RECOMMENDATIONS FOR A TRANSGENDER HEALTH PROGRAM

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For Lorna Howes, Director of Mental Health,
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BACKGROUND

This report was commissioned by Lorna Howes, Director of Mental Health Services, Vancouver Coastal Health Authority (VCHA) following the closure of the previous gender clinic in May 2002 (referred to as the Gender Dysphoria Program or "Gender Clinic"). For more details of the sequence of events, see Appendix 1, Community Survey: Transition/Crossdressing Services in BC – Final Report.

A crucial issue for transgendered people was that the previous Gender Clinic was the only Provincial gatekeeper with whom the Medical Services Plan of British Columbia (MSP) communicated for the purpose of determining which patients were suitable for a variety of surgical procedures, including sex reassignment surgery. The abrupt closure of the clinic left many individuals unclear about how to access appropriate transgender medical assistance. In addition, others were at various points in the transition process and understandably concerned about who would provide care.

Several transgender organizations arranged to meet with members from the Vancouver Coastal Health Authority in July 2002 to raise their concerns. As a result of this process, a survey was developed and distributed as broadly as possible. The results appear in Appendix 1 and indicate a high rate of commitment on the part of consumers to ensuring that ongoing services were made available. Transgender groups volunteered to work in collaboration with VCHA to develop this anonymous confidential survey in order to obtain input regarding the development of a new service relating to gender transition and crossdressing. In fact, two members from Transcend Transgender Support and Education Society (Nicholas Matte and Joshua Goldberg) rapidly coordinated the survey package. Subsequently, Maria Hudspith, VCHA Coordinator of Community Consultation and Partnerships for Vancouver became involved with the logistical elements. The survey was sent to approximately five hundred patients who were listed on the Gender Clinic mailing data sheet. In addition, Ms. Hudspith acted as a point of contact for community members as well as service providers, the media and other individuals or groups interested in the survey.

The following were interviewed or attended open discussions:

- transgender medicine experts: Drs. R. Stevenson, S. Elliott, O. Robinow, T. Corneil, S. Tregoning, P. Ren, F. Norrie, M. Zapf-Gilje; J. Young (therapist)
- Pride Health Services at Three Bridges Community Health Centre
- Executive Board of the Medical Services Plan; and
- representatives from a variety of community based transgendered services, including: Transcend Transgender Support and Education Society, Genderqueers, Transgendered Legal Education and Advocacy Foundation (TLEAF), Zenith Foundation, BC Female to

Male Network, Cornbury Society, Trans Alliance Society, Women/Trans Dialogue Planning Committee, and Youthquest. Health providers included: M. Scott, D. Lau, J. Powers, P. Toppings, P. MacDiarmid, D. Dubick, S. Kaplan, G. Llewellyn, and F. Parker.

For details about the above mentioned organizations see Appendix 4 – BC Trans-Specific Supports.

DEFINITION OF TERMS

It is important to define some terms, and briefly review the development of the nomenclature. The term 'transsexual' appeared initially in the 1950's and identified an individual who aspired to or actually lived in the gender role opposite to their birth sex, whether or not hormones had been administered or surgery had been performed. Later, in the 1960's and 70's, a variety of clinicians used the term 'true transsexual'. This latter term was thought to describe a person with a characteristic path of atypical gender identity development that was consistent with an improved life after a treatment sequence that often culminated in genital reassignment surgery (adapted from the Harry Benjamin International Gender Dysphoria Association [HBIGDA] Standards of Care for Gender Identity Disorders, 2001: see Appendix 2). The Diagnostic and Statistical Manual (DSM-IV) in 1980 recommended the term 'transsexualism' as a diagnosis for anyone who expressed at least two years of continuous interest in a physiological and social gender transformation. Others with gender dysphoria could receive the diagnosis Gender Identity Disorder of Adolescence or Adulthood, Non-transsexual Type; or Gender Identity Disorder Not Otherwise Specified (GIDNOS).

The DSM-IV, introduced in 1994, replaced the term 'transsexualism' with 'gender identity disorder'. Individuals with a strong and persistent cross-gender identification and a persistent discomfort with their sex or a sense of inappropriateness in the gender role of that sex would be considered to have a gender identity disorder of childhood, adolescence, or adulthood. For people who did not meet the specific criteria, 'Gender Identity Disorder Not Otherwise Specified' (GIDNOS) was to be used. The latter category included a broad range of individuals, including those who wished various levels of social and physiological gender transition but did not want genital surgery (see Appendix 2; DSM-IV GIDNOS).

