

**Planning for Culturally Safe Primary  
Health, Mental Health and Community  
Based Service Delivery for Trans, Two-  
Spirit, Intersex and Gender Diverse  
Communities in the Champlain Region**

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**April 28, 2017**

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## **Our Journey: Regional Planning Table**

The Regional Planning Table first came together in December of 2016. It is however, important to recognize and honour that many individuals and groups from the trans, two-spirit, intersex, and gender diverse populations have been advocating for and working towards improved services and access for several years. Similarly, most of the service providers at the Table have been learning, creating, developing, and improving services for the trans, two-spirit, intersex, and gender diverse populations for a number of years. In many instances, service providers and community members have had opportunities to speak together and meet about how to improve services.

The formal creation of the Table, with financial support from the Local Health Integration Network (LHIN) and the commitment for community members to work together with service providers was an incredible milestone in our region. The structure of the Table, with a commitment to ensure 50% membership from the trans, two-spirit, intersex, and gender diverse populations and the range of service providers participating is a significant achievement.

Working together as service providers and community members over the past four months has been challenging, exciting, invigorating and frustrating. Before we could work well together, we had to learn to trust each other. Trust is being built; it is a process that continues and improves the longer that the Table members work together.

Each and every member of the table shares a passion for the work and a commitment to improving services in our community. From that shared base, the Table worked through the process as outlined in the funding agreement with the LHIN. Meetings were long, spirited, dynamic and, at times discouraging. There have been delays and setbacks. One of the members resigned from the table, the original consultant resigned from the position and some elements of the shared work did not unfold as originally planned. There has also been much accomplished in a relatively short time. Over seventy-three (73) people and twelve (12) services were interviewed as part of the scan of services and six community focus groups/interview sessions were held with a diverse range of individuals from the trans, two-spirit, intersex, and gender diverse populations.

**Our most important recommendation is to continue the work that formally began in December 2016.** The Table's report is completed, but our work together is not. In addition to the formal recommendations in the report, the Table members unanimously agree that it is essential to continue to work together to continue to develop and implement a regional approach for planning for culturally safe primary health, mental health, and community based service delivery for the trans, two-spirit, intersex, and gender diverse and populations.

There is a shared understanding and commitment to the importance of ensuring that people with lived experience and who are affected by services/policies work together with service providers/policy makers. It is the best way to create, develop and implement sustainable, effective and culturally appropriate services. The Table members recognize that we need to do more than change services, we need to change health care systems.

Going forward, the Table plans to, at a minimum, continue its work, and explore other ways to expand the model of working collaboratively. The Table members will build on the insights, perspective and experiences of the past four months. In doing so, we will consider options for formalizing our approach including exploring the model used by the Addictions and Mental Health Network of Champlain (AMHNC). The model developed by the AMHNC formalizes the principal that health and social services must ensure that those affected by them /with lived experience are intentionally and structurally involved in creating a system that is responsive to their needs.

The recommendations in this report provide the path for planning and implementation of the next phase of working together.

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## **Executive Summary**

The Regional Planning Table was convened in December of 2016 to develop a regional approach for planning culturally safe primary health, mental health, and community based service delivery for trans, two-spirit, intersex, and gender diverse communities.

The Table was tasked with achieving the following:

- a) Detail the services which currently exist in the Champlain region to support the trans, two-spirit, intersex, and gender diverse communities, including services in rural areas and for Francophones
- b) Provide recommendations to improve client pathways among service delivery partners
- c) Recommend next steps and priorities for increasing gender affirming health services capacity in the Champlain region
- d) Describe the participatory community engagement with trans, two-spirit, intersex, and gender diverse communities that informed the recommendations

Over the past four months, through meetings, interviews, research, community consultation and surveys, the Table has concluded that there is an urgency to move quickly to stabilize the existing services for trans, two-spirit, intersex and gender diverse communities. There is also critical need for expanded and enhanced services in the Champlain LHIN. The report that follows contains the Table's full list of recommendations. This summary is a listing of the most pressing areas for immediate action.

### **Priority Recommendations**

*Please note that, with the exception of the first recommendation, the recommendations below are not in a ranked order. Each of the following priority recommendations are expanded upon in the full report. All recommendations are inclusive of every age group.*

1. ***Stabilize and augment existing services for trans, two-spirit, intersex, and gender diverse communities in the Champlain LHIN.***

The trans, two-spirit, intersex, and gender diverse communities are not being fully or consistently serviced in the Champlain LHIN. The health related services for these communities are under resourced, fragile, and unevenly supported. Most of the services do not have targeted or permanent funding and where funding is provided, it is not sufficient to meet the demand for service. In many instances, the staff members who provide services are not adequately trained to ensure the delivery of culturally appropriate services. The region needs new and enhanced services, however, it is essential that the existing network of services be stabilized and that we build capacity for Francophone and Indigenous populations and in rural areas within those services.

**2. *Create a systems planner position.***

A system planner will act as a hub and a capacity builder. They will work to change the system and model of care to better support trans, two-spirit, intersex, and gender diverse communities.

**3. *Improve pathways between service providers that currently deliver services to trans, two-spirit, intersex, and gender diverse communities.***

Service providers should create a formal means of working together to improve the pathways between their services and enhance awareness of the services available. In addition, service providers should improve collaborative relationships and partnerships to optimize the quality and efficiency of services. The creation of a system navigator will play an important role in enhancing pathways, by providing one-on-one support to trans, two-spirit, intersex, and gender diverse individuals as they navigate the services available in their community.

**4. *Build capacity and cultural competency for services for trans, two-spirit, intersex, and gender diverse communities across mainstream organizations.***

Trans, two-spirit, intersex, and gender diverse communities are entitled to the same levels of culturally competent care and understanding wherever they receive service, including agencies and providers outside of the health care system. Gender Identity and Gender Expression are protected grounds under the Ontario Human Rights Code.

**5. *Build the service delivery system so that the trans, two-spirit, intersex, and gender diverse communities are engaged and a formalized part of the service delivery infrastructure.***

It is essential that the trans, two-spirit, intersex, and gender diverse communities are actively and formally engaged with services providers around program planning and service delivery.

**6. *Expand and develop new services in key areas – Francophone and Indigenous.***

Our service scan has indicated that while there is a generalized lack of health related services for trans, two-spirit, intersex, and gender diverse communities; there are significant lacks in two key areas – Francophone and Indigenous. Dedicated services need to be funded and resourced. It is not sufficient for these communities to be asked to utilize services that are not created for them and/or are not accessible and relevant.

**7. *Build capacity for service delivery in rural areas. Develop dedicated services for trans, two-spirit, intersex, and gender diverse communities.***

Services for trans, two-spirit, intersex, and gender diverse communities are non-existent in many rural communities. There is an urgent need for the allocation of resources to rural areas so that culturally appropriate and diverse health related services are available for those who live rurally.

**8. *Maintain a funded, regional planning table for trans, two-spirit, intersex, and gender diverse health services.***

The work of the Regional Planning Table to improve primary and mental health services for the trans, two-spirit, intersex, and gender diverse communities has just begun. Going forward, it is important the trans, two-spirit, intersex, and gender diverse communities and service providers continue to work collaboratively in a formal and funded way. The Table's future work would include following through on its recommendations, system planning and data collection across agencies, related to the trans, two-spirit, intersex, and gender diverse communities.

**9. *Develop a standardized process for collecting socio-demographic data to enable improvements in the quality of care provided to individuals and to inform health system planning.***

There is no consistent way of collecting information regarding gender identity across the health system. Gender identity is a key element of a broader set of important socio-demographic data. This information allows organizations to better understand the clients they serve and tailor the care they provide to an individual's needs. At a system level, this information is fundamental to improving access and addressing health inequities. Irrespective of the benefits, an individual's right to not provide socio-demographic information should always be respected. By developing standardized processes for collecting patient data, we can improve the quality of care provided to individuals and support health system planning for gender diverse communities.

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# The Regional Planning Table: A Chronology

## Creation of the Table

In December 2015, Centretown Community Health Centre, the Children's Hospital of Eastern Ontario, Family Services Ottawa, Royal Ottawa-Champlain Pathways to Better Care, Seaway Valley Community Health Centre, the Youth Services Bureau of Ottawa, and individual practitioners met to discuss current gaps in gender affirming health services for the trans community. From that meeting, an application to acquire resources from Champlain Pathways to Better Care was submitted to evaluate current pathways and the application was declined. Keeping services status quo was not sufficient so more conversations were held in the spring with the agencies involved. Discussions revolved around the need to improve access to health care for trans clients, and to collaborate with the different communities to do so. At this time, the Royal Ottawa Mental Health Centre indicated an interest in participating in this initiative. Further discussions were held with Trans Health Information Ottawa and Rainbow Health Ontario over the summer months in order to share the intention of, and the hopes for a regional planning table.

Many organizations in the region are experiencing an increased demand for primary and other (e.g., surgery, endocrinology, etc.) health, mental health, and community services for trans, two-spirit, intersex, and gender diverse populations. At the time of these meetings there was a growing acknowledgment amongst these agencies of the current gaps in the system and a need to address them. Informal collaboration was taking place, but there was an identified need for a formal, inclusive, regional approach to planning. In order to move towards seamless service coordination and a continuum of care, and making the best use of limited resources, it was clear there was a need to develop a Regional Planning Table for Trans, Two-Spirit, Intersex, and Gender Diverse Health.

