Transition and Crossdressing Service Delivery: A review

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Introduction

While there is little consensus on the definition of *transgender* (indeed, the definition of this term is the subject of heated debate), in this review *transgender* (and its abbreviation, *trans*) refers to people who have a gender identity that is different than their birth sex, and/or express their gender in ways that contravene societal expectations of the range of possibilities for men and women. This may include crossdressers, drag kings/queens, transsexuals, people who are androgynous, Two-Spirit people, and people who are bi-gendered or multi-gendered.

A preliminary draft literature review underway for the Ontario Public Health Association (Raj, 2003) identifies hundreds of books and articles discussing the specific physical, mental, social, spiritual, and sexual health needs of trans people, and additional health needs of subpopulations within trans communities (youth, seniors, parents, families, Two-Spirit people, people of colour, sex trade workers, people with low incomes, people with disabilities, prisoners, and lesbian/gay/bisexuals). Because a comprehensive review of all trans health needs was not possible within the time available, I have focused my review of the literature on health needs relating to gender transition and crossdressing. However, as stated in the recent VCHA/community survey report, future work should include the development of "strategies to identify and address the broader health needs of transgendered people and family members" (Goldberg, Matte, MacMillan, & Hudspith, 2003, p. 26).

Some definitions of transgenderism include people who are intersex. Intersex people are "born with sex chromosomes, external genitalia, or an internal reproductive system that is not considered 'standard' for either male or female" (Intersex Society of North America, n.d.) Although some intersex people are also transgendered (and thus share some health needs with non-intersex trans people), gender identity and physical sex are not the same (Diamond, 2002), and intersex people have physical and mental health needs unrelated to gender identity; accordingly, treatment guidelines for intersexuality are not the same as those for gender dysphoria or gender transition (Intersex Society of North America, 1994; Diamond & Sigmundson, 1997; Diamond, 1999). As intersexuality is outside my area of expertise, I have not included materials on the specific health needs of intersex people (unrelated to gender transition/crossdressing) in this review.[1]

Standards of Care for Transgender Medicine

The Harry Benjamin International Gender Dysphoria Association (HBIGDA)'s *Standards of Care for Gender Identity Disorders* (2001) purports to represent a "professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders". However, while the HBIGDA guidelines are arguably the most familiar to service providers and service users, and used by some practitioners (e.g., Gender Dypshoria Program of Central Ohio, 2000; Green Mountain Gender Clinic, 2001), very few of the service providers surveyed in this review followed the HBIGDA guidelines. This suggests that while the HBIGDA guidelines may provide some theoretical guidance, there is little professional consensus about actual best practices.

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[1] The Vancouver Centre for Sexual Medicine Gender Clinic's services included assessment and treatment of intersex people. No steps have yet been taken to assess the impact of the Clinic's closure on intersex people and to determine a plan to address any resulting gaps in service delivery.

Standards of Care for Adults

HBIGDA's Standards of Care for Gender Identity Disorders

The HBIGDA *Standards of Care* (2001) focus on psychological assessment/diagnosis of gender identity disorders, and prescribe one or more elements of "triadic therapy": "real-life experience" (RLE), hormone therapy, and surgery. While the HBIGDA *Standards of Care* do include specific guidelines (e.g., three months of RLE or psychotherapy before hormone prescription/chest surgery, one year RLE before genital surgery), the authors encourage practitioners to be flexible in their application of the standards:

> Clinical departures from these guidelines may come about because of a patient's unique anatomic, social, or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol. These departures should be recognized as such, explained to the patient, and documented both for legal protection and so that the short and long term results can be retrieved to help the field to evolve. (HBIGDA, 2001)

This call for flexibility has been used by many service providers (particularly psychiatrically-oriented gender clinics) to support more stringent restrictions than those laid out in the HBIGDA *Standards* (Purnell, 1998). One psychologist commented:

> Because the SOC were minimal standards, they frequently were (and sometimes still are) zealously overinterpreted. Access to hormones and surgery were oft-promised and seldom delivered, and were, in fact, frequently used like carrots at the end of stick. Some transsexuals were kept in abeyance for years with false promises. Others were required (read forced) to make changes in their sexual orientation, marital status, career, manner of presentation, name, and physical characteristics. (Denny, n.d.)

Restrictions beyond the HBIGDA *Standards* continue to be standard practice. For example:

- The Gender Identity Clinic of New England (GICNE) requires patients to be assessed by three individual practitioners and then to appear twice before a board comprised of the practitioners and a Christian counselor (GICNE, n.d.).
- The *Italian Standards of Care for Sex Reassignment in Gender Identity Disorder* (Ravenna, 1998) extend the RLE to six months prior to hormone prescription and two years prior to surgery.
- The Monash Gender Clinic extends the pre-surgical RLE to two years (Monash Gender Clinic, n.d.).
- The Gender Identity Clinic at Charing Cross Hospital requires trans people who are married to have completed divorce proceedings before hormones will be prescribed (Reid, 1998). Patients must demonstrate "stability" for two consecutive years, including full-time employment for at least one year, before being approved for surgery (Barrett, 1998).
- Fenway Community Health requires that people seeking hormone prescription be over 21, have resolved all outstanding litigation (e.g., divorce, child custody), must not smoke or use tobacco products, have a minimum of 20 sessions of counseling specific to gender issues, a minimum 12 months of sobriety, and a pre-existing support network (Fenway Community Health, n.d.-a).
- The Toronto Gender Identity Clinic, run by the Centre for Addiction and Mental Health (CAMH), was the most restrictive of all the programs surveyed in this review: an extended RLE of one year is required prior to hormone prescription and two years prior to surgery; additionally, a person undergoing RLE must be employed, volunteering, and/or studying full-time for the duration of the RLE; must undergo legal change of all identification; and must not have a co-existent mental illness or considered to be abusing drugs/alcohol (CAMH, 2003).[2]

[2] Although CAMH does not explain the basis for its guidelines, they closely resemble German standards of care (Becker, Bosinski, Clement, Eicher, Goerlich, Hartmann, et al., 1998).

Health Law Standards of Care for Transsexualism

The *Health Law Standards of Care for Transsexualism*, also known as the ICTLEP guidelines, were "developed and adopted by consensus over a two-year period by the Health Law Project of the International Conference on Transgender Law and Employment Policy" (Health Law Project, 1993). While few services explicitly state that they are following the ICTLEP guidelines, those operating on a harm reduction principle (see page 11) often use an approach and guidelines similar to those set by ICTLEP (Dimensions, 2000c, 2000d; Flaherty, Franicevich, Freeman, Klein, Kohler, Lusardi, et al., 2001; Perez-Arce, 2000).

The ICTLEP guidelines reflect a major shift in the approach to trans medicine, from treatment being based on the assessment and diagnosis of a medically classifiable disorder (HBIGDA, 2001) to treatment based on the informed consent of a person mentally competent to make decisions about their care (Israel & Tarver, 1997; Health Law Project, 1993; Lev, 2000; MacDonald, 1999). The ICTLEP standards state that physicians should provide hormones upon request if the physician believes hormones will not aggravate a pre-existing health condition, the patient agrees to medical screening for side effects through periodic blood checks, and the patient and their spouse sign informed consent and waiver of liability forms; transition surgeries should be performed upon request if the surgeon believes the surgery will not aggravate a pre-existing health condition, the surgeon can verify that the patient has been taking hormones for at least one year, and the patient and their spouse sign informed consent and waiver of liability forms. To assist in ensuring patients are fully informed of risks and benefits, the ICTLEP standards require that all physicians provide prospective patients with statistics on the numbers of trans people treated per year, and the number and general nature of complaints or complications.

The ICTLEP standards were based in large part on complaints about the HBIGDA *Standards of Care* by trans people frustrated with barriers to accessing care (MacDonald, 1999). The clinical foundation of the HBIGDA *Standards* has also been debated, with some practitioners arguing that there is insufficient clinical research to determine what standards result in the best clinical outcomes for trans people (Flaherty et al., 2001; Health Law Project, 1993; Lawrence, 1999). In a 1997 interview, Richard Green, the President of HBIGDA, admits that the HBIGDA *Standards*' requirements are not necessarily motivated primarily by evidence-based research, but rather by politics and power:

> Public funding and insurance companies are refusing to pay for necessary treatment and so to the extent we can continue to exert pressure on public authorities to pay for treatment is to be able to demonstrate to them that we have professional criteria – that we are not just allowing someone who wants to do something to just do it because then they can say well it's not for us to pay – so we have a difficult road to walk between acknowledging a variety of treatments for people who need them and at the same time maintaining professional standards so that we have a legitimate base to ask for financial, political and legal support.

The inclusion of mandatory psychological assessment and diagnosis in earlier versions of the HBIGDA *Standards* was of particularly concern to the authors of the ICTLEP guidelines. The Health Law Project (1993) argued that "many, if not most, of the patients doctors see for gender medical services (hormones; surgery) do not require any psychological services." The revisions of the HBIGDA *Standards* in 1998 and 2001 addressed this criticism by removing the set length of time required for psychotherapy. However, a number of therapists specializing in trans medicine (Anderson, 1997; Bower, 2001; Lev, 2002; MacDonald; 1999; Vitale, 1997) suggest that the HBIGDA *Standards'* emphasis on assessment and diagnosis as a prerequisite for treatment continues to pose problems for both the trans client and the mental health practitioner:

> The trap is that, in order to be given hormones and surgery within the conditions prescribed by the SOC, the first step is to be classified as "transsexual", and, to successfully be classified as "transsexual", one must present symptoms which conform to the clinician's list of recognised symptoms. As this list of symptoms is drawn from observation of people who are only too well aware that if they require treatment they must appear to conform to those very symptoms, we are trapped in a self-perpetuating cycle of deception and the chances of obtaining reliable data from clinical observations are laughably slim. (MacDonald, 1999)

Another key difference remaining between the ICTLEP guidelines and the most recent version of the HBIGDA *Standards* is the requirement of RLE as a precondition to hormones and surgery in HBIGDA (which is not present in the ICTLEP guidelines). The mandatory RLE is problematic for numerous reasons. The very concept presupposes that the only people who could benefit from access to hormones and surgery are those who want to cross-live full-time and have a gender identity that is opposite to their birth sex. However, some people who do not meet the *DSM-IV* criteria for GID nevertheless experience discomfort with their sex or gender that may be alleviated by hormone therapy and/or surgery (Hage & Karim, 2000); Lawrence (1999) goes further to describe some males who wish to have a breasts and vagina to satisfy deeply felt sexual desires, without having a gender identity of a woman or wishing to live as a woman.[3] Even for those trans people who have a strong cross-gender identity, not all can cross-live full-time: some trans people are unwilling to disclose their status as trans to employers, friends and family, or others as dictated by the RLE (Carroll & Gilroy, 2002). Starting RLE prior to hormones and electrolysis/chest surgery also means trans people are forced to live as visibly gender-variant people (e.g., FTM with a large chest using a men's washroom, MTF with visible beard shadow trying to access women's services), resulting in greater risks of hate-motivated harassment, discrimination, and violence (Lawrence, 2001b). Additionally, the requirement of full-time immersion in mainstream society as part of RLE penalizes trans people with chronic illness or disability that limits the capacity to work/volunteer/study full-time; people who cannot find work or who work in jobs not recognized as "real" employment (e.g., parenting, sex trade work); trans immigrants and refugees who do not have legal status to work; and those without the financial resources to pay for legal name change, new clothing, services not covered by public health insurance such as electrolysis, and the other expensive processes involved in full-time RLE (Raj, 2001).

RLE is emphasized by the HBIGDA *Standards* as necessary to prevent postsurgical regret. However, in an analysis of postsurgical outcome studies, Rachlin (1999) concluded that key determinants of satisfaction post-surgery had very little, if anything, to do with duration of RLE. Similarly, a more recent study of post-operative MTF transsexuals (n=232) found that functional results of surgery and number of postoperative complications were the key factors associated with regret and satisfaction following genital surgery; duration of hormone therapy, duration of RLE, hours of preoperative psychotherapy, and degree of preoperative family support were not significantly associated with either satisfaction or regret following genital surgery (Lawrence, 2001a). Clinicians are beginning to ask, if there is no clinical evidence to support the necessity of the RLE, why is it mandatory for trans people seeking treatment? Lawrence (1999) concludes:

> 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 SRS. It is merely a tradition that has been enshrined as fact.

While the HBIGDA *Standards* have incorporated some of the aspects of the ICTLEP guidelines, the fundamental distinction between a psychological assessment process vs. assessment of ability to provide informed consent remains, as does the RLE requirement. These contentious elements of treatment should be carefully considered as part of the development of a new transition/crossdressing service plan. Additionally, if the HBIGDA *Standards* are adopted, measures should be taken to ensure the encouragement of flexible application within the *Standards* is not used to create unnecessary and harmful barriers to accessing care.

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[3] As a contact for the BC FTM Network, I have been receiving steadily increasing number of requests for advocacy and peer support from butch women who do not identify as men but still feel chest surgery is desirable for their personal comfort and safety. In consulting with surgeons to see if they will waive the RLE and hormonal requirement, a number have indicated that they are also seeing an increase in these types of requests.

