

ACCESS DENIED

A REPORT ON THE EXPERIENCES OF TRANSSEXUALS AND TRANSGENDERISTS WITH HEALTH CARE AND SOCIAL SERVICES IN ONTARIO

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This report is dedicated to Akina, a transsexual sex trade worker who died in May of 1995 in Toronto. Her death remains unexplained.

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SUMMARY

This report documents the discrimination faced by transsexuals and transgenderists in Ontario, with regards to health care and social services. Based on interviews with 33 transgendered people, as well as numerous service providers, the research outlines some of the main problems transgendered people have accessing health care and social services. Specific topics addressed include: safe, informed access to hormones; experiences in hospitals; gender identity clinics; the police; youth, homeless, and women's shelters; and alcohol/drug rehabilitation programmes.

RÉSUMÉ EN FRANÇAIS

On présente la discrimination vecue par les transexuel-le-s et les travesti-e-s de l'Ontario à l'égard de la santé et des services sociaux. Basée sur 33 entrevues avec les transexuel-le-s et les travesti-e-s, on discute quels sont les problèmes d'accès que vivent ces personnes. En particulier, on aborde les sujets suivants: l'accès sécuritaire aux hormones; les expériences dans les hôpitaux; les cliniques d'identité sexuelle; la police; les auberges pour les jeunes, les femmes, et les sans-abris; et les programmes pour les alcooliques et/ou les toxicomanes.

INTRODUCTION

This report provides an overview of health care and social services for transgendered people in Ontario. Before the results of the research are presented, however, it is useful to clarify the terms and definitions under which this study was conducted. The word "transgender" is used as an umbrella term to include all individuals who live outside normative sex/gender relations. The following groups of people are included within the category transgender:

Transgenderists: These are individuals who live in a gender other than the one assigned to them at birth on the basis of their biological sex. For instance, individuals who were born male, but who live as women. Transgenderists usually take hormones to live in their chosen gender.

Transsexuals: Transsexuals also live in a gender other than the one assigned to them at birth. Like transgenderists, they take hormones to change their physical appearance. Transsexuals also have surgery on their genitals. In the case of male-to-female (MTF) transsexuals, sex reassignment surgery involves the creation of a vagina. For female-to-male (FTM) transsexuals, surgery includes the removal of breasts, reconstruction of the chest wall, removal of the ovaries, and a hysterectomy. FTMs may also have phalloplasty, or the creation of a penis.

Cross-dressers: Cross-dressers wear the clothing and attire associated with the "opposite" sex. For example, men who are cross-dressers dress up as women. A synonym for cross-dressers is the term "transvestite," although many cross-dressers do not like the medical connotations of this term. Cross-dressers choose when and wear they will present themselves in their chosen gender.

Drag Queens: Drag queens are men who dress as women, and who usually circulate within gay male communities. Like cross-dressers, drag queens only dress as women at certain times and in certain places.

Transgenderists, transsexuals, cross-dressers, and drag queens are four of the most prominent groups within transgender communities. Transgendered people live their lives in a variety of ways, however, and the above categories are in no way mutually exclusive. Thus, some individuals identify themselves as both drag queens and transsexuals. Other people may take hormones, but still live in the gender assigned to them at birth. Many people cannot be classified within this framework.

All research projects need to establish priorities about what issues need to be investigated, which people need to be contacted, and what the focus of the study will be. This project is no exception. Project Affirmation allocated \$4000 to the research on transgendered people. As the person responsible for conducting this research, I had to decide which issues took priority. I decided to focus primarily on the issues of transsexuals and transgenderists. Having spoken to various representatives of organizations for cross-dressers about this project, I was informed that the cross-dressing community had few concerns about health care and social services. People dressed up only for fun, I was told, and there was only a problem in the event of an accident (in which, for example, ambulance attendants would not know how to treat cross-dressers). In initiating this research, I hoped to be able to document the experiences of transsexuals and transgenderists with regards to health care and social services in Ontario. This information, I believed, could also be useful to other members of the transgender communities. If hospital personnel were hostile to transsexuals, for instance, one could expect them to treat drag queens in a similar way. This is not to deny the unique situations of drag queens, cross-dressers, and other transgendered people when it comes to health care and social services. It is merely to outline the limitations of this research, given the funding constraints.

(A note on terminology: in presenting this research, I refer to "transsexuals," "transgenderists," and "transgendered people." I occasionally use the abbreviation "ts" [transsexual] and "tg" [transgender/transgendered/transgenderist].)

The interviews I conducted reveal that there are systemic barriers to health care and social services for transsexuals and transgenderists. The most significant issues raised by the interview subjects included: safe, informed access to hormones; experiences with hospitals; relations with the police; gender identity clinics; shelters for youth, homeless women and battered women; and addictions. I report my findings on these subject areas below.

It should be noted that this study is only a point of departure. Many issues remain to be investigated. A more in-depth examination of health care and social services for transgendered people would also analyze intersexuality, transsexuals in prison, mental illness, HIV/AIDS (see Bockting et al., 1993; Elifson et al., 1993; Namaste, 1995), legal complications faced by transsexuals and transgenderists, relations with welfare and FBA (disability), suicide, and the many surgeries transsexuals and transgenderists have (breast augmentation, rhinoplasty, tracheal shave, etc). All of these issues must remain avenues for future research.

While this study is certainly not exhaustive, it is hoped that the results will offer concrete documentation of the problems transgendered people face with regards to health care and social

services. Activists, community educators, health professionals, and social service providers can use the information contained herein to develop and implement services which are responsive to the needs of their transgendered clients.

METHODOLOGY

The information contained in this report was collected through interviews with transsexuals and transgenderists. Relying on the contribution of English Canadian sociologist Dorothy Smith (1987, 1990), I wanted this project to offer an overview of how health care and social services are accessed and experienced by transgendered people. Smith argues that researchers need to begin with the everyday social world. They need to develop methodologies which account for "official" versions of social reality, as well as alternative accounts thereof. In working with groups which have traditionally been marginalized and silenced, this approach uncovers how minority groups are perceived and located in social relations, as well as how they situate themselves in such relations. Such an approach focuses on how people positioned outside a ruling apparatus are related to the world in which they live.

Smith notes that this perspective represents a research strategy, rather than a methodology per se. One can employ a variety of methodological approaches in order to make sense of everyday social relations. For the purposes of this project, I chose to conduct interviews with transsexuals and transgenderists. I was interested in how they experienced health care and social services, the issues they identified as important, and their suggestions for change at the level of social policy. As Smith explains, this model recognizes that "official" accounts of knowledge legitimate certain conceptions and interpretations of the social world. The everyday experiences of people can contradict these versions of reality. Sociological researchers can help people to understand these differences. In Smith's words,

We want to be able to say, "Look, this is how it works; this is what happens" ... We want to be able to know because we also want to be able to act and in acting to rely on a knowledge beyond what is available to us directly (1990: 34).

A decision to interview transgendered people is a particularly significant methodological intervention, given the lack of control transsexuals and transgenderists have over their own bodies, desires, and identities. As I will document throughout this report, other people habitually pass judgement on the genders of transsexuals and transgenderists, and grant or deny them services accordingly. Whether it's the doctor who feels an individual is not *really* a transsexual, or the staff of a woman's shelter who do not think a transsexual needing their services is *really* a woman, or the police officer who refuses to take a report from someone who has been assaulted because she is transgendered and a sex trade worker, transsexuals and transgenderists rarely get to define and live their bodies on their own terms. For these reasons, it is absolutely crucial to employ a research methodology which acknowledges that transsexuals

and transgenderists are the experts on their lives. This is the premise from which I began my investigation.

Individuals were contacted through a variety of means: support groups; advertisements in transsexual/transgender publications; a notice distributed at the Gender Identity Clinic of the Clarke Institute of Psychiatry; contacts through social service agencies; word of mouth; direct outreach in bars and on the street; and snowball sampling (an individual interviewed was asked to provide the name and number of a ts/tg friend who could also be interviewed). Individuals were interviewed during the months of May, June, and July, 1995.

The total sample population consisted of 33 individuals. The population was quite diverse, with ages ranging from 20 to 60 years. Of the 33 people interviewed, 19 were enrolled in the Gender Identity Clinic. There were 7 people of colour: Black, Native, and Métis; Asian-Canadian transsexuals are a significant absence in the sample. Four of the individuals had a mother tongue other than English (French in three cases, Spanish in one instance.) A variety of sexualities was represented in the sample: of the 33 people I interviewed, 14 identified themselves as something other than heterosexual, including bisexual, lesbian, queer, polysexual, and asexual. Six of the male-to-female transsexuals interviewed were post-operative. Twelve people in the sample were sex trade workers, representing 36% of the sample population. Some of these individuals worked on the streets, some of them worked over the telephone out of their homes, and some of them worked both on the street and over the phone. Two individuals were female-to-male transsexuals. Although the sample population is predominantly MTF transsexuals and transgenderists, I try to outline some of the specific needs and concerns of FTMs with regards to health care and social services throughout the report. Further research on FTM issues is, however, necessary. Almost all of the people contacted were from the metropolitan Toronto region. Due to limited resources, I was unable to do extensive networking with ts/tg people in other parts of the province. The findings contained herein thus reflect the geographic location of this study. It is worth pointing out that Toronto is the largest city in Ontario, and that transgendered people have many problems accessing health care and social services in this city. These difficulties can only be exacerbated in smaller cities, and especially in rural regions of the province.

The interviewees and I met in a place chosen by them. The venues included public restaurants, cafés, bars, parks, and the private homes of the individuals. The actual interviews lasted anywhere from 25 minutes to more than two hours. I began by explaining the mission of Project Affirmation, and outlining the purposes of the research. I also informed the subjects that

anonymity was guaranteed, and that they did not have to answer any question they did not wish to answer. The interviewees were also free to end the interview at any time. I clearly explained that the interview subjects were in control of the situation, and they were the experts on their lives. My job was merely to write down what their experiences with health care and social services.

In addition, Project Affirmation provided honoraria of \$20 for each of the interview subjects. It is useful to clarify that this money was well appreciated by all of the people I interviewed. I also believe that it was an important factor in the decision of many transgendered people to meet with me. While doing street outreach in an attempt to talk with sex trade workers, for instance, I found that people were willing to speak with me in part because of the money. I was most successful with this population when I did street outreach during periods when they were not busy. They were open to the idea of meeting with me because I could pay them \$20, and because they would not lose any money from potential clients during a slow time of the night.

Although the interviews varied significantly in duration, each subject was asked the same questions on similar issues. I began with demographic information (race/ethnicity, age, mother tongue), and inquired about gender and sexual identity. I then proceeded to ask people if they were on hormones, where they got them from, whether they had any negative side effects from them, and their knowledge of the long term side effects of hormones. The remaining subject areas included primary care physicians, the Gender Identity Clinic, surgery, experiences with hospitals and/or emergency rooms, stays in shelters, relations with the police, and the issue of violence.

I also spoke with various service providers, although I devoted considerable less energy to this task. As I demonstrate in the section on shelters for youth, homeless, and battered women, staff of these agencies provide very different versions of reality than the transgender clients I interviewed who had used these services. In and of themselves, these contradictions are quite significant, and suggest some useful avenues for change at the level of social police (staff training on transgender issues, anti-discrimination policies which include gender identity, etc.) I return to these issues in the conclusion and recommendation sections of this report.