In June 2016 Centretown Community Health Centre submitted a proposal to the Champlain Local Health Integration Network (LHIN) to support this work that was revised and resubmitted in October 2016 based on feedback from the community. The goals were to create a regional planning table where both service providers and representatives from the trans, two-spirit, intersex, and gender diverse populations would work together to develop a regional approach to improve access to culturally appropriate gender affirming primary and other health (e.g., surgery, endocrinology, etc.), mental health, and community services for these populations. The Health System Improvement Proposal (HSIP) was approved, and the Regional Planning Table was active from November 2016 to April 2017.

## Deliverables

As per the terms and conditions of funding, Centretown Community Health Centre, the Health Service Provider (HSP) used the funding to achieve the following:

- Work with service providers across the region and members of the trans, two-spirit, intersex\*, and gender diverse communities to develop a regional approach for planning for culturally safe primary health, mental health, and community based service delivery for the population including integrated service delivery from childhood through adulthood, according to a locally developed framework
- Plan and facilitate meetings of a Regional Planning Table for health services for the trans, two-spirit, intersex\*, and gender diverse communities

- Provide a report to the Champlain LHIN, by April 28, 2017 that will:
  - a) Detail the services which currently exist in Ottawa to support the trans, two-spirit, intersex\*, and gender diverse population and their families, including services in rural areas and for Francophones
  - b) Provide recommendations to improve client pathways among partners working with this population
  - c) Recommend next steps and priorities for increasing gender affirming health services capacity in the Champlain region; and,
  - d) Describe the participatory community engagement with trans, two-spirit, intersex\*, and gender diverse communities that informed the above recommendations

**\*Note:** The intersex population was not initially identified as a community to be included in the work of the Table. After the funding was granted and the formal deliverables had been established, people from the community advocated that this population be included in the work and the Planning Table has supported this inclusion.

### **Formal Establishment of the Table**

#### *Project Consultant*

A Request for Proposal (RFP) was posted in the late summer of 2016, looking to hire a project consultant. The selection committee to hire the consultant was composed of representatives from Centretown Community Health Centre, the Children’s Hospital of Eastern Ontario, Family Services Ottawa, and Rainbow Health Ontario. Following candidate interviews, a consultant was hired. In January 2017 the consultant resigned from her position and an employee from Family Services Ottawa was seconded to the table to complete the work.

#### *Selection of Table Members*

It was decided that the Table would be comprised of the original six service providers; Centretown Community Health Centre (representing the six Ottawa Community Health Centres), the Children’s Hospital of Eastern Ontario, Family Services Ottawa, the Royal Ottawa Mental Health Centre, Seaway Valley Community Health Centre, and Youth Services Bureau of Ottawa as the Lead Agency for Ottawa children and youth services plus individual members of the trans, two-spirit, intersex, and gender diverse and communities. Rainbow Health Ontario was also invited to join the Table.

With the assistance of Trans Health Information Ottawa, a call to community members to participate on the Regional Planning Table was disseminated both online and offline throughout the community. The goal was to ensure that 50% of the Table’s seats were composed of members from the trans, two-spirit, intersex, and gender diverse communities. Deadline for applications was November 30, 2017. In December 2016, a selection committee comprised of the consultant, a representative from Trans Health Information Ottawa, and a representative from Youth Services Bureau of Ottawa successfully appointed a diverse, engaged group of members from the community. A total of nine community members were selected, including two representatives from Trans Health Information Ottawa. The community members are composed of six trans people, one who identifies specifically as a Francophone trans woman

and one who identifies specifically as a non binary transmasculine youth, a parent of a transgender youth, a two-spirit Michif woman, and one intersex person. In February of 2017 one of the members from Trans Health Information Ottawa resigned from their position on the Table.

### *Table Meetings*

The Table scheduled several meetings and required that all members attend each one. The first meeting was held in December 2016 for four hours. Subsequent meetings were scheduled twice a month until March 31, 2017 for two-hours. The initial meeting was held on December 11, 2016 at Family Services Ottawa from 12:00 PM to 4:00 PM. The remainder of the meetings were held at Centretown Community Health Centre (this allowed Seaway Valley Community Health Centre and Rainbow Health Ontario to participate via Ontario Telemedicine Network-OTN) on the following dates: January 9, 2017, January 23, 2017, February 13, 2017, March 20, 2017, April 10, 2017, and April 24, 2017. Both meetings in January ran from 6:00 PM to 8:00 PM. Beginning in February it was determined that in order to properly discuss and plan for the work to be completed, meetings would be held from 6:00 PM to 9:00 PM. Given the vast amount of work to be completed, and the time constraints to do so, the table agreed to hold two meetings in April 2017 to review the report that would ultimately be submitted to the Champlain LHIN.

The table meetings were used to strategize on how to meet the deliverables, consult with the community members present, find ways for the service providers and community members to work in collaboration with one another to achieve shared goals, and to create and review Table documents. Each member of the Table was asked to commitment approximately ten hours per month to the work of the table, to a maximum of 34 hours across the project. Community members received an honorarium for meetings and related required tasks, and were compensated for costs associated with travel and accommodations to attend the meetings.

### *Communications*

In November 2016 Trans Health Information Ottawa in consultation with the Project Consultant created a logo for the planning table, as well as a website for promotion of the work being done. The logo was utilized on all documents throughout the process (planning table documents, application form for community members to sit at the table, etc.).

The website was promoted throughout the community during events (e.g., Trans Health Surgery Workshop), during service provider interviews and community engagement activities for the table, and via members of the table through their various networks. The website was updated regularly and contains information regarding the purpose, planning and operation, and final results of the project. All documents posted to the site are available in both English and French. To view the website please visit <http://ottawatranshealthplan2017.weebly.com/>. It is a priority that final knowledge translation of the Table's work will be disseminated to the broader community once the project is complete.

### **Scan of Existing Services**

An important first step, identified before the table was formally established, was the completion of a scan of services in the Champlain LHIN region. In January 2017 the consultant, in consultation with some of the community members at the table worked to create a draft set of interview questions to be utilized in

the scan of existing services. This draft was later revised, with input from the Table members, to be pilot tested by interviewing the service providers at the Table. Please refer to Appendix A for the Service Mapping Questions (Pilot).

### *The Pilot Interviews*

In February 2017 the new consultant interviewed Centretown Community Health Centre, representing all six Community Health Centres in Ottawa, the Children’s Hospital of Eastern Ontario, Family Services Ottawa, the Royal Ottawa Mental Health Centre, Seaway Valley Community Health Centre, and the Youth Services Bureau of Ottawa. The interviews took place in person or by telephone, depending on one’s availability and preference. Each interviewee received the questions prior to the interview, with an invitation to review the questions, elicit feedback from co-workers, and to bring other staff to the interviews that could best capture the work being done. Interview responses were recorded and sent back to all agencies to review.

At the February 13, 2017 Regional Planning Table meeting members reviewed the results of the pilot interviews and made proposed changes to the pilot interview questions. Suggestions for change led to the creation of three separate interview question templates to better capture the work being done by different agencies and private practitioners. Interview question templates were created for agencies that do not provide targeted services to trans, two-spirit, intersex, and/or gender diverse populations, agencies that do provide targeted services for trans, two-spirit, intersex, and/or gender diverse populations, and private practitioners. Please refer to appendix B for the Service Mapping Questions Agency-No Targeted Services, Service Mapping Questions Agency-Targeted Services, and Service Mapping Questions Private Practitioner Version.

### *A Note on Questions*

The question “*Do you provide targeted/specialized services for Indigenous, racialized, and/or disabled people who come from the Trans, two-spirited, intersexed, or gender diverse populations?*  Yes  No. *If yes, please describe these services*” was asked across all sets of interviews. During the pilot interviews this question was followed up with a set of five questions particular to servicing Indigenous people. Based on the results from the pilot interviews it was clear that most service providers do not provide any specialized services. With this, these questions were removed from the new interview templates and only asked if the service provider indicated that they provide specialized services to Indigenous people. If a service provider indicated that they provided specialized services for racialized and/or disabled people, they would have been asked to describe these services. The draft interview templates were then reviewed by all table members and finalized for use. The consultant followed up with the agencies represented at the table to amend any of their initial interview responses provided during the pilot interviews, and collect information not previously discussed.

### *The Final Scan*

The next step was to take the finalized questions and interview a number of service providers within the Champlain LHIN. A list of potential agencies and private practitioners to interview within the community was compiled based on responses during the pilot interviews, and those provided from suggestions made by community members at the table. With this, the list was narrowed down to fourteen

agencies and/or private practitioners. The potential interviewees covered a cross section of age groups (children, youth, and adults), specialized services provided (e.g., Indigenous services, Francophone services), and services and supports in primary and other (e.g., surgery, endocrinology, etc.) health care, mental health, and community services. Given the limited time frame to complete the interviews, we could not interview every agency and private practitioner in the region who provides services to the targeted populations. The fourteen agencies and/or private practitioners selected to interview were as follows:

- Canadian Mental Health Association-Champlain East Branch
- Centre psycho-social pour enfants et familles d'Ottawa
- Crossroads Children's Centre
- Kind Space
- Ten Oaks Project
- Western Ottawa Community Resource Centre
- Valoris for Children and Families of Prescott-Russell
- Celine Goyette (Psychotherapist)
- Dr. Diane Watson (Psychiatrist)
- Dr. Hasina Visram (Endocrinologist)
- Dr. Helma Seidl (Social Worker)
- Dr. Jennifer Douek (Family Medicine Doctor)
- Dr. Mario Jarmuske (Plastic Surgeon).
- Dr. Blair Voyvodic (Family Medicine Doctor). Once the list was finalized, it was highly recommended that Dr. Voyvodic in Killaloe, Ontario be added to the initial list.