The international classification of disorders (ICD-10) lists five diagnoses under the gender identity disorders (see page 5, Appendix 2).

During the period between DSM-III and IV, "transgender" emerged as a term which would be applied in various ways. Although 'transgender' itself is not a formal diagnosis, many professionals and members of the public found it more manageable to use the former term rather than GIDNOS. The latter is the formal diagnostic term according to DSM-IV.

A helpful definition of transgender people, used in the survey (Appendix I, page 2), is quoted here:

> *Transgendered people have a gender identity that is different from their birth sex or express their gender in ways that contravene societal expectations of the range of possibilities for men and women. Some transgendered people identify as men or women, while others have an identity that is not as simple as 'man' or 'woman'. This umbrella term may include crossdressers, drag kings/queens, transsexuals, people who are androgynous, Two-Spirit people, and people who are bi-gendered or multi-gendered.*

While there remains some debate about an acceptable working definition of transgender, for the purposes of this report, the above will be employed.

The term ‘intersex’ requires clarification. Intersex people are “born with X chromosomes, external genitalia, or an internal reproductive system that is not considered standard for either male or female” (Intersex Society of North America 1994; Diamond and Sigmundson, 1997; Diamond 1999; see Bibliography, Appendix 3 for all references). While some intersex individuals are also transgendered and therefore share some health needs with non-intersex transgendered people, gender identity and physical sexual assignment are not the same (Diamond 2002). In addition, intersex people have physical and mental health needs which are unrelated to gender identity. Therefore, treatment guidelines for intersexuality are not the same as those for gender dysphoria or gender transition. Although this report will not address the specific needs of individuals in this category, the prior Gender Clinic provided specialty transgender services and other services for intersex people. Therefore, as the health needs of this group are distinct, the VCHA will need to assess the impact of the closure of the prior clinic on intersex people.

Prevalence

During the time when gender identity disorders first reached professional attention, prevalence figures were based on individuals seeking out sex reassignment surgery. However, it is now apparent that some individuals with gender identity disorders do not wish to proceed to genital surgery. Additionally, the numbers of people seeking services has risen with a growing awareness that services exist. The earlier estimates of prevalence for transsexualism in adults was 1/37,000 people born male and 1/107,000 people born female. More recently, prevalence data from the Netherlands suggests 1/11,900 people born male and 1/30,400 people born female (HBIGDA Standards of Care, 2001) meet criteria for transgender identity disorders.

Natural History of Gender Identity Disorders

Prospective data about the natural history of these disorders are sorely lacking and are essential to the process of informing treatment decisions.

The so called “triad” has been the major component of therapy and consists of:

1. Real-life experience in the desired role (RLE)
2. Hormones of the desired gender
3. Surgery to change the genitalia and other sex characteristics (e.g., chest)

What has become apparent is that even when individuals are carefully assessed and the diagnostic process completed, some spontaneously change their aspirations over time, others make more comfortable accommodations to their gender identity without medical intervention, while still others give up their wish to follow the triadic sequence during therapy. Some gender identity clinics have an unexplained high drop out rate, and the percentage or persons who do not benefit from ‘triadic therapy’ seems to vary from one study to the other.

The diagnosis of gender identity disorder constitutes the beginning of a careful clinical consideration of a number of therapeutic options. Not all persons with gender identity disorders either want or need all three elements of the 'triadic' model.

Cultural Differences and Gender Identity

According to the HGBIDA Standards of Care, crossing gender boundaries generates moral issues in most countries. Nonetheless, there are striking differences in certain countries regarding cross gender behaviours. Many of the latter are not stigmatized.

Standards of Care for Transgender Medicine

The Harry Benjamin International Gender Dysphoria Association (HBIGDA)'s Standards of Care for Gender Identity Disorders (2001) (Appendix 2) constitutes a widely followed set of guidelines. Professionals from psychiatry, psychology, general medicine (including endocrine) and surgical specialties update the standards on a regular basis. These have been employed by many centers internationally.