With the informed consent of participants, the interviews were audiotaped. However, resources were not allocated for the transcription of these interviews. In light of this limitation, I listened to the tapes at a later date, and transcribed sections I felt were important. The quotations offered in this document are taken from these transcriptions.

HORMONES: ACCESS, KNOWLEDGE, MAINTENANCE

Hormones are an integral part of the daily lives of transsexuals and transgenderists. They change one's physical appearance, and aid in an individual's level of comfort with one's body. In the case of female-to-male transsexuals and transgenderists, the administration of testosterone has dramatic effects: the voice lowers, facial and body hair develops, muscles develop, and menstruation ceases. In the case of male-to-female transsexuals and transgenderists, the ingestion of estrogen redistributes fat tissue throughout the body, softens the skin, promotes breast development, and arrests male pattern baldness.

Hormones can also have serious side effects, including nausea, vomiting, headaches, mood swings, blood clots, liver damage, heart and lung complications, and problems with one's blood circulation and veins (phlebitis) (see Kirk, 1992). For these reasons, it is important that individuals who take hormones have themselves monitored regularly by a medical doctor. In an ideal situation, an individual should have a complete physical examination before taking hormones. Blood tests ranging from liver and kidney levels to blood sugar and cholesterol should be taken and recorded (see Kirk 1992). As an individual undergoes transition, these levels can be monitored accordingly.

This is an admittedly brief summary of hormones, their effects on the body, and the importance of working with medical professionals to maintain one's health as a transsexual and/or transgenderist. My research indicates that, despite the central role hormones play in the lives of ts/tg people, and despite the value of being monitored for the effects of hormones, ts/tg people encounter serious difficulties in obtaining safe access to hormones. Furthermore, ts/tg people are generally more knowledgeable than their doctors about how hormones will affect their bodies. And finally, many of the subjects I interviewed reported that they often obtained their hormones from doctors without undergoing regular physical examinations and blood work. Each of these issues deserves more discussion.

HORMONES: ACCESS

The people I interviewed noted that it was extremely difficult to obtain hormones. As a rule, transsexuals and transgenderists obtained their hormones through three means: illegally; through a doctor; or through the Gender Identity Clinic of the Clarke Institute of Psychiatry.

Hormones acquired surreptitiously were obtained in one of two ways: either from a family member (often unknowingly), or through an underground market. In the first instance, transsexuals told me that they would take the medications prescribed for their wives and mothers:

Actually, well first of all I stole some, from my mother in law, actually. She had had a hysterectomy and I would go and take some of her pills every now and again.

My wife has a health problem, where she had to have her ovaries removed. So she's on Premarin [a form of estrogen]. So I took hers [hormones] for about six months.

While the individuals cited above took the hormones prescribed to genetic females in their lives, other people I interviewed stated that they would get a female friend to get a prescription for birth control pills, which the transsexual would proceed to take regularly.

More commonly, however, transsexuals and transgenderists would buy their hormones off the street. The usual way this procedure worked is that some transsexuals would obtain multiple prescriptions, and would sell hormones to any individuals interested -- friends or strangers. Sources for hormones could be contacted through bars known for transsexuals and transvestites, as well as through a community of transsexual/ transgendered people.

She [my transsexual friend] told me that whenever I would want hormones, she could get some for me. So what she did is when I decided to get hormones, I called her and asked for some. I paid for it, she got it from her own prescription.

I get them from my family doctor and sell them to the girls.

There are several reasons why transsexuals obtain their hormones on the street. Firstly, it is extremely difficult to find a doctor who is willing to prescribe hormones. This creates a situation in which transsexuals buy their hormones off the street even if they would like to secure them through a doctor and have their health monitored:

I bought hormones off the street for a year and a half before I attempted to go to my family practice I went to him [my doctor] and told him that if he doesn't give them [hormones]

to me, I'm going to continue buying them off the street. So he took it in his own hands to monitor me, and put me on them legally He believed in me.

For some transsexuals and transgenderists, obtaining their hormones from a doctor is not an option. The quotation below is from a conversation with four transgender sex trade workers (two of whom were on hormones, one of whom took hormones sporadically). When one transsexual reported that she obtained her hormones through an underground market, another transsexual made a joke:

You'd have to [buy your hormones illegally] or they'd ship your little ass back [to your country of origin]! [laughter].

As this intervention makes clear, transsexuals who do not have access to health care in Canada -- those who are illegal refugees -- are forced to buy their hormones on the street.

As mentioned previously, hormones can have serious side effects. For this reason, it is important that individuals have their health monitored. The transsexuals and transgenderists I interviewed who bought their hormones on the street did not consult with doctors about their hormones. Moreover, it should be noted that hormones could be bought on the street in both pill and injection forms. Research in the field of HIV/AIDS education has suggested that in the context of American inner-city transsexual communities, transsexuals may share needles with their lovers and friends in order to inject their hormones (Bockting et al., 1993; Elifson et al., 1993). This practice puts transsexuals at increased risk of contracting HIV, as well as other health complications (e.g., Hepatitis). The transsexuals I interviewed indicated that pills were most commonly sold on the underground market. Some of the individuals I spoke with, however, stated that they also bought injection hormones. These individuals maintained that they did not share needles to inject their hormones.

As previously mentioned, transsexuals had great difficulty in locating a doctor who would prescribe hormones. Some individuals went to doctors with "questionable" reputations. They knew that they could get a prescription for hormones, but they did not expect any follow-up work as to the maintenance of their general health. Nor did they necessarily expect these doctors to prescribe their hormones indefinitely. The following quotations illustrate these practices:

I got them from a little doctor who's famous for prescribing yellow jackets, and who'd been reprimanded in court ...

[I first got my hormones] through a back-street doctor, a pill pusher ... I ran away from home, to find myself, became a prostitute, and I met transsexuals and I wanted to know how I could get on hormones. I was living as a girl, I was dressing and everything, hooking as a girl, dressing. And they told me about this doctor _____ and he was like a pill pusher, and he would give anybody hormones. So I went in there and he just gave me them.

Q: You just walked in and said you wanted hormones?

A: Yeah.

Q: You were 18, 17?

A: 16. You know. I went in fully dressed and everything, and I told him I'd been living this way for about six months. And he examined me a bit and just gave me a prescription ... I got them off him for about a year.

While the transsexuals cited above obtained hormones from "pill-pushers," many of the individuals interviewed recounted stories of being flatly refused hormones by their general practitioners. People reported that their doctors knew little or nothing about transsexuality, and furthermore expressed little interest in pursuing the topic. Their doctors feared legal repercussions if they initiated hormonal treatment. Doctors would either refer their transsexual patients to the Gender Identity Clinic of the Clarke Institute of Psychiatry, or they would refuse the hormones without further discussion. In some instances, doctors would prescribe hormones if they had a letter of recommendation from a psychiatrist, presumably to protect them from any possible legal action in the future. This creates a situation in which transsexuals must consult other doctors and specialists before beginning hormones.

I just went to see a psychiatrist I was dressed up [as a woman] and I said I was a transsexual and I wanted to get hormones. So he said, "No problem." I sat down with him, he said, "How long have you been like that? How long have you been a transsexual?" I said, "Since I was born." And then he said, "Well I can see you're a sane person, blah, blah, blah." So he writes me a letter right away without any examination. And he wrote a letter saying ... "I have subjected _____ to a total psychological evaluation and I found her to be a sane person and a fit candidate for sex change procedures.

Q: And you'd spoken for how long?

A: About four or five minutes, maximum.

As the above quotation indicates, transsexuals needed to "prove" themselves as "really" transsexual in the eyes of their psychiatrists and doctors. As in the case of doctors who would prescribe hormones willingly, transsexuals shared the names of psychiatrists who would assist

them in the provision of letters and supporting documentation.

While some doctors insisted that their transsexual patients obtain letters from psychiatrists, others decided for themselves whether or not a particular individual was "really" transsexual. One male-to-female transsexual I spoke with recounted a rather humorous story which illustrates how much doctors relied on the visual presentation of transsexuals to determine gender identity.

And another time, I got them [hormones] from a female doctor and she wouldn't give them to me the first time [I went to see her]. But my friend _____ was going there, and _____, I knew they were getting them [hormones], so I, I just went back, and this time I did all my coal [make-up], inside and outside my eyes, my little fake fur jacket and my tight black pants. And she said, "You've come a long way since I saw you first. And now I'm convinced that you're transsexual." It was like three weeks later!

Q: Right. So you went in as a boy ...

A: And she said, "No [I won't prescribe hormones]. I'm not sure that you're transsexual. I don't believe that you are." So a little make-up, a little fun fur, and she's eating out of the palm of my hand! [laughter] I thought, "Is that all there is to being a girl?" Look between the ears! She said, "You've done a lot of work." And I thought, "What did I do? I went shopping! In my own closet!"

This anecdote clearly reveals the arbitrary judgements to which transsexuals are subjected when they request hormones. It also indicates the implicit sexism of the doctor, who judged "women" and "men" almost exclusively based on their physical appearance (cf. Bolin 1988).

My research indicates that transsexuals and transgenderists wanted to work with doctors to monitor their health. They took an active role in the maintenance of their own bodies. To be monitored while on hormones was justified for both physical and psychological reasons. The two quotations below are from male-to-female transsexuals who were taking hormones through an underground market. One subject had her hormones mailed to her from the United States, while another bought them from a transsexual friend. Both subjects indicate that there were important psychological benefits to being monitored by a doctor on hormones.

About two, three weeks, a month after I decided to [start hormones], I went to see a doctor, 'cos I wanted to have it [my health] normalized, 'cos I didn't, I didn't like, I felt very unstable and scared about going through all that and I wanted things to be well done, 'cos I thought it's scary enough like that, and I don't want to be all fucked up.

I really wanted to get on hormones from a doctor.

Q: Right. So you could be monitored?

A: Yeah. I... I wanted it just from an internal sense of wanting to be legitimate, like I

tried hard to get some physician to help me. I saw a bunch of them, I explained my situation, I was always completely honest, and I always, I always told them that I'd already gone to see ... uh ... other doctors and they'd said no, but I hope that they'd [prescribe hormones] .. but they'd always just look at me and say, "Well, I'm not qualified. I don't know anything about this."

Interestingly, both of these transsexual women emphasize the psychological aspects of seeing a doctor -- "I wanted to have it normalized" ; "wanting to be legitimate" -- rather than a strictly medical approach. This information suggests that the barriers transgendered people face in accessing hormones have serious psychological repercussions. The stress associated with initiating a transition can be compounded with the refusal of doctors to support that decision. When doctors deny requests for hormones, and especially when they express no interest in learning about this issue, transsexual men and women feel that the refusal of services is a judgement on who they are.

Finding a doctor who is ts/tg-positive is even more difficult for individuals located outside of large urban centres. Transgender and transsexual people in small towns would often drive for two or three hours for their health care needs, so they could remain anonymous in their home towns. One transsexual woman living in Southwestern Ontario told me about how she went about finding a doctor to start her transition:

I had a heck of a time in _____. I didn't want it to get back to my family physician ... I was afraid that it would get back to my family ... and I didn't want anybody to know. I started calling doctors in _____. And what I did is I would call a receptionist. I would say that I was a transsexual, that I wanted to be on hormones, and would these doctors consider doing it. Most of them would say no. Eventually I found one that would do it. So I went to see him.