Of the fourteen agencies and/or private practitioners selected to interview, twelve interviews total were completed. We were unfortunately not able to connect with anyone at Kind Space to participate in an interview. To replace the planned interview with Kind Space, we approached Planned Parenthood Ottawa. They were not able to participate in an interview. Valoris for Children and Families of Prescott-Russell were unable to participate in the planned interview as well.

From February 2017 to early April 2017 the consultant interviewed the twelve agencies and/or private practitioners. Interviews were conducted in person, by telephone, or via email. Prior to the interviews, all interviewees were sent the questions to review. Agencies were invited to elicit feedback from co-workers, and to bring other staff to the interviews that could best capture the work being done. Interview responses were recorded and sent back to all agencies and private practitioners to review. **NOTE:** All interview findings are as reported by interviewees.

### **Highlights from the Scan of Existing Services**

Through the detailed scan of gender affirming health services in the Champlain region for trans, two-spirit, intersex, and gender diverse communities several findings should be highlighted. Please note that all information below is as reported to the Table's consultant.

- Four of the agencies interviewed provide targeted services for trans, two-spirit, intersex, and/or gender diverse communities; all seven private practitioners as a part of their practice provide targeted services for trans, two-spirit, intersex, and/or gender diverse communities

- Of those agencies and private practitioners who provide targeted services;
  - Primary and Other Health Care**
    - The Children’s Hospital of Eastern Ontario is the only agency that provides other health care (e.g., endocrinology, etc.) to children and youth
    - Dr. Jennifer Douek, private practitioner provides primary health care to those 17 years and older
    - Dr. Blair Voyvodic, private practitioner provides primary health care to adults. “Adult” is based on level of readiness, not physical age. He will work with anyone who takes the initiative to self-refer. He does not work with those whose parents call on behalf of their children/youth/young adults
    - All other agencies and private practitioners who provide primary health care services, see those 18 years of age and older

### **Mental Health Care**

- The Children’s Hospital of Eastern Ontario provides mental health services to children and youth
- The Trans Health Youth Program with centralized access through Centretown Community Health Centre provide mental health services to youth 17 and 18 years of age
- Dr. Diane Watson and Dr. Helma Seidl, private practitioners provide mental health services to children, youth, and adults
- Dr. Blair Voyvodic provides short-term mental health services to adults. “Adult” is based on level of readiness, not physical age. He will work with anyone who takes the initiative to self-refer.
- All other agencies and private practitioners who provide mental health services, see those 18 years of age and older

### **Community Services**

- Family Services Ottawa provides the vast majority of community services to children, youth, and adults
  - Ten Oaks Project partners with Family Services Ottawa to provide a swim night for children and youth
- A couple of private practitioners have been providing targeted services for decades (20+ years), however the average length of time service providers and private practitioners in the Champlain region have been offering services to trans, two-spirited, intersex, and/or gender diverse populations is 5.3 years
  - Only three service providers (Centretown Community Health Centre, Family Services Ottawa, and Dr. Mario Jarmuske-Plastic Surgeon) receive targeted funding to provide services to trans, two-spirit, intersex, and/or gender diverse communities
  - 50% of agencies that provide targeted services offer services in English and French, the other 50% offer services in English only. 29% of private practitioners offer services in English and French; 57% of private practitioners only offer services in English; and 14% of private practitioners offer services in English and languages other than French

- The four service providers that provide targeted services have a defined catchment area, however three out of the four agencies who provide targeted services extend beyond their typical catchment. Geographic areas reached by these agencies include Eastern Ontario, Northern Ontario, Western Quebec, and Nunavut
- Wait lists for targeted services (primary and other [e.g., surgery, endocrinology, etc.] health care, mental health care, and community services) range anywhere from one week to six months
- There are approximately 6 full-time equivalent employees providing targeted services across all agencies
- 58% of agencies that provide non-targeted services see clients from the trans, two-spirit, intersex, and/or gender diverse communities regularly accessing particular programs and services
- 29% of agencies that provide non-targeted services offer services in English and French, 43% offer services primarily in English but have some staff that speak French, 14% offer services in English only, and the remaining 14% offer services in French only
- Private practitioners who provide non-primary health care services (psychotherapy) charge a fee for service and the private practitioner who provides plastic surgery charges a fee for those procedures not covered by OHIP (chest contouring and liposuction)
- No agencies interviewed for the scan provide specialized services for Indigenous, racialized, and/or disabled people from the targeted populations, although a couple integrate spaces, programming, and/or practices into their work with these populations. Two private practitioners indicated that they provided specialized services, both to Indigenous people
- Of the service providers who responded to this question, all take measures to record a client's self-identified gender, even if their client information systems do not allow for anything other than male or female
- No service provider expects a client to demonstrate a binary gender identity (male or female) to access services. The only stipulation to this is those agencies that offer violence against women services or have gender specific shelters. In these cases, clients can access services based on whether their self-identified gender matches that of the program
- Most service providers have received some training to provide services to trans and gender diverse communities. Very little training has been received to provide services to two-spirit and intersex communities. There was a keen interest amongst service providers to increase their cultural competency by attaining education and training
- Most service providers are connected to others in the community who provide services to address the needs of trans, two-spirit, intersex, and/or gender diverse communities

## Community Engagement

The Table identified three priority groups for further community engagement: two-spirit, Francophone, and rural. It was hoped that engagement would take place through focus groups, although interviews were also a possibility. Community members of the Table developed the focus group's guide and questions in February and March 2017. Through these communications the members also discussed the community engagement activities to be undertaken, and planned for the logistics of such activities. At the February 13, 2017 Regional Planning Table meeting it was confirmed that there would be focus groups for the three priority groups. Focus groups for youth and for parents whose children/youth/young adults identify as gender creative, trans, transgender were also planned.

Both formal focus groups and informal interviews were conducted with the community in March 2017. Formal focus groups were ultimately held for two-spirit people, Francophone people who identify from the trans, two-spirit, or gender diverse populations, people in rural areas who identify from the trans, two-spirit, intersex, or gender diverse communities, and a group for trans youth. Informal interviews were conducted with parents whose children/youth/young adults identify as gender creative, trans, transgender, with the intersex population, and with people of colour from the trans, two-spirit, or gender diverse communities. **NOTE:** All community consultations are as reported by interviewees. Please refer to Appendix E for the Community Engagement Background Documents.

### *Two-Spirit*

The two-spirit focus group was the first to be facilitated. Prior to the group, the community members from the table had not yet finalized the questions so the facilitator created and utilized their own set of interview questions. Please refer to Appendix C for the list of questions used. All other groups, both formal and informal utilized the same or a similar set of questions. Please refer to Appendix D for the list of questions used. Participants of the formal focus groups received a small honorarium for their time and contributions.

The two-spirit focus group took place March 9, 2017 from 6:00 PM to 8:00 PM at Kind Space in Ottawa, Ontario. There were eight two-spirit individuals who provided feedback during the focus group and all were contacted through snowball networking. The group was facilitated by Benny Michaud, a two-spirit Michif woman.

### *Francophone*

The Francophone focus group took place March 18, 2017 via teleconference. A toll-free number was provided for participants to connect to. Those with high-speed Internet connections could also connect with their computer if they so desired, by way of a provided link. The group was scheduled for 4:00 PM, however the Facebook page where the group was advertised erroneously indicated a time of 1:00 PM. As such, the focus group was held at both the erroneous time of 1:00 PM and the otherwise advertised time of 4:00 PM, to ensure that no one was missed. There ended up being only a single participant. As such, the format was altered on the spot to be more amenable to an interview format. After the official Francophone group was held, an interview with a single participant was conducted via email. Both the formal focus group and the interview were facilitated by Maëlys McArdle, a Francophone trans woman.

## *Rural*

The rural focus group took place March 19, 2017 from 1:00 PM to 3:00 PM at the Seaway Valley Community Health Centre in Cornwall, Ontario. There were seven individuals present. Stephanie Hemmerick, Health Promoter and LGBT Lead for Seaway Valley Community Health Centre advertised the focus group through Seaway Valley Community Health Centre's organizational website ([www.seawayvalleychc.ca](http://www.seawayvalleychc.ca) general), general Facebook page and its LGBT Facebook group, Diversity Cornwall, through a listserv email to over 120 community partners and direct outreach. The group was facilitated by Jaina Tinker and Rika Moorhouse, both trans identified people.

## *Youth*

The group for trans youth, defined as those under the age of 18 or those who received youth services in the last five years, took place March 18, 2017 from 6:00 PM to 8:00 PM at Kind Space in Ottawa, Ontario. There were nine trans identified participants, five under the age of 18, four over the age of 18. Participants for the focus group were recruited through multiple methods. A Facebook event was created by the facilitator and shared with their personal networks of queer and trans youth (their personal Facebook, to be shared by others; The Lisgar Rainbow Alliance, The High School Student Alliance, and the Gender and Sexuality Alliance Network), as well as the Facebook group FTM Canada. A poster was also created which was circulated to the members of the Regional Planning Table to be shared with their networks and was thoroughly circulated by the Children's Hospital of Eastern Ontario through their Diversity Clinic. Participants were asked to contact the facilitator in order to register ahead of time. The majority of them learned about the event through Facebook or from the Children's Hospital of Eastern Ontario's mailing list. The group was facilitated by Kaeden Seburn, a non binary transmasculine youth.