Table 1: Comparison of HBIGDA and Health Law standards of care for adults

	HBIGDA *Standards of Care* (2001)	Health Law Standards (1993)
approach	psychiatric, psychological, medical, and surgical management of gender identity disorders	people have the right to express their gender identity through changes to their physical appearance, including the use of hormones and reconstructive surgery
indication treatment is needed	concerns/uncertainties/questions about gender identity persist during a person's development, become so intense as to seem to be the most important aspect of a person's life, or prevent establishment of relatively unconflicted gender identity	a person says they need hormones/surgery to be able to express their gender identity
treatment	diagnostic psychological assessment, psychotherapy, real-life experience, hormones, surgery	medical assessement, hormones, surgery
mental health professionals		
role	1) diagnose the individual's gender disorder 2) diagnose and arrange treatment of co-existing psychiatric conditions 3) counsel individual about range of treatment options and their implications 4) psychotherapy 5) ascertain eligibility & readiness for hormones/surgery 6) make formal recommendations to medical and surgical colleagues 7) document patient's history 8) be a colleague on a team of professionals with an interest in gender identity disorders 9) educate family members, employers, and institutions about gender identity disorders 10) be available for follow-up of previously seen gender patients	involvement sought only if: ▪ the physician feels the patient has a mental illness that will be worsened by hormones/surgery or that prevents the patient from making a fully informed decision, or ▪ the patient requests involvement of a mental health professional
minimum credentials	1) master's or a more advanced degree, in a clinical behavioral science field 2) specialized training and skill in assessment of DSM-IV/ICD-10 Sexual Disorders 3) documented supervised training and competence in psychotherapy 4) continuing education in the treatment of gender identity disorders	not discussed
content of letter recommending hormones/surgery	1) patient's general identifying characteristics 2) initial and evolving gender, sexual, and other psychiatric diagnoses 3) duration and content of evaluation/tx 4) eligibility criteria that have been met, therapist's rationale for hormones/surgery 5) degree to which patient has followed and will continue to follow Standards of Care 6) whether the author is part of a gender team 7) welcome to call author to verify contents of letter	no letter of recommendation required
minimum requirement for psychotherapy	no set terms; depends on recommendations of mental health professional from initial assessment	none
goals of psychotherapy	long-term "stable lifestyle with realistic chances for success in relationships, education, work, and gender identity expression"	not discussed

	HBIGDA *Standards of Care* (2001)	Health Law Standards (1993)
hormones		
minimum requirement for hormones	1) letter from one mental health professional 2) 18+ years of age 3) demonstrable knowledge of what hormones can/cannot do and their social benefits/risks 4) documented RLE of at least three months, OR a period of psychotherapy of duration specified by the mental health professional (usually 3+ months), OR person is taking hormones of unmonitored quality and without supervision 5) patient has had further consolidation of gender identity during RLE or psychotherapy 6) patient has improved or continuing stable mental health (e.g., satisfactory control of co-existing mental illness, substance abuse) 7) hormones will likely be taken responsibly	1) physician believes hormones will not aggravate a pre-existing health condition 2) patient agrees to medical supervision of side effects through periodic blood checks 3) patient and their spouse are informed of the numbers of trans people treated by the physician in a year, and the number and general nature of complaints or complications 4) patient and spouse sign informed consent and waiver of liability forms
surgery		
minimum credentials / actions	1) surgeon should be a Board-certified urologist, gynecologist, plastic/general surgeon; have specialized competence in genital reconstructive techniques and documented supervised training with a more experienced surgeon; have therapeutic skills reviewed by peers; and attend conferences where new techniques are presented 2) surgeon must talk with at least one of the mental health professionals to verify content of letters 3) medical conditions must be monitored and the effects of the hormonal treatment upon the liver and other organ systems investigated 4) medical record should contain written informed consent for the specific surgery	1) physician believes surgery will not aggravate a pre-existing health condition 2) surgeon can verify the patient has been taking hormones for at least one year 3) patient and their spouse are informed of the numbers of trans people treated by the physician in a year, and the number and general nature of complaints or complications 4) patient and spouse sign informed consent and waiver of liability forms
minimum requirement for chest surgery	1) letter from one mental health professional 2) FTM: same time as starting hormones 3) MTF: after 18 months of hormones	
minimum requirement for genital surgery	1) letter from two mental health professionals (at least one psychiatrist/Ph.D. clinical psychologist) 2) legal age of majority (in patient's country) 3) 12 continuous months of hormones for those without a medical contraindication, OR person has lived convincingly as a member of the preferred gender for a long period of time and is assessed to be mentally healthy after a requisite period of psychotherapy 4) 12 months of successful continuous full timeRLE 5) regular participation in psychotherapy throughout the RLE if recommended by mental health worker 6) demonstrable knowledge of cost, required lengths of hospitalizations, likely complications, and post-surgical care for various surgical approaches 7) awareness of different competent surgeons 8) demonstrable consolidation of gender identity 9) demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (including control of problems such as co-existing mental illness, substance abuse, suicidality)	

Standards of Care for Children and Adolescents

Much of the emphasis in the psychiatric literature is the accurate diagnosis of Gender Identity Disorder in children and adolescents (Cohen-Kettenis & van Goozen, 1998; di Ceglie, 2000; HBIGDA, 2001; Money, 1994; Money & Russo, 1981; Rekers & Kilgus, 2001; Royal College of Psychiatrists, 1998). In 1980, "Gender Identity Disorder in Children [302.6]" was created as a classification in the *DSM-III* (and diagnostic criteria expanded in the *DSM-IV*), and in 1992 the *ICD-10* followed suit (di Ceglie, 2000).[4]

Concerns have been expressed that the diagnostic criteria laid out in the *DSM-IV* are too broad, pathologizing cultural nonconformity (especially in boys) and normal behaviors such as preference for playmates of the opposite sex (Wilson, 2002). Additionally, as most children who were diagnosed with GID grow up to be non-transgendered gay men or lesbians (di Ceglie, 1995; HBIGDA, 2001; Royal College of Psychiatrists, 1998; Zucker & Bradley, 1995), some critics suggest the diagnostic criteria are more clinically predictive of adult homosexuality rather than for adult transgenderism (Burke, 1996; Minter, 1999; Pleake, 1999; Wilson, 2002).

Given the debate about the diagnosis and assessment of GID in children, it is perhaps unsurprising that treatment and desired outcomes are equally contentious. Clinicians operating from the belief that transgenderism is bad and that treatment is necessary to prevent a child from becoming a gender or sexual "deviant" later in life often attempt to suppress a child's cross-gendered identity or expression (fantasy, language, play, dress, etc.) through parental punishment and psychological behavioral modification techniques (Burke, 1996; Minter, 1999; Rekers, 1995; Rekers & Kilgus, 2001). According to a woman who spent three years in a residential adolescent psychiatric facility for being an "inappropriate female":

> The staff was under orders to scrutinize my femininity: the way I walked, the way I sat with my ankle on my knee, the clothes I wore, the way I kept my hair... If I didn't emerge from my room with foundation, lip gloss, blush, mascara, eyeliner, eye shadow and feathered hair, I lost points. Without points, I couldn't go to the dining room, I couldn't go anywhere. (Scholinski, 1997, x)

Critics of this "policing" approach argue that cross-gendered behaviour is not intrinsically problematic; that treatment should only be offered if a child is experiencing internal distress about their gender; and that forcing children to lie, keep secrets, or conform to gender norms causes rather than alleviates distress (Burke, 1996; Israel & Tarver, 1997; Minter, 1999; Sharp, n.d.; Xavier, Sharp, & Boenke, 2001). The San Francisco Human Rights Commission (1996) and the American Public Health Association (1999) condemned the use of a GID diagnosis to try to neutralize the identity of children believed to be "pre-transsexual" or "pre-homosexual" (American Public Health Association, 1999, 35).

The standards of care set by HGBIDA (2001) are nearly identical to those in a 1998 position statement by the Royal College of Psychiatrists (RCP). According to both set of guidelines, the focus of treatment should be "reducing distress the child experiences from his or her gender identity problem and other difficulties" (HBIGDA, 2001). Pleak (1999) suggests that therapists may need to "intervene in the parents' extremely negative responses and overreactions to their child's cross-gender behavior" (p. 44), including open discussion of the parents' and the therapist's goals, providing information about childhood cross-gender behaviours and associations with homosexuality later in life, offering a non-pathologized view of homosexuality and bisexuality, and promoting parental acceptance and love regardless of their child's sexual orientation or gender. Israel & Tarver (1997) suggest that therapists and other health practitioners may also need to liase with a trans youth's school, to ensure that teachers and administrators are being respectful and have a plan to prevent and address peer harassment or violence.

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[4] The *DSM-IV* groups adolescents with adults (302.85, "Gender Identity Disorder in Adolescents or Adults").

Although gender identity is felt to be more fluid in children and adolescents than adults, HBIGDA and RCP guidelines recognize that some children and adolescents develop a very strong and persistent cross-gender identity, and treatment options include gender transition. HBIGDA discusses the possibility of supporting the child to "assume a gender role consistent with his or her gender identity" – that is, to use a name, clothing, pronouns, and other manifestations of gender that are consistent with their sense of self, regardless of their birth sex. Although there is caution that extensive exploration of psychological, family and social issues is necessary before considering physical intervention, physical transition is also discussed as a possible course of action for adolescents who "demonstrated an intense pattern of cross-sex and cross-gender identity and aversion to expected gender role behaviors" throughout childhood (HBIGDA, 2001), are experiencing significant increase of gender distress with the onset of puberty, and, if legal minors, have parental consent (Cohen-Kettenis & van Goozen, 1998). In a followup study of adolescents accepted for hormonal and surgical treatment after careful screening at a gender clinic in Utrecht that specializes in gender identity issues in children and adolescents, Smith, van Goozen, & Cohen-Kettenis (2001) found that those treated during adolescence experienced significantly *better* surgical and psychological outcomes than transsexuals treated later in life.

The HBIGDA and RCP standards outline three categories of physical interventions: (1) those that are fully reversible (the use of hormones to delay the physical changes of puberty), (2) those that are partially reversible (the use of hormones to masculinize/feminize the body), and (3) those that are irreversible (surgeries). Because gender identity development is felt to be fluid in children and adolescents, HBIGDA and RCP recommend delaying irreversible physical interventions as long as possible, and moving slowly and sequentially through the stages to give the adolescent and family members time to adapt. Delay of physical pubertal changes may be initiated after an adolescent reaches Tanner Stage Two of pubertal development; masculinizing or feminizing hormones may be prescribed after age sixteen. According to the HBIGDA and RCP standards, youth under the age of eighteen are not eligible for surgeries.

Israel and Tarver (1997) argue that maturity and physical development vary so greatly that arbitrary age limits for transition options may not be appropriate in some cases; instead they recommend case-by-case decisions made by the youth, physician, and a therapist with substantial expertise in gender issues (and, if the youth is a legal minor, the parents), with a two-year wait between the initiation of masculinizing/feminizing hormones and genital surgery. They also emphasize that youth services must be free, as most youth do not have financial resources (a finding echoed by Botzer, 1999), and that parental consent should not be required for support and counseling services.

Other youth services surveyed in this review (most notably the Dimensions program, which offers health and social care to LGBT youth in San Francisco; see Perez-Arce, 2000) were not clear in their distinguishment of age guidelines. Given that "youth" can include young adults as well as adolescents, it is not clear if the protocols for hormone use developed by programs such as Dimensions (Dimensions, n.d.-b, n.d.-e., 2000c, 2000d) are being applied to youth who are under the ages of the HBIGDA and RCP standards.

In the recent survey of service users in BC (Goldberg et al., 2003), no children under the age of ten participated, and only three (2%) adolescents completed the survey. It is not clear how many of the 10 participants who identified they were family members to a trans person were parents of trans children under the age of 18, but given the comments of these participants it is likely that most were adult partners/spouses rather than parents of trans youth. Given the lack of articulation of children's, adolescents', and parents' needs in the survey, specific efforts may be needed to ensure that the new system is responsive to the needs of this group of service users.

Additional Protocols and Guidelines

Because this review is intended to assist with the creation of an overall plan for delivery of services, specific endocrinological, hair removal, and surgical techniques/protocols have not been surveyed. However, development of a plan should include information for physicians who may be involved with hormone prescription and monitoring to ensure they are familiar with the options for prescription, recommended baseline tests, and recommendations for ongoing tests to assist with prevention of potentially harmful side effects (e.g., Asscheman & Gooren, 2001; Cascio, 2002; Dimensions, 2000c, 2000d; Gooren, 1999; Israel & Tarver, 1997; Kirk & Rothblatt, 1995; Lawrence, 1998, 2002a). While genital surgery is not currently offered in BC, clinical guidelines will need to be developed relating to FTM chest surgery, MTF breast surgery, hysterectomy and oophorectomy, urological/gynecological followup after genital surgery, facial surgeries, and any other surgical services that are offered in BC (Ako, Takao, Yoshiharu, Katsuyuki, Osamu, & Yutaka, 2001; Bushong, 2002; Hage, 1996; Hage, Becking, de Graaf, & Tuinzing, 1997; Hage, Vossen, & Becking, 1997; Intelligence Engineering, 2000; Israel & Tarver, 1997; Jarolím, 2000; Kanhai, Hage, Asscheman, & Mulder, 1999; Karim, Hage, Bouman, de Ruyter, & van Kesteren, 1995; Karim, Hage, & Mulder, 1996; Kirk, 1998, 2001; Kirk & Rothblatt, 1995; Lawrence, 2002b; Monstrey, Selvaggi, van Landuyt, Blondeel, Hamdi, & Hoebeke, 2001; Ousterhout, 1997; Summers & Li, 2001). Best practices and treatment protocols should also be developed for electrolysis or other hair removal methods (Burnham, 2002; Deboer & Gooren, 2001; James, 2002, 2003).

