. Through validated clinical instruments, we can measure how our inmate population responds to different treatment modalities or guidance in the various disease states. However, while we've been able to monitor the total number of inmates on cross-sex hormones throughout the BOP, neither the medical community, nor BOP has a standardized clinical assessment instrument available to measure gender dysphoria response to treatment. I am not aware of any evidence in our own experience of providing "gender-affirming" care that is considered critical in supporting its continued provision of such care.

17. Many of the BOP senior officials who wrote, consulted and applied the previous BOP policy were also responsible for evaluating, implementing, and ultimately formulating the 2026 policy. In my previous roles as Clinical Director and Chair of the TCCT, I was directly involved in the application of the prior policy. Like other senior officials, I used my experience with the prior policy to help formulate the 2026 Policy.

18. Third, Plaintiffs rely on the declarations of Cathy Thompson, a former BOP psychologist, to support their claim that cross-hormones for inmates with gender dysphoria is medically necessary. According to BOP records, Dr. Thompson only served as the Acting National Administrator for Psychology Services for approximately seven months (not for five years as she represents in her resume, attached as exhibit A to her declaration). In that role, she would have been consulted about the results of Transgender Executive Committee (TEC) meetings and specific mental health challenges agency wide as issues arose. However, to my knowledge, Dr. Thompson never

served as the senior agency psychologist on the TEC as she claims in her resume and did not attend TEC meetings regularly. Most of her time spent in BOP leadership focused on substance use treatment programs as the National Chief of Drug Treatment Programs, not on issues related to the population of trans-identifying inmates. Furthermore, in her role as a psychologist, she would not be a reliable expert to opine on what medications are considered "medically necessary" for treatment of any mental health disorder because psychologists do not prescribe cross-sex hormones or any other medication; only physicians, advanced practice providers, and pharmacists have the educational background, and licensure for that clinical skill.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

ELIZABETE STAHL Digitally signed by ELIZABETE STAHL
Date: 2026.05.13 07:31:44 -04'00'

Dated: May 12, 2026

ELIZABETE STAHL, D.O.

ATTACHMENT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JJS, Petitioner, v. WARDEN PLILER, Respondent.	19 Civ. 02020 (VSB) (SDA)

DECLARATION OF ELIZABETE M. STAHL
MEDICAL DIRECTOR OF THE FEDERAL BUREAU OF PRISONS

I, Elizabete M. Stahl, pursuant to 28 U.S.C. § 1746, and based upon my personal knowledge and information made known to me from official records reasonably relied upon by me in the course of my employment, hereby declare as follows relating to the above-captioned matter:

1. I have served as the Medical Director for the Federal Bureau of Prisons (BOP) in the Health Services Division, located in Central Office, Washington D.C., since February 28, 2021. The Health Services Division is responsible for the medical, dental, and mental health (psychiatric) services provided to BOP inmates, including healthcare delivery, infectious disease management, and medical designations. Our mission is to deliver medically necessary health care to inmates effectively in accordance with proven standards of care without compromising safety and security concerns inherent to the Bureau's overall mission. The BOP Medical Director is responsible for updating the BOP clinical guidance and protocols based on guidelines from experts in the field. My duties and responsibilities include interpreting and issuing guidance on a multitude of diseases and medical conditions for implementation in our prison setting. I am

responsible for ensuring that the BOP can provide care for any diagnosis, including gender dysphoria. Part of my duties include reviewing medical literature and information from medical organizations regarding developments within the medical community. The BOP has a team of physicians, pharmacists, and mental health professionals who also review medical literature and advise me on how best to apply new methods and procedures.

2. I received my Doctor of Osteopathic Medicine (D.O.) degree from the University of New England in June of 2005. In 2009, I completed my combined four-year residency in Internal Medicine and Pediatrics at Geisinger Medical Center in Danville, Pennsylvania. I am board certified by the American Board of Internal Medicine and the National Board of Physicians and Surgeons.

3. Prior to serving as Medical Director, I served as the Clinical Director at the Federal Correctional Complex in Allenwood, Pennsylvania (FCI Allenwood), from August of 2009, until February of 2021. As Clinical Director at FCI Allenwood, I provided direct patient care to incarcerated patients, which included providing hormones for patients diagnosed with gender dysphoria, transexualism, or gender incongruence, which are terms that can be used interchangeably.

4. In November 2014, I was appointed as the Chair of BOP's Transgender Clinical Care Team (TCCT). This team was composed of psychiatrists, pharmacists, social workers, psychologists, and physicians. The team was established to provide consultation and training to BOP primary care providers who provide treatment to trans-identifying patients.

5. In my role as the Chair of the TCCT, I presented several medical education trainings on transgender care, including for inmates with gender dysphoria at national in-person and virtual conferences within the BOP in 2015, 2016, 2017, and 2018. These trainings were

focused on instructing medical providers how to prescribe hormone treatment to trans-identifying individuals with gender dysphoria inside of our facilities.

6. Members of the TCCT participated in accredited Continuous Medical Education (CME) courses in Trans-Health on gender dysphoria to further the team's knowledge in hormone treatments for inmates with gender dysphoria, transsexualism, or gender incongruence. I, along with members of the TCCT attended courses in 2014 that were sponsored by the Mazzoni Center in Philadelphia, Pennsylvania. We attended courses in 2015 that were sponsored by the University of California, San Francisco School of Medicine in Oakland, California. We attended courses sponsored by the World Professional Association for Transgender Health (WPATH) in 2016 at Rush University Medical Center in Atlanta, Georgia. In 2018, we attended courses at the Harvard Medical School in Boston, Massachusetts.

7. Non-incarcerated individuals living in the community often receive treatment for their gender dysphoria at subspecialty clinics. The primary care providers at the Bureau safely provide this care within the confines of the prison setting. Most hormones prescribed in the BOP for patients diagnosed with gender dysphoria are provided by BOP primary care providers.

8. Many BOP prisons are located in rural locations without ready access to larger hospitals or subspecialty clinics. The BOP has succeeded at imbedding treatment of subspecialty medical conditions into our primary care model. This was possible through robust training programs, which targeted the education of primary care providers, preparing them to render subspecialty care inside our prisons. As relevant here, such training allows our providers to evaluate, examine, diagnose, and provide safe treatment to patients with gender dysphoria.

9. Providing medical care in a prison setting is challenging. BOP medical providers have to take several factors into consideration when providing a specific course of treatment that

providers outside of a prison setting do not. Prior to providing a specific medical treatment or procedure, BOP medical providers must assist in assessing the safety and security risks for the inmate, the rest of the inmate population, and the facility.

10. All of BOP's clinical guidance, including guidance on treatment for gender dysphoria, has aimed to reflect the evolving nature of treatment, based on what is considered the "community standard," while translating it to a carceral environment. In 2017, BOP issued the Transgender Offender Manual to provide guidance about transgender inmates. The last Transgender Care Clinical Guidance adopted by BOP was in June 2023. Several sources were utilized by BOP in writing the Transgender Care Clinical Guidance, which included information from the Endocrine Society, the University of California San Franciso School of Medicine, the World Health Organization, and WPATH. The 2023 guidance noted that significant changes were made "to more closely align with community standards and the [WPATH] Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 published in 2022." WPATH SOC 8.

11. In 1930, pursuant to Pub. L. No. 71-218, 46 Stat. 325 (May 14, 1930), Congress established the BOP within the Department of Justice and charged the agency with the "management and regulation of all Federal penal and correctional institutions." BOP did not have a policy regarding cross-sex surgery for individuals with gender dysphoria until the 2017 Transgender Offender Manual was issued. BOP rescinded the Transgender Offender Manual in 2025.

12. The Bureau first approved a cross-sex surgery in 2021, and although it has approved several cross-sex surgeries since, to date only one inmate was approved and provided with the surgery. Another inmate received surgery while in a half-way house pursuant to litigation.

13. On January 20, 2025, President Trump issued Executive Order 14168, "Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government." Section 4 (c) of the Executive Order provided, "The Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medical care to be consistent with this order and shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex."

14. Following the Executive Order, BOP repealed the section of the Transgender Offender Manual that included the policy on providing surgical procedures. Prior to the Executive Order, the policy provided that inmates who met certain criteria established by the Transgender Executive Counsel (TEC) would be referred to the Health Services Division for an evaluation. The TEC monitored the inmate's progress and made sure that the inmate was compliant with their medication, lived at least one year within a facility consistent with the inmate's preferred gender, and did not receive certain disciplinary infractions.

15. The TEC would refer suitable inmates to the Transgender Utilization Advisory Group (TURAG) to review and interview prospective surgical patients for clinical readiness and to ascertain if there were any absolute contraindications to surgery. The group was composed of clinicians appointed by the Medical Director. The TURAG would review reports made by the inmate's primary care provider, psychologist, and social worker to determine whether the inmate met standard criteria to undergo the referral to the surgeon for the medical procedure. The TURAG would send their findings to the Medical Director for review and final disposition.

16. InterQual criteria was used to verify basic criteria for surgical consideration, which included the diagnosis of gender dysphoria. InterQual is a Clinical Decision Tool utilized by

Medicare and large insurance companies like United Health and Blue Cross Blue Shield to validate that certain clinical criteria are met prior to medical testing or surgery.

17. The BOP used InterQual, among other medical references, to standardize the utilization review process across its institutions. In addition to meeting InterQual criteria for a surgical referral, members of the TURAG took special care to review the patient's electronic health record to find out whether there were any contraindications to major surgery. Supportive evaluations and written clinical summaries from the inmate's assigned social worker, psychologist, and attending physician were also required prior to any surgical evaluation consideration.

18. Inmates have higher rates of certain chronic conditions and infectious diseases compared to people living within the community. They have higher rates of hypertension, asthma, arthritis, and tuberculosis. They also suffer from higher rates of mental illness. These factors coupled with the safety and security concerns found in a carceral setting, provide challenges to BOP medical providers that are not present to medical providers who provide treatment outside of a prison setting.

19. The inmate's compliance with the overall plan of care was also an important factor for consideration. Patients were interviewed and underwent a typical pre-operative work-up, and if no absolute contraindications were found, the patient was referred to the Medical Director for review and decision on whether the patient met standard criteria to undergo surgical evaluation.

20. As stated earlier, to date, only one inmate underwent cross-sex surgery, after approval by the Medical Director. The procedure took place on January 5, 2023. The decision to approve the referral for surgery was made in good faith, according to what BOP believed to be based on the consensus in the medical community. At the time, we believed that providing the cross-sex surgery was in the best interest of the patient.

21. On March 22, 2024, while performing the duties of Medical Director, I approved a cross-sex surgery for Petitioner, a now 61-year-old inmate. This decision was based largely on WPATH's and other published written guidance. However, I no longer believe providing Petitioner or any other BOP inmate with cross-sex surgery is appropriate.

22. After initially approving the surgery for Petitioner in March 2024, I have learned that there is an ongoing clinical uncertainty surrounding whether to provide individuals, including inmates, with cross-sex surgeries. Medical evidence demonstrating the long-term benefits of the procedures is scant and even more so if the individual is in a prison setting and has a greater number of co-morbidities. I, in my role as the Medical Director for the BOP, along with the medical community, relied heavily on WPATH SOC 8 and trusted that the guidance was based on the best evidence to date.

23. More recently, I became aware of information regarding WPATH studies and data that brings into question the validity of their recommendations. WPATH's leaders have admitted to "gaps" in evidence, and I have determined that WPATH has not been careful, conscientious, or rigorous in reporting systematic reviews of all available evidence when it comes to cross-sex surgeries.