The transsexuals and transgendered people I interviewed told each other about which doctors would prescribe hormones. Increasingly, however, these doctors have large case loads and are unable to accept new patients. Thus even when transsexuals are interested in working with doctors to monitor their health, they cannot find a sympathetic caregiver to work with. Although transsexuals shared the names of transgender-positive physicians, this knowledge was of little practical import if the doctor in question did not accept new patients.

Doctors won't take new patients, either -- especially if they're transgendered. They're just so naive about it all. So they don't want to take anybody else on. 'Cos I've tried to refer a few of the [ts/tg] girls, that were close friends of mine, to my doctors. They will not take them.

Transsexuals and transgenderists experience profound difficulties in locating a doctor who is

transgender-positive, or who, at the very least, is willing to prescribe hormones. These barriers worked to prevent honest, direct communication between many transsexual patients and their care-givers. Transsexuals were afraid that if they told their doctors everything about their lives, they would no longer receive hormones. Several individuals interviewed admitted that they took more hormones than the prescribed dosage. Some obtained hormones from their doctors as well as from an underground market, but only spoke about their "legitimate" hormones in the health care setting. Other people did not tell their physicians if they had stopped taking their hormones. They feared that if they divulged such information, their doctors would judge them to be unbalanced, or not "true" transsexuals, and they would be without a source of hormones in the future, should they wish to take them again. One interviewee comments that she would start and stop hormones based on how she felt she was being treated in her primary relationship:

I'd go on and off. On one week and off the next. It was all emotional decisions, based on my boyfriend, how I was getting treated and perceived.

The same interviewee withheld this information from her doctors:

I tended not to tell them, because I wanted them to renew the prescriptions and not freak out about my stability. So I tended not to tell them.

HORMONES: KNOWLEDGE

Many of the transsexuals and transgendered people I interviewed were extremely well informed about hormones and their effects on the body. The people I interviewed were invested in learning more about hormones for a variety of reasons. Firstly, they wanted to change their bodies, and so sought information about the most effective means of so doing. People were generally familiar with the medical literature on hormones, particularly with reference to transsexuals. Furthermore, transsexuals and transgenderists would speak with each other about the various hormones available. Many of the people I interviewed asked me what I had learned about different hormones during the course of this research. Transsexuals also realized that an extensive knowledge of hormones aided their relations with their care-givers. Doctors were less reluctant to prescribe hormones if a patient had demonstrated knowledge about the drug and its effects on the body. The following comment reflects this situation:

I had to prove that I knew what the drugs were, what the drugs did, what the side effects were. I went in extremely knowledgeable.

For people interested in commencing hormones, it was a distinct advantage to be informed about hormones. Many transsexuals interviewed also stated that they were far more knowledgeable about hormones than their doctors. They would provide doctors with the appropriate documentation.

I haven't found people very knowledgeable or accomodating. The best I could do was look up information, photocopy it, and hand it to my doctors, and then they would say, "Well, this is in print, this is a paper, o.k." I had to look it all up myself.

She [an endocrinologist] said she had never done it [prescribe hormones to a male-to-female transsexual]. I said, "Well, I've got information for you."

The doctors I find are not very connected to, they are not really aware of the side effects [of hormones]. And if, sometimes, they are aware of the side effects, they are aware, but in relationship to genetic women, not to transsexuals.

Interviewees indicated that they needed to be continually informed about different hormones, in case the treatment regimen they were on had too many negative side effects, or if they wished to change regimens in the hopes of better results. Thus, transsexuals often educated their doctors about hormones at the beginning of the patient-doctor relationship. This work was ongoing throughout the interactions of doctor and patient.

As one of the above quotations indicates, doctors had very little knowledge of hormones with specific reference to transsexual women and transsexual men. One interviewee summarized the biases of medical professionals, and how these prevent adequate health care for transsexuals:

I had asked him [my doctor] before ... to have injectable estrogen and he rejected the idea,

he said that there was not such a thing. So you see, I taught him that, and now he has all his transsexuals on estrogen, on injectable estrogen. But the point is he doesn't really do research about it [hormones/ transsexual health care], he doesn't learn about it. He says things like, if you ask him, "I'd like to have progesterone," [he says] "Well you don't need it because you don't have a uterus." [He says this] without knowing, well, what does progesterone/ Provera do in people who don't have a uterus? It may still have some effects on their body.

HORMONES: MAINTENANCE AND FOLLOW-UP

In addition to finding a transgender-positive doctor, and/or a doctor who is knowledgeable about the effects of hormones on transsexual bodies, the subjects I interviewed revealed that their caregivers frequently neglected to do blood work to verify blood sugar and cholesterol levels, or liver functions. One person who has been taking hormones for more than 16 years commented that "No one [doctor] has ever insisted that I have blood tests." Another stated that she gets her blood work done only periodically, "and I have to bug him [my doctor] about it."

An interesting finding of my research relates to the possibility of breast cancer in the case of male-to-female transsexuals. One medical issue raised by the administration of female hormones in genetic males is a possible increased risk in cancer (see Pritchard et al., 1988). To that end, I asked the male-to-female transsexuals and transgenderists I interviewed if their doctors examined their breasts, and/or if they performed breast self-examination. About a quarter of the respondents indicated that these issues had been addressed by their doctors. More than half replied that they did not do breast self examination, with the justification that their breasts were too small anyway, or that they planned to do such examination at some unspecified time in the future. At least five people expressed surprise at the question, "Do you do breast self-examination, or does your doctor examine them?" These respondents were unaware of the theory that male-to-female transsexuals are at increased risk for cancer, and had no knowledge of what they could do in their own health care. One interview subject stated that her "hormone doctor never once asked if there was a family history [of cancer]." The question of breast cancer in male-to-female transsexuals clearly indicates that transsexuals and transgenderists routinely receive inadequate health care from their primary care physicians.

Although the sample population of this research was predominantly male-to-female transsexuals and transgenderists, female-to-male transsexuals experience similar problems of health care and maintenance. In particular, they face issues of proper gynecological care while living as men. One of the female-to-male transsexuals I interviewed informed me that he had only one gynecological exam in more than thirteen years with the same physician.

GENDER IDENTITY CLINICS

The Gender Identity Clinic (GIC) of the Clarke Institute of Psychiatry plays an important role in the lives of transsexuals in Ontario. If an individual wishes to have sex reassignment surgery (srs) covered through provincial health insurance, this person must be assessed and recommended for surgery by the GIC at the Clarke.

The GIC at the Clarke has an active client list of approximately 300 patients, meaning that about 300 people consult them at least once a year. Staff of the GIC informed me that, on average, they see one new patient every week. The GIC has established guidelines for their patients to be eligible for sex reassignment surgery. The individual must live in the chosen gender (the "opposite sex") full-time for at least two years. The GIC requires that this person provide written documentation supporting this claim. People can work, study, or do volunteer work full-time in order to meet this requirement. People can also engage in a variety of these activities (e.g., studying part-time and working part-time), as long as the total is equivalent to full-time work or school. This guideline is commonly referred to as the "real life test" (Clemmensen, 1990).

After one year of cross-living, the individual is eligible for hormones. There is an endocrinologist associated with the GIC, who monitors the health of people who obtain their hormones through the GIC. After two years of cross-living, the individual is eligible for surgery. Before an individual is recommended for surgery, however, several other conditions must be fulfilled: he or she must be legally divorced, if once married; the person must be at least 21 year of age; there must be no evidence of psychosis; and there should be no recent record of criminal activity (Clemmensen, 1990:124).

Strictly speaking, the GIC does not "approve" people for surgery. It merely makes a recommendation that the individual in question has been assessed, is of sound mind, is diagnosed to be transsexual, and will not suffer any adverse effects from srs. The GIC makes this recommendation to OHIP, who in turn decides whether or not the procedure will be covered through provincial health insurance plans. (A representative at OHIP stated that this was a rubber-stamp procedure, since they always followed the recommendation of the GIC.) Staff at the GIC reported that there are approximately six or seven individuals recommended for surgery each year. I confirmed this information with OHIP.

My interviews with transgenderists and transsexuals revealed that there is some mistrust and misinformation with regards to the GIC. Many people I met stated that the GIC works with a "quota" system, and that no more than one or two individuals are recommended for surgery each year. From my conversations with staff at the GIC, as well as with representatives at OHIP, this information is clearly erroneous. As mentioned previously, there are about six or seven people

recommended for surgery each year. This figure is merely an average; some years it is more, some years, it is less. Moreover, OHIP confirmed that the GIC is in no way working with a quota system.

While the rumours about quotas at the GIC are untrue, it is useful to think about some of the social relations which underlie this misinformation. The people I interviewed who were enrolled in the GIC voiced dissatisfaction with the services offered there. In particular, they claimed that the staff members of the GIC did not offer them a great deal of information about transsexuality. When one transsexual inquired about hormones, she was not offered any information from the GIC:

I asked about getting information [about hormones] and they were really evasive about it, like they wouldn't let me go into their library ... at the Clarke, I couldn't get in.

This same transsexual woman stated that the attitude of the GIC helped inform her decision to transition on her own:

I found that their [GIC] willingness to share information [about hormones and their side effects] was really minimal, so I ... that's why I didn't stay with them [to transition] It was more than just what the hormones were, it was the attitude, you know?

One post-operative transsexual woman I met, who was recommended for surgery by the GIC, stated that they needed to offer more information about the actual surgery, so that an individual could be psychologically prepared:

The only thing the Clarke didn't supply was enough information about what the whole experience over there [England] is like. Not like, actually physical ... it would have been nice if they gave me --I didn't realize some of the things that were going to happen that did, like needles in the stomach for 10 days, tubings .. it would have been nice [information about these medical procedures]. I'm the type of person that likes to know everything.

Another MTF transsexual I interviewed stated that the GIC offered little information about other resources or options available for transsexuals and transgenderists:

They [the GIC] don't provide an awful lot of support -- support in so far as, you know, "Well, this is what you can do, or one of the options that you can do. These are places that you can go, that we're aware of ..." Things of this nature. They don't supply that. You're left out on your own to do whatever.

A refusal to provide information about resources for transsexuals, the interview subjects maintain, was particularly stressful when the GIC presented its assessment of a candidate. One person, who was not recommended to begin the real-life test (one year of cross-living followed by hormones), expressed confusion as to how to proceed:

They didn't say whether they'd support me in the future, or what to do. Like, they didn't

give me any recommendation about what to do.

In addition to a lack of information about hormones and transsexuality, the people I interviewed took issue with the GIC's policy on the administration of hormones. The GIC specifies that an individual is to cross-live for one year before they begin hormone treatment. Staff at the GIC provided a number of reasons to justify this policy. They stated that the administration of hormones to female-to-male transsexuals has profound and lasting effects. Thus, they wanted to be sure that the individual in question was truly committed to living in the chosen gender. It would be unfair to require that FTMs wait one year before obtaining hormones while MTFs could get hormones after an initial diagnosis. For reasons of consistency, then, the GIC's policy requires that all of its clients wait one year before commencing hormone treatment. Staff at the GIC also stated that the delay was explained due to the possible health risks involved in taking hormones, as well as concern over a "snowball effect," in which individuals begin hormones too soon (in the opinion of staff at the GIC) and become heavily invested in having surgery soon thereafter.