Beyond standardizing clinical practices relating to transition services, there is increasing consensus among health professionals on the need for more general guidelines to ensure respectful and culturally competent care of trans people. Various health professional associations and community groups have suggested guidelines to improve the quality of health and social care offered to trans people seeking services relating to gender transition/crossdressing. This is particularly crucial in developing services that can adequately meet the needs of trans people with multiple barriers to accessing health services (people of colour, Aboriginal trans and Two-Spirit people, elders, youth, people with disabilities, intersex people who are trans, people living in poverty, sex trade workers, people who are HIV+, people in rural/remote communities, lesbian/gay/bisexual trans people, etc.) A comprehensive review of these materials is outside the scope of this review, but in designing a service plan, guidelines written by and for professionals should be considered (e.g., Australian Medical Association, 2002; Bockting, Robinson, & Rosser, 1998; Brown & Rounsley, 1996; Carroll & Gilroy, 2002; Cook-Daniels, 2002; Dimensions, n.d.-b, n.d.-e, 2000c, 2000d; Ettner, 1999; Feldman & Bockting, 2001; Gay and Lesbian Medical Association, 2003; Gay, Lesbian, Bisexual, and Transgender Health Access Project, n.d.; Grossman & D'Augelli, 2003; Haynes, 2001; Israel & Tarver, 1997; Leslie, Perina, & Maqueda, 2001; Lombardi, 2001; Raj, 2001; St. Claire, 2001), as should the guidelines recommended by service users (e.g., Burnham, 1999; Feinberg, 2001; Gender Education & Advocacy, 2001; Goldberg and Lindenberg, 2001; LGTB Population Health Advisory Committee & The Centre, 2000; MacFarlane, 2003; The 519, n.d.-c; The Wellness Project, 2001a, 2001b).

Transition/Crossdressing Service Delivery Models

Through an internet search and a search of medical and psychological journal citations, I found information about 35 programs providing health services relating to gender transition/crossdressing (in Canada, the USA, England, Australia, and South Africa). Thirteen are trans centres or gender clinics, and the remainder are trans health programs within a larger, non-trans-specific organization (nine lesbian/gay/bisexual/trans [LGBT] centres, seven public health clinics, and six HIV/AIDS organizations). Although there are longstanding, publicly-funded trans health programs in several European countries (e.g., Holland, Belgium, Italy, and Germany), I was not able to find any English-language information on any of these programs in my internet and literature search. As the numbers of peer-based trans groups throughout the world made it impossible to provide a detailed comparative review, peer-based trans groups have only been included if their programs illustrate models of collaboration between peer groups and other health providers.

This section is intended to provide a comparative review of models of service delivery, through examining patterns of approach, structure, and function across services. A list of the services and contact information for each of the 35 programs discussed here can be found in Appendix A.

Approach

There are two philosophically different approaches to delivery of gender transition and crossdressing services.

The ***medical/prescriptive*** approach is the model used by many gender clinics (Centre for Addiction and Mental Health, 2003; Damodaran & Kennedy, 2000; di Ceglie, n.d.; Gender Identity Clinic of New England, n.d.; Monash Gender Clinic, n.d.). This model emphasizes practitioner responsibility to screen out people who are "unsuitable" candidates for gender transition (to protect patients from future regrets), and practitioners typically employ various psychological tests to arrive at one of the diagnoses in the *DSM-IV* or *ICD-10* (HBIGDA, 2001) as the basis for recommending treatment. The treatment approach is typically a linear path of assessment/diagnosis, hormone therapy, and 1+ (often 2+) years of RLE, with the final step being surgery. Clinics using this approach are often (but not always) located in psychiatric hospital or university facilities, and are typically staffed by a team of physicians. While some clinics using this approach do follow the HBIGDA *Standards of Care* (2001), many programs follow guidelines that are more restrictive than those set out by HBIGDA (Barrett, 1998; Centre for Addiction and Mental Health, 2003; Fenway Community Health, n.d.; Gender Identity Clinic of New England, n.d.; Monash Gender Clinic, n.d.; Ravenna, 1998; Reid, 1998).

The ***harm reduction/client-directed*** approach is emerging as an adaptation of harm reduction practices used to ensure people who use illegal drugs have access to nonjudgmental health care (Harm Reduction Coalition, 2001). In this framework, the practitioner's role is to assist trans people to get the resources they need to make fully informed decisions about gender transition, to employ strategies to reduce the negative consequences of medically unsupervised hormone use, and to promote regular use of health care services (Dimensions, n.d.-a, n.d.-b, n.d.-c, n.d.-d, n.d.-e, 2000a, 2000b, 2000c, 2000d; Flaherty et al., 2001; Gender Centre, n.d.; Karasic & Kohler, 2000; Kohler, 2000; Lev, 1998; Positive Health Project, n.d.; Smith, 2003; Us Helping Us, n.d.). Programs using this approach are often (but not always) located in community-based organizations providing health services to people who experience multiple barriers to accessing appropriate health care (e.g., sex trade workers, injection drug users, youth, people living in poverty, people who are HIV+, people of colour, and Aboriginal people). Care is often provided by a team of service providers that includes physicians and other types of health/social practitioners working in partnership with trans community groups, and practitioners often offer advocacy and education as well as medical services. While some practitioners using this approach do follow the HBIGDA *Standards of Care* (2001), others reject them as an oversimplified response to the realities of clients' complex identities and needs (Dimensions, 2000c, 2000d), and either determine guidelines on a case-by-case basis (Lev, 1998) or follow a standardized set of guidelines different than those set by HBIGDA (Dimensions, 2000c, 2000d; Flaherty et al., 2001; Perez-Arce, 2000).

While these approaches are philosophically quite different, in practical application some programs combine elements of each. For example, the Callen-Lorde Community Health Centre is a medical clinic staffed by physicians and nurses, but hormone protocols are consistent with a harm reduction approach, and services include advocacy (Callen-Lorde Community Health Centre, n.d.). Conversely, while Fenway Community Health bills itself as a progressive, community-oriented facility (Mayer, Appelbaum, Rogers, Lo, Bradford, & Boswell, 2001), its standards for hormone administration are very restrictive and go far beyond the HBIGDA *Standards of Care* (Fenway Community Health, n.d.-a).

The table on the following page details the differences between these two approaches.

Table 2: Medical/prescriptive vs. Harm reduction/Client-directed approaches

	Medical / Prescriptive	Harm Reduction / Client-directed
clientele	▪ transsexuals (primarily MTF)	▪ any trans person needing assistance
crossdressers	▪ should be screened out	▪ are welcomed
who determines treatment plan?	▪ psychiatrist	▪ directed by client, with health practitioner as resource for information
role of client	▪ compliance with treatment plan	▪ creation and evaluation of treatment plan
role of practitioner	▪ assess/diagnose client ▪ determine treatment plan ▪ evaluate client's progress	▪ provide information and assess client's ability to make fully informed decision ▪ help client create and evaluate treatment plan ▪ help client address issues that are negatively affecting quality of life
disciplines of practitioners	▪ medicine (psychiatry, endocrinology, nursing, surgery, electrolysis) ▪ social work	▪ medicine (psychology, endocrinology, nursing, surgery, electrolysis) ▪ sociomedical (HIV, addiction, mental health) ▪ social work ▪ advocacy, legal aid, employment assistance
focus of treatment	▪ alleviate distress caused by gender dysphoria/GID	▪ provide physical, mental, and social assistance to improve quality of life
tools of treatment	▪ "triadic" therapy: RLE, hormones, surgery	▪ help client get resources to fulfill their desired course of action
progression of treatment	▪ assessment → counseling → hormones → RLE → surgery	▪ depends on client's needs and wishes
frequency of treatment	▪ more frequent initially to guide assessment, tapering as client progresses through transition ▪ treatment complete after surgery	▪ mutually agreed upon by client and practitioner ▪ support available at any stage of transition (including after surgery)
purpose of assessment	▪ diagnose GID/determine if a person is a "true transsexual"	▪ determine if a person is able to make a fully informed decision about treatment options
purpose of counseling	▪ diagnosis/assessment, preparation for and adjustment to new gender role	▪ exploration of options, cope with societal transphobia, broad psychosocial support
RLE / cross-living	▪ goal of RLE: prepare client for permanent gender change, assess readiness for surgery ▪ must accomplish set length of full-time (24/7) RLE to qualify for surgery ▪ during RLE client must be volunteering, working, or in school ▪ during RLE client is expected to use gendered facilities (washrooms, change rooms) of desired gender and to come out to all the people in one's life ▪ RLE necessary to prevent post-surgical regret ▪ emphasis on passing	▪ goal of RLE: help client explore what it might be like to cross-live full-time ▪ desire to cross-live varies among clients, cross-living full-time (24/7) not required ▪ if client wants RLE, time and goals should be set by client with therapist's assistance ▪ client should consider potential negative consequences of RLE (e.g., loss of relationships, job) as part of planning ▪ client's safety and comfort are important in determining course of RLE ▪ client satisfaction post-surgery relates primarily to factors other than RLE ▪ recognition that passing may not be desired or possible
hormone treatment	▪ should not be prescribed on client request but rather as the practitioner deems necessary ▪ once begun, use is continuous for rest of life (cycling is not an option)	▪ may be prescribed upon client request to reduce risk of self-administration of illegally purchased hormones ▪ use may or may not be continuous (cycling may be an option)
approach to surgery	▪ final stage of transition, completing transition process ▪ post-surgical outcome measured by success fitting in to mainstream society	▪ may or may not be desired, may occur at any stage of transition ▪ post-surgical outcome measured by quality of life

Structure

In the recent survey of BC transition/crossdressing service users (Goldberg, Matte, MacMillan, & Hudspith, 2003), three structures for service delivery were discussed: (a) a trans health centre, (b) an informal network of practitioners, and (c) the expansion of existing health programs to include a trans-specific component.

Centralized Service

Trans health centers and gender clinics 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 (Bockting, 2002; Centre for Addiction and Mental Health, 2003; Damodaran & Kennedy, 2000; di Ceglie, n.d.; Monash Gender Clinic, n.d.). Trans health centers tend to be community-based initiatives, often operating as a collaboration between one or more nonprofit organizations and/or public health facilities (Callen-Lorde Community Health Center, n.d.; Flaherty et al., 2001; Ingersoll Gender Center, 2002; LA Gender Center, n.d.; Mayer, Appelbaum, Rogers, Lo, Bradford, & Boswell, 2001; Perez-Arce, 2000; Sherbourne Health Centre, 2003; Smith, 2003; Whitman-Walker Clinic, n.d.).

Informal Network of Practitioners

In regions without centralized services, trans people often get services through an informal network of practitioners. Trans individuals and family members often report positive experiences with a health practitioner to trans groups and to their primary care providers, which then pass on names of these practitioners to others seeking services. Referrals may be made informally in response to individual requests, or through more formal means such as resource guides (FTM International, n.d.; Goldberg & Lindenberg, 2001; Maxey, 1999; Winnipeg Transgender Group, n.d.-a).[5]

In Manitoba, the Winnipeg Transgender Group, a peer-run support and advocacy organization sponsored by the Rainbow Resource Centre (an LGBT community centre), has fostered a network that now includes two community health centers, an adolescent treatment center, a GP, a plastic surgeon, two endocrinologists, a psychologist, a speech therapist, and a hair transplant specialist (Winnipeg Transgender Group, n.d.-a). In Victoria, Transcend Transgender Support & Education Society's resource guide lists 80+ health and social service practitioners who have expressed a willingness to work with trans people and family members.

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 trans 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 trans medicine, experience providing services to trans people). For example, as a precondition to being listed in the Transcend guide, prospective listees were asked to read a 4-page overview of the health and social issues faced by trans people and family members, were interviewed by a Transcend member, and were encouraged (but not required) to make use of Transcend's educational resources to provide training for staff and volunteers (Goldberg & Lindenberg, 2001).

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[5] There are many guides available via the internet, but most are American-specific, limited to surgeons or other specialists, and frequently outdated (for example, the Vancouver Gender Clinic was still listed in all guides reviewed for this project, and was often the only resource listed for western Canada). Although internet guides are easier to keep up-to-date than print guides, they are not accessible to people who do not have access to a computer and/or are not highly fluent in web searches.

Practitioners who operate in isolation can find collegial support and information through online networks. *TransMedicine* (http://groups.yahoo.com/group/transmedicine), an email discussion list specifically for health practitioners (primarily physicians), offers service providers the opportunity to talk with each other about hormone therapy, barriers/access to care, and transgender medical research. Numerous online sites contain free trans medicine archives written by and for physicians (e.g., *International Journal of Transgenderism*, http://www.symposion.com/ijt; TransGenderCare, http://www.transgendercare.com/; Anne Lawrence's site at http://www.annelawrence.com/twr).

Piggyback on Existing Programs

In some regions, community health centres, queer community centres, HIV/AIDS organizations, and other public health facilities have developed trans-specific health services and resources. Trans involvement in service development and delivery may be minimal (Advanced TransCare Health Associates, 2002; Centretown Community Health Centre, n.d.), or there may be extensive collaboration between trans groups and public health facilities (Flaherty et al., 2001; Positive Health Project, n.d.; Proyecto Contra SIDA por Vida, n.d.).

Community health centres (CHCs) are defined by the Association of Ontario Health Centres (n.d.) as "non-profit, community-governed organizations that provide primary health care, health promotion and community development services, using multi-disciplinary teams of health providers". A number of CHCs provide trans-specific services – often as a LGBT health clinic running one night a week at a CHC (Centretown Community Health Centre, n.d.; Navarro, Cazares, Diaz, & Gonzalez, 2002; Perez-Arce, 2000; San Francisco Community Clinic Consortium, n.d.; Sherbourne Health Centre, 2003; Verbena Health Clinic, 2003).