24. Published evidence surrounding the long-term effects of cross-sex surgeries is very limited, typically from observational studies with short-term follow-up and highly variable outcomes. The majority of the studies involve small groups comparing before and after cross-sex surgery reports of the impacts from the surgical outcome.

25. Most studies of the long-term effects of cross-sex surgeries reveal a complex picture. Some studies focus on patient reports of satisfaction with the reassignment procedure, which generally is rated highly. Some studies demonstrate improved quality of life and sexual

satisfaction in the short term. Some studies, however, demonstrate worsened urinary tract functioning, and increased risk for cardiovascular disease, HIV, and hepatitis C among those who have undergone cross-sex surgery. And, there are a number of studies that found poor mental health outcomes including worsening depression, anxiety, and increased suicidal ideation, making it impossible to determine the precise effects on mental health outcomes among these patients.

26. I have concluded that due to the high variability in study design and outcomes reported, lack of long-term follow-up and small study size, the long-term effects of cross-sex surgery in incarcerated patients who are diagnosed with gender dysphoria cannot be determined.

27. WPATH's SOC 8, Chapter 13, titled "Surgery and Post-operative care" does not discuss the evidence or lack thereof on the long-term outcomes of cross-sex surgery in patients diagnosed with gender dysphoria or its effects on mental health. In fact, the topic is largely avoided. The chapter's discussion surrounds surgical and sexual satisfaction outcomes, and rates of surgical complications and regret.

28. Until recently, I firmly believed WPATH's written guidance was reflective of all published evidence. I no longer believe that to be the case. WPATH was at the forefront, in establishing itself as the "standard" in treatment of patients with gender dysphoria. Over the years, all major medical societies generally have lined up behind WPATH, including the American Medical Association, American College of Physicians, major medical colleges and universities such as UCSF, CMS, the Endocrine Society, and BOP, even if for some, they did not fully adopt WPATH's recommendations, as is the case of BOP.

29. It wasn't until the Summer of 2024 that I learned of certain entities questioning the strength of evidence guiding the treatment of patients with gender dysphoria, including the

Cass Review published by the National Health Service (NHS) England. Shortly after, WPATH published a rejoinder report against the Cass Review.

30. The media's attention to this topic, coupled with the departure of medical societies and associations from WPATH's guidance, and the Executive Order 14168, prompted BOP to question its previous position on this topic.

31. As noted above, BOP has always used multiple sources in writing clinical guidance on different diagnoses, and this is also true for gender dysphoria. No single source was universally applied in writing the BOP gender dysphoria guidance. There were elements of WPATH's guidance that were never adopted by BOP. For example, BOP providers only provided treatment to patients with a validated medical/mental health diagnosis; this was in line with the Endocrine Society guidance, but not WPATH SOC 8, which did not require a medical diagnosis, and failed to consistently demonstrate and provide guidance on what constituted medical necessity. WPATH defines "medical necessity" as a term used by insurers or insurance companies. They further define it as health care services that a physician and/or health care professional, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. While this definition is generally accepted as stated by the medical community, it is in conflict with how WPATH applies the definition of "medical necessity". WPATH does not require a validated medical/mental health diagnosis in practice, which the medical community requires as a tenant of "medical necessity". Instead, according to section 13.6, of WPATH SOC 8, the guidance suggests that "health care professionals consider gender-affirming genital procedures in eligible transgender and gender diverse adults seeking these interventions when there is evidence the individual has been stable on their current treatment regime (which may include at least 6

months of hormone treatment or a longer period . . .” Moreover, Statement 13.6 guides the reader to review “eligibility criteria” for surgery in Appendix D, which does not require a medical diagnosis, unless it’s in situation where the diagnosis is necessary to access health care. In practice, this guidance does not require a medical diagnosis for a surgeon to perform the surgery.

32. WPATH does not endorse or require that an individual be diagnosed with gender dysphoria, transsexualism, or gender incongruence before being approved for cross-sex surgery. WPATH does not see these conditions as being an illness, injury, or disease. This is problematic because WPATH insists that “gender-affirming” surgeries are “medically necessary.” The medical community requires a medical diagnosis when submitting patients to undergo “medically necessary” care, as this is a very basic tenant of medicine. BOP did not adopt WPATH’s approach in not requiring an inmate to first have a diagnosis before being approved for cross-sex surgery.

33. In its definition, WPATH also refers to “medical necessity” as “the service provided by a physician and/or health care professional, exercising prudent clinical judgement.” In my medical opinion, a prudent physician would not consider any treatment “medically necessary” unless there is an associated medical diagnosis and evidence to justify it, especially inside of a prison setting.

34. When it comes to surgeries, WPATH lists facelifts, lipofilling, liposuction, hair line advancement, hair line transplants, body contouring, and other such procedures as “medically necessary,” when these procedures are considered purely cosmetic in the rest of the medical community.

35. I have seen firsthand the suffering and mental turmoil of patients with gender dysphoria and find it hard to accept that a uterine transplant and many of the other procedures recommended by WPATH SOC 8 might somehow "alleviate" and help a patient's symptoms, especially when the recommendations were made without robust evidence.

36. A primary care physician's first and most important responsibility is to do no harm, and there is simply not enough evidence on the long-term effects of these procedures to deem them "medically necessary," or suitable treatment modality in the long-term, especially inside a prison setting.

37. It is my opinion that the medical necessity and long-term benefit of cross-sex surgeries in the treatment of gender dysphoria is currently in question. The entities who have published guidance on such care outside of WPATH have been quiet or are revisiting the evidence before publishing updated guidance. The information that was believed to be the "standard of care" for treating individuals with gender dysphoria and related disorders is under a cloud of doubt and uncertainty.

38. Also concerning is that WPATH has not been transparent; it failed to publish all relevant evidence or at the very least "caution" the target audience and well-intended providers about the gaps in knowledge on potential long-term harms of these procedures.

39. In any other area of medicine, surgeries that are considered "medically necessary" are a last resort when other medical treatments have failed and are always associated with a medical diagnosis. WPATH asserts that a phalloplasty is as "medically necessary", as a uterine transplant, or chin reshaping, however many, if not all, of the aforementioned procedures like facelifts, lipofilling, liposuction, hair line advancement, hair line transplants, body contouring, and other such procedures listed under the Gender-Affirming Surgical Procedures are considered

cosmetic and not covered by private health insurance in the community, because medical necessity has not been well established in medical literature, and long-term effects remain largely unknown.

40. Patients entrusted to BOP receive effective medically necessary care. There currently is not any medical consensus for cross-sex surgeries that is trustworthy. The medical necessity of cross-sex surgery is in question, especially given the controversy surrounding its long-term effects on mental health. The medical associations that have published medical guidelines for purposes of guiding providers, clinicians and patients, followed WPATH's ideologies and effectively abandoned the rigorous scientific review steps required in all other areas of medicine. As the consumer of such published guidelines, BOP cannot trust the reliability of the guidance, when it has been so broadly questioned for lack of sound evidence and for being free from bias. Patient safety and well-being is paramount to BOP.

41. Accordingly, based on recent studies or lack thereof, consultation with Department of Justice's psychiatric expert Dr. Kristopher E. Kaliebe, M.D., and closer scrutiny of WPATH's recommendations, BOP has stopped cross-sex surgical referrals, because to knowingly render high-cost, high-risk, irreversible surgeries not vetted by robust medical evidence would be irresponsible.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

ELIZABETE STAHL Digitally signed by ELIZABETE STAHL
Date: 2025.08.19 14:25:04 -04'00'

Dated: August 19, 2025

ELIZABETE STAHL,DO

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*,

Plaintiffs,

v.

DONALD TRUMP, *et al.*,

Defendants.

Case No. 1:25-cv-691-RCL

ORDER GRANTING PLAINTIFFS' MOTION FOR AN UPDATED PRELIMINARY INJUNCTION AND TO STAY AGENCY ACTION

Upon consideration of [179] Plaintiffs' Motion for an Updated Preliminary Injunction and to Stay Agency Action ("Motion"), the opposition and reply, and the entire record herein,

It appearing to the Court that Plaintiffs are likely to succeed on the merits of their action, that they will suffer irreparable injury if the requested relief is not issued, and that the balance of the equities and public interest favor the entry of such an order, it is therefore

ORDERED that Plaintiffs' Motion is **GRANTED**; it is further

ORDERED that the Bureau of Prisons' ("BOP") February 19, 2026 Program Statement 5260.01 (the "Program Statement") is stayed pursuant to 5 U.S.C. § 705. It is further

ORDERED that Defendants Todd Blanche, William K. Marshall, III, Christopher A. Bina, Dana R. DiGiacomo, and Shane Salem, in their official capacities, and their contractors, employees, and agents (i) are enjoined from enforcing Program Statement 5260.01, and (ii) shall provide and continue providing Plaintiffs and class members with gender-affirming care in accordance with BOP policy and practice in effect immediately prior to the issuance of Executive Order 14168 on January 20, 2025. It is further

ORDERED that this injunction shall be effective upon service on the Defendants, and no bond shall be required.

In accordance with the Prison Litigation Reform Act, the Court finds that this preliminary injunction is narrowly drawn, extends no further than necessary to correct the harm that the Court finds requires preliminary relief, and is the least intrusive means necessary to correct that harm. 18 U.S.C. § 3626(a)(2). Plaintiffs have shown a substantial likelihood of success on their claims that application of the Program Statement to class members would be unlawful and would cause them immediate, irreparable harm. Because applying the Program Statement to Plaintiffs and class members would cause such serious and irreparable harm, a preliminary injunction preventing such application is necessary to correct the harm and is the least intrusive means necessary to do so. Furthermore, because this preliminary injunction prevents the application of the Program Statement, and Plaintiffs have demonstrated a likelihood of success on the merits and immediate, irreparable harm if that application is not enjoined, this Order extends no further than necessary to correct the harm that requires this preliminary relief. Finally, this Court has considered any adverse impact on public safety or on the operation of the criminal justice system caused by this relief and has given substantial weight to such impacts. After this consideration, the Court has concluded and so finds that no adverse impacts on public safety or the operation of the criminal justice system will result from maintaining the status quo of the class members' medical care while this litigation proceeds.

IT IS SO ORDERED.

Date: June 17, 2026

Royce C. Lamberth
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*,

Plaintiffs,

v.

DONALD J. TRUMP, *et al.*,

Defendants.

Case No. 1:25-cv-691-RCL

MEMORANDUM OPINION

Plaintiffs in this dispute are inmates in the custody of the Bureau of Prisons ("BOP") who have been medically diagnosed with gender dysphoria. During their periods of incarceration, BOP has provided Plaintiffs with hormone therapy, social accommodations, and surgery (collectively "gender-affirming care"), to mitigate the negative psychological effects of their condition. On January 20, 2025, President Trump issued Executive Order ("EO") 14168, titled "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government." Section 4(c) of the EO provides that federal funds shall not be spent on any medical treatment for the purpose of conforming an inmate's appearance to that of the opposite sex. BOP subsequently promulgated two Implementing Memoranda to guide the agency's execution of the EO's commands. On June 3, 2025, this Court stayed both Implementing Memoranda pursuant to 5 U.S.C. § 705, enjoined Defendants from enforcing the EO as applied to gender-affirming care, and ordered BOP to provide gender-affirming care in accordance with BOP policy and practice in effect immediately prior to the issuance of the EO on January 20, 2025. This Court also certified

a class consisting of "all persons who are currently or will be incarcerated in BOP facilities with a current diagnosis of gender dysphoria or who receive such a diagnosis in the future."