Two researchers associated with the GIC of the Clarke have recently published a study of the policies of gender identity clinics around the world (Petersen and Dickey, 1995). They surveyed 19 different gender identity clinics in Canada, the United States, and Europe. On the subject of hormones, they learned that 13 of the 19 clinics delayed estrogen treatment (in the case of MTF transsexuals) even when a diagnosis of transsexualism had been made (Petersen and Dickey, 1995:138). Most of these clinics had the same policies for male-to-female and female-to-male transsexuals. One clinic stated that they were more cautious with FTMs, due to the irreversible effects of the hormones (e.g., voice change). Another clinic replied that since they were generally more certain about the diagnosis of transsexuality for their FTM clients, as opposed to their MTF clients, there was less delay in the administration of hormones to FTMs.

The contribution of Petersen and Dickey is important, and their interpretation of these policies is even more interesting. They conclude their article with a discussion of emerging transgender activism -- notably, prominent American transgender and transsexual activists who seek to facilitate access to hormonal treatment and surgical sex reassignment (Health Law Standards of Care 1993). In Petersen and Dickey's view,

it may not be overstating the case to describe their view of hormonal and surgical reassignment as a "right" and their goal as achieving surgical reassignment on demand, i.e., by treating it as any other cosmetic surgery (1995:150).

Petersen and Dickey maintain that the internationally recognized *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (HBIGDA) contradict this approach (the *Standards* are reproduced in Denny 1994). Their argument is valid in the case of

sex reassignment surgery; the *Standards of Care* are certainly designed to ensure that individuals are well informed and prepared to undergo such surgery. But the case of hormonal treatment is somewhat different, since the *Standards of Care* do not contraindicate the administration of hormones to an individual who is diagnosed as transsexual. It is unfortunate that Petersen and Dickey collapse hormones and surgery in their discussion; the availability of hormones and the availability of sex reassignment surgery are distinct, yet related, issues.

Petersen and Dickey's discussion of these issues is especially noteworthy for the types of oppositions it perpetuates. They present a situation in which there are gender identity clinics, whose function is "to protect individuals from making precipitous decisions of such an irreversible character," (Petersen and Dickey, 1995:150) and transsexual rights advocates, who fight for surgery and hormones on demand. It is curious that Petersen and Dickey neglect to mention the work of the American Educational Gender Information Service (AEGIS), which strikes a balance between these positions (AEGIS, 1992). On the subject of hormones, AEGIS notes that the administration of hormones can be used quite effectively as a diagnostic tool for transvestites; many male transvestites begin hormones and learn that they are not interested in pursuing surgery. Moreover, AEGIS notes that a policy of cross-living without hormones can bring on unnecessary stress, since it requires that an individual inform lovers, co-workers, and landlords she or he is undergoing a gender transition. AEGIS suggests, in contrast, that an individual could begin hormone therapy while still living in the gender assigned to them at birth. A full-time gender transition can occur at a later date. While the GIC at the Clarke justifies the delay in hormone therapy in part due to health reasons, AEGIS raises the important point that "health" includes one's psychological state:

The result of failed hormonal therapy is at worst some physical characteristics which run counter to type and which may be difficult for the individual to explain. The result of a failed real-life test is a life in shambles. Family, friends, and employers cannot be un-told about transsexualism, marriages and family life are unlikely to be resumed, and lost employment is unlikely to be regained. A non-passable appearance, which is likely if the individual has not been on hormones for a significant period, can be highly stigmatizing, and can place the individual in danger in this era of hate crimes. Furthermore, a failed real-life test can result in a high potential for self-destructive behavior, including suicide (AEGIS, 1992).

Two additional factors should be mentioned. The first concerns the ways in which people access hormones. The information I presented in the section on hormones clearly shows that transsexuals and transgenderists are creative, resourceful, and informed individuals who will go to great lengths in order to obtain their hormones. The staff of the GIC I spoke with estimated

that 30-50% of their clients received their hormones outside the GIC. Interestingly, the GIC does not expel individuals engaged in the first year of their "real-life test" who obtain hormones through their own means. It seems somewhat contradictory that the GIC has a policy wherein individuals are supposed to cross-live for a year without hormones, while at the same time disregarding the high number of individuals who initiate hormone treatment outside of the GIC during this period. The second point to note is that the gender identity clinic in Vancouver -- which performs the same functions of assessment, diagnosis, and treatment as the GIC of the Clarke -- does not delay hormones to individuals diagnosed to be transsexuals. The practices of this clinic indicate that it is possible to make hormones available to individuals diagnosed to be transsexual through a Canadian gender clinic without a one year delay. This policy, moreover, follows the international *Standards of Care* of the HBGDA. Contrary to what Petersen and Dickey imply, this in no way creates a situation of surgery on demand.

The subjects I interviewed who were familiar with the GIC -- both MTF and FTM -- objected to the one year delay before hormone treatment. Transsexuals made a point of telling me that they understood the necessity of ensuring an individual was serious about undergoing a gender transition. They did not agree, however, with a delay in hormone treatment once a diagnosis had been made. In the words of one interviewee:

I think hormones should go to anyone who can give informed consent, an informed decision. As long as they know what they're [hormones] for, what the side effects are, I think that an intelligent adult should be given access to hormones. Period.

My research indicates that transsexuals and transgenderists who objected to the GIC's hormone policy were informed not only about how transsexuality is administered here in Toronto, but how health care is organized for transsexuals elsewhere. This finding parallels the research of Dallas Denny and Jan Roberts, who learned that most transsexuals and transgenderists were overwhelmingly aware of the Harry Benjamin International Gender Dysphoria Association, its policies, and its procedures (Denny and Roberts, 1995).

The current situation with respect to transsexuals and transgenderists in Canada is complex. The people I interviewed clearly stated that they objected to a real-life test without hormones. Representatives of the GIC, of course, uphold this policy. In point of fact, Petersen and Dickey argue that the HBGDA *Standards of Care* were only intended as minimal criteria, suggesting that the HBGDA ought to consider more stringent policies with respect to hormone therapy. Whichever position one endorses, it is clear that people on both sides of this debate are not able to effectively communicate and listen to each other. Transsexuals and transgenderists hold erroneous assumptions about the workings of the GIC, while staff at the GIC enact policies with little regard for the input of transgendered people.

I believe that we need to open a dialogue on these matters. Open, honest communication would allow transgendered people to present their concerns, while the GIC could clarify some of the justifications for its policies. Collectively, we could then work together to develop innovative, responsive solutions to this stalemate. It seems to me that with transsexual and transgender clients working in tandem with their service providers, we can create the very best in health care.

HOSPITALS AND EMERGENCY ROOMS

The transgendered people I interviewed told me numerous stories of their experiences in hospitals and visits to the emergency rooms. In most instances, transgendered people were treated with absolute contempt by hospital staff. Such treatment continued throughout one's stay, from the initial intake to a formal discharge.

Documentation proved to be a dilemma for ts/tg people in a hospital setting. The most recent OHIP cards include a photograph of the bearer. Yet for transsexuals who are pre-operative, or for those who have no interest in surgery, there is a discrepancy between the gender of the person in the photograph and the sex indicated on the card. One male-to-female transsexual commented that the "M" on her card caused her considerable anguish: "It's going to certainly make me feel very reticent about going for medical care anywhere." Another subject interviewed remarked that a hospital she visited refused to issue her a hospital card in her female name. Her transsexual friend, however, who was also pre-operative, had precisely such a card issued from the same hospital. This person noted that, as was often the case when transsexuals sought health care, policies were inconsistent even within the same institution. At best, transsexuals were left to hope for a sympathetic employee to facilitate their requests.

Transsexuals and transgenderists who arrived in a hospital emergency room were treated quite badly. One subject arrived in intense pain, was seated in an emergency room and was asked to disrobe and put on a hospital gown. She was able to remove her clothes, but was too ill to put on her gown. A nurse came into the room and demanded that she leave, telling her, "You're not sick. Get your clothes on and leave." I heard numerous stories of this kind of contempt throughout the course of this research:

I was having kidney failure and I had od'd and they [the emergency room staff] were literally humiliating me. One of the nurses actually said, "We'll keep that thing in there a little longer so we can have some entertainment value." And this is while I'm going through withdrawal and shaking and everything else. They were calling me "thing" and, like, "it." This is right in the emergency room! It was unbelievable.

Another male-to-female transsexual told me about her experience accompanying a transsexual friend to the hospital, in which they were both mocked by the paramedics:

_____ was brought in an ambulance ... and they [the paramedics] were laughing at us in the ambulance, the whole time saying, "Did you see the fag (sic) freaking out?" Because I had screamed at them.

Sometimes, transsexuals were not outright ridiculed by hospital staff, but their reception was less than hospitable. One MTF sex trade worker I interviewed recalled her experience in an emergency room. The examining physician asked her to explain her body, since she had breasts

and a penis. She informed him that she was transsexual. The provision of this information seemed to only make matters more confusing for the doctor. This physician, in her words, *was an idiot. He thought I was a sex change into a man. He thought I had a breast reduction. He was really stupid.*

Other respondents stated that they did receive medical attention in hospitals, but with an attitude of reluctance and disdain:

... they weren't really as helpful with me as I would have liked. They saw me and everything, but it was one of those, they put on two sets of gloves and stuff just to come in the room and feel my throat, and it was really, I thought quite bizarre.

Other people interviewed remarked that even an initial intake could be a stressful situation for transsexuals. In the following anecdote, the transsexual woman was forced to disclose her transsexual identity in front of a room full of strangers:

She asked, "What medication are you on?" And I said, "Estinyl" and something else. And she asked, "Why do you take that?" And I said -- there was about 15 people in the waiting room with me -- and I said, "I don't feel like answering that question." And she said, "Listen!" She started to raise the tone, and she was really, really rude and bitchy. She said, "Listen! I'm busy! I don't have time for that kind of confidentiality! You're in an emergency room here!" So I had to tell in front of everybody that I was taking those medications because I was a transsexual. She asked me [if] I was operated on or not. So I had to talk extensively about my genitals in front of everybody in the waiting room. That was not pleasant!

The transsexuals and transgenderists I spoke with noted that hospital staff repeatedly and consistently referred to them with inappropriate pronouns (i.e., "he" in the case of MTF transsexuals, "she" in the case of FTM transsexuals.) One person interviewed stated that this practice continued despite repeated requests to address her in the third person with the pronoun "she." Transsexuals also noted that the use of inappropriate pronouns persisted even when an individual had legally changed her/his name, and even when this name (reflecting the chosen gender) appeared on the hospital card.

Another MTF subject remarked on the different treatment she received from nurses (mostly women) and doctors (mostly men):

All the nurses were great. They called me "Miss" and referred to me as "she." They came in and washed my hair. The doctor, however, and the interns, referred to me as "he." So the nurses did something really neat on the door jambs. On one side of the door jamb it said: "Good words -- her, hers, she." [And on the other side of the door jamb it said] "Bad words -- he, him, his."