## *Parents*

A formal focus group for parents of gender creative, trans, or transgender children/youth/young adults was scheduled for March 28, 2017 from 6:00 PM to 8:00 PM at Family Services Ottawa, in Ottawa, Ontario. Unfortunately due to time lines for the project, availability of group participants, and a booking error at Family Services Ottawa, the group could not be held. With this, the set of questions for the focus group were sent out via email to parents by the Around the Rainbow program at Family Services Ottawa. The questions were sent out on March 21, 2017, with a deadline of March 24, 2017 at 4:00 PM for completion. No responses were submitted. Prior to this, Patricia Vincent, a parent of a transgender youth more informally collected some feedback from a few parents of transgender children/youth/young adults regarding gaps in gender affirming health services in the Champlain region and recommendations for improved client pathways among partners.

## *Intersex*

The intersex interviews were to be conducted one-on-one by a method of the participants choosing (in person, on the telephone, or email). There were two potential interview participants who reached out, but after brief email conversations with the interviewer, both participants excused themselves from further participation in the study. 1) Participant One's intersex status was irrelevant for the reasons they sought care in Ottawa, thus this difference was not disclosed to health professionals. 2) Participant Two has no diagnosis for an intersex condition, but reported a physician noting non-binary developmental issues at

adolescence, which Participant Two doubts were recorded, and which were never investigated. Participant Two now suspects possibly being intersex. Participant Two was referred to the Trans Youth Focus Group. Mel Thompson, an intersex person facilitated the interviews, and wrote up a case study on their difficulties in accessing care. The poster for the intersex interviews were physically distributed to five locations in the downtown core of Ottawa, to 312 Parkdale Avenue in Ottawa, and were handed out to people who wanted to post them somewhere. Posters were also advertised on Facebook pages of University student associations and groups, bookstores, LGBT sites, Trans Health Information Ottawa, and The Canadian Centre for Gender and Sexual Diversity. Representatives from the Regional Planning Table from the Children's Hospital of Eastern Ontario and the Royal Ottawa Mental Health Centre disseminated the posters within their hospitals.

### *People of Colour*

Non binary and trans people of colour who resided in Ottawa, Ontario within the last five years were sent an email asking if they would be interested in participating in an interview. The email went out to those within the facilitator's personal network. There were three trans people of colour participants who responded, none who currently reside in Ottawa, Ontario, but have within the last five years. Each participant was contacted, and interview times were set up. The interviews were done one-on-one over the telephone while the facilitator entered information directly into the survey questions. The interviews were conducted by Mikki Bradshaw, a trans identified person.

### **Preparing the Final Report**

Data was collected during all meetings of the Table. Later in the process, at the March 20, 2017 Regional Planning Table meeting, members provided a brief, point form list of knowledge/understanding of gaps in gender affirming health services in the Champlain region, suggested recommendations for improved client pathways among partners, and ideas on an outline for the report itself. Agencies were encouraged to create their list of gaps and recommendations based on their respective agencies and the clientele they serve. Community members were encouraged to create their list of gaps and recommendations based on personal experiences, the results from their focus groups/interviews, and discussions that occurred between the community members throughout the Regional Planning Table project. These materials along with the service provider interviews, community engagement activities, and discussions amongst table members have formed the basis of the report. Ideas, specific words and wording, and pieces of community engagement summaries and reports were utilized throughout.

The report was drafted, by the project consultant in March and April of 2017. All community members were invited to review and provide feedback during the writing process. On April 10, 2017, the Table reviewed the draft report, and made suggestions for additions and edits. Once all edits were made, the table had one last chance to review the report before it was finalized. The final report was completed and submitted to the Champlain LHIN on April 28, 2017.

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## **Identified Gaps in Primary and Other Health, Mental Health, and Community Services for Trans, Two-Spirit, Intersex, and Gender Diverse Communities**

The gaps identified in this report are informed by service provider interviews, community engagement, focus group interviews and by the members of the Table. As much as possible, the text below includes phrasing taken directly from the service provider interviews and community focus group reports. The gaps have been categorized by theme: Pathways to Care and Pathways Through Care. Pathways to Care includes the process of seeking services, and the barriers to offering and accessing such services. Pathways Through Care includes the services offered and the experience of individuals when they utilize services.

### **Pathways to Care**

#### *Lack of a basic code of good practice/conduct*

Currently there is no provincial protocol (although there are international standards created by the World Professional Association for Transgender Health and primary care guidelines created by Rainbow Health Ontario) of care/standards of practice for gender affirming services for trans, two-spirit, intersex, or gender diverse people. There is a lack of accountability in providing good practice, and adhering to a code of conduct. In addition, there are gaps in adhering to or ensuring compliance with the Ontario Human Rights Code. An Ombudsperson for trans two-spirited, intersex and gender diverse health services does not exist.

#### *Lack of clear pathways in the Champlain region*

There is a lack of any organized network of providers that makes it challenging for clients to navigate the system. Currently there is no central service provider, website, or phone number you can call to get the information and resources you need. Most clients learn about services, information, and resources through trusted friends and their respective communities. A recent survey of health care for trans, two-spirit, intersex, and gender diverse communities in the Champlain region found that 80% of people have got accurate information on trans-related care from friends or peers.<sup>1</sup> In addition to or instead of navigating the system by word of mouth, others will conduct their own research online. This can be a helpful method to gain the information they are seeking, but can also lead people to incorrect content. In rural areas, it can take several years to find and/or access services.

Pathways to care that do exist are often fragmented and are not available through each level of care from primary to secondary to specialized tertiary. Clients often must go through the “referral cycle” where they are referred on to the wrong place where they are then refused service, and referred on to the next service provider. Clients have to repeat their personal story over and over again until they find what they need.

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<sup>1</sup> Moorhouse, R., Seburn, K., Rivard, S., Michaud, B., Thompson, M., McArdle, M., Bradshaw, M., Tinker, J., & Vincent, P. (2017). “Health Care Access Around Ottawa (“Champlain Region”) for Trans, Two-Spirit, Gender Diverse and/or Intersex People”. Unpublished raw data.

*Lack of targeted services and supports for trans, two-spirit, intersex, and gender diverse communities in the Champlain region*

Services and supports for trans, two-spirit, intersex, and gender diverse people are lacking in primary and other (e.g., surgery, endocrinology, etc.) health care, mental health services, and community services. Specialized services for those within these diverse communities including Francophones, two-spirited people, people of colour, children and youth, parents/caregivers, intersex people, and those in rural areas are limited or non-existent.

Areas where service is lacking include:

- Limited number of primary care practitioners who can and will offer hormone therapy
- Gaps related to post-surgical care
  - Clients without access to primary care have no place for trans positive post-surgical care—may present in pain/experiencing complications/risk of infection/fearful, may not be able to articulate their post-surgery needs well and need to re-share their whole story with new providers, which can be traumatic, or may avoid/delay accessing care which can exacerbate issues
  - Not enough local expertise related to trans surgery wound care, limited local specialists (with trans experience) to consult with or see clients as needed post-surgery (e.g., Urology, Gynecology)
  - Lack of advanced planning for clients with health professionals involved regarding what to expect and what measures would be helpful post-surgery
  - Many clients lack coverage for home care benefits, unless paid out of pocket or have sufficient social supports to assist. This may lead to poorer post-surgery compliance and thus lead to an increased risk of infection or complications
- Lack of support to clients who require secondary surgery assessments
- Limited access to and therefore choice of psychiatrists and other private practice practitioners
- Lack of access to specialized mental health and addictions services
- Lack of structured, professionally facilitated support groups
- Lack of counselling for adults on the gender spectrum
- Lack of access to social supports including housing, employment assistance, and practical assistance such as changing names on government documents
- Lack of support and opportunities for trans, two-spirit, intersex, and gender diverse people to get together for social support
- Lack of support for children and families through networks, information, social events, and community events
- No supports or services specifically for Francophone people who identify as trans, two-spirited, intersex, or gender diverse; no supports or services for those who identify as two-spirit
- No supports or services tailored to the unique needs of people of colour who identify as trans, two-spirit, intersex, or gender diverse
- Lack of community based services for children and youth, especially those without supportive parents
- Lack of support for children/youth of parents who are transitioning
- Lack of support and counselling for families at every stage of transition, particularly families whose parents/caregivers are unsupportive

- Lack of parenting resources for those who are transitioning or who have a child/youth/adult or other family member who is transitioning
- No supports or services about or for intersex conditions
- Very little access to gender affirming services in rural areas, with no identified services specifically for trans people

### *Barriers*

A number of barriers to accessing care, including financial, geographic, specific group seeking care, and physical health and mobility issues were identified.

### **Geographic**

People in rural areas have to travel to Ottawa for trans health services, and with limited access to gender affirming surgeries in the region, other than one known provider who performs top surgery; clients are burdened with the financial costs associated with travelling to Ottawa and outside the region. Services that are available are often centralized in Ottawa, and can be financially difficult to attain. In rural areas, there are often no services available which means that individuals may not access any service at all or they will look to alternative routes for Hormone Replacement Therapy (HRT) that are not medically supervised.

### **Financial**

In regards to primary health care needs, OHIP does not cover the cost of the entire procedure for male chest reconstruction, and access to some medications can be quite expensive. Many clients struggle to pay for Hormone Replacement Therapy (HRT) and/or blockers, and often times are not provided with the information on the Lupron Cares program to cover blockers. Fertility options are expensive and not accessible to those on low incomes.

Of the limited specialized counselling and mental health services available, the majority operate on a fee-for-service basis. If a client does not have access to private health insurance benefits they are expected to pay out of pocket. For many, this is not financially possible.