On February 19, 2026, BOP Issued Program Statement 5260.01 ("the Program Statement"), titled "Management of Inmates with Gender Dysphoria," that superseded the original Implementing Memoranda. Like those Memoranda and the EO, the Program Statement is a near total ban on gender-affirming care. At bottom, the Program Statement seeks to provide only psychotherapy and psychotropic medication to treat gender dysphoria. Plaintiffs, on behalf of the class, have moved to preliminarily enjoin enforcement of the Executive Order and the Program Statement, and to stay the Program Statement while this litigation is pending. For the reasons that follow, Plaintiffs' Motion is **GRANTED** with a modification to the scope of the requested injunction.

With this Opinion, the Court has no intention of wading into the culture war being waged against transgender individuals. As detailed below, the Court simply decides whether the Bureau of Prisons followed mandatory administrative procedure when it issued its new policy concerning the provision of gender-affirming care to inmates diagnosed with gender dysphoria.

I. BACKGROUND

Before considering the merits of Plaintiffs' challenge to the Program Statement, the Court finds it necessary to summarize the evidence both parties present regarding gender-affirming care, as well as the factual background of the new policy and the procedural history of this case.

A. Gender Dysphoria and Gender-Affirming Care

Gender dysphoria is a serious medical condition codified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Declaration of Dr. Dan H. Karasic in Support of Plaintiffs' Motion for a Preliminary Injunction ("First Karasic Decl.") ¶ 48, ECF No 7-2. The term "gender dysphoria" describes distress related to the

incongruence between one's gender identity and attributes related to one's sex assigned at birth. *Id.* ¶ 47. "The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning." *Id.* ¶ 49. "When untreated, gender dysphoria can cause significant distress including increased risk of depression, anxiety, self-harm and suicidality." *Id.* ¶ 51. Defendants do not contest that gender dysphoria exists and that it can have serious manifestations. Where the parties split is over the medical necessity and efficacy of several modes of treatment collectively known as "gender-affirming care." That care includes hormone therapy, social accommodations to help patients live in line with their gender identities, and surgery when clinically indicated. Plaintiffs present evidence that gender-affirming care is widely accepted and effective to treat gender dysphoria. Defendants, by contrast, point primarily to caselaw and the declaration of a single medical expert with little experience treating gender dysphoria to demonstrate an emerging "medical debate" over the efficacy and risks associated with this care.

Through the declarations of medical expert Dr. Dan H. Karasic,[1] Plaintiffs present evidence of what they characterize as the dominant medical view on gender-affirming care. That view is summarized as follows: Gender dysphoria is amenable to treatment and the prevailing treatment for it—gender-affirming care (including hormone therapy, social transition, and surgery when clinically indicated)—is highly effective. *Id.* ¶¶ 50–52, 64, 66. Gender-affirming care can eliminate the distress of gender dysphoria by helping patients live consistently with their gender

[1] Dr. Karasic, is a psychiatrist and Professor Emeritus of Psychiatry at the University of California – San Francisco. He has more than 30 years of experience treating patients with gender dysphoria, has served as the chair of the American Psychiatric Association Workgroup on Gender Dysphoria, and previously sat on the Board of Directors of the World Professional Association for Transgender Health ("WPATH"). First Karasic Decl. ¶¶ 4–8, ECF No. 7-2. Dr. Karasic contributed to the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People and remains active in the work of WPATH. *Id.* ¶ 8.

identity. *Id.* ¶¶ 63, 72. It is supported by all major American medical and mental health professional organizations and is reflected in the clinical practice guidelines for the treatment of gender dysphoria that are regularly relied on by healthcare providers. *Id.* ¶¶ 53–62.

Gender-affirming care has been studied for over half a century and decades of scientific research and clinical experience have demonstrated that social transition and hormone therapy are effective in treating gender dysphoria. *Id.* ¶¶ 28, 72, 73; Declaration of Dr. Dan Karasic in Support of Plaintiffs' Motion for an Updated Preliminary Injunction ("Third Karasic Decl.") ¶ 24, ECF No. 179-2. This evidence is of the type and quality that supports many other widely accepted medical treatments. First Karasic Decl. ¶ 73, ECF No. 7-2; Third Karasic Decl. ¶ 25, ECF No. 179-2. Moreover, there is substantial evidence that hormone therapy for treatment of gender dysphoria is safe and presents risks comparable to the risks associated with other well-accepted medical treatments, including the use of hormones to treat other conditions in cisgender individuals. *See generally* Declaration of Dr. Ole-Petter Hamnvik ("Hamnvik Decl."), ECF No. 179-3.

For patients for whom gender-affirming care is clinically indicated, no alternative treatments have been demonstrated to be effective. First Karasic Decl. ¶ 81, ECF No. 7-2. Moreover, there is no evidence that psychotherapy or psychotropic medications on their own can alleviate the distress of gender dysphoria. Third Karasic Decl. ¶¶ 41–45. Gender-affirming care is, therefore, medically necessary. First Karasic Decl. ¶ 28, ECF No. 7-2. Denying individuals with gender dysphoria the ability to socially transition or obtain hormone therapy will predictably lead to mental health risks. *Id.* ¶¶ 28, 39, 80, 82. These risks include exacerbated depression, anxiety, suicidal ideation, and self-harm. *Id.* ¶ 83. In extreme cases, individuals may even resort to self-treatment by attempting to self-castrate or remove their own breasts. *Id.* ¶¶ 83–84.

The government, for its part, suggests that the dominant view no longer enjoys consensus. To support the ban on gender-affirming care contained in the Program Statement, Defendants point to evidence throughout the administrative record that purports to demonstrate a "debate" in the medical community concerning the efficacy of and risks associated with gender-affirming care. That evidence primarily includes citations to other judicial opinions[2] and a declaration from medical expert Dr. Kristopher Kaliebe, a psychiatrist retained for the purposes of this litigation with limited experience treating patients with gender dysphoria. Declaration of Dr. Kristopher Kaliebe ("Kaliebe Decl.") ¶ 1, ECF No. 160-2; *see also* Deposition of Dr. Kristopher Kaliebe in *Keohane v. Dixon* ("Kaliebe Tr.") at 6 (16:07–16:10), 9–10 (20:9–21:10), ECF No. 179-5 (testifying that he has only ever treated around 6 to 8 adult patients with gender dysphoria out of approximately 20,000 patients over the course of his career).

The government argues that the "debate" in the medical community results from newly available information that WPATH is a political organization whose guidelines cannot withstand scientific scrutiny. Mem. in Opp'n to Mot. for Prelim. Injunction ("Opp'n") at 1–2, ECF No. 186. Specifically, the government claims that concerns about the body of research underlying the WPATH model have resulted in a "newer more rapidly evolving clinical landscape" that has hampered the identification of a universal standard of care. Administrative Record ("AR") at 3–8, ECF No. 186–1. As a result, the government notes that many European countries "have distanced themselves" from the WPATH standards and that leading organizations in the United

[2] The government repeatedly cites caselaw as demonstrating "medical debate." *See, e.g.*, Mem. in Opp'n to Mot. for Prelim. Injunction ("Opp'n") at 3, 17–19, 33–37, ECF No. 186. But judicial opinions state legal standards—they typically do not carry evidentiary value absent a court taking judicial notice of the facts established in them, and even then, a court must "reach its own, independent findings of fact" notwithstanding what other judges have said in prior cases implicating the same issues. *Rimkus v. Islamic Republic of Iran*, 750 F. Supp. 2d 163, 172 (D.D.C. 2010); *see also* Fed. R. Evid. 201(b). Because the government has not attempted to argue that the factual assertions in these cases are deserving of judicial notice, the Court affords no evidentiary weight to these citations.

States are also reevaluating their clinical guidance. *Id.* at 4. The government does not suggest that the "debate" has resulted in medical consensus around any alternative treatment method, but nevertheless claims—primarily through the declaration of Dr. Kaliebe—that it is better to treat gender dysphoria with psychotherapy and psychotropic medications than with gender-affirming care. AR at 2613–18, ECF No. 186–2. *But see* Kaliebe Tr. at 46–47 (144:9–145:4), ECF No. 179-5 (admitting that there is no evidence showing that psychotherapy is efficacious in treating gender dysphoria).

After becoming aware of this "new" evidence and the "debate" in the medical community, the government concluded that it was necessary to revise its prior policy of providing gender-affirming care to inmates diagnosed with gender dysphoria.

B. Factual Background & Procedural History

1. BOP's Treatment of Individuals with Gender Dysphoria Prior to the EO

BOP is responsible for "the safekeeping, care, and subsistence of all persons charged with or convicted of offenses against the United States." 18 U.S.C. § 4042(a). BOP's Health Services Division is tasked with delivering "medically necessary health care to inmates effectively[,] in accordance with proven standards of care[, and] without compromising public safety concerns inherent to the Bureau's overall mission." Program Statement 6010.05 (June 26, 2014), *Health Services Administration* § 1, ECF No. 36-2. "Providing health care within a correctional environment presents unique challenges not encountered by practitioners elsewhere." *Id.* § 2. When there is an "incompatibility between medical and correctional guidelines," conflicts "should be resolved, as far as practical, in favor of medicine." *Id.* The Health Services Division follows certain "core principles," including that all inmates "deserve medically necessary health care" that is evidence based, meaning that it is "generally supported by outcome data." *Id.*

Prior to the issuance of EO 14168, inmates in BOP's custody diagnosed with gender dysphoria received gender-affirming care when clinically indicated. Declaration of Dr. Cathy Thompson ("First Thompson Decl."), ¶ 33, Ex. B thereto ("2022 Transgender Offender Manual"), and Ex. C thereto ("2023 Clinical Guidelines"), ECF No. 7-3. That care applied well-accepted medical protocols, including the WPATH guidelines, to individualized patient need. *See generally* 2023 Clinical Guidelines, ECF No. 7-3. BOP first issued clinical guidelines concerning the care of individuals with gender dysphoria in 2017 and periodically updated those guidelines to more "closely align [them] with community standards." *Id.* at i. The guidelines were developed in response to the fact that transgender individuals in BOP custody were more likely to require services to manage mental health crises than other inmates who are not transgender. First Thompson Decl. ¶ 27, ECF No. 7-3. The guidelines were most recently updated in 2023 and included the provision of hormone therapy, social accommodations, and surgical interventions when clinically indicated.

In 2017, BOP issued the "Transgender Offender Manual," which called for individualized assessment for hormone therapy and other treatment in accordance with BOP's clinical guidelines, and also set forth the clothing and commissary policies applicable to transgender inmates. *Id.* ¶¶ 28, 32–38 and Ex. B thereto. To implement these policies, BOP's Health Services Division created a Transgender Clinical Care Team made up of physicians, pharmacists, and social workers. *Id.* ¶ 33. BOP also created a Transgender Executive Council, which was the "decisionmaking body on all issues affecting the transgender population." *Id.* ¶ 31. That body included senior correctional leaders from BOP's Women and Special Populations Branch as well as BOP's senior psychologist, psychiatrist, security expert, and medical administrator. *Id.*

2. EO 14168 and the Original Implementing Memoranda

On January 20, 2025, President Donald J. Trump signed an executive order, which provides in pertinent part:

> Sec. 4(c): The Attorney General shall ensure that the Bureau of Prisons revises its policies concerning medial care to be consistent with this order, and shall ensure that no Federal funds are expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex.
>
> * * *
>
> Sec. 8(b): This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

Exec. Order 14168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8615 (Jan. 20, 2025) (the "Executive Order" or "EO").