Many queer community centres and programs have expanded their "LGB" (lesbian/gay/bisexual) mandate to include a "T" (for trans). While some queer centres welcome trans people but do not provide resources or services to address trans-specific needs, the centres included in this review offer trans-specific health services (Callen-Lorde Community Health Center, n.d.; Fenway Community Health, n.d.-a, n.d.-b; Lesbian, Gay, Bisexual, and Transgender Community Center, n.d.; Los Angeles Gay & Lesbian Center, n.d.; Perez-Arce, 2000; Rainbow Resource Centre, 2003; San Diego Lesbian, Gay, Bisexual, Transgender Community Center, n.d.; Smith, 2003; The 519, n.d.-a, n.d.-b; Warren, Ritter, & Pollack, 1993; Whitman-Walker Clinic, 2003).

There are high rates of HIV infection among trans people (Bockting, Robinson, & Rosser, 1998; Brennan & Giles, 1996; Clements, Wilkinson, Kitano, & Marx, 1999; Clements-Nolle, Marx, Guzman, & Katz, 2001; Flaherty, 2001; Reback, Simon, Bemis, & Gatson, 2001; San Francisco Department of Public Health, 1999), and HIV/AIDS organizations may be a primary care provider for trans people who do not feel comfortable accessing or are not welcomed at mainstream health services. While some HIV/AIDS organizations serving trans people offer solely needle exchange and other non-trans-specific programs, others have created a range of health programs for those undergoing gender transition or living/working crossdressed (Asian & Pacific Islander Wellness Centre, n.d.; Flaherty et al., 2001; Pink Triangle Services, 2002; Positive Health Project, n.d.; Proyecto Contra SIDA por Vida, n.d.; Reback, Simon, Bemis, & Gatson, 2001; San Francisco Department of Public Health, 1999; Smith, 2003; Tenderloin AIDS Resource Center, n.d.; Us Helping Us, n.d.). The Tom Waddell Health Center initiated a hormone assessment, prescription, and maintenance program through a Transgender Health Clinic running one night per week, with the aim of encouraging trans people with HIV to access the range of primary care services available at the organization (Flaherty et al., 2001; San Francisco Department of Public Health, 2002).

Function

While some trans 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, mental, and social health services (Burnham, 1999; Goldberg et al., 2003; HBIGDA, 2001). However, few of the programs examined in this review provided a full range of services.

1) *Peer support, advocacy, and education*. Virtually all trans peer groups offer group and/or individual support and information to trans people and family members, with many also providing advocacy and education for both service users and service providers. While organizers/facilitators may be professionals or may have paraprofessional training, the services offered are typically at a lay level. As mentioned earlier, peer-based trans groups have only been included in this review if their programs illustrate models of collaboration between peer groups and other health providers (e.g., Goldberg & Lindenberg, 2001; Lesbian, Gay, Bisexual, and Transgender Community Center, n.d.; Positive Health Project, n.d.; Proyecto Contra SIDA por Vida, n.d.; Rainbow Resource Centre, 2003; Tenderloin AIDS Resource Center, n.d.; The 519, n.d.-a, n.d.-b; Vancouver Coastal Health Authority, 1999; White, 2003).

2) *Counseling and diagnosis/assessment*. Many programs entail salaried or contracted mental health professionals (therapists, psychologists, and/or psychiatrists) providing individual/couples/group counseling to trans people (Asian & Pacific Islander Wellness Center, n.d.; Centretown Community Health Centre, n.d.; Gender Dysphoria Program of Central Ohio, 2000; Gender Identity Clinic of New England, n.d.; Ingersoll Gender Center, 2002; LA Gay & Lesbian Center, n.d., Lesbian, Gay, Bisexual, and Transgender Community Center, n.d.; Lev, 2000; San Diego Lesbian, Gay, Bisexual, Transgender Community Center, n.d.; Us Helping Us, n.d.). While some offer assessments of readiness for hormones/surgery (CAMH, 2003; GDPCO, 2000; GICNE, n.d.; Ingersoll, 2002; LA Gender Center, n.d.; LGBTCC, n.d.; Lev, 2000; SDLGBTCC, n.d.), clients are referred to other programs for the management of the physiological and legal aspects of transition, and for services relating to the determinants of health (housing, employment, etc.)

3) *Counseling, diagnosis/assessment, and physical health services*. Some programs offer a combination of counseling, diagnosis/assessment, services, and management of physical aspects of gender transition (e.g., electrolysis, surgery, hormones) (Australian Transgender Support Association-Queensland, n.d.; Bockting, 2002; Centre for Addiction and Mental health, 2003; Damodaran & Kennedy, 2000; Green Mountain Gender Clinic, 2001; Monash Gender Clinic, n.d.; San Francisco Community Clinic Consortium, n.d.; Sherbourne Health Centre, 2003; Whitman-Walker Clinic, 2003). The former Gender Clinic at the Vancouver Centre for Sexual Medicine provided this level of assistance.

4) *Counseling, diagnosis/assessment, physical health services, and social/legal services.* A few programs offer a comprehensive range of services to assist with the various psychosocial aspects of gender transition/crossdressing (e.g., housing, legal and welfare advocacy, employment assistance), and the physical aspects of gender transition (Albany Clinic, n.d.; Callen-Lorde Community Health Center, n.d.; di Ceglie, n.d.; Flaherty et al., 2001; Gender Centre, n.d.; Perez-Arce, 2000; San Francisco Department of Public Health, 2002; Verbena Health Clinic, 2003).

Comparison of Services and Staffing

The tables on the following four pages offer comparisons between the services and staffing of each of the gender clinics/centres, LGBT centres, community health centres, and HIV/AIDS organizations included in this review.

Trans Centres / Gender Clinics

- Albany Clinic (England)
- Brisbane Gender Clinic (Australia)
- Centre for Addiction and Mental Health Gender Identity Clinic, aka "The Clarke" (Canada)
- Gender Centre (Australia)
- Gender Dysphoria Program of Central Ohio (USA)
- Gender Identity Clinic of New England (USA)
- Green Mountain Gender Clinic (USA
- Ingersoll Gender Centre (USA)
- LA Gender Center (USA)
- Monash Gender Clinic (Australia)
- Portman Clinic (England)
- Transgender Clinic, Tom Waddell Health Center (USA)
- Transgender Health Services, University of Minnesota Program in Human Sexuality (USA)

	Albany	Brisbane	CAMH	Gender Centre	GDPCO	GICNE	Green Mountain	Ingersoll	LAGC	Monash	Portman	Tom Waddell	U of MN
Services	♀ only										youth		
Addictions				✓					✓			✓	
Advocacy	✓			✓				✓	✓		✓	✓	✓
Aftercare							✓	✓		✓	✓	✓	
Appearance	✓			✓				✓			✓		✓
Assessment	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
Counseling	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Electrolysis													
Employment	✓			✓									
Food				✓								✓	
HIV/AIDS				✓					✓			✓	✓
Hormones	✓		✓			✓	✓			✓	✓	✓	✓
Housing				✓									
Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mental health				✓				✓	✓		✓	✓	
Peer support			✓	✓	✓			✓	✓			✓	
Referrals	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sexuality									✓				✓
Speech	✓									✓			
Staff	No info		No info				No info						
Counsellor		✓		✓	✓			✓	✓		✓	✓	✓
Endocrinolog.						✓				✓	✓		
GP		✓									✓	✓	✓
Nurse												✓	
Peer support		✓		✓				✓	✓				
Psychiatrist						✓				✓	✓		
Psychologist						✓			✓	✓	✓		✓
Social Worker												✓	

LGBT Centres with Trans Health Component

- Callen-Lorde Community Health Center (USA)
- Fenway Community Health (USA)
- Gender Identity Project, LGBT Community Center (USA)
- LA Gay & Lesbian Centre (USA)
- Rainbow Resource Centre (Canada)
- The 519 (Canada)
- The Centre (Canada)
- Transgender Counseling Program, San Diego LGBT Community Center (USA)
- Whitman-Walker Clinic & Lambda Health Centre (USA)

	Callen-Lorde	Fenway	GIP	LA	Rainbow	519	The Centre (Vancouver)	TCP	Whitman-Walker
Services									
Addictions		✓	✓	✓	✓	✓	✓		✓
Advocacy	✓	✓	✓	✓	✓	✓	✓		✓
Aftercare		✓							
Appearance									
Assessment	✓	✓						✓	planned
Counselling	✓	✓	✓	✓	✓	✓	✓	✓	✓
Electrolysis									
Employment				✓			✓		
Food		✓		✓		✓			✓
HIV/AIDS	✓	✓		✓		✓	✓		✓
Hormones	✓	✓							planned
Housing				✓					✓
Information	✓	✓	✓	✓	✓	✓	✓		✓
Mental health	✓	✓		✓		✓			✓
Peer support		✓	✓		✓	✓	✓		✓
Referrals	✓	✓	✓	✓	✓	✓	✓		✓
Sexuality	✓	✓	✓	✓	✓	✓	✓	✓	✓
Speech									
Staff				No info	No info	No info			No info
Counsellor	✓	✓	✓				students		
Endocrinolog.									
GP	✓	✓							
Nurse	✓	✓							
Peer support			✓				✓		
Psychiatrist	✓	✓							
Psychologist		✓						✓	
Social Worker		✓	✓						

Community Health Centres

- Castro-Mission Health Center (USA)
- Centretown Community Health Centre (Canada)
- Lyon-Martin Women's Health Services (USA)
- Sherbourne Health Centre (Canada)
- Three Bridges Community Health Centre (Canada)
- Verbena Health Clinic (USA)
- Village Clinic/Nine Circles Community Health Centre (Canada)

	CMHC	Centretown	Lyon-Martin	Sherbourne	Three Bridges	Verbena	Village Clinic
Services	youth		♀ only			♀ only	
Addictions			✓	✓	✓	✓	
Advocacy	✓	✓	✓	✓	✓	✓	✓
Aftercare	✓		✓	✓			
Appearance							
Assessment	✓		✓				
Counselling	✓	✓	✓	✓	✓	✓	✓
Electrolysis							
Employment					✓		✓
Food							
HIV/AIDS	✓		✓	✓	✓	✓	✓
Hormones	✓		✓	✓			
Housing				planned			
Information	✓		✓	✓	✓	✓	✓
Mental health	✓	✓	✓	✓	✓		✓
Peer support		✓		✓	✓	✓	✓
Referrals	✓		✓	✓	✓	✓	✓
Sexuality		✓	✓	✓	✓	✓	
Speech							
Staff						No info	
Counsellor	✓	✓		✓	✓		✓
Endocrinolog.							
GP	✓		✓	✓	✓		✓
Nurse				✓	✓		✓
Peer support				✓			
Psychiatrist							
Psychologist	✓						
Social Worker							

HIV/AIDS Organizations

- Asian & Pacific Islander Wellness Centre (USA)
- Oasis (Canada)
- Positive Health Project (USA)
- Proyecto Contra SIDA Por Vida (USA)
- Tenderloin AIDS Resource Center (USA)
- Us Helping Us (USA)

	APIWC	Oasis	Positive Health Project	PCSPV	TARC	Us Helping Us
Services						
Addictions	✓	✓	✓		✓	
Advocacy	✓		✓	✓	✓	✓
Aftercare						
Appearance						
Assessment						
Counselling	✓		✓	✓	✓	✓
Electrolysis						
Employment						
Food			✓		✓	
HIV/AIDS	✓	✓	✓	✓	✓	✓
Hormones						
Housing					✓	
Information	✓	✓	✓	✓		✓
Mental health	✓		✓			
Peer support	✓		✓	✓	✓	✓
Referrals	✓	✓	✓	✓		✓
Sexuality	✓					✓
Speech						
Staff						
Counsellor	✓	✓	✓	✓		✓
Endocrinolog.						
GP						
Nurse	✓	✓				✓
Peer support	✓		✓	✓		✓
Psychiatrist						
Psychologist						
Social Worker			✓			✓

Conclusions

The recent survey of transition/crossdressing service users in BC (Goldberg et al., 2003) concluded that service delivery should be based on the HBIGDA *Standards of Care* (2001), and that a blended structure for services would meet the needs of the greatest number of people. The blended structure is the least contentious of these two issues: as the programs reviewed in this survey show, there are many options for creative and flexible service delivery within a range of facilities. Community health centres, HIV/AIDS organizations, GLBT centres, and other public health facilities in BC may be more willing to consider creating a trans health component to services if they are made aware of the success of programs run by their counterparts. Similarly, it may be more feasible to recruit physicians, nurses, electrologists, speech therapists, counselors, and psychologists to participate if they can see evidence that multidisciplinary teams are working well in other regions. Unfortunately, all the of the programs examined in this review were based in large cities; more is needed to explore options for rural and remote areas without the client base to justify large investments of time and money to create new services.

The approach and guidelines that should form the basis for a new service plan are more difficult issues. The old system followed a medical/prescriptive approach, using standards beyond those suggested by the HBIGDA *Standards of Care*. Practitioners most familiar with the old approach may be reluctant to drastically change it by adopting a harm reduction approach or following the ICTLEP guidelines (some may even feel that the HBIGDA *Standards* are too loose). However, others will likely appreciate having information about the two approaches and an option to choose. For example, many organizations in Vancouver already operate from a harm reduction approach, and may appreciate knowing that programs such as the Transgender Clinic at Tom Waddell Health Center and the Dimensions program at Castro-Mission Health Center have been able to create guidelines for hormone prescription and supervision that fit with this model. For this reason, I have included the consent forms and hormone protocol forms used by Dimensions as Appendix B.