In addition, the **Health Law Standards of Care for Transsexualism**, also referred to as the **ICTLEP** guidelines, were produced by the Health Law Project of the International Conference on Transgender Law and Employment Policy (Health Law Project, 1993; see Appendices 5 and 5a). Services which embrace a **harm reduction model** (e.g., Dimensions, 2000; Flaherty Rand et. al., 2001; Perez-Arce, 2000) follow guidelines very similar to those set out by ICTLEP (see Appendix 6 for a description of the Dimensions program). One of the main differences between the two sets of guidelines is the focus on the ability of the individual involved to provide informed consent to make decisions about their care.

The ICTLEP guidelines articulated 5 important principles:

> **Principle 1**. Transsexualism is an ancient and persistent part of human experience and is not in itself a medical illness or mental disorder. Transsexualism is a desire to change the expression of one's gender identity.
>
> **Principle 2**. Persons have the right to express their gender identity through changes to their physical appearance, including the use of hormones and reconstructive surgery.
>
> **Principle 3**. Persons denied the ability to exercise control over their own bodies in terms of gender expression, through informed access to medical services, may experience significant distress and suffer a diminished capacity to function socially, economically and sexually.

Principle 4. Providers of health care (including surgical) services to transsexuals have a right to charge reasonable fees for their services, to be paid in advance, and to require a waiver of all tort liability except negligence.

Principle 5. It is unethical to discriminate in the provision of sex reassignment services based on the sexual orientation, marital status, or physical appearance of a patient.

In addition, five standards were included:

Standard 1. Physicians participating in transsexual health care shall provide hormonal sex reassignment therapy to patients requesting a change in their sexual appearance subject only to (1) the physician's reasonable belief that the therapy will not aggravate a patient's health conditions, (2) the patient's compliance with periodic blood chemistry checks to ensure a continued healthy condition, and (3) patient's signature of an informed consent and waiver of liability form. If the patient is married, the physician may not require divorce but may also require the spouse to sign a waiver of liability form.

Standard 2. Physicians providing hormonal sex reassignment therapy shall collect and publish on an annual basis the number of hormone prescriptions they have issued and the number and general nature of any complications and complaints involved. The publication requirement of this Standard shall be satisfied by providing the collected statistics in writing, together with other current information on the potential risks and complications of sex hormone therapy, to all prospective patients inquiring into the physician's hormone therapy services.

Standard 3. Surgeons participating in transsexual health care shall provide sex reassignment surgery to patients requesting a change in their sexual appearance subject only to (1) the surgeon's reasonable belief that the surgery will not aggravate pre-existing health conditions, (2) the surgeon's reasonable determination that the patient has been under hormonal sex reassignment therapy for at least one year, and (3) the patient's signature of an informed consent and waiver of liability form. If the patient is married, the surgeon may not require divorce but may also require the spouse to sign a waiver of liability form.

Standard 4. Surgeons providing sex reassignment surgery shall collect and publish on an annual basis the number of sex reassignment surgeries they performed and the number and general nature of any complications and complaints involved. The publication requirement of this Standard shall be satisfied by providing the collected statistics in writing, together with other current information on the potential risks and complications of sex reassignment surgery, to all prospective patients inquiring into the sex surgeon's sex reassignment services.

> **Standard 5**. Physicians and surgeons shall not divulge the nature or identity of any patient requesting or receiving sex reassignment services except as explicitly directed in a notarized written request by the patient.

On a final note, the inclusion of mandatory psychological assessment and diagnosis in earlier versions of the HBIGDA standards was of concern to the authors of the ICTLEP guidelines. In 1993, the Health Law Project suggested that “many, if not most, of the patients doctors see for gender medical services (hormone/surgery) do not require any psychological services”. In fact, the revisions of the HBIGDA standards in 1998 and 2001 addressed this criticism by removing the set length of time required for psychotherapy.

Developing Evidence-Based Treatment Guidelines

Medical practice guidelines are not only required, but must be implemented and evaluated. There is consensus amongst health professionals as to the need for guidelines to ensure respectful and competent care to all transsexual people requesting it. In addition, there has been a general shift in health care provision to encompass principles of harm reduction. Whatever guidelines are adopted, measures must be taken to ensure that any flexible application does not create unnecessary and harmful barriers to accessing care. Importantly, evaluation of all programs is essential. This issue will be addressed in more detail under a subsequent section.