Pursuant to the command contained in Section 4(c), BOP began the process of formulating a policy consistent with the Executive Order. On February 21, 2025, BOP issued an implementing memorandum (the "First Implementing Memorandum") which provided, in relevant part, that "[n]o appropriated funds should be utilized to purchase any items that align with transgender ideology (e.g., binders, stand-to-pee devices, hair removal devices, etc.)" and that "[r]equests for clothing accommodations (e.g., issuance of smocks for male inmates and undergarments that do not align with an inmate's biological sex) will not be issued." Compl. Ex.1 thereto ("First Implementing Memorandum"), ECF No 1-1. On February 28, 2025, BOP issued another implementing memorandum providing that "Consistent with Executive Order (EO) 14168, . . . no Bureau of Prisons funds are to be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex." Compl. Ex. 2 thereto ("Second Implementing Memorandum"), ECF No. 1-2.

The three named plaintiffs in this case—transgender inmates who were diagnosed with gender dysphoria by BOP medical staff, who were in BOP's custody at the time that the Executive

Order and Implementing Memoranda were issued, and who remain in BOP custody today—initiated this action on March 7, 2025. Compl. ¶¶ 1, 4, 24–26, ECF No. 1.

3. June 3, 2025 Preliminary Injunction

On March 17, 2025, Plaintiffs moved for a preliminary injunction and for class certification. Mot. for Prelim. Injunction, ECF No. 7. On June 3, 2025, this Court certified a class consisting of "all persons who are currently or will be incarcerated in BOP facilities with a current diagnosis of gender dysphoria or who receive such a diagnosis in the future," Mem. Op. at 27, ECF No. 67, stayed the Implementing Memoranda pursuant to 5 U.S.C. § 705, and enjoined Defendants from enforcing EO 14168 or the Implementing Memoranda, *id.* at 1–2. This Court concluded that Plaintiffs were likely to succeed on the merits of their APA claim that the Implementing Memoranda were arbitrary and capricious based, in part, on the lack of a reasoned explanation for the policy. *Id.* at 20–23. As a result, this Court did not delve into the merits of Plaintiffs' Eighth Amendment claim. *Id.* at 23.

After the preliminary injunction issued, Defendants informed Plaintiffs' counsel that BOP would not produce an administrative record for the Implementing Memoranda, and would instead produce an administrative record for the new policy it was working on when it issued. Li Nowlin-Sohl Decl. ¶¶ 10–11, ECF No. 87–2. On February 19, 2026, BOP issued Program Statement 5260.01, titled "Management of Inmates with Gender Dysphoria." Notice of New BOP Policy, ECF No. 125. Like the Implementing Memoranda and the EO, the Program Statement is a near total ban on gender-affirming care.

4. Program Statement 5260.01

At bottom, the Program Statement (or policy) seeks to provide only mental health services and psychotropic medication to treat gender dysphoria. It prohibits gender-affirming surgery,

hormone therapy, and social accommodations, with exceedingly few exceptions. *Id.* §§ 5(a)-(c), at 6–8.

The policy's "Treatment" section purports to establish "individualized, treatment plans that are tailored to the specific clinical needs of the inmate," *id.* § 5(a), at 6, but goes on to state that "[i]n general, identified medical and psychiatric comorbidities should be addressed before treatment for [gender dysphoria] proceeds," *id.* Indeed, the policy states that "[p]sychotherapy should be prioritized," and that further treatment for gender dysphoria may only "proceed once these medical and psychiatric comorbidities are resolved or ruled out as the potential cause of" gender dysphoria. *Id.* The policy then goes on to prohibit several modes of gender-affirming care for individuals who have not already received them, and to "taper" off those who have.

To begin, BOP will no longer provide sex trait modification surgeries to treat gender dysphoria. *Id.* § 5(b), at 7. For inmates who have already received these surgeries, medical care will be provided to address complications and resulting conditions. *Id.* Additionally, BOP will no longer provide social accommodations such as clothing and hair-removal devices to inmates diagnosed with gender dysphoria. *Id.* § 5(d), at 8. "If the inmate currently has social accommodations, the Bureau shall no longer provide the social accommodations and, when practicable, [will] remove or confiscate the social accommodations." *Id.*

Regarding the provision of hormone therapy, the Program Statement differentiates between several groups of inmates diagnosed with gender dysphoria. For those who are not currently receiving hormones, BOP will not provide hormone therapy to address gender dysphoria. *Id.* § 5(c)(i), at 7. For inmates who are currently receiving hormones, BOP will place "all such inmates" on a "tapering plan" that considers "the appropriate factors such as the duration the inmate has been receiving hormones to address [gender dysphoria], the initial rationale for

receiving the hormone intervention, the response by the inmate to the intervention, and whether the inmate has undergone sex trait modification surgery." *Id.* § 5(c)(ii), at 7–8. For those who have "recently begun receiving hormones," the tapering plan will include "a rapid discontinuation" of hormones. *Id.* at 8. For inmates who have been receiving hormones "for an extended period of time," the tapering plan will include "an appropriately paced discontinuation of the hormone intervention." *Id.*

BOP places inmates who are (1) post-surgery or (2) have been receiving hormones for an "extended period of time *and* develop severe physiological and psychological withdrawal effects from tapering" in a category of their own. *Id.* (emphasis added). For these especially vulnerable individuals, "it may not be appropriate in all cases for the initial tapering plan to include cessation of hormones." *Id.* However, even for these special groups, "tapering plans should be reevaluated regularly with respect to cessation of hormones." *Id.* Foreseeing that tapering may lead to complications, the Program Statement notes that for all groups, "[t]apering plans may be adjusted as necessary . . . but the adjusted tapering plans must still be consistent with the purpose of this policy." *Id.*

5. Administrative Record

On March 12, 2026, BOP filed a certified index of the administrative record associated with the Program Statement, AR, ECF No. 151, and produced the entire 3,000-page administrative record to Plaintiffs. Defendants represent that in revising its policy for the treatment of gender dysphoria, BOP "conducted extensive reviews of, among other things, relevant medical studies, state correctional policies, pertinent case law, prison administration and security concerns, and expert medical opinions." Opp'n at 7, ECF No. 186 (citing AR at 1–4, 5–47, ECF No. 186-1). Of note, the AR includes a four-page memo on the administrative record itself ("AR Memo"), as well

as a 43-page policy memo ("Policy Memo") explaining the agency's reasoning for the new policy. In sum, the agency concluded that due to new evidence of a debate in the medical community regarding the efficacy of and risks associated with gender-affirming care, the benefits to inmates of providing such care no longer outweighed BOP's other security and prison-administration concerns. *See generally* Policy Memo, AR at 5–47, ECF No. 186-1. As a result, BOP decided it would no longer provide gender-affirming care and would instead use psychotherapy and psychotropic medication to treat gender dysphoria. *Id.* at 29–30.

6. Motion for an Updated Preliminary Injunction

On April 29, 2026, Plaintiffs Alishea Kingdom, Solo Nichols, and Jas Kapule, on behalf of all class members, filed a supplemental complaint to challenge the new policy, Supp. Compl., ECF No. 182, and moved this Court for a preliminary injunction enjoining Defendants, their contractors, employees, and agents (1) from enforcing Executive Order 14168 as applied to medical care and social accommodations for people in BOP custody and from enforcing Program Statement 5260.01, and (2) to provide Plaintiffs and class members gender-affirming care in accordance with BOP policy and practice in effect immediately prior to the issuance of the EO on January 20, 2025. Mot. for Prelim. Injunction, ECF No. 179. Additionally, Plaintiffs moved for a stay of the Program Statement pursuant to 5 U.S.C. § 705. *Id.* On May 13, 2026, Defendants opposed the motion and filed a motion for summary judgment on all of Plaintiffs' claims. Opp'n, ECF No. 186. On May 27, 2026, this Court held a hearing on the motion for preliminary injunction. Today, the Court decides only that motion.

II. LEGAL STANDARDS

A. Preliminary Injunction

Preliminary injunctive relief is warranted if the movant meets its burden to show that (1) the movant is likely to succeed on the merits; (2) the movant is likely to suffer irreparable harm unless

preliminary relief is granted; (3) the balance of the equities favors a preliminary injunction; and (4) that a preliminary injunction is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Courts in this Circuit have adopted a sliding scale approach to the preliminary injunction analysis, whereby a relatively strong showing on one of these factors may partially offset weakness in another, although some non-speculative showing of irreparable harm is essential. *CityFed Fin. Corp. v. Office of Thrift Supervision*, 58 F.3d 738, 747 (D.C. Cir. 1995). Where, as here, the government is a party, the latter two factors of the analysis merge into one, because the interest of the government is taken to be identical to the interest of the public. *Nken v. Holder*, 556 U.S. 418, 435 (2009). In evaluating these factors, a Court must bear in mind that preliminary injunctive relief is an extraordinary form of relief that "should be sparingly exercised." *Dorfmann v. Boozer*, 414 F.2d 1168, 1173 (D.C. Cir. 1969) (cleaned up). A motion to stay agency action pending review under 5 U.S.C. § 705 is governed by the same standard. *Green Oceans v. U.S. Dep't of the Interior*, No. 24-cv-141-RCL, 2024 WL 3104945, at *2 n.3 (D.D.C. June 24, 2024).

B. Judicial Review Under the APA

The Administrative Procedure Act provides for judicial review of final agency action. 5 U.S.C. §§ 702, 704. A reviewing court must "hold unlawful and set aside agency action" that is, among other defects, "arbitrary, capricious, . . . or otherwise not in accordance with law." *Id.* § 706(2). The APA generally limits judicial review to the administrative record. *Theodore Roosevelt Conservation P'ship v. Salazar*, 616 F.3d 497, 514 (D.C. Cir. 2010). Moreover, "to the extent necessary to prevent irreparable injury," the APA authorizes courts to "postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings." *Id.* § 705. "The four-factor standard used by courts for a motion to stay agency action is the same

legal standard as that used in a motion for preliminary injunction." *Hill Dermaceuticals, Inc. v. U.S. Food & Drug Admin*, 524 F.Supp.2d 5, 7 (D.D.C. 2007).

III. DISCUSSION

A. The Court's Jurisdiction to Enjoin Enforcement of the EO

Plaintiffs moved this Court for a preliminary injunction enjoining Defendants, their contractors, employees, and agents (1) from enforcing Executive Order 14168 as applied to medical care and social accommodations for people in BOP custody and from enforcing Program Statement 5260.01, and (2) to provide Plaintiffs and class members gender-affirming care in accordance with BOP policy and practice in effect immediately prior to the issuance of the EO on January 20, 2025. ECF No. 179. Additionally, Plaintiffs moved for a stay of Program Statement 5260.01 pursuant to 5 U.S.C. § 705.

Defendants argue that this Court lacks jurisdiction to enjoin enforcement of the executive order. Plaintiffs counter that the Court has already done so in this case. *See* Mem. Op. at 1–2, ECF No. 67 (enjoining Defendants from enforcing the EO "as applied to medical hormone therapy and social accommodations for people in the custody of BOP"). While that may be true, it is also true that jurisdiction was not contested when this Court issued its June 3, 2025 preliminary injunction. At this early stage of litigation and without more extensive briefing, the Court declines to take up this question on an expedited basis. Instead, the Court grants Plaintiffs' injunction with the following modification:

> Defendants, their contractors, employees, and agents are enjoined (1) from enforcing Program Statement 5260.01, and (2) are ordered to provide Plaintiffs and class members gender-affirming medications and social accommodations in accordance with BOP policy and practice in effect immediately prior to the issuance of the EO on January 20, 2025. Additionally, Program Statement 5260.01 is stayed pursuant to 5 U.S.C. § 705.