Whatever approach, model, and guidelines are chosen for a new health service delivery plan, recruitment, training, and retention of professionals from the variety of disciplines needed to provide the essential components of care will be an enormous challenge. Few practitioners in BC have clinical training in transgender medicine. As part of this literature review, I contacted several multidisciplinary health services for trans people to ask for advice on implementation. A staff member at one facility wrote:

> The challenges that we're having are in not only finding staff who have experience (far less expertise!) in LGBT health issues, but also in finding staff who want to work for us full-time, particularly physicians. Our ideal is to have a full-time staff team who participate and support each other in all areas of our work. But many physicians are loathe to work in a salaried position in a health centre, preferring the option of private practice or other situations where they bill fee-for-service. We have had several part-time offers from docs who would be willing to work for example, a couple half-days a week, and we'll probably end up having to settle for an arrangement like this for the time being. The other issue is that we are building a practice from scratch and this is not attractive to docs who are used to hustle and bustle. I think there's a bit of wait-and-see out there in the physician community and hopefully as we grow, we will become a more attractive option.

Although the recent federal plan for health care may leave private practitioners and community-based organizations feeling more optimistic about the future of the health care system, many are currently operating with workloads that are already impossible to sustain, and publicly funded health and social care agencies (including regional health authorities) are facing devastating cuts to infrastructure and funding. These political climates will create additional hurdles for the establishment of a new service: service providers and service users are unlikely to be willing to invest time, energy, and money to create something that may only last one fiscal year.

Care will also need to be taken to ensure that peer involvement is sustainable and that trans organizations and volunteers are not being exploited. In BC, no trans groups have funding, paid staff, or office space; although a strong informal infrastructure exists in Vancouver and Victoria, trans individuals and family members outside these cities are tremendously isolated and will need support to be able to participate in a meaningful way in service planning, delivery, and evaluation.

Despite these challenges, it is an exciting time to be involved in trans health service delivery. Programs in other regions have established that it is possible to create programs that are truly collaborative health service and research partnerships between health regions, professionals in private practice, non-profit organizations, and trans community members. I am hopeful we can do the same in BC.

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* Note: this article includes graphic colour photographs taken during surgery.

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Appendix A: Trans Health Programs Included in Review

Trans-specific Centres / Gender Clinics

1) Albany Clinic
Mail: 401 Bury Old Rd, Prestwich, Manchester, M25 1PS England
Tel: 011-44-161-773-2525
Email: info@albany-gender-clinic.com
Web: http://www.albany-gender-clinic.com/main.html

Private fee-for-service clinic in England providing services to male-to-female (MTF) crossdressers and transsexuals. Services include medical testing, counseling, legal and employment assistance, speech therapy, assistance with appearance, and endocrinology. Hormones are prescribed and dispensed directly by the clinic (in person or via mail-order); the focus of the Clinic website is the sale of hormones and other products to assist with transition, and it is not clear what if any standards are used to assess hormone readiness (Albany Clinic, n.d.).

2) Brisbane Gender Clinic
Mail: 484 Adelaide St, Brisbane 4000, Australia
Tel: 011-61-73-227-8679
Fax: 011-61-73-227-8697
Web: http://www.atsaq.com.au/version2/clinic.htm

Staffed by a physician and two trans peer counselors who assist clients in coordinating the various aspects of their care. Hormones may be prescribed through the Clinic, but referrals and regular visits to a psychiatrist and endocrinologist are mandatory for at least two years (Australian Transgender Support Association-Queensland, n.d.) The Clinic follows Queensland standards (which could not be found through a search of the internet and the literature).

3) Centre for Addiction and Mental Health (CAMH) Gender Identity Clinic (aka "The Clarke")
Mail: 33 Russell Street, Toronto, ONT M5S 2S1
Tel: 416-535-8501, ext. 4094
Fax: 416-979-6965
Email: maxine_petersen@camh.net (Coordinator), anne_perry@camh.net (Secretary)
Web: http://www.camh.net/mental_health/gender_identity_clinic.html

Support and time-limited counselling to anyone who wishes to explore issues relating to gender identity or cross-gender expression. Assessment of readiness for hormones/surgery is offered, but criteria are extremely strict (the most strict of any programs surveyed in this review). An endocrinologist is available to assist with hormone prescription/maintenance (CAMH, 2003).

4) Gender Centre, Inc.
Mail: 75 Morgan Street, PO Box 266, Petersham, NSW 2049, Australia
Tel: 011-61-29-569-2366
Fax: 011-61-29-569-1176
Email: gendercentre@bigpond.com
Web: http://www.gendercentre.org.au/

Peer-driven program providing housing, peer support, counseling, advocacy, referrals, social support, and outreach to trans people and family members, and workshops and educational resources for employers, health practitioners, and social workers. Its mandate, philosophy, and structure are similar to the Ingersoll

Centre in Washington (see #8 below) – but with a residential and outreach component aimed specifically at offering refuge and protection to trans people who are homeless or at risk of becoming homeless (Gender Centre, n.d.)

5) Gender Dysphoria Program of Central Ohio (GDPCO)
Mail: PO Box 82008, Columbus, OH, USA 43202
Tel: 614-451-0111
Email: crane@genderprogram.com
Web: http://www.genderprogram.com/contact.html

Private fee-for-service program for people who wish to undergo gender transition (with or without hormones and/or surgery). Individual counseling, group support, and assessment/referrals for hormones and surgery are offered by the Clinic (GDPCO, 2000). The GDPCO follows the HBIGDA *Standards of Care* (2001).

6) Gender Identity Clinic of New England (GICNE)
Mail: c/o Central Connecticut Counseling Associates, 82 Vine Street, New Britain, CT, USA 060502
Tel: 860-225-4672
Web: http://www.gicne.org/

Offers private, fee-for service counseling for people with gender concerns, and assessments of transsexuals to determine readiness for hormones and surgery (GICNE, n.d.). The Clinic follows a modified version of the HBIGDA *Standards of Care* (2001), with an added assessment component: after assessment by the Clinic's psychologist, psychiatrist, and endocrinologist, people seeking approval for hormones or surgery must appear twice before the Clinic's Board (three clinicians that have already assessed the client plus a religious minister who founded the Clinic) for further assessment. The Clinic's affiliated (but independent) peer-run support group, the Twenty Club, provides peer support and information to transsexuals (The Twenty Club Inc., n.d.).

7) Green Mountain Gender Clinic
Mail: c/o 4185 St. George Road, Williston, VT, USA
Web: http://hometown.aol.com/grnmtclin/

Formed by trans medical specialists to coordinate services for transsexuals undergoing gender transition. The Clinic follows the HBIGDA *Standards of Care* (2001), and offers all the services listed in the *Standards* (assessment/diagnosis, counseling, endocrinology, surgery, and post-transition followup) (GMGC, 2001).

8) Ingersoll Gender Centre
Mail: Suite 106, 1812 East Madison Street, Seattle, WA, USA 98122
Tel: 206-329-6651
Fax: 206-860-6064
Email: ingersoll@ingersollcenter.org
Web: http://www.ingersollcenter.org/

Runs peer support groups, organizes social events, and maintains a clearinghouse of information for trans people, family members, and other service providers. Contracted therapists offer fee-for-service assessment, counseling, and exploration of options relating to transition and crossdressing (Ingersoll, 2002).

9) LA Gender Center (LAGC)
Suite 2, 1923½ Westwood Boulevard, Los Angeles, CA, USA 90025
Tel: 310-475-8880
Web: http://www.lagendercenter.com

Group practice of six mental health professionals offering individual/group/couples psychotherapy on issues relating to gender identity, sexual orientation, and sexual dysfunction, as well as psychopharmacology and assessment of co-existing mental illness (Keller, Ring, Vollmer, Turen, Silvestri, & Milrod, 1999). Staff encourage exploration of identity and options, without pressure to conform to any particular gender norms (L.A. Gender Center, n.d.). Follows HBIGDA *Standards of Care* (2001).

10) Monash Gender Clinic
Mail: Gender Dysphoria Clinic, Department of Adult Psychiatry, Monash Medical Centre, 246 Clayton Road, Clayton 3168, Australia
Tel: 011-61-38-541-6303
Web: http://www.tgfolk.net/sites/gtg/monash_intro.html

Multidisciplinary medical clinic co-managed by Monash Hospital and the Monash University of Psychological medicine. The clinic is a mixture of salaried staff and professionals in private practice (psychiatrists, psychologists, plastic surgeons, gynecologists, endocrinologists, and speech pathologists) who operate out of the clinic (similar to the setup of the old Gender Clinic in Vancouver). Services are primarily for transsexuals who want to track towards surgery (Monash Gender Clinic, n.d.). With the exception of a two-year RLE, the clinic follows the HBIGDA *Standards of Care* (2001) and endeavours to directly provide all services outlined by HBIGDA, rather than referring clients to external specialists (Damodaran & Kennedy, 2000).

11) Portman Clinic
Mail: Gender Identity Development Service, Portman Clinic, 8 Fitzjohns Avenue, London, England NW3 5NA
Tel: 011-44-207-794-8262
Fax: 011-44-207-447-3748
Email: gidu@tavi-port.org
Web: http://www.tavi-port.org/Departments/B_PatientServices/gids.htm

Multi-disciplinary clinic providing services to children and adolescents who are experiencing difficulty in the development of gender identity, as well as children of transsexual parents or parents with other gender identity concerns. While it is a service for children and adolescents, parents, schools, and other social agencies involved in the child's life are often heavily involved. Staff include experts in child and adolescent psychiatry, psychology, social work, psychotherapy, and pediatrics (di Ceglie, n.d.).

12) Transgender Clinic, Tom Waddell Health Center
Mail: 50 Ivy Street, San Francisco, CA
Tel: 415-554-2727
Email: barry_zevin@sfgh.org (Medical Director)
Web: http://www.dph.sf.ca.us/chn/HlthCtrs/transgender.htm or http://hathawaypage.com/twhc2/

Comprehensive range of primary care services, including hormone assessment, prescription, and maintenance; urgent care; nutrition assistance; acupuncture; smoking cessation; and a peer support group supervised by a staff social worker (Flaherty et al., 2001; San Francisco Department of Public Health,

2002). Hormones are prescribed according to the ICTLEP guidelines (Health Law Standards, 1993), with informed consent being the only requirement (Flaherty et al., 2001).

13) Transgender Health Services, University of Minnesota Program in Human Sexuality
Mail: Center for Sexual Health, Family Practice and Community Health, University of Minnesota Medical School, Suite 180, 1300 South Second Street, Minneapolis, MN, USA 55454
Tel: 612-625-1500
Email: bockt001@umn.edu (Dr. Walter Bockting, Coordinator)
Web: http://www.med.umn.edu/fp/phs/tgs.htm

One of the first American transgender HIV/AIDS research, prevention, and education programs (running for 11 years), the centre also offers individual and group therapy for trans people of all ages, education seminars for trans people and service providers, and hormone assessment/management.

LGBT Centres with Trans Health Component

14) Callen-Lorde Community Health Center (CLCHC)
Mail: 356 West 18th Street, New York, NY, USA 10011
Tel: 212-271-7200
Web: http://www.callen-lorde.org/v_tour.php?svc=transgender

Medical centre that specifically serves the queer/LGBT community. It offers a wide range of health services to trans people, including general primary health care, prescription and monitoring of hormones, counseling, education, assistance with legal forms (e.g., name change), and referrals to gender-transition surgeons. They also offer gynecological care and mammography services that are described as "trans-affirmative" (CLCHC, n.d.).

15) Fenway Community Health
Mail: 7 Haviland Street, Boston, MA, USA 02115
Tel: 617-267-0900
Web: http://www.fenwayhealth.org/

Large LGBT health center affiliated with Beth Israel Deaconess Medical Center and Harvard Medical School. Offers wide range of health research programs and health care, including primary care, HIV/AIDS services, OB/GYN care, podiatry, nutritional counseling, mental health and addictions services, complementary therapies (chiropractic, massage, acupuncture), violence prevention and services for survivors, health promotion, and parenting/family services (Mayer, Appelbaum, Rogers, Lo, Bradford, & Boswell, 2001). Follows criteria more stringent that the HBIGDA *Standards of Care* (2001) in the assessment and prescription of hormones to trans people (Fenway Community Health, n.d.).

16) Gender Identity Project, Lesbian, Gay, Bisexual & Transgender Community Center
Mail: 208 West 13th Street, New York, NY, USA 10011
Tel: 212-620-7310
Email: gip@gaycenter.org
Web: http://www.gaycenter.org/programs/mhss/gip.html

Free and confidential addiction counseling, HIV/AIDS prevention and intervention services, one-on-one peer support and support groups, information and referrals to trans specialist services, community health education, and education/sensitivity training for health professionals (Lesbian, Gay, Bisexual, and Transgender Community Center, n.d.). The overall aim of the project is to affirm trans identity, destigmatize gender-variance, and empower trans people (Warren, Ritter, & Pollack, 1993). The LGBT

Community Center also hosts a trans legal clinic one night a month to help trans people with legal change of name and ID (Gay City News, 2002).

17) LA Gay & Lesbian Centre
Mail: McDonald/Wright Building, 1625 North Schrader Boulevard, Los Angeles, CA, USA 90028
Tel: 323-993-7400
Web: http://www.laglc.org/

Wide range of educational, social, and health programs for LGBT people (LAGLA, 2002). LAGLA's Lambda Medical Group offers crisis intervention, intake/assessment, and counselling for individuals, couples, and families; addictions counselling; services for survivors of same-sex relationship abuse (peer support groups, counseling) and for same-sex abusers (batterers' treatment program, anger management groups, counseling); sexual health and STD prevention, testing, and treatment; and a full range of HIV/AIDS prevention, testing, and care services (LAGLA, n.d.). Residential services offer homeless LGBT youth safe emergency and short-term housing, meals, employment training, and intensive support, and a legal clinic provides assistance to LGBT people at no charge.