With reference to the above, and as mentioned previously, the so called “real life experience (RLE)”, which is emphasized in the HBIGDA standards as necessary to “prevent post surgical regret”, may be unnecessary in certain instances. In a recent study, Rachlin (1999) concluded that the key determinants of satisfaction post-surgery had very little, if any, to do with duration of the real life experience. Another study of post-operative male to female transsexuals (n=232) found that functional results of surgery and the number of post-operative complications were the key factors associated with regret or satisfaction following genital surgery. The duration of hormone therapy or real life experience, the hours of preoperative psychotherapy, or the degree of preoperative family support were not significantly associated with either satisfaction or regret following genital surgery (Lawrence, 2001). Understandably, some clinicians are questioning whether there is any clinical evidence to support necessity of real life experience, particularly in adults. Lawrence (1999) concluded that:

> *“Carefully selected individuals should be allowed to receive hormone therapy and genital surgery without a full-time real life experience. Our insistence on linking somatic treatments to a particular kind of full-time gender presentation reflects only tradition – not science. There is in fact no experimental evidence that a full-time real life experience is necessary or desirable prior to sexual reassignment surgery. It is merely a tradition that has been enshrined in fact”*.

The above quotation refers to adults. The issues as they relate to children and adolescents demand careful consideration by multiple professionals and parents.

Standards of Care for Children and Adolescents

The DSM-IV and ICD-10 specified diagnostic criteria for children and adolescents with gender identity disorders. The standards set out by the HGBIDA (2001) are virtually identical to those published in 1998 by the **Royal College of Psychiatrists (RCP)**. The focus of treatment was to be "reducing distress the child experiences from his or her gender identity problem and other difficulties" (HBIGDA 2001). In the majority of instances, members of the care team will need to work with parents, teachers, and school administrators and identify appropriate medical care. The latter will be crucial for those individuals imminently entering puberty who strongly object to the transformations that are occurring in their body and may be at risk of anxiety/depression, peer harassment or suicide.

The HBIGDA and RCP standards include 3 categories of physical intervention:

- those that are fully reversible (the use of hormones to delay the physical changes of puberty);
- those that are partially reversible (the use of hormones to either masculinize or feminize the body);
- those that are irreversible (surgeries).

Because many professionals believe that gender identity development is fluid in adolescence and children, the HBIGDA and RCP recommend delaying irreversible physical interventions as long as possible and slowly and sequentially moving through the stages to allow the adolescent and involved family members time to consider all options. Physical puberty can be delayed and in some instances this is desirable. Those under the age of 18 are not eligible for surgeries (see page 8, Appendix 2).

Philosophical Approaches

According to the HBIGDA, the overall goal of psychotherapy, endocrine interventions or surgical therapy for persons with Gender Identity Disorders is to provide a lasting, personal comfort with the gendered self in order to maximize overall psychological well-being and self fulfillment (see Appendix 2, page 1). More specifically however, there are different philosophical approaches to the delivery of such services.

Medical/Prescriptive

This model has been used by many gender clinics (e.g., Centre for Addiction and Mental Health, 2003; Damodaran Kennedy, 2000; di Ceglie; Monash Gender Clinic; Gender Identity Clinic of New England). The model emphasizes practitioner responsibility for assessing and screening out individuals who are not suitable candidates for gender transition. Presumably, the philosophy driving this is to protect individuals from future regret. The practitioners often employ a variety of psychological tests in order to assist them in arriving at a diagnosis consistent with DSM IV and/or ICD-10 (required by HBIGDA, 2001). The latter forms a basis for recommending treatment. The treatment approach usually follows a straightforward pathway from assessment/diagnosis, the possibility of hormone therapy and one (sometimes two plus) years of real life experience, and then surgery. The majority of the clinics using this approach are located in a hospital setting within a psychiatric service. Some are affiliated with universities. Generally, the staff consists of a team of physicians (psychiatrists and family physicians), along with psychologists, social workers, and endocrinologists. Referral to appropriate surgeons can be made when required.

Harm Reduction/Client-directed Approach

Harm reduction is based on the principle that health interventions are most effective when people are assisted to improve their quality of life and meet their own goals, rather than a health professional demanding an individual change to meet the practitioner's goals. First developed in the addictions field (e.g., Harm Reduction Coalition, 2001), harm reduction has expanded to have wide application in public health. In the context of transgender medicine, a practitioner's role in assisting transgendered individuals would be to access the resources required to allow them to make fully informed decisions about gender transition. Additionally, employing strategies to reduce the negative consequences of medically unsupervised hormone use would be valuable. Supporting individuals to make regular use of health care services would diminish the impact of potentially hazardous practices. Regular monitoring facilitates the opportunity to intervene quickly (see Appendix 7, Medical/prescriptive vs. Harm reduction/Client-directed approaches).