B. The Plaintiffs Are Likely to Succeed on the Merits of their APA Claim

Plaintiffs argue that the Program Statement violates the APA on multiple grounds. First, because the APA requires courts to set aside unconstitutional agency action, and here the Program Statement violates the Eighth Amendment. Second, because the Program Statement is arbitrary and capricious based on its lack of reasoned decisionmaking. *Dep't of Com. v. New York*, 588 U.S. 752, 773 (2019). The Court agrees that the Program Statement amounts to arbitrary and capricious action and accordingly holds that Plaintiffs are likely to succeed on the merits of their APA claim. The Court declines to reach Plaintiffs' constitutional arguments at this time, and accordingly does not take up this aspect of Plaintiffs' APA claim.

"[A]s a matter of judicial restraint and 'governance,' courts generally should endeavor to resolve cases on non-constitutional grounds and should entertain constitutional questions only when necessary." *Uthman v. Trump*, 486 F. Supp. 3d 350, 356 (D.D.C. 2020) (Lamberth, J.) (quoting *Ashwander v. Tenn. Valley Auth.*, 297 U.S. 288, 346 (1936)). It stands to reason that the need for such "judicial restraint" is heightened in cases, such as the one at hand, where the factual record is necessarily thin due to the procedural posture of the litigation. Therefore, because the Court assesses that Plaintiffs are likely to prevail on their APA claim, the Court need not delve into the merits of their Eighth Amendment claim at this time.

1. The Plaintiffs Are Challenging Final Agency Action

As a threshold matter, the Court must determine whether BOP's actions constitute "final agency action" susceptible to APA review. 5 U.S.C. § 704. Executive orders themselves are not susceptible to APA review for the simple reason that "the President is not an 'agency' under" the APA. *Chamber of Comm. of U.S. v. Reich*, 74 F.3d 1322, 1326 (D.C. Cir. 1996); *see also League of United Latin Am. Citizens v. Exec. Off. of President*, 780 F. Supp. 3d 135, 171 (D.D.C. 2025) (holding that because the President is not an agency, "the APA does not supply a cause of action

to challenge an executive order"). However, where the President delegates the implementation of an executive order to an agency, that agency's actions are not derivatively shielded from APA review. *See Tate v. Pompeo*, 513 F. Supp. 3d 132, 142 (D.D.C. 2021) (holding that an "attempt to bootstrap the nonreviewability of presidential actions to discretionary authority delegated to" an agency did "not have support in precedent"); *Gomez v. Trump*, 485 F. Supp. 3d 145, 177 (D.D.C. 2020) ("To the extent Defendants contend that the court is foreclosed from reviewing agency actions taken to implement [Presidential] Proclamations, they are wrong.") (emphasis omitted); *O.A. v. Trump*, 404 F. Supp. 3d 109, 147 (D.D.C. 2019) ("The Court . . . need not pause over the fact that presidential actions are not themselves subject to APA review because it is the Rule, and not the Proclamation, that has operative effect.") (citation omitted).

Here, such a delegation plainly appears on the face of the Executive Order. *See* EO 14168 Sec. 4(c) (instructing the Attorney General and BOP to "revise[] [BOP's] policies concerning medical care to be consistent with this order"). Moreover, the Program Statement itself states that the "Bureau will comply with . . . Executive Order [14168] unless compliance with the Executive Order is prohibited by a court injunction or court order." Program Statement § 5, at 5–6, ECF No. 125. As a result, BOP's actions taken pursuant to this directive, including the Program Statement, do not partake of the President's exemption from APA review.

Having determined that the actions challenged here are those of an "agency," the next question is whether they are "final." An agency's action is final if it "mark[s] the 'consummation' of the agency's decisionmaking process" and is "one by which 'rights or obligations have been determined,' or from which 'legal consequences will flow . . . .'" *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (first quoting *Chi. & S. Air Lines, Inc. v. Waterman S.S. Corp.*, 333 U.S. 103, 113 (1948), and then quoting *Port of Bos. Marine Terminal Ass'n v. Rederiaktiebolaget Transatlantic*,

400 U.S. 62, 71 (1970)). Both aspects of the *Bennett* test are met here. BOP's mind was made up as to its obligation to provide gender-affirming care by the time the Program Statement was issued on February 19, 2026. The only reason the new policy has not yet taken effect is because of the existence of this Court's preliminary injunction that was first issued on June 3, 2025. So even though the Program Statement has not yet been applied to class members, BOP's "decisionmaking process" undergirding the future termination of Plaintiffs' gender-affirming treatments is complete, which is all that *Bennett* requires. Moreover, the government does not dispute that the Program Statement represents final agency action.

2. The Plaintiffs Have Demonstrated a Likelihood that BOP's Action Was Arbitrary and Capricious

The APA provides that agency action may be set aside if it is "arbitrary" or "capricious." 5 U.S.C. § 706(2)(a). Agency action is arbitrary or capricious if the agency "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). "The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency." *Id.* "A court simply ensures that the agency has acted within a zone of reasonableness and, in particular, has reasonably considered the relevant issues and reasonably explained the decision." *F.C.C. v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).

Plaintiffs contend that the Program Statement is arbitrary and capricious for several reasons, including that BOP did not properly consider its own prior experience providing gender-affirming care to inmates diagnosed with gender dysphoria, and because the Program Statement's

prohibition on gender-affirming care is objectively unreasonable given the evidence before the agency. For these reasons, Plaintiffs argue that the Program Statement was preordained, rests on a pretextual basis, and is reverse engineered to implement the Executive Order. The government disputes each of these claims and points to the 3,000-page administrative record as containing ample evidence of its reasoned decisionmaking. For the reasons that follow, the Court agrees with Plaintiffs and holds that the Program Statement amounts to arbitrary and capricious agency action.

(i) BOP Did Not Properly Consider Its Own Experience Providing Gender-Affirming Care Under the Prior Policy.

The D.C. Circuit has held that "an agency's refusal to consider evidence bearing on the issue before it constitutes arbitrary agency action within the meaning of § 706." *Butte Cnty., Cal. v. Hogen*, 613 F.3d 190, 194 (D.C. Cir. 2010). "This proposition may be deduced from case law applying the substantial evidence test, under which an agency cannot ignore evidence contradicting its position." *Id.* Here, Plaintiffs contend that the government failed to consider critical information it had in its possession when formulating the Program Statement: BOP's own experience providing gender-affirming care to inmates diagnosed with gender dysphoria for many years under its prior policy. Based on the current record, the Court agrees that Defendants did not adequately consider this experience.

The government states that in revising its medical policies on gender-affirming care, it "considered the relevant issues," including among other things: "extensive reviews of existing research, medical expert opinions, medical journals, national media reports, recent medical studies, state correctional policies, BOP's prior policies, and pertinent case law." AR Memo at 1, ECF No. 160-1. Based on this review, the government concluded that gender-affirming care is "unproven" and "not medically necessary to treat gender dysphoria, *especially* in the correctional context," Policy Memo at 5, 9, 12, 20–21, ECF No. 160-2 (emphasis added). It also concluded that these

treatments pose "serious security and prison-administration concerns" within BOP facilities. *Id.* at 14, 24. As a result, BOP decided that with very limited exceptions, it would no longer provide gender-affirming care to inmates diagnosed with gender dysphoria.

These conclusions imply that the government considered evidence *from* the correctional environment when formulating its new policy. Indeed, the government acknowledges that it reviewed "five different state correctional policies (Florida, California, Kentucky, Oklahoma, and Minnesota) to understand how those states address gender dysphoria in the correctional context." Opp'n at 8 (citing AR 3). To be sure, this evidence is relevant to BOP's new policy. But the government has other relevant evidence of the efficacy and safety of gender-affirming care in correctional facilities—its own experience providing this care to inmates diagnosed with gender dysphoria for nearly a decade.

Recall that BOP first issued clinical guidelines concerning the care of individuals with gender dysphoria in 2017 and periodically updated those guidelines to more "closely align [them] with community standards." 2023 Clinical Guidelines at i, ECF No. 7-3. The guidelines were most recently updated in 2023 and included the provision of hormone therapy, social accommodations, and surgical interventions when clinically indicated. In addition, in 2017, BOP issued the "Transgender Offender Manual," which called for individualized assessment for hormone therapy and other treatment in accordance with BOP's clinical guidelines and also set forth the clothing and commissary policies applicable to transgender inmates. First Thompson Decl. ¶¶ 28, 32–44, 38 and Ex. B thereto, ECF No. 7-3. To implement these policies, BOP's Health Services Division created a Transgender Clinical Care Team made up of physicians, pharmacists, and social workers. *Id.* ¶ 33, Ex. C thereto at 1. BOP also created a Transgender Executive Council, which was the "decisionmaking body on all issues affecting the transgender

population." *Id.* ¶ 31, Ex. B thereto at 4. That body included senior correctional leaders from BOP's Women and Special Populations Branch as well as BOP's senior psychologist, psychiatrist, security expert, and medical administrator. *Id.* ¶ 31.

And yet, the government does not meaningfully discuss this experience anywhere in the 43-page Policy Memo supporting the Program Statement. Despite providing gender-affirming care to inmates in its custody for years, the government cites in the Program Statement zero evidence from its own medical or mental health professionals to support its conclusions. Moreover, the government does not point the Court to evidence that gender-affirming care was ineffective or harmful to its own inmates diagnosed with gender dysphoria, or that providing this care previously led to security concerns at BOP facilities.

In its opposition to Plaintiffs' motion, the government argues that the APA does not require it to scrutinize "any particular documents" concerning inmates' treatment histories under the prior policy, "especially here where many of the BOP senior officials who wrote, consulted[,] and applied the previous BOP policy were also responsible for evaluating, implementing, and ultimately formulating" the Program Statement. Opp'n at 32, ECF No. 186. The government claims that "those officials" used their "experience with the prior policy to help formulate the 2026 Policy." *Id.* at 31 (internal quotation marks omitted). But this claim is not supported by the Policy Statement or the AR, and instead, it comes solely from the declaration of BOP Medical Director Dr. Elizabete Stahl, which appears in the record for the first time as an attachment to Defendants' opposition. *See generally* Stahl Decl., ECF No. 186-3.

Notwithstanding the fact that Dr. Stahl goes on to essentially concede that the government did *not* consider its own experience, *see id.* ¶ 16 (attesting that the treatment histories of BOP inmates would not be helpful because "there is not a vetted, or validated clinical instrument that

measures the success or failure of gender dysphoria treatment"), her declaration cannot be credited. "It is a foundational principle of administrative law that judicial review of agency action is limited to the grounds that the agency invoked when it took the action." *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 591 U.S. 1, 20 (2020) (internal quotation marks omitted). Post-hoc rationalizations during litigation cannot replace the type of reasoned analysis the government must undertake at the front end. *See American Textile Mfrs. Inst., Inc. v. Donovan*, 452 U.S. 490, 539 (1981) (stating that "the post-hoc rationalizations of the agency or the parties to this litigation cannot serve as a sufficient predicate for agency action."). Here, the government does not invoke this evidence from Dr. Stahl anywhere in the administrative record. Moreover, Dr. Stahl's declaration is dated May 12, 2026—nearly three months after BOP formally announced the Program Statement. Stahl Decl. at 7, ECF No. 186-3. Thus, Dr. Stahl's post-hoc statements cannot ameliorate the government's failure to demonstrate that it meaningfully considered its prior experience.