While this MTF transsexual had a positive experience with the nursing staff, other transsexuals I spoke with were not so fortunate. One nurse at a hospital in a mid-size city in Ontario told me about a MTF transsexual who had entered the hospital as a result of a drug overdose. The patient was administered activated charcoal, which induces vomiting and rids the body of toxins. This nurse explained to me, however, that the activated charcoal is quite messy, and that it stains the skin. When this particular nurse came on shift, she discovered that none of her co-workers in the previous three shifts had helped the transsexual woman clean herself since she had been administered the activated charcoal. This nurse engaged the woman in conversation, cleaned her up, and washed her hair. She told me that the transsexual woman began to cry as she did this, and commented,

For me, for her to be crying because of something I was doing, or something I was saying, it made me really wonder the attitude she had encountered the previous three shifts ... We wouldn't treat any other patients the way those [transgendered] patients were treated.

The above anecdotes illustrate that transgendered people are treated as less than human within the hospital setting. Staff ridicule transsexuals, deny them basic services, refer to them with the wrong pronouns, and limit their interactions with them at all times.

POLICE

I asked transgendered people if they had had any positive or negative experiences with the police, since living in their chosen gender or when cross-dressed. As a general rule, most respondents indicated that they had experienced few difficulties with the police. The question, however, had certainly crossed their minds. In the words of one interviewee:

I don't even want to get a traffic ticket until I get this finished.

Q: Why?

A: Well, what I'm doing is not illegal. I just wouldn't want them to call me "sir."

The trepidation expressed by this woman is certainly not unfounded. One métis transgendered person I interviewed told me about her encounter with the police in Northern Ontario, where, in her opinion, "you don't get much more redneck." Driving in her car, she was pulled over for a broken headlight. Upon discovery that she was transgendered, however, the police changed their dealings with her -- from a routine situation of a warning or a ticket to one of blatant harassment. They arrested her (without just cause) and locked her in the local jail. One of the arresting officers commented that "People like you should all be killed at birth."

While most of the transgendered people I interviewed were fortunate enough to not be subjected to similar situations, *all* of the sex trade workers I spoke with recounted stories of police harassment, intimidation, and verbal abuse.

Verbal abuse consisted of uniformed police officers yelling "faggot" and "queers" at sex trade workers in areas known for transgender prostitutes. In addition to such insults, police officers would harass transgender sex trade workers in a variety of ways. The people I interviewed reported that police officers would stand right next to them on the street corner where they were working, thus preventing any client from approaching. Officers would also follow sex trade workers down the street in their cars, keeping pace with them as they walked. Officers would also take polaroid photographs of sex trade workers, and would tell them that now they had their pictures on file. This tactic was particularly used against the young sex trade workers I interviewed, and may have been employed to scare the individuals from prostitution.

The interactions between police officers and transgender sex trade workers offer additional evidence to police harassment, both subtle and overt. Officers would ask MTF transsexuals for their male names, even when these individuals had their documentation legally changed. If an individual did tell the officers this information, they would refer to the transsexual woman by her male name. At all times, police officers would refer to MTF transsexuals with male pronouns. Indeed, transgender sex trade workers stated that police officers seemed to make a point of calling them "sir," "boy," and "guy." At times, police officers would refer to transsexuals as objects. One MTF sex trade worker I interviewed told me that she was ridiculed by her

arresting officers. When her mother arrived at the police station to post bail, they shouted, "It's mother is here to bail it out."

When transgendered people were assaulted, the police officers they sought on the street refused to take a report of the incidents. The people I interviewed informed me that the officers said things such as, "Well, what did you expect in the big city?" and "Well, you shouldn't have gone out looking like that." Sex trade workers were also told that violence against prostitutes was not important enough to file a report:

If something happens to us [sex trade workers], though, they don't do anything. I got assaulted three weeks ago, and they told me they can't do anything with that guy because I was a prostitute.

One black transgendered sex trade worker told me about an incident in which she was being held against her will by a client. She called the police, who responded rapidly. Their attitude changed, however, when they arrived at the scene and learned that she was transgendered:

And the minute they found out I was a transie, they were like ... their attitude was like, "This is what we came here for?" kind of thing.

In addition to scorn, ridicule, and harassment, police officers would intimidate transgendered people with whom they came in contact. One interview subject, a sex trade worker who is post-operative, related an incident in which she was working in an area close to a transgender sex trade zone. Two uniformed police officers drove by, and yelled, "Hey guy! You better watch what you're doing!" She replied that she was not a guy. One of the officers then asked her what she had under her skirt. She lifted it, exposing her vagina. The officers proceeded to try and intimidate her, telling her that they were going to arrest her for indecent exposure. She calmly stated that if they did so, she would tell the judge why she exposed her genitals. The officers departed.

One transgendered youth interviewed encountered a different sort of police intimidation. This person was assaulted with a group of friends. They wished to report the assault, so they called the police, and two of them agreed to drive in the police cruiser to look for the assailants. Shortly after entering the police car, they realized they had made a mistake:

Basically, this is what they said, they go, "O.k., come with us, we'll drive around and look for them, and you can tell us the story." So we did, and then they just started harassing us. As soon as the car drove away from all my friends ... they totally changed and became like real assholes. And it really upset us large, because we couldn't get out.

Q: Yeah, right. Because you were in the back [of the police cruiser]?

A: Exactly. And so we couldn't get out. We couldn't say nothing, or they'd like do something. Like we were real scared they were gonna gaybash us or something. The

police in this city don't like gays, let alone transsexuals! That's worse! 'Cos then they're like, "Oh, this fucking faggot (sic) is becoming a girl! He can't make up his fucking mind!"

The police drove these individuals around the city for more than an hour. They refused to take a report, stating that the area where the assault occurred was "a tranny prostitute area." The officers also made disparaging comments about the individuals, such as "What are you? Are you a guy or a girl? We don't like these fucking half-breeds."

In certain instances, police officers would beat transgender sex trade workers. In the events recounted below, the police chased and beat a transgendered sex trade worker who they merely suspected of a crime:

Just before I went into jail, actually, they said that I was, I had a warrant out for my arrest, ok? And I didn't have no warrants out! I was clean, my record was clean and everything. It's not that my record was clean, I just had no charges, outstanding charges. So next thing I know, I'm running from them, right? I ran from them, and when they caught me they broke my nose, they blackened both my eyes, my face was scraped all along here [gesture along the left side of the face], because what they did was they grabbed my face and shoved it right into the cement. And then they put me in the back of the cop car with handcuffs on and found that I didn't have no warrants. So they let me go.

Stories like this one parallel those of visible minorities, who also face police violence. A community inquiry into policing practices in Toronto revealed that Native people would be driven down to Cherry Beach, stripped of their clothes, thrown in Lake Ontario, and/or beaten (Ontario Legal Aid Plan, 1994). Interestingly, the transgender sex trade workers I spoke with also mentioned Cherry Beach:

I've been taken down to Cherry Beach, and literally beaten by them [police officers], and told to walk back.

Sex workers claimed that it was futile to file complaints against the police, because it would make their working conditions even worse:

You have to [forget police violence]. You got no choice. I mean, if you're trying to make a living out here, you can't be fucking charging the cops or whatever. And if I would have charged them for what they did to me [police violence], I'd just, I'd never be able to forget it, because I'd be out here trying to make money, and they'd just hassle me, right?

Many of the transgender sex trade workers I interviewed did not trust the police. They knew that they would be blamed for whatever incidents they wished to report, and consequently did not report any assaults. The words of one sex trade worker interviewed reflect this situation.

She had been badly beaten by her boyfriend when he discovered that she was transsexual. She explains why she did not report the incident:

I couldn't phone the police. What am I going to say? "Oh, I had my boyfriend here and he just found out I had a penis and almost killed me"?! They would have just humiliated me, you know. It would have been a big joke.

In a different example, a native transgendered person was assaulted. Her friend tried to persuade her to report the incident to the police, who were across the street. She refused, having already experienced harassment and ridicule from uniformed police officers:

... my friend said, "Well, the cops are fucking right across the street." And I was like, "What the fuck do I want cops for?" I said, "I don't want to involve any fucking cops." I said, "Forget it; it's not worth it to me." She said, "Well, they're fucking sitting right there!" I said, "I don't fucking care! Let's just get the fuck home, and I want to go home and clean my fucking face, you know? Fucking lick my wounds. Fuck it."

The distrust of police officers evident in the above quotation is informed by her dealings with the police as a transgendered person of colour and a sex trade worker. In their everyday dealings with transgender sex trade workers, police engage in verbal abuse, ridicule, harassment, and intimidation. My findings about the conduct of police officers confirm other research in this domain, which documents the discrimination faced by sex trade workers, homeless people, and visible minorities (Ontario Legal Aid Plan, 1994).

HOMELESS SHELTERS: YOUTH, WOMEN

There are few resources for transsexuals and transgenderists who are homeless. This section of the final report documents the lack of staff training on transgender issues, an absence of anti-discrimination policies which include ts/tg people, as well as some of the attitudes and beliefs which underlie the exclusion of transsexual and transgendered women from youth and homeless shelters.

Given the limited resources allocated to transgender issues within Project Affirmation, my research on questions of shelters remains incomplete. Since some work has already been carried out on the subject of transsexual and transgendered women in battered women's shelters (Ross, 1995), I decided to concentrate my energies on youth shelters, shelters for homeless women, and drop-ins for street people. I spoke with representatives of 14 different agencies: four shelters for homeless youth in Toronto, six shelters and/or drop-ins for homeless women in Toronto, three shelters/drop-in's for youth in the Ottawa area, and one women's shelter in Ottawa. I asked staff members if their organizations accepted transgendered people, and if transgendered people had been or presently were among their clients. (A definition was supplied in the event that the individuals I contacted were unfamiliar with the term "transgender.") Furthermore, I inquired as to the existence of an anti-discrimination policy which includes transgendered people. Finally, I asked people what kind of training the staff members received on transgender issues. It should be noted that this research is only a beginning. In many ways, it focuses on the policies and positions of staff members working in shelters and drop-in's for homeless women and homeless youth with regards to transgendered people. This research needs to be supplemented with the voices of transgendered people speaking about their experiences with these agencies.

HOMELESS SHELTERS: YOUTH

Representatives of shelters and agencies which work with homeless youth were generally ignorant of transgendered people. In several cases, staff members asked for a clarification of the term "transgender." When I explained this research project to one worker, she responded

We do outreach with street kids -- that's our mandate. We don't serve them [transgender youth]. Well, I guess maybe some of the kids are like that [transgendered]. I don't know.

As this quotation illustrates, staff at agencies which work with homeless youth have very little training on transgender issues. Moreover, staff members are often unaware of the way compulsory sex/gender relations can make home, school, and traditional work environments unsafe places for transgendered youth, leaving the street and sex work as places where they can live their bodies as they choose. One person I spoke with claimed that "it [transgender identity] is a case for people in their 20s."

The above attitudes clearly indicate that staff at shelters for homeless youth receive inadequate training on transgender issues. When asked about the situation of transgender clients, representatives of these agencies stated that anyone was welcome to use their services. I was informed that these shelters were environments "free from oppression," that people were "asked to keep their prejudices to themselves," or that "discrimination is not tolerated here." None of the agencies I contacted had a written anti-discrimination policy which includes transgendered people. Furthermore, only one agency indicated that it sought out training on transgender issues. In this case, I was informed that the shelter invited outside facilitators to do presentations on transgender issues. I inquired as to the names of these people, since I was interested in speaking with them, and since I imagined I would already know them. The names were not offered. Likewise, this person could not tell me where he obtained written information on transgendered youth that he claimed to distribute to staff members of his agency. A staff member of a different youth shelter stated that education on transgender issues was "not a training priority."