18) Rainbow Resource Centre
Mail: PO Box 1661, Winnipeg, MB R3C 3Z6
Tel: 204-284-5208
Fax: 204-478-1160
Email: wglrc@mts.net
Web: http://www.mts.net/~wglrc/

Provides peer support, referral, information, and educational services to LGBT people (Rainbow Resource Centre, 2003). Drop-in services are available to people living in Winnipeg, with programs to people in northern/rural Manitoba and northwestern Ontario by mail and a toll-free phone line. The Centre sponsors the *Winnipeg Transgender Group*, which offers a bi-weekly peer support group and advocacy on equitable access to health services (Winnipeg Transgender Group, n.d.-b), an LGBT legal clinic, a twelve-step group, and a resource list of trans-friendly and trans-competent practitioners.

19) The 519
Mail: 519 Church Street, Toronto, ONT M4Y 2C9
Tel: 416-392-6878, ext. 104
Email: info@the519.org
Web: http://www.the519.org/public_html/programs/trans/

LGBT centre in Toronto offering six trans-specific programs, including bi-weekly peer support groups for MTFs and FTMs (run separately), a drop-in meal program for poor and street-involved trans people, a monthly support group for partners of FTMs, a trans self-defense class, and a drop-in for trans youth (under 26). The 519 publishes trans-specific peer education resources (including *The Happy Transsexual Hooker*, a comic by and for MTF sex trade workers) and training materials for health professionals. In addition to trans-specific programming, training on trans issues is provided for staff and volunteers at the 519's general LGBT programs (e.g., support for survivors of relationship abuse, child and family services, lay counselling, legal clinic, and seniors' programs) to make them fully inclusive of and accessible to trans people (The 519, n.d.-a). The 519 provides meeting space for over 300 community groups providing a range of services to Toronto's LGBT communities (The 519, n.d.-b).

20) The Centre
Mail: 1170 Bute Street, Vancouver, BC V6E 1Z6
Tel: 604-684-6548
Fax: 604-684-5309
Email: educationoutreach@lgtbcentrevancouver.com (Peter Toppings, Education Coordinator)
Web: http://www.lgtbcentrevancouver.com/

The Centre sponsors a trans drop-in group, and Education and Outreach Services offers education and resources about trans health issues for service users as well as service providers. Although other programs do not have trans-specific content, trans people are involved as volunteers and service users in a range of Centre programs, including Prideline, a toll-free peer support, information, and referral line that runs three hours in the evening every day of the week.

21) Transgender Counseling Program, San Diego LGBT Community Center
Mail: Health Services Building, 2313 El Cajon Boulevard, San Diego, CA, USA 92104
Tel: 619-260-6380, ext. 115
Email: kbuis@thecentersd.org (Dr. Kurt Buis, Coordinator)
Web: http://www.thecentersd.org/pr_02b.htm

Counseling specifically for trans people, including assessments for gender transition (SDLGBTCC, n.d.).

22) Whitman-Walker Clinic & Lambda Health Centre
Mail: 1407 S Street NW, Washington, DC, USA 20009
Tel: 202-797-3500
Fax: 202-797-3504
Web: http://www.wwc.org/

Range of health programs for LGBT people, including mental health and addiction treatment services and HIV/AIDS prevention, outreach, and education. WWC facilitates a support/therapy group for partners of trans people (WWC, 2003) and is planning to offer trans-specific health services in 2003 by expanding programs at two of its health care sites; hormone assessment and maintenance will be among the new programs offered, but the main focus will be primary health care, HIV prevention and testing, mental health, and vaccinations (Smith, 2003).

Community Health Centres

23) Dimensions, Castro-Mission Health Center
Mail: 3850 17th Street, San Francisco, CA, USA 94114
Tel: 415-487-7500
Web: http://www.dph.sf.ca.us/chn/HlthCtrs/castro-mission.htm

Dimensions: Health Services for Queer and Questioning Youth is “a comprehensive health care clinic dedicated to serve gay/lesbian/bisexual/transgender/queer and questioning youth aged 12 to 25”(Perez-Arce, 2000), open four hours per week at the Castro-Mission Health Center. The program is a collaboration between six agencies (three are part of the San Francisco Department of Public Health and three are non-profit community-based agencies). Trans-specific services include hormone assessment, prescription, and maintenance, following the ICTLEP guidelines (Health Law Standards, 1993).

24) Centretown Community Health Centre
Mail: 420 Cooper Street, Ottawa, ONT K2P 2N6
Tel: 613-233-4443
Fax: 613-233-3987
Email: egibbs@centretownchc.org (Ernie Gibbs, Mental Health Counsellor for GLBTTQ youth)
Web: http://www.rainbowyouthtalk.com/Resource/CCHC.htm

Outreach, support, and counseling program for youth (up to age 25) who are gay, lesbian, bisexual, trans, Two-Spirit, and questioning. A peer support group is facilitated by a mental health worker who is also a LGBT community member, with the intention of "exploring issues around sexual orientation and gender identity in a confidential, non-judgemental setting" (CCHC, n.d.).

25) Lyon-Martin Women's Health Services
Mail: Suite 201, 1748 Market Street, San Francisco, CA, USA 94102
Tel: 415-565-7667
Fax: 415-252-7490
Web: http://www.sfccc.org/clinics/lmwhs.htm

Women's health center with strong lesbian focus, providing primary care, gynecology, HIV/AIDS care, cancer screening, support groups, community forums, addictions programs, and outreach to homeless women. Explicitly includes transgendered women and offers hormone assessment/prescription for those undergoing gender transition (San Francisco Community Clinic Consortium, n.d.).

26) Sherbourne Health Centre
Mail: 333 Sherbourne Street, Toronto, ONT M5A 2S5
Tel: 416-324-4180
Fax: 416-324-4181
Email: info@sherbourne.on.ca
Web: http://www.sherbourne.on.ca/

In 1997, Wellesley Central Hospital (WCH) closed. The Health Services Restructuring Commission of Ontario's Ministry of Health created Sherbourne Health Centre (SHC), a community-based non-profit primary health care organization, to meet the needs of the community formerly served by the WCH – including the largest LGBT neighbourhood in Canada. Although the LGBT Primary Health Care Clinic in SHC is still developing (it has only been open since December 2002), planned services include a comprehensive range of primary care services (health promotion, treatment of minor illness, monitoring long-term illness), counseling and support, parenting and family services, addiction counseling and referrals, short-term residential health services for people who are ill and don't have housing, mobile outreach, complementary therapies (chiropractic, naturopathy, homeopathy, acupuncture), and health education workshops (Sherbourne Health Centre, 2003). Trans-specific programs include counseling; hormone assessment, prescription, and maintenance; and a group for trans youth.

27) Three Bridges Community Health Centre
Mail: 1292 Hornby Street, Vancouver, BC V6Z 1W2
Tel: 604-663-4201
Fax: 604-734-5918

Community health centre serving downtown Vancouver, close to neighbourhoods with high numbers of gay and trans people. While LGBT people are welcome at all hours, Pride Health Services is a drop-in primary care clinic specifically for LGBT people that operates three hours per week. Trans-specific services include assistance with ID changes and other advocacy, employment support, and a peer support

group that meets weekly (White, 2003). Boys R Us operates a drop-in centre three nights a week, with peer support and advocacy for men and trans people in the sex trade (Vancouver Coastal Health Authority, 1999).

28) Verbena Health Clinic (formerly Sappho's Health Services)
Mail: c/o Country Doctor Community Clinic, 500 19th Avenue East, Seattle, WA, USA 98112
Tel: 206-299-1600, ext. 405
Email: sappho_health@hotmail.com
Web: http://www.geocities.com/sappho_health/

Offers a full range of naturopathic and allopathic medicine to lesbians, bisexual, women, and trans people (both MTF and FTM). The clinic runs for three hours per week at the *Country Doctor Community Clinic*. Services include primary health care, OB/GYN care, STD exams, breast exams, mental health care, peer support, advocacy, and education (Verbena Health Clinic, 2003). All staff openly self-identify as LGBT.

29) Village Clinic/Nine Circles Community Health Centre
Mail: 705 Broadway, Winnipeg, MB R3G 0X2
Tel: 204-940-6000
Fax: 204-940-6003
Email: lmanning@ninecircles.ca (Liz Manning, Community Advocacy Coordinator)

Community health centre primarily focused on LGBT primary health care and HIV/AIDS. Trans-specific services include primary care, counseling, education for trans people and service providers, advocacy, referrals to the CAMH Gender Clinic in Toronto for assessment (Manitoba Health requires assessment by the CAMH clinic to approve health insurance coverage for surgery), and a trans volunteer program that gives people undergoing RLE the opportunity to fulfill the CAMH requirements (Manning, 2003). The centre is in the process of developing programming specifically for Aboriginal people who identify as Two-Spirit and/or trans.

HIV/AIDS Organizations

30) Asian & Pacific Islander Wellness Centre
Mail: 4th Floor, 730 Polk Street, San Francisco, CA, USA 94109
Tel: 415-292-3420, Ext. 351
Fax: 415-292-3404
Email: tamikag@apiwellness.org (Tamika Gonzales, Trans Program Supervisor)
Web: http://www.apiwellness.org/v20/tg/tg.html

In addition to a primary care clinic offering medical and psychiatric services to all A/PI people affected or infected by HIV, APIWC offers two social/support programs for Asian/Pacific Islander trans people, trans-specific educational materials, and research on HIV prevention in trans communities (APIWC, n.d.).

31) Oasis, Sandy Hill Community Health Centre
Mail: Suite 200, 116 Lisgar Street, Ottawa, ONT K2P 0C2
Tel: 613-569-3488, ext. 218
Web: http://www.sandyhillchc.on.ca/programs.html#5

Nursing care and health promotion to people who are HIV+ or at risk for HIV, with an emphasis on people who are living in poverty, homeless, and/or struggling with addictions. Oasis explicitly welcomes trans women (MTF) in their promotional materials (Pink Triangle Services, 2002).

32) Positive Health Project
Mail: 2nd Floor, 301 West 37th Street, New York, NY, USA 10018
Tel: 212-465-8304
Fax: 212-465-8306
Email: bcassis@phpnyc.org or mmoses@phpnyc.org (Barbara Cassis/Moshay Moses, Trans Advocates)
Web: http://www.7sign.com/positive/transgender.html

Support, education, and advocacy to people infected or affected by HIV/AIDS. The Transgender Initiative employs trans people to design and conduct outreach services to trans sex workers and trans people who inject illicit drugs/hormones, create and distribute peer education materials, run peer support groups, and staff the needle exchange for trans-exclusive dedicated hours (PHP, n.d.).

33) Proyecto Contra SIDA por Vida
2973 16th Street, San Francisco, CA, USA 94103
Tel: 415-575-1643
Fax: 415-575-1645
Web: http://www.pcpv.org/sections/TG_Folks.html

Latino/a organization in San Francisco dedicated to the prevention of HIV infection through community empowerment. The Transgender Program provides outreach, peer support, counseling, and advocacy to trans Latino/a people and organizes social and educational trans community events (PCSPV, n.d.).

34) Tenderloin AIDS Resource Center
Mail: 187 Golden Gate Avenue, San Francisco, CA, USA 94109
Tel: 415-934-1793 (Adela Vazquez, Transgender Service Coordinator)
Fax: 415-431-3959
Email: info@tarcsf.org
Web: http://www.tarcsf.org/

Emergency and long-term housing, medical care, counseling and peer support, and nutrition supplements to people living in the Tenderloin district. Some programs are specific to people who are HIV+, while others are open to all Tenderloin residents. Many trans people live and/or work on the streets in the Tenderloin; as part of its mandate to provide services to all members of the Tenderloin, trans people are explicitly welcomed as service users, staff, and volunteers, and a trans support group meets daily (TARC, n.d.).