The Trans PULSE study of transgendered people in Ontario found that 71% of respondents had some post-secondary education; however about half had a gross income of \$15,000 a year or less.<sup>2</sup> This study also found that “37% of respondents had full-time employment, while 15% had part-time employment. 25% were students, 3% were retired, and 20% were unemployed.”<sup>3</sup>

### **Youth**

Youth face particular barriers to accessing services. Youth who have no parental support face the most barriers to accessing gender affirming services. Many services require or expect youth to have

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<sup>2</sup> Bauer G, Nussbaum N, Travers R, Munro L, Pyne J, Redman N. “We’ve Got Work to Do: Workplace Discrimination and Employment Challenges for Trans People in Ontario.” Trans PULSE e-Bulletin, 30 May, 2011. 2(1). <http://transpulseproject.ca/research/workplace-discrimination-and-employment-challenges-for-trans-people-in-ontario/>

<sup>3</sup> The Canadian Press. “Transgender Unemployment is a Result of Discrimination, Advocate Says.” CBC News, 1 September, 2014: 1. <http://www.cbc.ca/news/canada/toronto/transgender-unemployment-is-a-result-of-discrimination-advocate-says-1.2752459>

parental support, although that is not the reality. Many youth do not have the financial resources to travel to and access services. If they have been rejected by their families, many youth have little to no financial supports to attain services, and may be struggling with trying to meet their basic living needs such as housing and food. In addition, the free services that do exist for youth are at capacity, and overwhelmed by demand.

## **Ability**

It can be extremely challenging for those with physical health and mobility issues to access services. Travelling to and from service providers can be challenging and may put a significant financial strain on some. For some, travelling may not be an option, so unless services are close to home, they are unable to get the support and help they require.

## **Diversity**

For those from the Francophone, two-spirit, intersex, or people of colour communities, if they want to attain gender affirming services to meet their specific needs, they may need to travel outside the region to attain them. As with others, this may be financially burdensome and not even plausible. If they are to acquire services in the region, clients may not feel as comfortable and confident in the services they ultimately receive.

## **Pathways Through Care**

### *Gaps in cultural competency*

There is a generalized lack of training, awareness, comfort, sensitivity and understanding amongst service providers for gender affirming services. This often results in clients receiving poor initial experiences and /or receiving incorrect information.

The community engagement focus groups and interviews reported a range of negative experiences with service providers. Through community engagement we found that service providers who lack cultural competency sometimes ask inappropriate, unnecessary, invasive questions, and irrelevant questions such as those related to a client's sexuality, and they may repeatedly ask the same questions (e.g., Are you sure about transition?). It was also reported that some service providers demonstrate a sense of entitlement to clients bodies, by for example asking for details about the physical transition process when that has no relevancy to the services being sought (e.g. going in for a flu shot and the nurse asks about what surgeries they have and have not had, etc.). Often times clients feel the need to hide certain pieces of information about themselves knowing it may be 'used against them' in transitioning. There is a sense of a lack of empathy by service providers about the client's personal situation, feelings, and experiences. At times, minimal to no discretion is used when dealing with personal information such as name assigned at birth versus preferred name (e.g., calling out names in a waiting room), particular tests being taken and who they are shared with (e.g., information is shared when making referrals without checking with the client first as to what personal information they would and would not like shared), etc.

Without training, education, and knowledge many service providers are not able to provide gender affirming services. Others are lacking the cultural competency to provide the highest quality of gender

affirming services. There is currently minimal to no training in medical school on trans, two-spirit, intersex, and gender diverse people. Some feel that universities and colleges lack the ability to fully comprehend Indigenous issues, let alone the needs of two-spirited people.

With a lack of information, training and knowledge, clients often have to do the educating. Patients feel an expectation to educate their providers if they are to receive culturally competent services. The process of educating and teaching service providers can be overwhelming, exhausting and draining, and one of the reasons clients may not access services. However, a few clients in the community engagements sessions found their service providers to be receptive to the information they were sharing, and thus empowering.

The majority of non-specialist primary health care providers, mental health care providers, and community service providers have no knowledge or cultural competency of trans, two-spirit, intersex, or gender diverse people. This makes accessing standard, non-transition related services difficult. Within the larger, multi-service agencies cultural competency is not always consistent throughout the organization. For example, staff who provide general services do not always have the cultural competency that some of their co-workers who provide trans specific services may have.

### **Hormone Replacement Therapy**

In primary care there is a lack of knowledge and/or willingness to engage in hormone treatments or to co-follow patients following the initial assessment and treatment plan. There is not enough training, support, and mentoring for those in primary care who may have taken training in hormone therapy but are unsure about utilizing it in practice. Without support the patients do not get treatment, and the physicians do not have the opportunity to learn. There have been issues with some pharmacies who lack awareness and knowledge of trans health, and thus are not re-filling prescriptions. Pharmacists who are not familiar with certain drugs used with HRT, given it off label use often ask clients questions about why they are using that particular drug(s).

### **Stereotypes**

Stereotypes and/or stigmas of trans, two-spirit, intersex and gender diverse people still exist, and have a significant impact on clients accessing and receiving services. Indigenous people are challenged about their Indigeneity by non-Indigenous practitioners because of the lightness of their skin for example. Assumptions are made about them based on stereotypes about Indigenous people and addictions or stereotypes about Indigenous people and poverty. Particularly in rural areas, there is a significant amount of homophobia, biphobia, and transphobia. These have a particular impact on older adults who are housed in supportive living facilities.

### **Intersectionalities**

Medical staff and mental health providers often lack an understanding of the complexities of intersectionality among the different groups. Clients in these populations often come with previous traumas relating to their minority sex or gender status. Clients frequently report feeling discriminated against, traumatized or triggered by health professionals in their attempts to access care. It has been noted that neither historical trauma, nor the trauma or micro-aggressions faced in accessing care are being factored in

nor even considered in regards to a client's mental or physical health. Two-spirited participants explained that while some service providers were knowledgeable about the queer community, and others were knowledgeable about Indigenous issues, very few seemed to understand the complexity of being both queer and Indigenous. Health care providers do not recognize and acknowledge the unique health needs of two-spirit people from a medical and mental health perspective. In addition, there seems to be no willingness or acknowledgement of colonialist tendencies or lens point as to how a service provider interacts with a person of colour.

## **Two-Spirit**

Non-Indigenous service providers and mainstream agencies often do not have an awareness of Indigenous communities, and the existence of two-spirit people, often referring out to Indigenous programs, rather than taking responsibility to serve two-spirit people. There is no access to safe mental health/social services, particularly in Aboriginal/Inuit organizations. The majority of participants interviewed were hesitant to seek care through Indigenous programs run in Ottawa because maintaining confidentiality was extremely difficult. The community is very close-knit and things get out. The difficulty in accessing ceremony and key elements of spirituality had negative impacts on the overall health and well being of focus group participants. Participants wanted practitioners to understand more fully the challenge faced by two-spirited people wanting to access spirituality and the role that colonization has had on diminishing traditional valued role of two-spirit people in Indigenous communities. Many traditional elders and ceremony-makers had been greatly influenced by their time in residential school where Indigenous understandings of gender fluidity were replaced by Christian notions of the gender binary

## **Intersex**

A lack of cultural competency or knowledge on intersex topics has been identified. There is a well-documented cultural taboo within medicine towards the intersexed. Since the 1950s, medicine has enforced the gender and sex binary through non-disclosure of pertinent medical information relating to intersex conditions, coupled with unconsented sex reassignment surgeries on infants and children, practices that do not respect the legal and human rights of clients. Medicine uses the oversimplified idea of binary sex to describe what science has shown is a spectrum of sex, as people can have both male and female sex markers across or within physical sex markers (i.e.: gonads, genitals, genes, hormones, phenotype, internal sex organs), without any visible cues or problems. Thus the rate of occurrence of intersex conditions is simply unknown, but much higher than has been assumed. The medical profession often espouses long disproven and inherently discriminatory myths about intersexuality (i.e.: stating such conditions are a "congenital defect," "aberration" or "abnormality," or that the sexually non-binary are necessarily infertile or defective). Physicians disputed the existence of intersex conditions, or espoused scientifically untenable beliefs, pointing to gaps in training. Physicians remain unwilling to accept that humans are not reliably or completely sexually binary, revealing a resistance to established science, displaying a medical belief that sex should be, or must appear to be binary.

## **Francophone**

Significant gaps exist in providing adequate services to Francophones regarding transitions, and supports and services through the LGBTQ community in general. Listings of private practitioners assume English as the language of communication. Participants desire French-speaking service providers but

cannot locate them. Even if French language services are requested, services are offered in English. Often times a service may be advertised as being offered in French, but the service provider speaks English, or they speak French but it is so poor the client has to request services in English so they can understand them.

## **Youth**

Youth noted that providers were very fixated on talking with their parents, even in cases where they were over the age of 18, did not live with their parents or where it had already been identified that their parents were not supportive and were not to be contacted. Some participants also noted that provider's responses to questions regarding whether and when they could be referred for services seemed to change after talking to the individual's parents. With regards to social services, many youth also noted that a large number of services for youth are run by other, slightly older youth who do not receive the necessary training or support, particularly regarding mental health and crisis support. As a result these youth leaders are not able to work effectively and have extremely high rates of burn-out.