Youth shelters have different areas segregated according to gender. Staff informed me that transsexuals would be housed according to their biological sex, not the gender in which they live. In discussing a hypothetical situation of a MTF transgendered person using the services of the shelter, however, the staff I interviewed admitted that perhaps the shelter would not be a safe place:

youth with gender issues might not feel that this is a safe place for them ... [with regards to] how the other men would act.

Interestingly, I also spoke with several individuals in homeless shelter about the situation of FTM transgender youth. If MTF were located on male floors and residences, due to their

biology, I asked if FTM youth -- who lived, identified, and interacted as men -- would be housed with young women. Unfortunately, I did not receive an answer to this question; I spent a great deal of time trying to explain the concept of female-to-male transsexuality to the staff in homeless youth shelters. This line of inquiry must remain an avenue for future research.

The experiences of transgendered youth contradict the official policies of non-discrimination espoused by shelters for homeless youth. In her research on the treatment of lesbian and gay youth in group homes and youth shelters, Carol-Anne O'Brien (1992) documents the difficulties MTF transgendered youth have in such organizations. Youth hostels are reluctant to accept transgendered people. She cites a cross-dressing Aboriginal youth's experience:

This one hostel said, "It's best that we don't let you in here for your own good. It's best to just go elsewhere. We don't want any trouble here. We don't want you to get hurt either." I said, "You can't do that, you know. I need a place to stay tonight. So if something happens, it's my fault. I can take care of myself. Just give me a bed." They just can't do that.

Q: So they wouldn't let you in?

A: No. (quoted in O'Brien, 1992:65).

The justification for denying this person admittance into the shelter is interesting. Staff claimed that the issue was one of "trouble" and potential violence. Paradoxically, by forcing a homeless transgendered youth back onto the street, these staff members claimed to be protecting this individual's safety! The comment that "We don't want any trouble here" also implies that the "trouble" is directly associated with the cross-dressing Aboriginal youth, rather than any shelter residents who may attack this person. This shifts the focus of the situation profoundly: it is no longer a question of a social service agency offering its services to a client, it is now about that client causing "trouble." In this way, transgendered youth are blamed for any confrontations or violent situations which could result from their presence in a shelter. It is especially noteworthy that even when transgendered people accept this situation ("So if something happens, it's my fault"), they are still refused services.

In the event that a transgendered youth is admitted into a shelter, staff demand strict adherence to their idea of masculinity and femininity. O'Brien (1992) discovered that staff members enforce normative sex/gender codes.

They said, "No make-up, no nothing ... Try to dress as masculine as you can." (quoted in O'Brien, 1992: 76)

Youth shelters are segregated according to gender, with sections for females and sections for males. Transgendered youth challenge these boundaries. As the following quotation makes clear, this creates a situation in which transgendered people do not feel welcome in youth

shelters.

There's nowhere to put me. In the female section or the male section. So they put me in the hall ... Basically people like me don't go there. They go elsewhere, or on the street to try to make their own way, trying to make enough money to get hotel rooms. (quoted in O'Brien, 1992: 72).

O'Brien's findings were confirmed in my own research. The transgendered youth I spoke with informed me that shelters were generally unsympathetic to them. One youth recounted the following incident:

The staff [of a shelter for homeless youth] just looked at my [MTF cross-dressing] friends and went, "Hmmmph!"

Q: Did they say anything?

A: They just kind of looked at them and went, "Hmmmph! Oh great, look who's here now," type of look. My friends said they felt really out of place, really uncomfortable, but it was a place for them to stay for the night. So they were, like, kind of freaked out about it. And I felt bad for them.

This quotation clearly demonstrates that shelters are unsafe and even hostile places for transgendered youth. Staff members refuse them access, tell them how to dress, act, and carry their bodies, subject them to unfair treatment (e.g., placing them in hallways), and implicitly blame them for any confrontations or violent incidents which arise from transphobic residents of these shelters. For all of these reasons, transgendered youth only use these services as a last resort.

The sex workers I interviewed who work the street rarely considered shelters as an option for safe, temporary housing. The following quotation is an excerpt from a conversation I had with four transgender sex trade workers. I asked them if they had ever used the services of a women's, youth, or homeless shelter:

A: No. You go to the bathhouse.

B: Exactly. The saunas.

C: Someone else's house.

D: Exactly. Or the crack house.

A: If there's girls that need places to stay, though, a lot of the other girls help them out.

Among transgender sex trade workers, several options were explored for temporary housing as an alternative to shelters: the bathhouse (this was true for the drag queens and MTF transsexuals interviewed), a crack house, or a friend's place.

HOMELESS SHELTERS: WOMEN

Staff members of the shelters and drop-in's for homeless women I contacted were generally more familiar with transgender issues than individuals working with homeless youth. Many of the people I interviewed told me that they had worked with transsexual clients in their agency. Some people even noted that the question of MTF transsexuals in shelters for homeless women had been raised as an important issue in recent years.

In general, the shelters I spoke with held one of at least three different positions on the question of transsexual women in homeless women's shelters: outright refusal to admit; acceptance if the individual was post-operative; and acceptance if the individual could provide documentation that they were undergoing a gender transition (i.e., a letter from the Gender Identity Clinic at the Clarke Institute of Psychiatry or a doctor). In certain situations, a MTF transsexual would be housed in a motel room. While this situation addresses the immediate needs of a particular transgendered person, it is only a short-term solution. Furthermore, this does not address the necessity of shelter agencies developing clear policies and guidelines on transsexual and transgender issues.

There are different reasons for accepting, or challenging, each of the positions of acceptance of ts/tg women outlined above. In the case of outright rejection of transsexual women, it is useful to reflect on one of the basic tenets of feminist theory and practice: that one's biological sex and one's social gender are not the same thing. Assuming that women's shelters emerged from the feminist movement, a mere rejection of an individual based on their biological origins seems to be a flagrant contradiction of this feminist axiom.

The justification of post-operative status can also be questioned on these grounds. The representatives of shelters which hold the view that post-operative transsexual women can use their services frequently cited the safety and comfort of the other women residents. The presence of a pre-operative transsexual woman, it was claimed, would create a remarkably stressful situation for all women involved, since rooms and bathrooms are shared. It is interesting to note the slippage between the *penis* of a transsexual woman and her *gender* identity: this woman would not be welcome, nor would other women feel safe (I was repeatedly told), due to the presence of her penis. This position suggests that one's genitals and one's gender are the same. If this position is followed through, it means that female-to-male transsexuals could use the services of a women's shelter, since they have vaginas (at least those individuals who have not had phalloplasty). And yet the safety and comfort level of women residents would most probably be challenged with the presence of a man, albeit a man with a vagina. Quite simply, genitals and gender are not the same, and it is inappropriate to formulate feminist social policy based on their equation.

My findings with regards to shelters for homeless women parallel research done on transsexuals and women's shelters (Ross 1995). In her research on shelters for battered women, Mirha-Soleil Ross discovered that the refusal of services to a pre-operative or non-operative transsexual woman was justified on the grounds of the "safety" and comfort level of the other women residents. As Ross makes clear, this concern over "safety" does not extend to transsexual women:

If I have fear and concerns for anyone's safety in a shelter, it is for an isolated TS woman, not for a non-transsexual who doesn't have to prove to anyone that she is a woman (1995:9).

As Ross so eloquently explains, this rationale absolves shelters of their responsibility in educating themselves and their residents about the diversity of women's lives:

Even the argument that TS women should be excluded for their own safety is not acceptable on a long term basis. Just like any other form of prejudice and discrimination, if some non-transsexual women are threatening the safety of a TS woman because she is a transsexual, it should be dealt with immediately and efficiently. The non-transsexual women should be confronted about their own ignorance and violence. I don't see why TS women should be restricted from access to such vital services because of somebody else's transphobia and hatred (1995:9).

The treatment of transgendered and transsexual women in homeless and women's shelters parallels their treatment in shelters for homeless youth. In all instances, the transgendered person in question is singled out as the "cause" of this "problem," or the reason non-transsexual women in the shelter will not feel safe. This focuses attention on the transgendered person in question, and neglects the real issue at hand: the provision of services to those in need.

The acceptance of post-operative transsexuals in women's shelters is questionable for four other reasons. Firstly, it ignores the financial expenses associated with sex reassignment surgery (srs); such a procedure costs more than \$7000 in Canada through private surgeons, and can cost up to \$25 000 elsewhere. Questions of race and class thus figure centrally in who has access to srs. Moreover, the only way to have srs paid for through health insurance is to enroll in a gender identity clinic. As Ross (1995) points out, these clinics treat prostitutes and individuals with criminal records with disdain. The requirement that transsexual women be post-operative works against transsexual sex trade workers and those with criminal records. A policy which only accepts post-operative transsexual women in a woman's shelter neglects the everyday realities of transgendered people of colour and those who are poor. Secondly, this position assumes that all transsexual and transgendered women want to have genital surgery. This is belied by the fact that many women live quite happily for decades with their penises.

Thirdly, surgeons will not operate on transsexuals who are seropositive. Thus, a shelter for homeless women which only accepts post-operative transsexual women excludes seropositive transgendered people. Finally, gender identity clinics do not recommend individuals for surgery who are younger than 21. We have already observed the unfair treatment of MTF transgendered people in youth shelters; they are routinely denied access to these places. Consequently, the insistence that transsexual women be post-operative before accessing the services of a shelter for homeless women forces young MTF transgendered people to live on the street.

Some of the agencies I spoke with stated that they accepted pre-operative transsexual women. These individuals, however, had to provide documentation as to their commitment to a transgender lifestyle. A letter from the Gender Identity Clinic of the Clarke Institute of Psychiatry or a doctor would fulfill this requirement. Although the acceptance of a pre-operative or non-operative transsexual woman is an improvement over her outright rejection, this policy remains disconnected from the everyday realities of many transgendered people. As I demonstrated in the section on hormones, access to hormones and supportive, knowledgeable medical personnel is difficult at the best of times. Transgendered people cannot find doctors with whom they can work. To require written documentation from a doctor as to one's transgender identity thus ignores the broader social relations of health care for transsexual and transgendered people. Moreover, doctors generally charge fees to provide written documentation of a patient's medical status. To force transgendered women to pay such fees in order to find shelter creates an undue stress on them. One of the reasons they are homeless, of course, is because they are also poor. Consequently, a policy which requires transgendered people to provide medical proof actively discriminates against them and their limited financial resources.

One of the interesting things that came up in my conversation with staff members of shelters for homeless women relates to the physical appearance of transsexual women. I was informed that a MTF transsexual would be accepted into some shelters "if the person doesn't come across as too terribly masculine." Staff people claimed that the physical appearance of transsexual women was related to their ability to "fit in." These comments illustrate the judgements to which transsexual women are subjected when they attempt to access social services. Other people decide if a transsexual woman is "feminine" enough, if she is "really" a woman, if her presence will be "disruptive," and if she has the right to the services offered to women. One wonders whether staff members judge all their clients on this basis, or just those who are known to be transsexual.