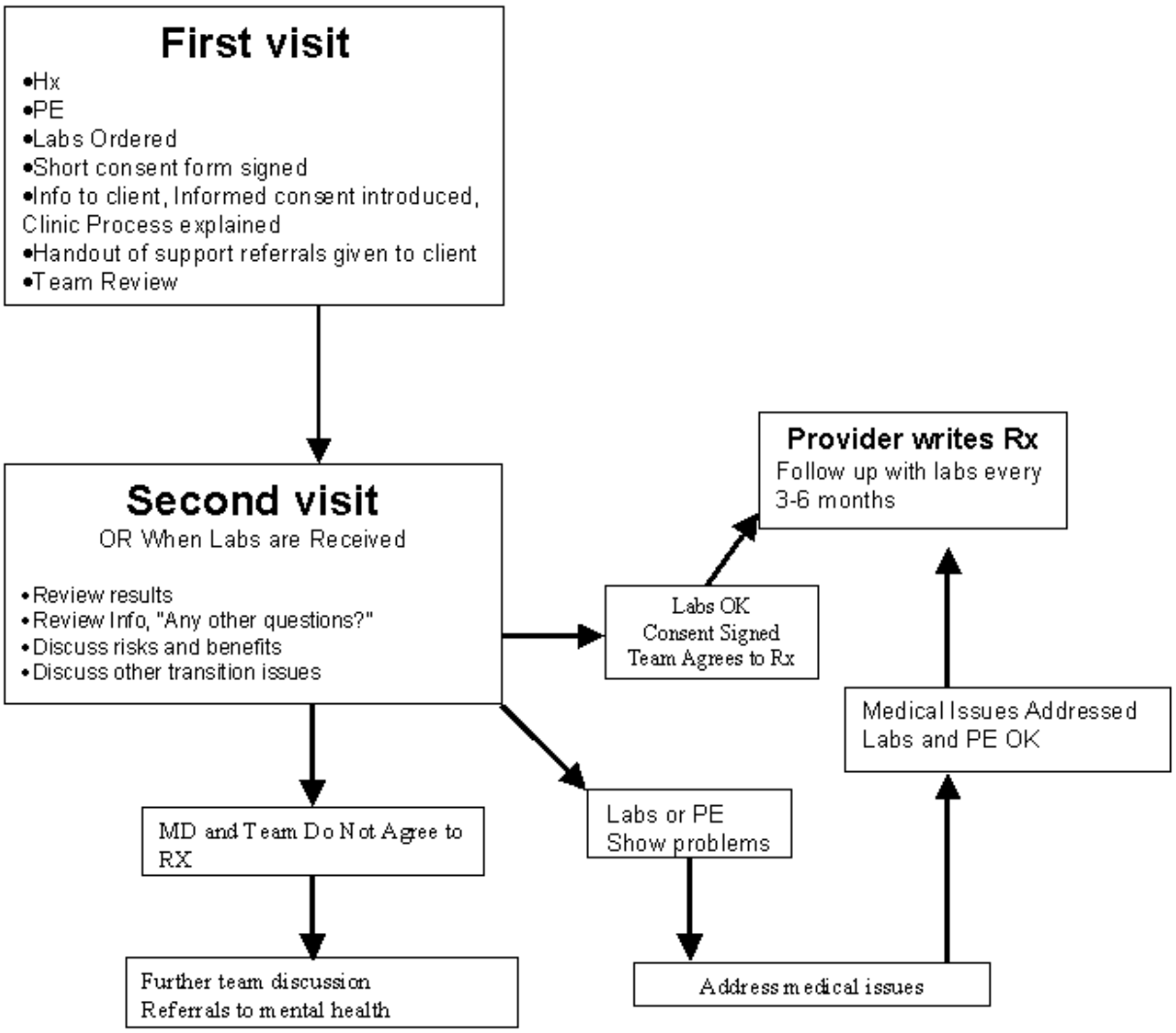
35) Us Helping Us
811 L Street SE, Washington, DC, USA, 20003
Tel: 202-546-8200
Fax: 202-546-4511
Web: http://www.ushelpingus.com

HIV/AIDS prevention and support services for Black gay and bisexual men, and Black trans people of all sexual orientations. In addition to general services for GBT (gay/bi/trans) people who are HIV+ (e.g., health education, discussion groups, case management, psychotherapy, and massage), UHU offers a bi-weekly peer support group for Black trans people and a drop-in centre for Black and Latino trans people (UHU, n.d.). UHU will be assisting the Whitman-Walker Clinic with their new trans health program (Smith, 2003).

Appendix B: Materials from Dimensions Program, Castro-Mission Health Center, San Francisco

retrieved February 21, 2003 from http://tghealth-critiques.tripod.com/

FLOW CHART FOR NEW PATIENT CONTINUING TRANSGENDER HORMONAL TREATMENT



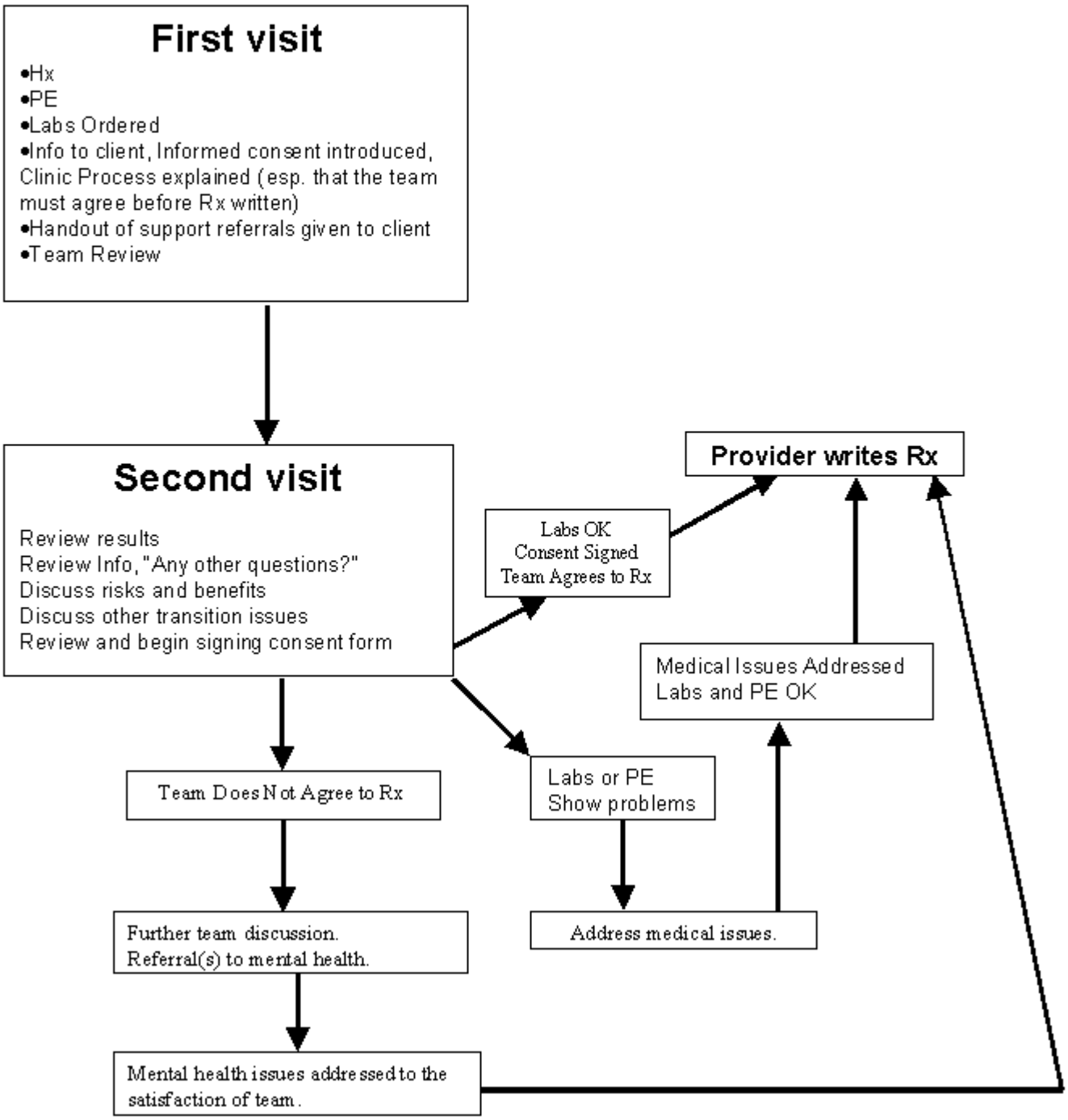
Consent for Transgendered Patients Continuing Hormones

1. I have informed my provider that I have been taking hormones for gender transition for _____ (# of months or years).
2. I agree to complete the full informed consent form within the next 30 days.
3. I agree to complete all lab work, or other tests that my provider may order, within the next thirty days.
4. I understand that, until I complete the labs and the informed consent, my provider will only write me a prescription for 30 days worth of hormones.

_____ _____
Patient Signature Date

_____ _____
Medical Provider Signature Date

New Patient Flow Chart for Transgender Hormonal Treatment



Treatment Guidelines for FTM Transition

Philosophy of Care:

i. Since the inception of the Harry Benjamin guidelines, there have been changes in the definition of "gender", both socially and generationally. Gender expression no longer needs to be divided along rigid masculine/feminine lines in American society. Transgender and questioning youth appear to range on a spectrum of gender identity never addressed by the Harry Benjamin guidelines. We recognize the right of each patient to define their own gender identity independent of our preconceptions. We do not discriminate or withhold hormones on the basis of gender identity definition.

ii. A transgender identity is not a psychiatric illness. Many youth do have mental health needs, regardless of gender identity. If we do not define a trangsendered person as mentally ill, it would be discriminatory on the basis of diagnosis to force such clients to undergo evaluation and/or treatment by mental health personnel. However, if anyone in the Dimension team feels that a mental health evaluation is needed, hormonal treatment may be postponed until this evaluation is done and any mental health issues are resolved. We do not withhold general medical services from patients who refuse to see a therapist or psychiatrist. All youth at Dimensions are routinely offered appropriate mental health services and/or referrals.

iii. The Dimensions team cares for our patients as a team. The team will make decisions on appropriate care for each transgender patient, with adequate input from medical, nursing, mental health and social services staff. If a conflict exists among the team regarding appropriate care for an individual, then further evaluation will be pursued to resolve this conflict.

Treatment

I. Discussion of patient goals and expectations. Assess desire and readiness for gender transition. Assess connection with transgender community and exposure to persons who have completed transition.

II. Screening:
   A. Complete physical, HCM. Dimensions does not require routine pelvic exams and pap smears for FTMs, but will recommend them where indicated by the patients history.
   B. Labs ordered for:
      1. CBC w/differential
      2. Liver Panel
      3. Lipid profile
      4. Renal Panel
      5. Hormonal studies indicated by findings in history and physical
   C. Assess individual medical issues

I. Discussion and signing of Informed Consent.

II. Treatment options
   A. Non-hormone options
   B. Testosterone. Be aware of drug interactions: increases anticoagulant effect of warfarin, increases clearance of propranol, increases the hypoglycemic effects of sulfonylureas.

Available forms:

1. Testosterone enanthate or cypionate 50 mg IM q 2 wks x 6-8 weeks. Increase by 25- 50 mg q 2 weeks as needed up to max of 200mg q 2 weeks. (Check for allergy to sesame or cottonseed oil)
2. Transdermal testosterone is expensive therefore not immediately recommended. It can cause skin irritation in some patients. It is beneficial for patients who are emotionally sensitive to fluctuations in testosterone level, since it provides a consistent dose. It is available as Androderm or Testoderm TTS 2.5 – 10.0 mg patch qd.
3. Oral preparations of testosterone are not used due to dangerous side effects.
4. Testosterone Gel. New on the market.

III. Follow up
   A. Monitor labs 3 months after start of testosterone then every 6-12 months
      1. CBC
      2. ALT or Liver panel
      3. Lipid profile
      4. Creatnine
      5. Glucose
      6. Testosterone level study 100 mg q 2 weeks.
   B. Review medication use and dosage
   C. Assess masculinization
   D. Monitor mood cycles and adjust medication as indicated
   E. Complete forms for name/gender change, if desired.
   F. After menses have stopped, do provera challenge within 3 to 6 months. (It is very important to explain to the patient that this may cause a menstrual period.) If bleeding occurs, repeat cycling every 2-3 months until none occurs.
   G. Asses vaginal dryness and problems with sex. Consider topical estrogens if desired.
   H. Review CAD risk factors
   I. Continue routine HCM (including breast exam, STD screening, pap smears, mammograms after age 40)

Informed Consent for Testosterone Therapy

For Female-to-Male Transition

This form refers to the use of testosterone by persons who wish to become more masculinized as part of a gender transitioning process.

You are being asked to initial the various statements on this form to indicate that the risks as well as the changes which may occur as a result of the use of testosterone have been explained to you and that you understand them. If you have any questions or concerns about the information below, we encourage you to take all the time you need to: ask questions, read, research , talk with clinic staff and think about these important aspects of your treatment.

Please initial and date.

Patient Provider Date

1. _____ _____ ___/___/___ I have been informed that masculinizing effects of testosterone may take several months to become noticeable, up to five years to be complete. Some of these changes will be permanent, including:

    - Hair loss, especially at my temples and crown of my head and, possibly, becoming completely bald
    - Beard and mustache growth
    - Deepening of my voice
    - Increased hair growth on my arms, legs, chest, back, and abdomen
    - Enlargement of my clitoris

    These additional changes will not be permanent if I stop testosterone:

    - Decrease of fat in my breasts, buttocks and thighs
    - Increase of fat in my abdomen
    - More muscle development
    - More red blood cells in my blood
    - Behavioral changes, similar to those experienced at puberty, and increased sex drive
    - Acne, which may become severe and may cause permanent scarring if not treated

2. _____ _____ ___/___/___ I understand that it is not known exactly what the effects of testosterone are on fertility. I have been informed that, if I stop taking testosterone, I may or may not be able to become pregnant in the future.

3. _____ _____ ___/___/___ I understand that there are brain structures which are affected by testosterone and estrogen, and that current medical science does not understand these adequately. I understand that taking a hormone may have long-term effects on the functioning of my brain which are impossible to predict. These effects may be beneficial, damaging, or both.

4. _____ _____ ___/___/___ I understand that everyone's body is different and that there is no way to predict what will be my response to hormones. There is a very complex interaction in each person between all the different hormones. I understand that the right dosage for me may not be the same as for someone else.

5. _____ _____ ___/___/___ I will have physical examinations and blood tests periodically to make sure I am not having a bad reaction to the hormones. I understand this is required to continue testosterone therapy through this clinic.

6. _____ _____ ___/___/___ I have been informed that using testosterone may increase my risk of developing diabetes in the future because of changes in my ovaries.

7. _____ _____ ___/___/___ I understand that the endometrium (the lining of my uterus) is able to turn testosterone into estrogen and so increase my risk of cancer of the endometrium. I have been informed that not having my period for prolonged times may increases this risk. In order to reduce this risk, another hormone may be recommended to induce a menstrual period (shed the endometrium) several times a year.