Accordingly, the Court finds that the Program Statement amounts to arbitrary and capricious agency action because the government failed to seriously consider its own experience providing gender-affirming care to inmates for years under its prior policy.

(ii) The Program Statement is Objectively Unreasonable Given the Evidence Before the Agency.

The Program Statement is separately arbitrary and capricious because it reaches a conclusion "so implausible that it could not be ascribed to a difference in view or the product of agency expertise," as evidenced by its explanation, which "runs counter to the evidence before the agency." *Evergreen Shipping Agency (Am.) Corp. v. Federal Mar. Comm'n*, 106 F.4th 1113, 1117 (D.C. Circ. 2024) (quoting *State Farm*, 463 U.S. at 43). "Such illogical decisions are not rationally

connected to the facts and are thus arbitrary and capricious." *Markel v. Del Toro*, 2025 WL 304875, at *6 (D.D.C. Jan. 27, 2025).

Instead of relying on BOP's own medical or mental health professionals, the agency supports its new policy with a declaration by a doctor it retained specifically for this litigation, who has limited experience treating gender dysphoria, and who promotes a treatment for gender dysphoria that he himself acknowledges is not evidence based. *See* Kaliebe Tr. at 9–10 (20:9–21:10), ECF No. 179-5 (conceding minimal experience treating individuals diagnosed with gender dysphoria); *id* at 46–47 (144:9–145:4) (admitting that no evidence supports psychotherapy as a treatment for gender dysphoria). But as Plaintiffs have demonstrated, the evidence before the agency suggests that denying gender-affirming care to patients for whom such care is medically necessary can lead to a deterioration in mental health and increase depression, anxiety, and self-harm rates. *See* First Karasic Decl. ¶¶ 39, 80–85, ECF No 7-2. And whereas the government provides no support for its assertion that gender-affirming care could increase self-harm, Policy Memo at 24, ECF No. 160-2, Plaintiffs' experts—who unlike Dr. Kaliebe, have considerable experience treating gender dysphoric patients—testify that this claim is unfounded, Third Karasic Decl. ¶ 49, ECF No. 179-2; Second Thompson Decl. ¶ 29, ECF No. 179-4.

An agency's judgment "must be based on logic and evidence, not sheer speculation." *Council of Parent Att'ys and Advocates v. Devos*, 365 F. Supp. 3d 28, 51 (D.D.C. 2019) (quoting *Sorenson Commc'ns Inc. v. F.C.C.*, 755 F.3d 702, 708 (D.C. Cir. 2014)) (cleaned up). Banning evidence-backed care for an alternative that has no evidentiary support is an "implausible strategy" to treat gender dysphoria, *Bedford Cnty. Mem'l Hosp. v. Health & Hum. Servs.*, 769 F.2d 1017, 1022 (4th Cir. 1985), to say the least. Nor can the government's attacks on the WPATH standards of care overcome decades of research and clinical experience demonstrating the efficacy of gender-

affirming care. *See* Third Karasic Decl. ¶ 60, ECF No. 179-2. Thus, the government has not demonstrated a reasonable basis to adopt a policy prohibiting this care. Because the Program Statement does not follow from the evidence in the record, it is likely arbitrary and capricious.

(iii) The Program Statement is Pretextual and Reverse Engineered to Implement EO 14168.

Finally, Plaintiffs contend that the Program Statement violates the APA because it is pretextual, preordained, and reverse engineered in response to this litigation to implement EO 14168's directives. Mot. at 34–36, ECF No. 179-1. To support this claim, Plaintiffs point to identical language contained in the Program Statement and the EO, BOP's failure to consider its prior experience, and the lack of a rational connection between the evidence and BOP's new policy. *Id.* Defendants counter that the Program Statement could not be pre-ordained because it is the result of approximately 12 months of study, and in any event the policy *is* rationally connected to the facts found during that time. Opp'n at 30–31, ECF No. 186. The Court is not convinced.

When the record reveals that an agency "preordained [its] decision," *Miot v. Trump*, 818 F. Supp. 3d 126, 175 (D.D.C. 2026), *cert granted before judgment*, 2026 WL 731087 (U.S. Mar. 16, 2026), and the agency merely "reverse engineered" a policy to justify the same outcome—thereby engaging in a "pretextual" action, *Saget v. Trump*, 375 F. Supp. 3d 280, 361 (E.D.N.Y. 2019) (quoting *Cowpasture River Pres. Ass'n v. Forest Serv.*, 911 F.3d 150, 176 (4th Cir. 2018)), that is itself a violation of the APA. Based on the existing record, the Court finds that is the case here.

Recall that the stated intent of the Program Statement "is for federal funds to not be expended for any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex." Program Statement 5260.01 § 8, at 9, ECF No. 125. That

language comes directly from EO 14168, a fact the Program Statement acknowledges directly. *Id.* § 5, at 5–6 ("Executive Order 14,168 . . . prohibits the Bureau from expending federal funds for 'any medical procedure, treatment, or drug for the purpose of conforming an inmate's appearance to that of the opposite sex' . . . . The Bureau will comply with this Executive Order unless compliance with the Executive Order is prohibited by a court injunction or court order."). Nevertheless, BOP insists that, even though the EO "supports this policy, the Bureau also adopts this policy independently" of the EO. *Id.* § 5, at 6. As Plaintiffs say, "[t]he suggestion that BOP happened to independently reach the same result as the one required by the EO is preposterous." Mot. at 36, ECF No. 179-1. It is more likely, given the record before the Court, that the government disregarded significant evidence in its possession to reach the EO's mandated result.

The Court's conclusions in subsections (B)(2)(*i*)–(*ii*) provide further evidence of pretext. If the government intended to form a policy based on the evidence, one would expect it to have seriously considered its own experience providing gender-affirming care to inmates in its custody. Moreover, the government would not have concluded that this care is "not medically necessary" and "poses security and prison-administration concerns" despite ample record evidence to the contrary. Plaintiffs theorize that after this Court enjoined BOP's original Implementing Memoranda for lack of even a basic explanation, the agency "cherry-picked" materials to support the same predetermined policy choice. Mot. at 36, ECF No. 179-1 (quoting *Afr. Communities Together v. Noem*, 2026 WL 395732, at *10 (D. Mass. Feb. 12, 2026)). The government disputes this series of events. Instead, it argues that the new policy is more than a mere repacking of the 2025 Implementing Memoranda because it took nearly 12 months to create. This argument is unavailing. No length of consideration can convince the Court that a policy is anything other than pretext when the agency has not demonstrated that it considered the relevant evidence and drew a

reasonable conclusion from that evidence. Because the Program Statement appears to be pretextual, it is arbitrary and capricious under the APA.

Having found that BOP's prohibition on gender-affirming care is likely arbitrary and capricious under the APA, the Court leaves Plaintiffs' Eighth Amendment claims for another day.

C. The Plaintiffs Have Shown Sufficient Likelihood of Irreparable Harm

To obtain a preliminary injunction, Plaintiffs must demonstrate that irreparable injury "is likely in the absence of an injunction." *Winter*, 555 U.S. at 22 (emphasis omitted). Irreparable harm results where damages cannot adequately compensate for the loss if the injunction is denied. *National Senior Citizens Law Center, Inc. v. Legal Services Corp.*, 581 F. Supp. 1362, 1372 (D.D.C. 1984).

Recall that all class members have "a current diagnosis of gender dysphoria or [will] receive such a diagnosis in the future." Mem. Op. at 27, ECF No. 67. Plaintiffs have put forward evidence that gender-affirming care is the only effective treatment for gender dysphoria, and that severe harms flow from the cessation of such care. While not every class member requires the same treatment for their gender dysphoria, Plaintiffs argue that irreparable harm flows from the government's categorical ban on the only type of care that is effective at treating their condition. On this record, the Court finds that Plaintiffs have carried their burden of showing irreparable harm.

1. Efficacy of Gender-Affirming Care

Through their expert, Dr. Dan Karasic, Plaintiffs assert that a substantial body of research and clinical experience has proven that gender-affirming care is effective in treating gender dysphoria, and that this conclusion is widely held in the medical community. First Karasic Decl. ¶¶ 72–76, 78, ECF No. 7-2; Third Karasic Decl. ¶¶ 32–35, ECF No. 179-2. According to Dr.

Karasic, every major medical and mental health professional organization in the United States recognizes the efficacy of gender-affirming care, including the American Medical Association, the American Psychological Association, the American Psychiatric Association, and the Endocrine Society. Third Karasic Decl. ¶ 33, ECF No. 179-2; *see also id.* ¶ 11 (opining that "social transition and hormone therapy for the treatment of adults with gender dysphoria are not the subject of controversy or debate within the medical and mental health fields" and that "[t]o the extent there is any controversy about these treatments in public discourse, it is limited to the context of pediatric patients with gender dysphoria"). Dr. Karasic further attests that, those "[f]or whom gender affirming medical care is indicated, no alternative treatments have been demonstrated to be effective." First Karasic Decl. ¶ 70, ECF No. 7-2. "Denying patients with gender dysphoria the ability to socially transition or obtain gender-affirming medical care where indicated predictably will lead to significant deterioration in mental health." *Id.* ¶ 82.

It's true that the government puts forward some evidence to contest these conclusions. *See* Kaliebe Decl., ECF No. 160-3. There is, however, a clear winner in the battle of the experts. Only Plaintiffs have put forward evidence attested to by medical professionals with meaningful experience treating people with gender dysphoria. The government's evidence comes principally from Dr. Kaliebe, a psychiatrist hired by DOJ to be its "psychiatric expert." Stahl Decl. ¶ 41, ECF No. 186-3. As mentioned, Dr. Kaliebe has limited experience treating patients with gender dysphoria. Kaliebe Tr. at 9–10 (20:9–21:10), ECF 179-5 (testifying that he has only ever treated around 6 to 8 adult patients with gender dysphoria out of approximately 20,000 patients over the course of his career). Similarly, BOP's Medical Director, Dr. Stahl, who "consult[ed] with" Dr. Kaliebe, also has little experience treating gender dysphoria. Stahl Decl. ¶¶ 13, 41, ECF No. 186-3 (admitting that she treated a "small number of patients").

What's more, although the government acknowledges that gender dysphoria is a serious disorder, the only treatment options it intends to provide are psychotherapy and psychotropic medication—even though Dr. Kaliebe has previously admitted that there is no evidence showing that psychotherapy is efficacious in treating gender dysphoria, Kaliebe Tr. at 46–47 (144:9–145:4), ECF No. 179-5, and Dr. Stahl has acknowledged that psychotropic medication treats co-morbidities, Stahl Decl. ¶ 6, ECF No. 186-3, not the condition of gender dysphoria itself, *see also* Third Karasic Decl. ¶¶ 41–48, ECF No. 179-2 (agreeing that these treatments do not ameliorate gender dysphoria).

The government also attempts to challenge the efficacy of gender-affirming care by suggesting that there is a lack of "high quality" research backing these treatments. Opp'n at 8, ECF No. 186 (citing AR at 1552). But Dr. Karasic explains that "high quality" research is a term of art generally referring to randomized controlled trials, while all other types of research are deemed "low quality" by comparison. Third Karasic Decl. ¶¶ 25–26, ECF No. 179-2. While randomized controlled trials may be the gold standard, they are often infeasible or unethical, and many widely accepted medical treatments are supported only by "low quality" evidence, such as cross-sectional and longitudinal observational studies—the same type and quality of research demonstrating the efficacy of gender-affirming care. *Id.* ¶ 25.