Moreover, the arbitrary criterion of physical appearance is (once again) disconnected from the everyday realities of transgendered women -- especially those who are poor and living on the

streets. MTF transsexuals have to rid themselves of their facial hair. The only permanent way to achieve this is through electrolysis. This service costs anywhere from \$35 to \$75 an hour; most transsexuals need at least 100 hours (often much more) to rid themselves entirely of facial hair. If a transsexual woman has no money for a roof over her head, she will probably also have little money for electrolysis. Therefore, it is quite likely that some transsexual women who present themselves to shelters for homeless women will have visible facial hair.

In addition to the problem of visible facial hair, the relations MTF transsexuals have with the legal system need to be acknowledged. If arrested, MTF transsexuals who are pre-operative are jailed with men. Their hormones are taken away in prison (Masters 1993). This creates a situation in which an individual who identifies and lives as a woman will undergo physical processes of masculinization. Upon her release, she may not look as "feminine" as she once did, since she has been denied hormones in jail.

Given these realities, it thus makes little sense to only accept transsexual women who look like genetic women; this does not acknowledge the complexity of their situation as poor, homeless, and/or ex-con transsexual women. Moreover, the psychological effects of being refused admittance to a woman's shelter should not be under-estimated. Transsexual and transgendered women want to change their bodies, and work to do so actively. To be refused admittance into a woman's shelter on the basis of one's physical appearance can reinforce the hatred that transsexuals feel for their bodies. This rejection can also lead an individual to low self esteem, increased alcohol/drug consumption, and even attempts at suicide. In this complex way, the denial of services to transsexual women has repercussions which range beyond their immediate housing needs.

The research on shelters for homeless youth demonstrates that transgendered people do not access these services, or make use of them only as a last resort. Transgendered people espouse a similar mistrust of women's and homeless shelters. One MTF transsexual I interviewed informed me that although she was homeless for a few months upon her arrival in Toronto, she did not even attempt to access shelter services because of her gender presentation:

When I first came down from _____, I was homeless. I didn't have much money. I didn't dare go near any shelters because I knew I'd have a lot of trouble, being a tv [transvestite]. I just didn't dare. I would just sleep in the park, that kind of stuff.

The current policies and practices of shelters for battered women, homeless women and youth clearly do not address the needs of transgendered and transsexual women. Agencies deny transgendered people services with the rationale that other shelter residents will not feel safe, with no sustained consideration of safety issues for MTF transgendered people, whether in a shelter or on the street. In many instances, the gender of transsexuals and transgenderists is

decided by someone other than the transgendered person - a gender identity clinic, a doctor, or staff members of these organizations. And finally, policies which accept post-operative transsexual women for admittance into a shelter do not serve the most disenfranchised transgendered people: those who are poor, sex trade workers, ex-convicts, and/or seropositive. This type of discrimination is never acceptable. It is particularly ironic that such exclusionary practices continue in social service agencies designed to aid people with few resources.

What is perhaps most remarkable about the current situation of shelters and transgendered people, however, is that the issue is consistently addressed on a case-by-case basis. Staff have little or no training on transgender issues, and shelters do not have written anti-discrimination policies which include transgendered people. This creates a situation in which the "problem" is individualized, such that a particular transgendered person is perceived as the root of this issue. Although many staff people of shelters stated that their facilities would not be safe for transgendered people, few people addressed the responsibility of the agency in creating, providing, and maintaining a safe space for a transgendered person in need of assistance. As one staff member of a drop-in for homeless women remarked, "No one thinks it's [the provision of services to transgendered people] their responsibility."

ALCOHOL, DRUG, AND SUBSTANCE USE

One of the topics that arose frequently in my conversations with the transgendered people I interviewed related to the use of alcohol, drugs, and/or illicit substances. Due to limitations of time and money, I was unable to pursue this line of inquiry in any great depth. (Indeed, this subject needs its own independent study!) Having said this, the issues raised by the transsexuals and transgenderists I spoke with are too important to not mention. While this section of the research remains incomplete, the information contained herein may be of use to people working in the field of addictions, and/or to those interested in offering social services to transgendered people.

The people I interviewed spoke at great length about the long and difficult process through which they came to terms with their gender identities. Some of these people used alcohol and drugs as a way to escape their confusion, pain, and suffering. This information will not come as a surprise to people familiar with questions of alcohol and substance use. What my research further reveals, however, are the barriers transgendered people face once they attempt to access alcohol/drug rehabilitation programmes.

Several of the individuals interviewed stated that the traditional forms of support available for people dealing with substance abuse were not welcoming of transsexuals. One subject recounted her experience with Alcoholics Anonymous (AA) in a small city. She had been attending meetings regularly and received a great deal of support. When it was discovered that she was transsexual, however, AA members were less than hospitable:

This is AA, where they're all supposed to hug and shake your hand. There were actually people that walked away from me when I went up to shake their hand.

When transsexuals enrolled in more formal alcohol/drug rehabilitation programmes, they would often feel alone and isolated. Several of the individuals I interviewed went through rehabilitation programmes in the gender assigned to them at birth (i.e., MTFs with men, FTMs with women). This made the process of their recovery even more difficult and stressful.

There was nobody in the group that I could relate to in the least.

In many situations, transsexuals did not feel safe or comfortable enough to speak about their gender issues. The following quotations illustrate the ways in which transsexuals are forced to deny their transsexuality. The first quotation is from a female-to-male transsexual who underwent treatment with women, while the remaining quotations are from male-to-female transsexuals who went through recovery with men:

Here I am ... and I can't even say why I was drinking. Because at bottom it's this [transsexuality].

I just kept it [transsexuality] my little secret.

I wasn't quite ready to bring this issue up on the table at an all men's discussion meeting.

While the above quotations come from transsexuals who went through counselling and rehabilitation services in the gender assigned to them at birth, things were not necessarily much better for transsexuals who received services in their chosen gender. One MTF transsexual I spoke with was housed in a women's detoxification programme. Although no one denied her services outright as a woman, she overheard the staff make disparaging comments about transsexuals. A FTM transsexual I interviewed went through a recovery programme with men. He explains the stress of hiding his transsexuality, both in terms of day-to-day life and in terms of the counselling/group therapy context:

It [the treatment facility] was all men. So I had to become very sensitive to the fact, when I took a bath [at] certain hours, when I went to the bathroom, when I went to bed, you know? And nobody knew. We shared rooms and whatnot. I was more sensitive to that, protecting myself. And I didn't want to bring up my gender issue because I knew that they would isolate me, make me feel different. I really believe that they would have looked at me differently. And I didn't want that to be there when I was dealing with alcoholism.

It is noteworthy that transsexuals deny their transsexuality both when they go through treatment in the gender assigned to them at birth, as well as when they seek assistance in their chosen gender. In neither situation is it safe to declare one's transsexual status.

Most existing alcohol/drug agencies are clearly unsympathetic to transsexual and transgender issues. Counsellors working in this area also lack knowledge. One female-to-male transsexual I interviewed was referred to a service for alcohol and drug counselling. From the beginning, he was uneasy with this agency:

To tell you the truth, I didn't want to go there, 'cos it's for women.

This man further stated that although his counsellor was pleasant, she was quite ignorant of transsexuality:

She's very nice, even if she doesn't think I should do this [transition] She thinks I'm trying to mutilate my body. I said, "Dear, I have scars all over me. I'm trying to take care of me now. I don't want to do that anymore."

This quotation illustrates the dilemma transsexuals face when they go for counselling. The FTM had to educate his counsellor about the ways in which his addiction and gender issues are related: in living as a woman, he hated his body and how he was perceived, and so used alcohol to deal with that pain. His decision to live as a man decreased this anxiety, and thus lessened a need to consume alcohol. This is not to suggest that when a transsexual with addictions issues begins a transition, they will suddenly no longer have any drinking or substance abuse problems. But it is to underline some of the reasons why some transsexuals may use drugs or alcohol.

Transsexuals and transgenderists have to deal with counsellors who are ignorant of ts/tg issues. In many cases, this redefines the counselling situation. As the following quotation indicates, transsexuals spend their time educating their counsellors on transsexuality, instead of exploring their addictions issues. The FTM transsexual cited above reflects on his counselling situation:

She [my counsellor] said she'll support me [to transition and live as a man], but she doesn't want me to do this. We've had long talks about it, like she just, it freaks her out. She wants me to try and just be gay. [laughter!]

As this passage indicates, the FTM spent much of his time in the counselling context informing his care-giver about transsexuality. In particular, he had to explain the difference between sexual orientation and gender identity.

Finding an addictions treatment programme or a counsellor who is transgender-positive is a formidable challenge. Indeed, locating resources which accept transsexuals is difficult in and of itself. Finding support where the staff have knowledge of transsexual and transgender issues is even less likely. These problems of access are compounded when questions of race and ethnicity are considered. Locating addictions counsellors or recovery programmes for Aboriginal transsexuals, or those of South Asian descent, seems an insurmountable task at the present time.

CONCLUSION

Currently, transsexuals and transgenderists face systemic barriers with regards to health care and social services in Ontario. Ts/tg people lack informed, safe access to hormones, are mistreated by the staff of hospital and emergency rooms, are harassed and beaten by the police, face rejection from traditional alcohol and drug rehabilitation programmes, and are denied entry into youth, homeless, and women's shelters. In all of these areas, basic access to health care and social services is denied.

Drawing on interviews with a diversity of transsexual and transgendered people, my research demonstrates that the experience of transgendered people contradicts an "official" version of reality, in which all Ontario residents have the same rights and opportunities to access health care and social services. This report clearly documents that transgendered people are habitually refused the services they seek to live their bodies as they choose. Furthermore, my study indicates that the situation is perhaps most serious for transgendered people with few resources. While stories of being declined assistance were common to almost all of the people I interviewed, transsexuals and transgenderists who are sex workers, homeless, ex-convicts, and/or seropositive face discrimination not only from their doctors or hospital personnel. They also have to confront abuse by the police, rejection from shelters, and unfair treatment in alcohol/drug rehabilitation programmes.

It should be underlined that the current context of health care and social services for transgendered people creates unnecessary stress on the health care system. Transsexuals search for sympathetic doctors who will prescribe them hormones, sometimes consulting more than a dozen physicians. In addition to an increased burden on the health care and social service systems, it is evident that most health care and social service organizations do not serve transgendered people. Transsexuals and transgenderists take hormones without being monitored by a physician, because they cannot find a sympathetic doctor with whom to work. Transsexuals transition without the support and/or recommendation of the GIC, because they feel that the clinic does not provide them with adequate information about transsexuality.

Transgendered youth find forms of temporary housing other than shelters, sex trade workers do not report harassment from the police for fear of reprisal, and transsexuals deny their transsexual status while enrolled in alcohol/drug recovery programmes. In all of these instances, ts/tg people choose to deal with their health care and social service needs on their own, rather than subject themselves to the judgement, harassment, or discrimination of health care and social service agencies.

RECOMMENDATIONS

Given the current situation of health care and social services for transgendered people in Ontario, the following recommendations are offered:

Hormones: That the Ministry of Health provide funding for a transsexual/transgender health care centre, in which individuals can obtain informed, safe access to hormones. This would alleviate the concerns doctors have in prescribing hormones (legal repercussions), and would ensure that transsexuals and transgenderists monitor their health regularly. For transgendered youth and the street ts/tg community, such a centre supports a "harm reduction" model. For all ts/tg people, a health care centre would encourage individuals to take active roles in their health promotion.