### *Lack of resources to meet demands for service*

The demand for services for trans, two-spirit, intersex, and gender diverse people is increasing significantly. At the Children's Hospital of Eastern Ontario for example the number of initial new referrals are doubling each year. At Family Services Ottawa the number of parents/caregivers participating in the support group for gender creative, trans, and transgendered children, youth, and young adults has tripled in the last year. There is a high demand for counselling services regionally, with a local survey indicating that 81% of respondents feel that there is an urgent need to improve mental health services in area.<sup>4</sup> Unfortunately there is a lack of targeted and sustained funding to provide such services. With this, there is a lack of services in general, and those services that are available are at capacity and have waiting lists. Agencies that do not have funding for targeted services are working hard to fill in the gaps and meet the needs through other programs and services.

Due to funding constraints many agencies have only a small number of staff that can provide targeted services. Often times what is happening is that staff with the knowledge and skills to work with trans, two-spirit, intersex and gender diverse people are splitting up their time between their funded positions and those programs and services that support these populations. Providers have shared that they feel isolated and unable to meet the multiple needs of clients who may require gender affirming health care alongside other types of supports such as transitioning supports/counselling and/or practical supports. With a lack of staff providing these services, there is limited ability to work, and provide support as an interdisciplinary team.

Capacity does not meet the demand and nearly all targeted programs have waiting lists to access services. Children and youth have to wait approximately three months for an initial consultation for other health care services. Adults have to wait two weeks for an intake appointment for trans health primary care and one to two months to access services. The wait for support groups for parents/caregivers of gender creative, trans, transgendered children, youth, and young adults is six months. Clients often have to choose between timely services or having providers who understand trans, two-spirit, intersex, and gender diverse identities and experiences.

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<sup>4</sup> Moorhouse, R., Seburn, K., Rivard, S., Michaud, B., Thompson, M., McArdle, M., Bradshaw, M., Tinker, J., & Vincent, P. (2017). "Health Care Access Around Ottawa ("Champlain Region") for Trans, Two-Spirit, Gender Diverse and/or Intersex People."

Both the Children’s Hospital of Eastern Ontario and Centretown Community Health Centre have long waitlists to support children and youth, and cannot refer elsewhere as there is a lack of other access points for families. The Children’s Hospital of Eastern Ontario has limited capacity and is now redirecting youth as young as 16 to Centretown Community Health Centre’s LGBTQ youth counselor, which only compounds wait times. This also results in a less than smooth transition of the Children’s Hospital of Eastern Ontario’s transitional age youth to primary care providers (currently only one endocrinologist).

With a limited network of primary health care providers who will support patients with gender affirming care, and providers who perform gender affirming surgery, waitlists for all transition related services are extremely long. The Ottawa Trans Health Clinic recently implemented a time-limited clinic focused on provision of hormone therapy for those who wish to medically transition. This clinic cut wait times from ten months to four to six weeks. This clinic ends in June 2017. Given the limited network of primary care providers offering hormone starts, the wait times for service will increase.

#### *Gaps in client data collection*

Depending on the type of agency (hospital versus social service agency), and whether one works in private practice or not, client data collection varies. Several agencies are mandated to utilize specific client information systems, which constrains them to recording client sex and gender as binary (male or female), when a client may actually be both male and female or neither, in terms of gender and/or physiology. Many client information systems across the province have been or are currently being updated to be more inclusive of sex and gender spectrums, and of the client’s preferred name and pronouns, but these are not yet being utilized by all. In addition, there is no way of rolling up the data at a system level to inform health system planning and evaluation.

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## **Recommendations to Improve Client Pathways Among Partners Working With Trans, Two-Spirit, Intersex, and Gender Diverse Communities**

Based on the identified gaps in primary and other (e.g., surgery, endocrinology, etc.) health, mental health, and community services for trans, two-spirit, intersex, and gender diverse populations several recommendations to improve supports and services have been made. Recommendations are divided into those that we would like to see achieved in the short term, medium term, and long term, and are categorized by whether they are recommendations to improve Pathways to Care or Pathways Through Care. Short term is defined as one to two years, medium term is defined as three to five years, and long term is defined as five years and over. Recommendations have also been made for advocacy needed by the LHIN and others in the province.

### Short Term Recommendations

#### *Pathways to Care:*

#### **1) Improved promotion of existing supports and services for trans, two-spirit, intersex, and gender diverse communities**

As a first step, service providers identified and/or interviewed for the scan should all receive a copy of the results. This is a good way to advertise existing services in the region and create better awareness of what service providers do. To ensure advertising and promotion is sustained, the Regional Planning Table website can be used, and social media accounts can be created where service providers can document their supports, services and upcoming events. With the help of community members and community groups, this information can be shared amongst the community. It would also be helpful to have in-service sessions for interested service providers, as well as information nights for the community at large.

Service providers should continue to promote internal programs and services that are targeted for the trans, two-spirit, intersex, or gender diverse communities, and non-targeted programs and services that trans, two-spirit, intersex, and gender diverse communities are often attending. Promotion can occur through social media, service provider websites, pamphlets, and at community events. Community partners can work as a collaborative, sharing information about, and promoting services for each other. This may include sharing links to one's another's websites and social media accounts, sharing events both electronically and in house, and keeping pamphlets of one another's programs and services within one's respective agency/office.

#### **2) Create a system planner position to assess and make improvements to client pathways of care**

The system planner would act as a hub and capacity builder, working to change the system and model of care to better support trans, two-spirit, intersex, and gender diverse communities. Existing supports and services for trans, two-spirit, intersex, and gender diverse communities would be considered as part of any broader initiatives to improve health system navigation and information and referral. Initially, the planner will work at the system level for health care and mental health services to achieve change and

improvements in the models of care. Ideally, the system planner will have a clinical background and training (e.g. psychologist) so that they can provide counselling and support services to clients once the planning process is complete. At that time, they would focus their efforts on providing clinical counselling and support services to trans, two-spirit, intersex, and gender diverse clients. This position could replace that of the system navigator position(s) or work in collaboration with them.

### **3) Create a system navigator position(s) to improve client pathways to care**

The system navigator(s) would act at the individual level by providing one-on-one service to those from the trans, two-spirit, intersex, and gender diverse communities. In addition, the navigator(s) will create a shared knowledge base of services and expertise that exist, and would be able to direct clients on how best to access these supports and services. By creating linkages and making connections with service providers, the system navigator(s) would have up-to-date knowledge about the supports and services available within the region, and be able to streamline the referral process for clients. Similar to that of Transitional Support Workers in the Violence Against Women sector, the system navigator(s) would be available not only to make referrals and advocate on behalf of the client for service, but also to assist with practical supports such as finding housing and changing names on identification cards. It is important to have a system navigator available in both the rural and urban settings.

In developing a list of resources, the system navigator(s) would work in conjunction with Rainbow Health Ontario to build upon and complement the existing database of service providers in primary and other health care, mental health care, and community services that are involved in health care for trans, two-spirit, intersex, and gender diverse communities. This database should identify the services available, which communities(s) the services are targeted for, locations(s) of services, accessibility of services, language(s) services are available in, and be made available in both official languages. Ideally, the system navigator(s) would have members from the trans, two-spirit, intersex, and gender diverse communities compile and validate a list of service providers.

Once established, the system navigator(s) should be part of future planning processes to determine gaps in gender affirming health care and to make recommendations for improvement. Those from the trans, two-spirit, intersex, and gender diverse communities have invaluable knowledge and experiences with the complex systems to navigate. With this, it might be helpful to look to the trans, two-spirit, intersex, and gender diverse communities to do this work.

### **4) Create resources and supports for trans, two-spirit, intersex, and gender diverse communities**

To facilitate awareness and build knowledge of trans, two-spirit, intersex, and gender diverse communities amongst service providers and community members, online and offline resources and supports should be created. Resources and supports may include resource guides, infographics, and online communities of support. Ideally a consultant who identifies from each community will be hired to create such resources and supports. These individuals would engage with their respective communities throughout the process and will have experience in curriculum and resource development.

**5) Increase access to services for trans, two-spirit, intersex and gender diverse communities in rural areas**

Utilizing the hub and spoke model, create and enhance formal connections and supports between the rural areas and agencies in Ottawa who provide services to trans, two-spirit, intersex, and gender diverse communities. The hub would emanate from within Ottawa, acting as a resource for those in rural areas (spokes) by offering different/more complex services or by leading in another way. This model will require financial support for service providers in rural areas (spokes) to increase and create services. The hubs will be important players and will provide a distinct subset of services.

In addition to an allocation of resources to rural areas, primary care physicians, specialists, and mental health professionals coming from Ottawa should provide access to services via telemedicine methods including, but not limited to, OTN. Primary care physicians/specialists from Ottawa should offer culturally competent care a dedicated number of times a month across different rural areas in the Champlain region. The few primary care physicians and specialists in rural areas who work with trans, two-spirit, intersex, and gender diverse communities should promote the work they are doing amongst their colleagues and when time permits, mentor and train those who are interested.

The supporting health care organizations (spokes) should be provided with funding and resources (financial and human) to allow clients of all ages to access appointments in Ottawa (when not available in their home location) with coordination of transportation. For example, youth, particularly those whose parents are not supportive are in most need of financially accessible transportation.

**6) Continue to engage the trans, two-spirit, intersex and gender diverse communities in planning**

Continue formal connections with, and conversations between service providers and community members. Sustained relationship-building and community engagement are an important part to increasing trust between service providers and community members, and ensuring the trans, two-spirit, intersex, and gender diverse communities' needs are adequately being met. Through these consultations with community members, service providers will be better equipped to implement changes to administrative and clinical practices that are more sensitive and responsive. As a collaborative, service providers and community members would need to determine how to resource coordination and administration for ongoing engagement.