Based on this record, the Court concludes that Plaintiffs have demonstrated that gender affirming care is the only effective treatment for gender dysphoria. The Court now turns to the question of whether denying this medically necessary care gives rise to irreparable injury.

2. Consequences of Denying Gender-Affirming Care

The named plaintiffs, along with other class members, have described the harms they faced when BOP previously denied them hormone therapy. Declaration of Alishea Sophia Kingdom

("Kingdom Decl.") ¶¶ 21–22, ECF No. 7-4 (experiencing symptoms including anxiety, panic attacks, thoughts of self-harm and suicidal ideation when hormone therapy was withdrawn); Third Declaration of Solo Nichols ("Third Nichols Decl.") ¶ 3, ECF No. 179-7 (experiencing hot flashes, rapid mood swings, insomnia, and "unreasonable sad[ness]"); Third Kapule Decl. ¶¶ 2–9, ECF No. 179-8 (experiencing depression, anxiety, and worsening gender dysphoria); Declaration of Rebecca-James Meskill ("Meskill Decl.") ¶ 12–13, ECF No. 107-11 (experiencing worsening mental health and "feeling diminished in every aspect of life" due to "re-masculinizing" body). The government insists that this time will be different because it will provide class members with "individualized" tapering plans for their hormone therapy, along with mental health counseling. *See* Opp'n at 41–44, ECF No. 186. But even if the government's tapering process mitigates severe withdrawal symptoms, it will "not prevent the predictable serious harms of denying hormone therapy to those who have a medical need for it." Third Karasic Decl. ¶ 19, ECF No. 179-2. Put simply, there is reason to believe, based on the record, "that withdrawing people from hormone therapy they have been receiving to treat gender dysphoria"—regardless of the rate of tapering and regardless of the availability of psychotherapy—will "cause[e] significant mental health distress." *Id.* ¶ 21. And the same is true of the government's plan to confiscate class members' social accommodations. *Id.* ¶ 9; *see also* Supplemental Declaration of Solo Nichols ("Nichols Supp. Decl.") ¶ 6, ECF No. 56-1 (describing worsening mental health and gender dysphoria absent social accommodations); Declaration of Grace Pinson ("Pinson Decl.") ¶ 20, ECF No. 107-2 (same); Declaration of Valerie Simpkins ("Simpkins Decl.") ¶ 13, ECF No. 107-4 (same); Declaration of Justine Finley ("Finley Decl.") ¶ 11, ECF No. 107-6 (same); Declaration of Tiffany Larson ("Larson Decl.") ¶ 16, 107-12 (same); Declaration of Gigi Auliyaa ("Auliyaa Decl.") ¶ 9, ECF No. 107-13 (same).

The government next argues that under *Doe v. Blanche*, 172 F.4th 901 (D.C. Cir. 2026), the Court is required to make individualized findings of each class member's risk. But in *Doe*, the Circuit held that fact-finding was required because the plaintiffs in that case expressly disclaimed the argument that BOP's categorical ban on housing transgender women in women's prisons was unlawful as to every transgender woman in BOP's custody. *See id.* at 916–18. Rather, the *Doe* plaintiffs argued on appeal that they possessed certain characteristics that made them particularly vulnerable to being housed in men's facilities. *Id.* at 916. Here, Plaintiffs argue that the government's categorical ban—which precludes medical professionals from prescribing a gender-affirming treatment plan based on an inmate's unique needs—puts all class members at risk of being denied medically necessary care. Unlike in *Doe*, the *Kingdom* class members are injured by virtue of their gender dysphoria diagnosis alone, making individualized findings unnecessary for irreparable harm purposes.

The record shows that denying class members gender-affirming hormone therapy and social accommodations will cause irreparable injuries, including the exacerbation of their gender dysphoria and increased risk of depression, anxiety, self-harm (including attempts to self-castrate), and suicidality. First Karasic Decl. ¶¶ 72, 83–86, ECF No. 7-2; *see also* Third Karasic Decl. ¶¶ 18–25, ECF No. 179-2 (detailing the harms associated with withholding medically necessary care to treat gender dysphoria). Plaintiffs have therefore carried their burden of showing irreparable harm.

D. The Balance of the Equities and the Public Interest Favor an Injunction

Where, as here, "the Government is the opposing party," the balance-of-equities factor and the public-interest factor "merge," *Nken*, 556 U.S. at, because "the government's interest *is* the public interest," *Pursuing Am.'s Greatness v. Fed. Election Comm'n*, 831 F.3d 500, 511 (D.C. Cir. 2016). As this Court noted in its prior opinion, the "only deleterious public effect of the Court's

injunction will be to require that, during the pendency of the litigation, [] BOP will continue to shoulder" the "administrative cost" of gender-affirming care, which it had voluntarily "borne for many years prior" to the commencement of this action. Mem. Op. at 26, ECF No. 67. The same remains true today. Then, as now, the equities tilt in Plaintiffs' favor because their interests in receiving medically prescribed treatment outweighs the minimal cost to the government of continuing such treatment. The government also emphasized its interest in effectuating the administration's agenda, Opp'n at 44, ECF No. 186, but that consideration is outweighed by the public's interest in the government's adherence to the law.

Finally, the government raises the specter of prison safety, asserting that gender-affirming care leads to security and prison-administration concerns. *Id.* at 37. Though the Court does not discount the possibility that a highly feminized transgender woman faces threats to her safety in a men's facility (or that a highly masculinized transgender man faces the same in a women's facility), the government has not cited a single instance of gender-affirming care giving rise to safety concerns despite having provided such care for many years. This failure is conspicuous. The Court's previous injunction has been in place for more than a year, yet the government provides no evidence of gender-affirming care giving rise to prison safety issues during this time.

The balance of the equities therefore favor Plaintiffs.

E. No Bond Should Be Required

Federal Rule of Civil Procedure 65(c) provides that "[t]he court may issue a preliminary injunction . . . only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongly enjoined." Fed. R. Civ. P. 65(c). "Courts in this Circuit have found the Rule vests broad discretion in the district court to determine the appropriate amount of an injunction bond, including the discretion to require no

bond at all." *P.J.E.S. v. Wolf*, 502 F. Supp. 3d 492, 520 (D.D.C. 2020) (cleaned up). Here, Plaintiffs seek an injunction of illegal conduct by a government agency, and because there is little risk of monetary harm to Defendants if they are eventually found to be wrongfully enjoined, the Court will waive the requirement for an injunction bond.

IV. CONCLUSION

For the foregoing reasons, Plaintiffs' Motion for a Preliminary Injunction will be **GRANTED**. Defendants, their contractors, employees, and agents are enjoined (1) from enforcing Program Statement 5260.01, and (2) are ordered to provide Plaintiffs and class members gender-affirming care in accordance with BOP policy and practice in effect immediately prior to the issuance of the EO on January 20, 2025. Additionally, Program Statement 5260.01 is stayed pursuant to 5 U.S.C. § 705. A separate Order consistent with this Opinion shall issue.

As stated, the Court does not wade into the culture war being waged against transgender individuals. The Court simply concludes that the government violated the APA when it issued a new policy restricting the provision of gender-affirming care to inmates diagnosed with gender dysphoria.

Date: June 17, 2026

Royce C. Lamberth
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*,

Plaintiffs,

v.

DONALD J. TRUMP, *et al.*,

Defendants.

Case No. 1:25-cv-691-RCL

ORDER

This Court issued a preliminary injunction on June 17, 2026. ECF No. 215. On June 22, 2026, Defendants appealed that decision to the D.C. Circuit. ECF No. 221. The same day, Defendants moved for this Court to stay the preliminary injunction pending appeal. ECF No. 222. Defendants argue that "for the reasons discussed in their opposition to Plaintiffs' Motion for an Updated Preliminary Injunction and to Stay Agency Action," they have met the standard for a stay pending appeal. *Id.* at 1–2. On June 25, Plaintiffs opposed Defendants' request for a stay, arguing that "[t]his Court has already rejected Defendants' arguments in its earlier opposition after full briefing and argument and has explained its reasoning for rejecting those arguments in detail . . . Nothing in Defendants' motion warrants a different outcome." ECF No. 226 at 2. The Court agrees.

A stay pending appeal is an "extraordinary" remedy. *Citizens for Resp. & Ethics in Washington v. Fed. Election Comm'n*, 904 F. 3d 1014, 1017 (D.C. Cir. 2018). This Court already considered and rejected Defendants' arguments on the preliminary injunction factors. In their request for a stay, Defendants do not explain why the Court reached the wrong result on any of those factors or offer any new arguments for the Court to consider. Defendants simply state that

they are "likely to succeed on the merits of their appeal because they are likely to show that there is no Administrative Procedure Act violation and that the balance of equities decidedly tip against issuance of the injunction." ECF No. 222 at 2. Importantly, Defendants do not make any showing that they will be irreparably injured absent a stay. *KalshiEX LLC v. Commodity Futures Trading Comm'n*, 119 F.4th 58, 64 (D.C. Cir. 2024) ("[A] showing of irreparable harm is a necessary prerequisite for a stay."). By contrast, this Court previously found that Plaintiffs would face irreparable harm in the absence of injunctive relief. *See* ECF No. 216 at 29 ("The record shows that denying class members gender-affirming hormone therapy and social accommodations will cause irreparable injuries, including the exacerbation of their gender dysphoria and increased risk of depression, anxiety, self-harm (including attempts to self-castrate), and suicidality.").

For the same reasons stated in the Memorandum Opinion accompanying the June 17, 2026 preliminary injunction, the Court finds that Plaintiffs are likely to succeed on the merits, that they would face irreparable harm if a stay were issued, and that the balance of the equities and public interest favor denying Defendants' request for a stay.

It is therefore **ORDERED** that Defendants' Motion is **DENIED**.

Date: 6/25/2026

_____/s/_____
Royce C. Lamberth
United States District Judge

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ALISHEA KINGDOM, *et al.*,

Plaintiffs,

v.

DONALD TRUMP, *et al.*,

Defendants.

Case No. 1:25-cv-691-RCL

ORDER GRANTING PLAINTIFFS' MOTION FOR RENEWED PRELIMINARY INJUNCTION

This Court entered an updated preliminary injunction in this case on June 17, 2026. ECF Nos. 215, 216. This injunction is currently on appeal, ECF No. 221, and will automatically expire on September 15, 2026, as required by the Prison Litigation Reform Act (PLRA). *See* 18 U.S.C. § 3626(a)(2) ("Preliminary injunctive relief shall automatically expire on the date that is 90 days after its entry, unless the court makes the findings required under subsection (a)(1) for the entry of prospective relief and makes the order final before the expiration of the 90-day period."). Plaintiffs now move to renew this preliminary injunction, and Defendants oppose. ECF No. 240.

District courts regularly renew or extend preliminary relief for additional periods under the PLRA while litigation on the merits of a case continue, so long as preliminary relief is still warranted. See ECF Nos. 79, 96, 114, 202; *Doe v. Blanche*, 172 F.4th 901,912 (D.C. Cir. 2026) (noting BOP's agreement "that section 3626(a)(2) does not limit a district court's ability to issue a new preliminary injunction at the end of the ninety-day period set forth in that statute" and that "every court of appeals that has reached the issue agrees" (quotations omitted)); *Smith v. Edwards*, 88 F.4th 1119, 1125 (5th Cir. 2023) ("Though a preliminary injunction entered under the PLRA

otherwise automatically expires ninety days after entry, the injunction may be extended by the district court if it makes the requisite findings."); *Mayweathers v. Newland*, 258 F.3d 930, 935 (9th Cir. 2001) ("Nothing in the statute limits the number of times a court may enter preliminary relief. . . . the provision simply imposes a burden on plaintiffs to continue to prove that preliminary relief is warranted."); *see also Alloway v. Hodge*, 72 F.App'x 812, 817 (10th Cir. 2003) (unpublished) (renewal of preliminary injunction that expired under the PLRA is not an abuse of discretion). Courts retain jurisdiction to make renewals even when the original preliminary relief has been appealed. *See Doe v. Blanche*, 172 F.4th at 912.