8. _____ _____ ___/___/___ I understand that through an interaction in the blood, my taking testosterone may actually increase the effectiveness of the estrogen in my body. The results of this are not known.

9. _____ _____ ___/___/___ I have been informed that if my periods stop while I am taking testosterone I probably will not be able to become pregnant. I understand that testosterone should not be used to prevent pregnancy. Even if I have stopped having periods I should still use birth control (preferably barrier methods) if I am having sex where semen could enter my vagina or uterus.

10. _____ _____ ___/___/___ I understand the effects of testosterone will not protect me from sexually transmitted diseases or from HIV.

11. _____ _____ ___/___/___ I understand that the effects of testosterone will not protect me from cervical cancer or breast cancer. It is important to continue to be alert to the health care needs of my body. I understand that annual breast exams and monthly self-breast exams are recommended, even after chest reconstruction. My provider may also recommend periodic pap smears.

12. _____ _____ ___/___/___ I understand that fatty tissue in my breasts is able to turn testosterone into estrogen, which may increase my risk of breast cancer in the future.

13. _____ _____ ___/___/___ I have been informed that testosterone puts a stress on the liver which may lead to liver inflammation. I will be monitored for liver problems before starting testosterone and periodically during therapy

14. _____ _____ ___/___/___ I have been informed that if I take testosterone my good cholesterol (HDL) will probably go down and my bad cholesterol (LDL) will probably go up. This will likely increase my risk of a heart attack or stroke in the future. The rates of risks for FTMs on testosterone are similar to the risks that are found in non-transgender men.

15. _____ _____ ___/___/___ I understand that there are emotional changes I will likely experience as a result of testosterone therapy, and that clinic staff can assist me in finding resources to explore these changes.

16. _____ _____ ___/___/___ I understand that once injected, if I have any adverse reactions to testosterone I must wait for them to wear off.

17. _____ _____ ___/___/___ I agree to tell my medical provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs or medications I might be taking. I understand that being honest with my provider is crucial to developing a trusting relationship. Sharing this information will help my provider to prevent potentially harmful interactions. **I have been informed that clinic staff will continue to provide me with medical care, regardless of what information I share with them.**

18. _____ _____ ___/___/___ I agree to take hormones as prescribed and to inform my provider of any problems or dissatisfactions I may have with the treatment. I've been informed that if I take too much testosterone that my body may convert it into estrogen. This may slow or stop the desired effects of the hormone.

19. _____ _____ ___/___/___ I understand that there are medical conditions that could make taking testosterone either dangerous or damaging. I agree that if clinic staff suspect I may have one of these conditions, I will be evaluated for it before the decision to start or continue testosterone therapy is made.

20. _____ _____ ___/___/___ I understand that I can choose to stop taking testosterone at any time. I also understand that my provider can discontinue treatment for clinical reasons.

All the above information has been explained to my satisfaction.

_____I choose to begin testosterone therapy.

_____ I do not wish to begin testosterone therapy at this time.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Medical Provider Signature Date

Treatment Guidelines for MTF Transition

Philosophy of Care:

i. Since the inception of the Harry Benjamin guidelines, there have been changes in the definition of "gender", both socially and generationally. Gender expression no longer needs to be divided along rigid masculine/feminine lines in American society. Transgender and questioning youth appear to range on a spectrum of gender identity never addressed by the Harry Benjamin guidelines. We recognize the right of each patient to define their own gender identity independent of our preconceptions. We do not discriminate or withhold hormones on the basis of gender identity definition.

ii. A transgender identity is not a psychiatric illness. Many youth do have mental health needs, regardless of gender identity. If we do not define a trangsendered person as mentally ill, it would be discriminatory on the basis of diagnosis to force such clients to undergo evaluation and/or treatment by mental health personnel. However, if anyone in the Dimension team feels that a mental health evaluation is needed, hormonal treatment may be postponed until this evaluation is done and any mental health issues are resolved. We do not withhold general medical services from patients who refuse to see a therapist or psychiatrist. All youth at Dimensions are routinely offered appropriate mental health services and/or referrals.

iii. The Dimensions team cares for our patients as a team. The team will make decisions on appropriate care for each transgender patient, with adequate input from medical, nursing, mental health and social services staff. If a conflict exists among the team regarding appropriate care for an individual, then further evaluation will be pursued to resolve this conflict.

Treatment

I. Discussion of patient goals and expectations. Assess desire and readiness for gender transition. Assess connection with transgender community and exposure to persons who have completed transition.

II. Screening:
   A. Complete physical, HCM
   B. Labs ordered for:
      1. CBC w/differential
      2. Liver Panel
      3. Lipid profile
      4. Renal Panel
      5. Hormonal studies indicated by findings in history and physical
   C. Assess individual medical issues

III. Discussion and signing of Informed Consent.

IV. Treatment options
  A. Non-hormone options
  B. Estrogens: Available forms
    a. Premarin 0.625 – 5 mg qd or estradiol 1-10 mg qd (Occasional occurrences of allergies to Premarin have been reported. If this occurs, synthetic estrogens can be substituted.)
    b. Injectable estradiol in oil, 10-20 mg q 4 week.
    c. Estradiol patch 0.05 - 0.3 mg 7d (check for latex allergy)
  C. Antiandrogens: Spironolactone 25 – 50 mg po bid (benefits may include: modest breast development, softening of facial hair. Risks of use include; hyperkalemia, hypotension, drug interactions).
  D. The use of Propecia (Finasteride) is currently being explored, but there is little data on its use and effectiveness in this population. (Finasteride is a competitive and specific inhibitor of Type II 5α-reductase, an intracellular enzyme that converts the androgen testosterone into DHT.)
  E. Progesterone- not recommended

V. Follow up
  A. Monitor labs 3 months after start of estrogen then every 6-12 months
    0. CBC
    1. ALT or Liver panel
    2. Lipid profile
    3. Renal panel (if taking sprinolactone)
    4. Testosterone level if needed
    5. Prolactin level (may discontinue after 3 years of normal values; level between 25-100 may indicate improper use of estrogen)
  B. Review medication use
  C. Assess feminization
  D. Monitor mood cycles and adjust medication as indicated
  E. Complete forms for name/gender change, if desired.
  F. Review CAD risk factors
  G. Continue routine HCM (including breast exam, STD screening, prostate screening, and mammograms after age 40).

Informed Consent for Estrogen Therapy

for Male to Female Transition

This form refers to the use of estrogen by persons who wish to become more feminized as part of a gender transitioning process.

You are being asked to initial the various statements on this form to indicate that the risks as well as the changes which may occur as a result of the use of estrogen have been explained to you and that you understand them. If you have any questions or concerns about the information below, we encourage you to take all the time you need to: ask questions, read, research , talk with clinic staff and think about these important aspects of your treatment.

Please initial and date.

Patient Provider Date

1. _____ _____ ___/___/___ I have been informed that the feminizing effects of estrogen can take several month to become noticeable. Some of these changes will be permanent. Permanent changes include:

    a. _____ _____ ___/___/___ I will probably develop breasts. These may take several years to develop to their full size. (There is extreme variation in the size of breasts I may expect. Some of this is predictable based on the size breasts my mother and sisters have, but not completely.) If I stop taking estrogen they may shrink somewhat but not completely.

    b. _____ _____ ___/___/___ I understand that there are brain structures that are affected by testosterone and estrogen, and that current medical science does not understand these structures adequately. I understand that taking a hormone which will likely affect a part of my brain whose function is not clear may have long-term effects on the functioning of my brain which are impossible to predict. These effects may be beneficial, damaging, or both.

2. _____ _____ ___/___/___ These additional changes will <u>not</u> be permanent and should go away if I stop taking estrogen:

    - Acne I might have will probably decrease
    - If I am going bald, it will probably slow down. It will probably not stop completely
    - My skin may become softer
    - Hair growth on my body may become less noticeable; however, it will not go away
    - My beard may become less prominent; however, it will not go away.
    - The way my body smells, especially the sweat from my armpits, will probably become less noticeable and may change in quality
    - The fat on my abdomen may decrease
    - The fat on my buttocks and thighs may increase in a more feminine pattern

3. _____ _____ ___/___/___ I have been informed estrogen may cause, or contribute to, depression. If I have a history of depression, I will discuss this with clinic staff to explore what treatment options are available to me.

4. _____ _____ ___/___/___ Estrogen will decrease two brain hormones that support size and function of my testicles, which may then effect my overall sexual function. These effects should go away if I stop taking estrogen. These effects include:

    a. _____ _____ ___/___/___ Up to about 40% shrinkage in the size of my testicles. I understand that, even while I am on estrogen, monthly testicular exams are still recommended.

b. _____ _____ ___/___/___ Decrease in the testosterone production from my testicles.

c. _____ _____ ___/___/___ The amount and quality of my ejaculation may decrease, or it may stop entirely. My sperm will still be present in my testicles but will probably stop maturing, so I may become infertile. I have been informed that I may still be able to make someone pregnant. I have been informed that, if I am having sex with someone who can become pregnant, some form of birth control should be used.

d. _____ _____ ___/___/___ I have been informed that, if I stop taking estrogen, my ability to make sperm normally may or may not ever come back.

e. _____ _____ ___/___/___ My erections when aroused may no longer be hard enough for intercourse.

f. _____ _____ ___/___/___ Decrease or loss of morning and spontaneous erections.

g. _____ _____ ___/___/___ My sex drive may decrease.

5. _____ _____ ___/___/___ I understand the effects of estrogen will not protect me from sexually transmitted diseases or from HIV.

6. _____ _____ ___/___/___ If I have experienced significant breast development from hormonal therapy, I understand that it is recommended that I do a breast self-examination on a monthly basis, and have an annual breast exam.

7. _____ _____ ___/___/___ I have been informed that taking estrogen can increase my risk of blood clots, which can result in:

. _____ _____ ___/___/___ chronic leg vein problems,

a. _____ _____ ___/___/___ a pulmonary embolism (blood clot to the lung) which may cause permanent lung damage or death.

b. _____ _____ ___/___/___ a stroke which might result in permanent brain damage, such as being paralyzed or unable to talk or death.

8. _____ _____ ___/___/___ I have been informed the risk of blood clots is much worse if I smoke tobacco, especially if I am over 35. I understand that the danger is so high I have been advised that I should stop smoking tobacco completely if I start taking estrogen. My provider can give me referral to smoking cessation resources.

9. _____ _____ ___/___/___ I have been advised estrogen can cause increased blood pressure. If I have high blood pressure, I may be able to take estrogen if my blood pressure is controlled with medications and/or diet and/or lifestyle changes. Clinic staff will help me address this problem.

10. _____ _____ ___/___/___ I have been informed that estrogen puts a stress on the liver which may lead to liver inflammation or a back-up of liver products in the bile ducts (the liver's "plumbing system"). I will be monitored for liver problems before starting estrogen and periodically during therapy. I have also been informed that there is a slight risk of long-term estrogen use causing liver cancer.

11. _____ _____ ___/___/___ I have been informed estrogen may increase migraine headaches and this may be a reason to choose to stop taking estrogen.

12. _____ _____ ___/___/___ I have been informed estrogen may cause nausea and vomiting, similar to morning sickness in a pregnant woman. If nausea and vomiting are severe or prolonged, I understand that is recommended that I talk with my health care provider.

13. _____ _____ ___/___/___ I understand I am more likely to have dangerous side effects from estrogen if I smoke, am overweight, am over 40, have a history of blood clots, high blood pressure, or prior estrogen-dependent cancers.

14. _____ _____ ___/___/___ I understand estrogen may cause changes in my cholesterol. My HDL (good cholesterol) may go up and my bad cholesterol (LDL) may go down. This will probably decrease my risk of heart attacks and strokes in the future

15. _____ _____ ___/___/___ I understand taking estrogen should prevent prostate problems. There is a slight chance that taking estrogen will cause overgrowth of the prostate. An annual prostate exam is recommended for people over 50 and older.

16. _____ _____ ___/___/___ I agree to tell my medical provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs or medications I might be taking. I understand that being honest with my provider is crucial to developing a trusting relationship. Sharing this information will help my provider to prevent potentially harmful interactions. **I have been informed that clinic staff will continue to provide me with medical care, regardless of what information I share with them.**

17. _____ _____ ___/___/___ I understand that everyone's body is different and that there is no way to predict what will be my response to hormones. I understand that the right dosage for me may not be the same as for someone else.

18. _____ _____ ___/___/___ I agree to take hormones as prescribed and to inform my provider of any problems or dissatisfactions I may have with the treatment. I've been informed that, if I take too much estrogen, my body may convert it into testosterone. This may slow or stop the desired effects of the hormone.

19. _____ _____ ___/___/___ I will have physical examinations and blood tests periodically to make sure I am not having a bad reaction to the hormones. I understand this is required to continue hormone therapy through this clinic.

20. _____ _____ ___/___/___ I understand that there are medical conditions that could make taking estrogen either dangerous or damaging. I agree that if clinic staff suspect I may have one of these conditions, I will be evaluated for it before the decision to start or continue estrogen therapy is made.

21. _____ _____ ___/___/___ I understand that I can choose to stop taking estrogen at any time. I also understand that my provider can discontinue treatment for clinical reasons.

All the above information has been explained to my satisfaction.

_____I choose to begin estrogen therapy.

_____ I do not wish to begin estrogen therapy at this time.

_____ _____
Patient Signature Date

_____ _____
Medical Provider Signature Date

_____ _____
Parent/Guardian Signature Date