Any service provider planning to review services or implement substantive changes to services for trans, two-spirit, intersex or gender diverse communities should ensure that representatives from these communities are included in the process and have an equal say in the outcome. Service providers can ask their respective funder to ensure that when making a substantive change, they consult with the trans, two-spirit, intersex, and gender diverse communities. For a formalized set of guidelines, core values, and code of ethics around community engagement it may be useful to build on the work of other similar initiatives. These include the International Association for Public Participation and the Addictions and Mental Health Network of Champlain.

### *Pathways Through Care:*

#### **1) Improve funding to existing and established services providers in order to maintain and stabilize services**

Fund existing and established service providers who provide targeted services to trans, two-spirit, intersex, and gender diverse communities. This will maintain access to services, address wait times, and increase pathways to service across the health and social services sector. Utilizing a model of community building and partnerships amongst existing service providers will help to improve the existing disconnect between, and fragmentation of services.

#### **2) Find sources of stabilized funding for community supports outside the traditional health system**

Community providers can work together to identify avenues for stabilized funding for community supports, and ways to optimize existing funding. It will be essential to identify and explore both private and public funding streams that support grassroots and not-for-profit agencies. There may also be opportunities for already funded agencies and supports to utilize the resources they have to amend existing services.

#### **3) Create and enhance opportunities for peer support and connection for trans, two-spirit, intersex, and gender diverse communities**

Agencies and community groups should create opportunities for peer support and connection. Peer support reduces isolation, creates connection, and can reduce physical, emotional, and social issues. If agency resources permit, peer support could become a part of a Volunteer Coordinator position for example. If and when more targeted funding becomes available, agencies should hire a Peer Support Coordinator to develop volunteer training materials, recruit peer supporters, and manage the logistics around running such a program. Peer supporters can be matched with clients to provide one-on-one support in ways that suit the client and/or can be facilitated during drop-in programs. Once a peer support program is up and running, the Coordinator of such should host bi-monthly meetings for peer supporters to connect with, and learn from one another, discuss issues and concerns, and learn about resources and supports.

### Medium Term Recommendations

#### *Pathways to Care:*

#### **1) Improve opportunities for training and awareness building to increase clinical and cultural competency within primary and other health, mental health, and community services**

Service providers in primary and other (e.g., surgery, endocrinology, etc.) health, mental health, and community services should seek out training and awareness building opportunities to work with and support trans, two-spirit, intersex, and gender diverse populations. Training and education opportunities should be made available not only for those currently working with these populations, but also for all service providers. It would be useful to leverage Rainbow Health Ontario resources, as well as current local resources to assist with this. Existing models of training that have proved successful should be utilized.

When possible, training and education should be developed and facilitated by people who identify from these communities.

A couple of specific recommendations made include, more training and education around decolonization practices within Aboriginal organizations by two-spirit people, and having Black Lives Matter or a similar organization give Anti-Blackness workshops to service providers on trans and gender diverse people of colour at least once every two years. Skills learned in the Anti-Blackness workshops would be helpful in working with various people of colour, not just those who are black.

## **2) Create and expand collaborative relationships and partnerships among service providers**

Create and expand collaborative relationships and partnerships among service providers to optimize the quality and efficiency of services provided. Consultation and collaboration both internally and externally with other service providers in the community will assist with care plan development, and linking clients back to the community through various improved pathways. Multidisciplinary teams should be made available for case consultations and to respond to client crises.

### ***Pathways Through Care:***

#### **1) Develop and implement a plan for both clinical and quality/process improvement capacity building across the Champlain region**

Build capacity in working with and supporting trans, two-spirit, intersex, and gender diverse communities, and establish a structured system of accountability for service providers working with these populations. Appoint a capacity building oversight agency, with locally contracted staff in order to meet the needs of the region's unique and diverse population. It would be important to ensure there is a strong connection, whether it is a formal reporting relationship or a formal partnership between those agencies tasked with capacity building and those leading referral pathway development so neither proceed in silos. If a regional program is developed, it may be useful to consider appointing a clinical lead.

#### **2) Expand supports and services for trans, two-spirit, intersex, and gender diverse populations**

There is a demand and need for the expansion of supports and services across primary and other (e.g., surgery, endocrinology, etc.) health, mental health, and community services for trans, two-spirit, intersex, and gender diverse people.

Within primary and other (e.g., surgery, endocrinology, etc.) health care there should be:

- More primary care services, and service providers available
- Improved coordination of referrals for primary care
- Fewer administrative barriers/hurdles
- More family physicians who offer hormone therapy starts and maintenance, as well as surgery support (pre-operation and post-operation) within urban and rural areas
- Reliable access to injections and access to self-injection teaching
- More access to other services such as surgeons and specialists (e.g., endocrinologists)
- A listing of current fluent French-speaking family medicine doctors and endocrinologists
- Youth access to care outside a hospital setting

- Providers/specialist who offer culturally competent care in rural locations (e.g., 1 day a month in a rural location)

Within mental health care there should be:

- Improved access to culturally competent allied health supports such as counselling, psychiatry, and psychology within urban and rural areas
- More trans positive counsellors, psychiatrists, and psychologists available
- Culturally competent mental health and addictions services for trans, two-spirited, intersex, and gender diverse populations
- Waiting lists for culturally competent mental health supports that are similar to other mental health supports so that those requiring more urgent care are not forced to choose between receiving timely or culturally competent care
- An avenue for mental health geared towards people of colour, and specifically immigrants for those from trans, two-spirit, intersex, and gender diverse populations
- A part time Indigenous Masters of Social Work (MSW) Therapist for two-spirit people that is covered by Non-Insured Health Benefits (benefits not covered by an Indian Status Card)
- A listing of current fluent French-speaking mental health providers
- A culturally competent, registered social worker responsible for mental health and social services for trans youth and adults

Within community service there should be:

- More access to practical supports such as housing and employment assistance
- Ongoing and regular events and programs for families and individuals
- More social get-togethers for trans, two-spirit, intersex, and gender diverse populations and their families
- A structured, professionally facilitated group for parents/caregivers of children/youth/young adults who are newly exploring or coming out as gender creative, trans, transgendered
- More support groups available for parents/caregivers whose children/youth/young adults are gender creative, trans, transgendered
- A familial support group for teens who are trans, two, spirit, intersex, or gender diverse and their parents/caregivers
- A support group for children/youth/young adults whose parents are trans, two-spirit, intersex or gender diverse
- A support group for adults whose parents have transitioned later in life
- Teen dating violence prevention programming for trans, two-spirit, intersex, and gender diverse populations
- Gender-Based Violence services for trans, two-spirit, intersex, and gender diverse populations
- A full time, dedicated position for education and outreach whose responsibility it would be to work within the community and with Indigenous and non-Indigenous service providers
- Continuous funding for a dedicated space out of which two-spirit social and support based programming could operate. The dedicated space should be separate from other queer spaces and housed outside of an Indigenous organization. The space should be smudge friendly
- Francophone groups for trans, two-spirit, intersex and gender diverse communities

- Community level advocacy in rural areas
- Groups specific for trans, two-spirit, intersex or gender diverse people and families in rural areas

Across all areas of service there should be improved services available for Francophones, an increased capacity to better serve youth and families utilizing integrated, multidisciplinary care, and affordable and accessible care for all.

**3) Look to increase opportunities for trans, two-spirit, intersex, and gender diverse communities to be on staff teams in all areas of service**

Agencies should look into opportunities to increase the involvement of the trans, two-spirit, intersex, and gender diverse communities at all levels of employment. The development of trans, two-spirit, intersex, and gender diverse leadership positions where they have decision-making power should be encouraged. Employing people from these populations creates a feeling of safety for clients, and a sense of understanding about how the world looks and feels.

This should entail working with colleges and service providers to develop trainings, internships, placements and residency opportunities. This should also include working with human resources professionals to look for ways to identify and recruit community members, and to examine current hiring practices including community supportive competencies, job descriptions, interviewing and assessment guides etc.

Long Term Recommendations

*Pathways Through Care:*

**1) Agencies ensure gender affirming health services for trans, two-spirit, intersex, and gender diverse communities become a part of everyday health service**

Services for trans, two-spirit, intersex, and gender diverse communities should become mainstream services, not a speciality service. All service providers should strive to become competent and skilled to serve these populations, and address their varying needs. To achieve this, it would be useful to get more people from all professions interested in the work, starting with one's colleagues.

Advocacy by the LHIN and Other Provincial Bodies

Recommendations for advocacy by the LHIN and other provincial bodies include:

- 1) Advocate for the province to take a leadership role in defining a provincial policy/vision/goals for service delivery to trans, two-spirit, intersex, and gender diverse communities.
- 2) Advocate for in-depth gender affirming health care for trans, two-spirit, intersex, and gender diverse populations be added to the medical education curriculum, and other training programs for health professionals.