Gender Identity Clinic: That an independent committee be established, composed of representatives of the GIC of the Clarke Institute of Psychiatry and transsexual/transgender clients using the GIC's services. The purpose of this committee would be to clarify the services provided by the GIC, and to determine which additional services are desired by ts/tg people. Given the wide dissatisfaction with the GIC's policy on cross-living one year before hormones, this committee should also review that issue. It is important that the diversity of transgendered people be represented on this body (e.g., sex trade workers, people of colour), and that the committee work actively to solicit the participation of transsexual and transgendered people.

Hospitals and Emergency Rooms: That all emergency room personnel and hospital staff receive training on proper etiquette in dealing with transsexual/transgender clients (correct pronoun use, ts/tg health care issues, etc.) Collaborative work with doctors' and nurses' associations, as well as with medical school administrators, might be useful avenues to proceed to ensure this training takes place.

Police: That all police officers in Ontario receive training on proper etiquette in dealing with transgendered clients (correct pronouns, etc.)

Shelters: The current practices and policies of youth, homeless and women's shelters must be reviewed, in light of the information presented in this report. In all cases, staff members need training on ts/tg issues. Such training must address not only proper etiquette, but also the responsibility of an agency to provide services to transgendered people in need. Staff and agencies, moreover, are responsible for ensuring that ts/tg people who use their facilities are safe from violence, discrimination, and harassment from other shelter residents.

A review of these policies needs to occur in each shelter agency in Ontario, as well as at the level of shelter associations. Transgendered people have the right to know which

shelters they can go to, and which ones will turn them away.

Alcohol/Drug Rehabilitation: That the Ministry of Health provide funding for a pilot project on addictions and the transsexual/transgender community. This project would serve at least two purposes: it would allow for further research on this question, and it would offer transgender-positive recovery services to a ts/tg clientele.

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RESOURCES

Transsexual/Transgender/Transvestite Groups

Canadian Crossdressers' Club

161 Gerrard St. E.

Toronto, Ontario

M5A 2E4

(416) 921-6112

A social organization for cross-dressers and drag queens.

Gender Mosaic

PO Box 7421

Vanier, Ontario

K1L 8E4

(613) 770-1945.

A group which offers support, social events, and information to all transgendered people.

Monarch Social Club

Box 386, Station A

Mississauga, Ontario

L5A 3A1

A social group for transsexuals, transvestites, and transgenderists.

TransEqual

165 Ontario St., #609

St. Catharines, Ontario

L2R 5K4

(905) 688-0276

TransEqual is a transsexual/transgenderists rights group, active in the area of human rights and the law.

Transition Support

c/o 519 Community Centre

519 Church St.

Toronto, Ontario

M4Y 2C9

(416) 392-6874 (messages only).

Primarily a transsexual support group, but other transgendered people are welcome. They currently meet the second and fourth Fridays of every month, at the 519 Community Centre in Toronto (address above).

Xpressions

PO Box 233, Station A

Toronto, Ontario

M5W 1B2

Xpressions serves cross-dressers, drag queens, transsexuals and transgenderists through social

events.

Gender Identity Clinic

Gender Identity Clinic
c/o Clarke Institute of Psychiatry
250 College St.
Toronto, Ontario
M5T 1R8
(416) 979-2221 extension 2221

The GIC performs assessment and diagnosis of gender dysphoric individuals (transsexuals, transvestites, transgenderists). In order to have sex reassignment surgery covered through provincial health insurance, an individual must be recommended for surgery by the GIC. The GIC also offers a support group for transgendered people, as well as education on transsexualism for employers.

Social Service Agencies

Listing in the resource section does not guarantee that a particular organization or agency has transgendered people on staff, or that the staff members are aware of all aspects of ts/tg health care. Organizations listed here, however, usually had at least one staff person who was familiar with transgender/transsexual issues, and/or who was interested in learning more about these questions. While this is hardly an ideal situation for a resource directory, it is hoped that the information contained herein will facilitate locating transgender-positive social services.

Asian Community AIDS Services

33 Isabella #107
Toronto, Ontario
M4Y 2P7
(416) 963-4300

An organization which offers education and support to Asian communities with regards to HIV and AIDS.

Central Toronto Youth Services

65 Wellesley St. East, 3rd floor
Toronto, Ontario
M4Y 1G7
(416) 924-2100

Mental health agency for youth, with services for youth, their families, and other agencies. CTYS also has programmes for lesbian, gay, and bisexual youth.

Hassle Free Clinic

556 Church St., 2nd floor
Toronto, Ontario
M4Y 2E3
(416) 922-0603 (men)
(416) 922-0566 (women)

A clinic for sexually transmitted diseases, which offers testing, counselling and referrals for STDS and HIV (anonymous testing, by appointment only). Transsexuals and transgendered people are welcome at either clinic.

Maggie's Prostitute Resource Centre and Safe Sex Project of Toronto

PO Box 1143

Station F

Toronto, Ontario

M4Y 2T8

(416) 964-0150

Resource centre run by and for sex trade workers. Legal referrals, condoms, AIDS/HIV information, etc. Drop-in Mondays and Wednesdays, 12-6 pm at 298 Gerrard St. E., 2nd floor.

PASAN - Prisoners' AIDS/HIV Support Action Network

517 College Street, suite 237

Toronto, Ontario

M6G 4A2

(416) 920-9567

Toll Free number: 1-800-263-9534

PASAN accepts collect calls from prisoners.

PASAN offers information and support for prisoners with HIV and AIDS. They are aware of transgender/transsexual prison issues.

Shout Clinic

467 Jarvis

Toronto, Ontario

M4Y 2G8

(416) 927-8553

A community health clinic for street-involved youth under 25 years of age. Primary health care by doctors and nurses, counsellings, referrals.

Street Outreach Services (SOS)

622 Yonge St., 2nd floor

Toronto, Ontario

M4Y 1Z8

(416) 926-0744

S.O.S. assists youth involved in prostitution. They deal with ts/tg youth on a regular basis.

Legal, medical, welfare, and AIDS/HIV counselling available. Drop-in centre, Monday-Friday 10-6.

Two-Spirited People of the First Nations

2 Carlton St. #1419

Toronto, Ontario

M5B 1J3

(416) 944-9300

An organization for lesbian and gay people of Aboriginal ancestry. They also work with some Native transgendered people. HIV/AIDS education and prevention, counselling, support, referrals, advocacy, talking circles, traditional teachings, sweat lodges, social events.

Voices of Positive Women
PO Box 471
Station C
Toronto, Ontario
M6J 3P5
(416) 324-8703

Voices of Positive Women is a community organization run by and for women living with AIDS/HIV in Ontario. Their services are available to anyone with HIV/AIDS who identifies as a woman.

Youth Services Bureau of Ottawa-Carleton
147 Besserer Street
Ottawa, Ontario
K1N 6A7
(613) 241-7788

YSB offers employment counselling, referrals, a drop-in centre, and outreach. They also facilitate a support group for lesbian/gay/bisexual/questioning youth.

Shelters

As discussed in the report, few shelters have written anti-discrimination policies regarding transgendered and transsexual women. Moreover, agencies have different criteria for the acceptance of transsexuals (documentation, post-operative status). All of the agencies listed below accept transsexuals, although not all of them accept pre-operative or non-operative transsexuals. Contact them to find out more about their policies.

416 Drop In
416 Dundas St. East
Toronto, Ontario
M5A 2A8
(416) 928-3334

The 416 is a drop-in centre for homeless and/or transient women over 16. Services include laundry facilities, breakfast, lunch and diner, clothing, food depot, medical clinics on site, individual drug counselling, and street outreach. Transsexuals and transgenderists are welcome.

Nellie's
275A Broadview avenue
Toronto, Ontario
M4M 2G8
(416) 461-1084

Nellie's is a shelter for women 16 years and over. Services include counselling, food, clothing, crisis intervention, advocacy, and referrals.

North York Women's Shelter
592 Sheppard avenue W., Box 77570
Downsview, Ontario
M5H 6A7
(416) 635-9630
Emergency shelter for women. Counselling, referrals.

Rendu House
240 Church St.
Toronto, Ontario
M5B 1Z2
(416) 864-0792
Residence for homeless women 16 years of age and older.

Sistering
523 College St.
Toronto, Ontario
M6G 1A8
admin: (416) 926-9762
drop-in: (416) 926-1946
outreach: (416) 588-3939
Sistering is a drop-in centre and outreach programme for homeless women, including transsexual and transgendered women. Referrals for counselling, welfare, housing, legal problems, education, and employment.

Stop 86 (YWCA)
86 Madison avenue
Toronto, Ontario
M5R 2S4
(416) 922-3271
Short term shelter for women. Counselling, referrals.

Women's Residence
674 Dundas St. West
Toronto, Ontario
M5A 2R9
(416) 392-5650
Women's Residence provides short term emergency shelter for women 16 years and over.

Addictions
416 Drug Programme
416 Dundas St. E.
Toronto, Ontario
M5A 2A8

(416) 964-6936

Individual counselling on addictions issues for women. Transsexual women are welcome.

Publications

This list of publications contains resources produced in Canada. The newsletters for female-to-male transsexuals are included here, given the difficulties in finding information about female-to-male transsexuality. For a more complete listing of transsexual and transgender publications, consult *gendertrash*.

Boys' Own: The FTM Newsletter.

FTM Network, BM Network

London, United Kingdom

WC1N 3XX

Boys' Own is a publication for female-to-male transsexuals. Write for subscription information.

DQ International

161 Gerrard St. E.

Toronto, Ontario

M5A 2E4

(416) 921-6112

A quarterly publication of the Canadian Crossdressers' Club. Subscriptions are \$20/year.

Police

Ottawa Police Lesbian and Gay Liaison Committee

474 Elgin Street

Ottawa, Ontario

K2P 2J6

(613) 236-0311 - ask for the Bias Crimes Unit.

The Lesbian and Gay Liaison Committee works with the police force to address policing and safety issues with respect to lesbian, gay, bisexual, and transgendered people.

Office of the Police Complaints Commission

595 Bay Street, 9th floor

Toronto, Ontario

M5G 2C2

(416) 325-4700

Toll Free: 1-800-267-5648

This office provides an independent civilian review of all complaints involving police conduct in Ontario. Contact them for more details on how to file a complaint.

Other Groups, Organizations, and Relevant Information

AEGIS - American Education Gender Information Service

PO Box 33724

Decatur, Georgia

USA

30033-0724

(404) 939-2128

AEGIS offers information and education on transsexualism and transgenderism. They have produced numerous educational materials, have recently established a national archive for documents relating to transgendered lives, and publish a journal, *Chrysalis Quarterly*. Contact AEGIS for more information.

International Foundation for Gender Education (IFGE)

PO Box 367

Wayland, Massachusetts

01778

(617) 894-8340

IFGE is an educational organization which serves the transsexual and transvestite communities. They offer a speaker's bureau, peer counselling, and related services. IFGE also publishes material of interest to transsexuals, including Dr. Sheila Kirk's book on hormones. Call or write for more information.

Intersex Society of North America-Canada

PO Box 1076

Haliburton, Ontario

K0M 1S0

ISNA offers education, support, and advocacy on the subject of intersexuality (hermaphrodites and pseudohermaphrodites). Services are for intersexuals as well as for the parents of intersexed infants and children.