To optimize access, such programs are frequently located in community-based organizations. These programs could provide overall health services to people who may otherwise experience multiple barriers. Multidisciplinary teams of general physicians, nurse practitioners, social workers, and transgender peer counselors, could form a network. Referral to specialties such as endocrinology, psychiatry, surgery, etc. would be requested when needed.

These two approaches may initially appear to be dramatically different. In actual practice, most programs combine elements of each. For example, the Callen-Lorde Community Health Centre is staffed by physicians and nurses, but hormone protocols are consistent with a harm reduction approach. Other services include advocacy. In contrast, the Fenway Community Health Centre is considered by some to be community-oriented, but its standards for hormone administration are viewed by many to be excessively restrictive and go far beyond the HBIGDA standards (Fenway Community Health. See Appendix 4a. for details of this and other international programs).

Proposed Service Delivery Models

While some transgendered people do not require assistance relating to their gender identity or expression, crossdressers and those undergoing gender transition often require a wide range of physical, psychological and social health services (Burnham, 1999; Goldberg et al., 2003; HBIGDA, 2001). From the recent Survey (see Appendix 1), several different service delivery models were proposed:

(a) a transgender health centre
(b) an informal network of practitioners, and
(c) the expansion of existing health programs to include a transgender-specific component.

Transgender health centers function as a centralized base for care in a geographic region. Gender clinics tend to be tied closely to medical research, teaching, and practice facilities, while transgender health centers tend to be community-based initiatives, often operating as a collaboration between one or more nonprofit organizations and/or public health facilities.

In regions without centralized services, transgendered people often get services through a network of practitioners in private practice, often with transgender community groups passing on referral information to community members through word of mouth or public referral lists. In some regions, a network operates extremely informally and the threshold for being included in the network is simply having an interest in working with transgender people (without necessarily having specialized skills or experience). In others, there are more stringent requirements (e.g., commitment to following the HBIGDA Standards of Care, specialized training in transgender medicine, experience providing services to transgender people). In certain regions, community health centres, lesbian/gay/bisexual community centres, HIV/AIDS organizations, and other public health facilities have developed transgender-specific health services and resources.

Transgender community groups may play a significant role in health care delivery. Peer-based services include facilitation of group support and individual peer support, assistance with housing, advocacy, education of consumers and health care professionals, and assistance with name change and other legal forms. In programs such as the Ingersoll Gender Center, Asian & Pacific Islander Wellness Center, Positive Health Project, and The 519, peer lay services are combined with professional medical care to ensure access to a professional level of counseling, diagnosis/assessment, and management of physical aspects of gender transition (e.g., electrolysis or other forms of hair removal, surgery, hormones).

A comparison of the types of services provided along with staffing from a variety of international centers appears in Appendix 8.

Program Evaluation, Education, Research

As mentioned earlier in this report, there is a profound need for an ongoing evaluation process of any new gender service. All persons seeking care from this service could be asked to participate in this process. This data is crucial to all parties (clients, caregivers, governing bodies, payers, and international groups who may wish to compare their approaches). Determining which interventions are most effective is a top priority.

Ongoing broad-based education activities are a necessary component part of establishing high standards of care, recruiting and educating skilled professionals, and decreasing stigma, discrimination and abuse (see Appendix 9 for some case histories which highlight the issue). This could be accomplished by creating ongoing education for all clinicians, policy makers and any other stakeholder groups. Trans People in the Criminal Justice System, written by Joshua Goldberg for the Justice Institute of BC and the Women/Trans Dialogue Planning Committee, is an excellent example of an educational module (see Appendix 10).

Transgender health research is an emerging discipline, and the American Public Health Association emphasized in its resolution regarding transgender health the need for research to "enable a better understanding of the health risks of transgendered individuals, especially the barriers they experience within health care settings" (American Public Health Association, 1999). A new transgender health program could facilitate community-based research directed by interested persons or groups, with appropriate consent sought from all potential participants. Scholarly work in this discipline should be encouraged.

Overall Recommendations

1. Create a new community-based Transgender Health Centre in Vancouver to coordinate referrals, case management, education, advocacy, outreach, evaluation, and research. This would best be located at a Health Clinic.

2. Establish a professional advisory committee comprised of representatives from the transgendered community, VCHA, health care providers, and academic experts.