The Court has reviewed Plaintiffs' motion, ECF No. 240, Plaintiffs' memorandum in support, ECF No. 240-1, Defendants' opposition, ECF No. 240-2, and the entire record herein. Both the actions taken by Defendants that led to Plaintiffs' motion for an updated preliminary injunction and the facts that supported preliminary injunctive relief remain unchanged. Accordingly, the Court incorporates the reasoning contained in its memorandum opinion, ECF No. 216, for its June 17 preliminary injunction.

It appearing to the Court that Plaintiffs are likely to succeed on the merits of their action, that they will suffer irreparable injury if the requested relief is not issued, and that the balance of the equities and public interest favor the entry of such an order, it is therefore

ORDERED that Plaintiffs' Motion for Renewed Preliminary Injunction is **GRANTED**; it is further

ORDERED that the Bureau of Prisons' ("BOP") February 19, 2026 Program Statement 5260.01 (the "Program Statement") is stayed pursuant to 5 U.S.C. § 705. It is further

ORDERED that Defendants Todd Blanche, William K. Marshall, III, Christopher A. Bina, Dana R. DiGiacomo, and Shane Salem, in their official capacities, and their contractors,

employees, and agents (i) are enjoined from enforcing Program Statement 5260.01, and (ii) shall provide and continue providing Plaintiffs and class members with gender-affirming care in accordance with BOP policy and practice in effect immediately prior to the issuance of Executive Order 14168 on January 20, 2025. It is further

ORDERED that this injunction shall be effective beginning on September 15, 2026, and no bond shall be required.

In accordance with the Prison Litigation Reform Act, the Court finds that this preliminary injunction is narrowly drawn, extends no further than necessary to correct the harm that the Court finds requires preliminary relief, and is the least intrusive means necessary to correct that harm. 18 U.S.C. § 3626(a)(2).

Plaintiffs have shown a substantial likelihood of success on their claims that application of the Program Statement to class members would be unlawful and would cause them immediate, irreparable harm. Because applying the Program Statement to Plaintiffs and class members would cause such serious and irreparable harm, a preliminary injunction preventing such application is necessary to correct the harm and is the least intrusive means necessary to do so. Furthermore, because this preliminary injunction prevents the application of the Program Statement, and Plaintiffs have demonstrated a likelihood of success on the merits and immediate, irreparable harm if that application is not enjoined, this Order extends no further than necessary to correct the harm that requires this preliminary relief.

Finally, this Court has considered any adverse impact on public safety or on the operation of the criminal justice system caused by this relief and has given substantial weight to such impacts. After this consideration, the Court has concluded and so finds that no adverse impacts

on public safety or the operation of the criminal justice system will result from maintaining the status quo of the class members' medical care while this litigation proceeds.

IT IS SO ORDERED.

Date: August 26, 2026

Royce C. Lamberth
United States District Judge

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 26-5236 **September Term, 2026**

1:25-cv-00691-RCL

Filed On: September 18, 2026

Alishea Sophia Kingdom, Reg. No. 13131-089, et al.,

Appellees

v.

Donald J. Trump, in his official capacity as President of the United States, et al.,

Appellants

Consolidated with 26-5310

BEFORE: Wilkins, Walker*, and Garcia, Circuit Judges

O R D E R

Upon consideration of the motion for stay pending appeal filed in No. 26-5236, the opposition thereto, and the reply; and the letter filed September 3, 2026, which the court construes as a motion to stay the district court's August 26, 2026, order on appeal in No. 26-5310; it is

ORDERED that the motion for stay in No. 26-5236 be dismissed as moot. It is

FURTHER ORDERED that the motion for stay in No. 26-5310 be denied. Appellants have not satisfied the stringent requirements for a stay pending appeal. See Nken v. Holder, 556 U.S. 418, 434 (2009); D.C. Circuit Handbook of Practice and Internal Procedures 33 (2026).

Appellants have not shown a strong likelihood of success on the question of whether Program Statement 5260.01 is arbitrary and capricious because the Bureau of

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* Circuit Judge Walker would grant the motion to stay in No. 26-5310 for the reasons in the attached dissenting statement.

United States Court of Appeals
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 26-5236 **September Term, 2026**

Prisons (BOP) did not adequately consider its own experience providing gender-affirming care under its prior policy. See Int'l Dark-Sky Ass'n, Inc. v. FCC, 106 F.4th 1206, 1213 (D.C. Cir. 2024) ("An action is arbitrary and capricious when the agency relies on inappropriate factors, fails to consider important aspects of the problem, or ignores relevant evidence."); Butte Cnty., Cal. v. Hogen, 613 F.3d 190, 194 (D.C. Cir. 2010) (explaining that "an agency's refusal to consider evidence bearing on the issue before it constitutes arbitrary agency action"). For example, BOP makes claims about the security impact of providing gender-affirming care without addressing whether such issues have occurred.

Moreover, appellants have not made a strong showing that the district court's order violates the PLRA or improperly grants class-wide relief. Additionally, appellants' argument that the district court's order is overbroad to the extent it affects the Program Statement's provisions regarding surgical procedures is likely forfeited because it was not raised first in the district court. See Gov't of Manitoba v. Bernhardt, 923 F.3d 173, 179 (D.C. Cir. 2019) ("Absent exceptional circumstances, a party forfeits an argument by failing to press it in district court.").

Because appellants have not made a strong showing that they are likely to succeed on the merits, it is not necessary to address whether they have established irreparable harm or whether the remaining factors favor a stay.

The Clerk is directed to enter a briefing schedule.

Per Curiam

FOR THE COURT:
Clifton B. Cislak, Clerk

BY: /s/
Selena R. Gancasz
Deputy Clerk

WALKER, *Circuit Judge*, dissenting from the denial of the stay in 26-5310:

In February 2026, the Bureau of Prisons issued Program Statement 5260.01, titled "Management of Inmates with Gender Dysphoria." It announced the BOP's decision to "prioritize[]" psychotherapy in the treatment of federal inmates' gender dysphoria.[1]

The Program Statement also announced, among other things, three policies related to that decision. First, the BOP will no longer provide "sex trait modification surgeries."[2] Second, the BOP will not start inmates on hormone therapy, and each inmate currently receiving hormones will begin an individualized "tapering plan."[3] Third, the BOP will no longer provide "social accommodations" like makeup and wigs, and "when practicable," the BOP will "remove or confiscate the social accommodations" previously provided.[4]

On June 17, the district court issued an order, set to expire 90 days from then, that preliminarily enjoined the Government from executing Program Statement 5260.01. On August 26, the district court reissued the preliminary injunction with a new order set to expire 90 days later.

I would grant the Government's motion to stay the district court's August 26 order.[5] "The government has established that it is likely to succeed on the merits . . . , that it would likely

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[1] Add. 39.

[2] *Id.* at 40–41.

[3] *Id.*

[4] *Id.* at 41.

[5] The Government's motion to stay the June 17 order is moot because that order expired on September 15. *Cf.* Order at 1 (construing the Government's September 3, 2026, letter "as a motion to stay the district court's August 26, 2026, order").

suffer irreparable harm without a stay, and that the balance of equities tips in its favor."[6]

The government is likely to succeed on the merits because the district court lacks the authority to reissue the 90-day preliminary injunction first issued on June 17. In *Doe v. Blanche*, Judge Randolph explained why the "practice of issuing rolling injunctions" exceeds the limits imposed on courts by the Prison Litigation Reform Act.[7] The question remains open in our circuit,[8] and though the panel in *Doe* found waiver on the record there,[9] I would not find waiver on the different and still-developing appellate record before us in this new appeal.

The Government will likely suffer irreparable harm without a stay because "[t]he Government is irreparably harmed by 'an improper intrusion by a federal court into the workings of a coordinate branch of the Government.'"[10] And

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[6] *National Park Service v. National Trust for Historic Preservation in the United States*, No. 26A203, slip op. at 2 (U.S. Aug. 31, 2026).

[7] 172 F.4th 901, 926, 930 (D.C. Cir. 2026) (Randolph, J., dissenting).

[8] *See id.* at 912 (majority op.).

[9] *See id.*

[10] *Kingdom v. Trump*, No. 26-5181, 2026 WL 1905418, at *2 (June 17, 2026) (quoting *Miot v. Trump*, No. 26-5050, 2026 WL 659420, at *4 (Mar. 6, 2026) (Walker, J., dissenting)); *see also Trump v. California*, Nos. 26A124 and 26A139, slip op. at 8 (U.S. Aug. 24, 2026) (per curiam) (granting a stay of a district court's injunction because that injunction "interfere[d] with the internal operations of the Executive Branch."); *Mullin v. Doe*, 146 S.Ct. 2121, 2127, 2133 (2026) (rejecting sub silentio our court's contention in *Miot*, 2026 WL 659420 at *1–2, that "generalized assertions of injury are insufficient to support a stay pending appeal" (cleaned up)); *Trump v. CASA*, 606 U.S. 831, 859 (2025) ("When a federal court enters a universal injunction against the Government, it improperly intrudes

the balance of equities tips in the Government's favor for the reasons already considered when, on June 17, this court stayed the preliminary injunction obtained by this same class of plaintiffs against these same defendants.[11]

I therefore respectfully dissent.

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on a coordinate branch of the Government and prevents the Government from enforcing its policies against nonparties." (cleaned up)); *Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers) ("Any time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." (cleaned up)); *American Foreign Service Association v. Trump*, No. 25-5184, 2025 WL 1742853, at *3 (D.C. Cir. June 20, 2025) ("The district court's preliminary injunction inflicts irreparable harm on the President by interfering with the national-security determinations entrusted to him by Congress."); *Media Matters for America v. FTC*, No. 25-5302, 2025 WL 2988966, at *19 (D.C. Cir. Oct. 23, 2025) (Walker, J., dissenting) ("The FTC has an interest in lawfully 'enforcing consumer protection laws,' and it was irreparably harmed when the district court enjoined its lawful activity." (cleaned up)); William Baude et al., *Hart & Wechsler's The Federal Courts and the Federal System* 388 (8th ed. 2025) ("The rule in *Maryland v. King* — that the government as applicant for emergency relief suffers irreparable injury whenever its statutes (or regulations) are enjoined — appears now to be followed by most of the Justices. The satisfaction of the irreparable harm prong in any case where the government seeks emergency relief from an injunction of one of its programs is an important reason why, in such instances, the Court's analysis of the merits predominates." (citing *Abbott v. Perez*, 585 U.S. 579, 602 n.17 (2018); *Republican Party of Pennsylvania v. Degraffenreid*, 141 S. Ct. 732, 733 (2021) (Thomas, J., dissenting from denial of certiorari); *Little v. Reclaim Idaho*, 140 S. Ct. 2616, 2617 (2020) (Roberts, C.J., joined by Alito, Gorsuch, and Kavanaugh, JJ., concurring in grant of stay))).

[11] *Kingdom*, 2026 WL 1905418 at *1–2.