3. Employ the principles developed by primary Health Care Reform and Harm Reduction movements to articulate the values that will guide the development of a new Transgender Health System

4. Adopt the Harry Benjamin International Gender Dysphoria Association (HBIGDA) Standards of Care. Endeavour to provide all services identified in these standards.

5. Require all members of the clinic, along with affiliated organizations, to follow the HBIGDA standards of care, along with specific clinical guidelines.

6. Develop clinical guidelines for all practitioners to ensure professional competence in the various specialty transition/crossdressing services. These should include specialty input from endocrinologists, surgeons, speech therapists, counselors and electrologists (or other hair removal specialists). In addition, post-operative care must be provided.

7. Develop a program evaluation component such that data from all clients is compiled and subsequently analyzed. Outcome measures must be articulated by the advisory group and reported to the VCHA.

8. Develop a resource list of professionals and agencies throughout the province who provide services to transgendered individuals and their family members. These providers of care must abide by the HBIGDA standards.

9. Make information about health resources available through a website and quarterly newsletters.

10. Develop a province-wide toll-free phone line, so that service users and service providers can obtain information and assistance in crisis situations or with reference to new referrals.

11. Encourage the adoption of a harm reduction approach to hormone prescription and maintenance.

12. Educate primary care providers about cross-gender hormone use, and provide sample protocols and a list of endocrinologists with expertise in transgender medicine.

13. Encourage the advisory committee to develop strategies to reach populations under-represented in consultation and planning.

14. Assist peer support groups in their role as health care providers (e.g., subsidize crisis intervention training and other professional development for peer support leaders).

15. Create a third-party body which could act as a complaint centre. Follow the lead that many hospitals and community clinics have adopted for the resolution of consumer complaints.

16. Provide ongoing, continuing medical education in the area of transgender medicine.

17. Create a working group of VCHA educators, health providers and transgendered community members to develop Transgender Health Information packages, workshop curricula, an interactive website, and education materials for youth and secondary/post-secondary institutions. As mentioned, specific educational materials for family doctors is crucial. The survey indicated that the majority of people were receiving transgender care from their family doctors. Specific clinical guidelines for appropriate care could be provided through the website or mailed directly to family doctors.

18. Work with the Medical Services Commission, the Ministry of Health Services, and other health governance bodies to ensure access to essential medical and surgical services.

19. Create a formal mechanism through a professional advisory committee to sustain ongoing collaboration between health planners, health practitioners, and service users.

APPENDICES

Note: any that are not available online can be accessed by emailing joshua_goldberg@vrhb.bc.ca

1. *Community Survey: Transition/Crossdressing Services in BC – Final Report.* Available online at http://www.transgender.org/transcend/survey/

2. *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders* (6th ed.). Available online at http://www.hbigda.org/socv6.html

3. *Bibliography*.

4. *BC Trans-specific Supports: Resource Listings* (available online at http://www.transalliancesociety.org/contact/support.html or http://www.zenithfoundation.ca/other_res.shtml) and *Transgender Health Programs*.

5. *International Conference on Transgender Law and Employment Policy (ICTLEP) Health Law Standards of Care for Transsexualism*. Available online at http://www.transgendercare.com/guidance/resources/ictlep_soc.htm

    5a. Comparison of HBIGDA and Health Law standards of care for adults

6. Materials from Dimensions Program, Castro-Mission Health Center, San Francisco. Available online at http://tghealth-critiques.tripod.com
    - *Flow Chart for New Patient Continuing Transgender Hormonal Treatment*
    - *New Patient Flow Chart for Transgender Hormonal Treatment*
    - *Treatment Guidelines for FTM Transition*
    - *Treatment Guidelines for MTF Transition*
    - *Consent for Transgendered Patients Continuing Hormones*
    - *Informed Consent for Estrogen Therapy for Male to Female Transition*
    - *Informed Consent for Testosterone Therapy for Female to Male Transition*

7. *Medical/Prescriptive vs. Harm Reduction/Client-directed Approaches* and *The HBIGDA (2001) Standards of Care: A Mixed Approach*

8. *Comparison Charts: Transgender Centres/Gender Clinics, LGBT Centres with Transgender Health Component, Community Health Centres, HIV/AIDS Organizations*

9. *Transgender Access to Medical Care: Stories.*

10. *Trans People in the Criminal Justice System: A Guide for Criminal Justice Personnel* (in press – not yet available for public release)