- 3) Advocate for a system of accountability for human rights concerns. Make physicians and facilities aware of their responsibilities to stay within the law w.r.t. the criminal code and human rights code, and to act on such allegations with due concern.
  - 4) Advocate that patient's raw data is collected and recorded with care. Have patient's validate or enter raw data collected and provider's understanding of concerns (paper forms or computer input forms).
  - 5) Advocate for the development of a web-based diagnostic system. As used in Europe, variables are entered, and credible possible diagnoses are presented. Nurses in Europe do this, and doctors choose from alternatives.
  - 6) Advocate for credible feedback loops for physician information and education. The province has the responsibility to ensure we are offered credible, up-to-date health care that respects our human rights.
  - 7) Advocate for the development of a web-based provider information system. With a system like this patients and doctors can research specialist's areas of interest and wait times.
  - 8) Advocate for improvements in the ways client data information systems record gender and sex. Client data information systems should allow for one to record a gender other than male or female, and should accept both male and female sex designations with aspects of both sexes in their physiology.
  - 9) Advocate for provincial ministries to implement ways for supports and services for trans, two-spirit, intersex and gender diverse populations to be more financially accessible. Specifically, find ways to offer free services or a sliding fee scale for counselling services obtained by social workers, psychotherapists, and psychologist in private practice, and ways to access fertility preservation prior to transition for those who cannot afford to pay.
  - 10) Advocate for OHIP to cover all costs related to gender affirming surgeries (e.g., chest contouring in chest masculinization surgeries). OHIP should also separately recognize different gender affirming surgery procedures, such that client are able to receive their preferred technique and have it covered, even if it is only available outside the province (e.g., T-anchor method of top surgery as opposed to the standard double incision method)
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## Appendix A



### Service Mapping Questions (Pilot)

**Organization:**

**Name(s):**

**Title(s):**

**Contact information:**

1. Please describe the services you provide for trans, two-spirit, intersex, or gender diverse people.
2. For how many years have you been providing these services?
3. Do you charge a fee for any of these services?
4. Do you provide targeted/specialized services for Indigenous, racialized, and/or disabled people? If so, how?
5. How many of your staff have knowledge of traditional medicines and understand the importance smudging has in health and well-being?
6. How many spaces within your organization are there where smudging can occur?
7. Have your staff received training on inter-generational trauma stemming from the residential school system, the sixties scoop, and other colonial policies?
8. Have your staff received training on the traditional role and responsibilities two-spirited people had and continue to have in Indigenous communities?
9. Have your staff received training on how colonial policies have negatively impacted the health and well-being of two-spirited people by degrading their place within communities?
10. In what language(s) do you provide services to trans, two-spirit, intersex, or gender diverse people.
11. What are the ages of the people served by the services you provide to trans, two-spirit, intersex, or gender diverse communities?
12. What catchment area(s) does your organization serve? Are your services for trans, two-spirit, intersex, and gender diverse people provided to those outside of your catchment? If so, where?

13. Do you have any data that reflect where people are coming from?
14. How many unique individuals do you serve with these programs each year? How many contacts do you have with these people each year? How many service hours do you provide each year?
15. What percentage of the people served through these programs are trans, two-spirit, intersex, or gender diverse people?
16. Do you have a waiting list for service for these programs?
17. Do you receive targeted funding to provide services for trans, two-spirit, intersex, or gender diverse people?
18. How many individuals at your agency provide services to the trans, two-spirit, intersex, or gender diverse communities? What is the FTE equivalent? Can you provide their names and contact information?
19. What services for trans, two-spirit, intersex, or gender diverse people would you like to provide, but are not able to? Why are you not able to provide these services?
20. Have you and/or your staff received training to provide services for trans, two-spirit, intersex, or gender diverse populations? What training(s) have been received?
21. Are you connected in any other way with organizations or private practitioners that provide services that address the needs of trans, two-spirit, intersex, or gender diverse populations?
22. Are you aware of other organizations or private practitioners providing services to the trans, two-spirit, intersex, or gender diverse communities that we should include in this scan?
23. Is there anything that you would like to add that will help support our planning process?
24. Would you like to be kept informed of this process? If so, how?

## Appendix B



### Service Mapping Questions (Agency-No Targeted Services Version)

**Agency:**

**Name(s):**

**Title(s):**

**Contact information:**

1. If you do not provide targeted services for trans, two-spirit, intersex, or gender diverse populations, please indicate whether you serve these populations through other programs and services?  Yes  No
2. Are there any particular programs or services you find that trans, two-spirit, intersex, or gender diverse populations are accessing more so than others?  Yes  No. If yes, please describe these services.
3. Do you charge a fee for any of these services?  Yes  No. If yes, please explain.
4. Do you provide targeted/specialized services for Indigenous, racialized, and/or disabled people who come from the trans, two-spirit, intersex, or gender diverse populations?  Yes  No. If yes, please describe these services.
5. In what language(s) do you provide services to trans, two-spirit, intersex, or gender diverse people?
6. Does your agency provide French Language Services (FLS) for all your programs?  Yes  No. Some of your programs?  Yes  No. If you provide French Language Services in some of your programs, which ones?
7. If you do not provide targeted services, but are serving clients from the trans, two-spirit, intersex, or gender diverse populations, what are their ages?
8. What catchment area(s) do you serve? Are you serving trans, two-spirit, intersex, or gender diverse people outside your catchment area? If so, where?

9. Do you collect information about client gender identity other than male/female?  Yes  No.  
If yes, what client information system do you use? What gender identifying terms are used by your client information system?
10. Are clients expected to demonstrate a binary gender identity (male or female) to receive services?  Yes  No
11. If you do not provide targeted services, what percentage of people accessing services identify as trans, two-spirit, intersex, or gender diverse?
12. Have you and/or your staff received training to provide services for trans, two-spirit, intersex, or gender diverse people?  Yes  No. If yes, what training(s) have been received?
13. What services for trans, two-spirit, intersex, or gender diverse people would you like to provide but are not able to? Why are you not able to provide these services?
14. Are you connected in any other way with other agencies or private practitioners that provide services that address the needs of trans, two-spirit, intersex, or gender diverse populations? If yes, who?
15. Is there anything that you would like to add that will help support our planning process?
16. Would you like to be kept informed of this process? If so, how?



Service Mapping Questions (Agency-Targeted Services Version)

**Agency:**

**Name(s):**

**Title(s):**

**Contact information:**

1. Please describe the targeted services you provide to trans, two-spirit, intersex, or gender diverse populations.
2. For how many years have you been providing these services?
3. Do you receive targeted funding to provide services for trans, two-spirit, intersex, or gender diverse people? Yes No
4. Do you charge a fee for any of these services? Yes No. If yes, please explain.
5. Do you provide non-targeted services for trans, two-spirit, intersex, or gender diverse populations through other programs and services?  Yes  No
6. Are there any particular programs or services you find that trans, two-spirit, intersex, or gender diverse populations are accessing more so than others?  Yes  No. If yes, please describe these services.
7. Do you provide targeted/specialized services for Indigenous, racialized, and/or disabled people who come from the trans, two-spirit, intersex, or gender diverse populations? Yes No. If yes, please describe these services.
8. In what language(s) do you provide services to trans, two-spirit, intersex, or gender diverse people?
9. Does your agency provide French Language Services (FLS) for all your programs?  Yes  No. Some of your programs?  Yes  No. If you provide French Language Services in some of your programs, which ones?
10. What are the ages of people served through your targeted services to trans, two-spirit, intersex, or gender diverse populations?

11. What catchment area(s) do you serve? Are you serving trans, two-spirit, intersex, or gender diverse people outside your catchment area? If so, where?
12. Do you collect information about client gender identity other than male/female? Yes No. If yes, what client information system do you use? What gender identifying terms are used by your client information system?
13. Are clients expected to demonstrate a binary gender identity (male or female) to receive services?  Yes  No
14. If you provide targeted services to trans, two-spirit, intersex, or gender diverse people, what percentage identify from these populations? Please include parents/caregivers who receive services and supports for their children/youth/young adults into this calculation.
15. If you provide targeted services to trans, two-spirit, intersex, or gender diverse people, do you have a waiting list?  Yes  No. If yes, how long do clients wait for service?
16. How many individuals at your agency provide targeted services to the trans, two-spirit, intersex, or gender diverse communities? What is the FTE equivalent?
17. Have you and/or your staff received training to provide services for trans, two-spirit, intersex, or gender diverse people? Yes No. If yes, what training(s) have been received?
18. What services for trans, two-spirit, intersex, or gender diverse people would you like to provide but are not able to? Why are you not able to provide these services?
19. Are you connected in any other way with other agencies or private practitioners that provide services that address the needs of trans, two-spirit, intersex, or gender diverse populations? If yes, who?
20. Is there anything that you would like to add that will help support our planning process?
21. Would you like to be kept informed of this process? If so, how?



## Service Mapping Questions (Private Practitioner Version)

**Name(s):**

**Title(s):**

**Contact information:**

1. Please describe the targeted services you provide to trans, two-spirit, intersex, or gender diverse populations.
2. For how many years have you been providing these services?
3. Do you receive targeted funding to provide services for trans, two-spirit, intersex, or gender diverse people?  Yes  No
4. Do you charge a fee beyond that covered by provincial health insurance for any of these services?  Yes  No. If yes, please explain.
5. Do you provide targeted/specialized services for Indigenous, racialized, and/or disabled people who come from the trans, two-spirit, intersex, or gender diverse populations?  Yes  No. If yes, please describe these services.
6. In what language(s) do you provide services to trans, two-spirit, intersex, or gender diverse people?
7. What are the ages of people served through your targeted services to trans, two-spirit, intersex, or gender diverse populations?
8. What catchment area(s) do you serve? Are you serving trans, two-spirit, intersex, or gender diverse people outside your catchment area? If so, where?
9. Do you collect information about client gender identity other than male/female?  Yes  No. If yes, what client information system do you use? What gender identifying terms are used by your client information system?
10. Are clients expected to demonstrate a binary gender identity (male or female) to receive services?  Yes  No

11. If you provide targeted services to trans, two-spirit, intersex, or gender diverse people, what percentage identify from these populations? Please include parents/caregivers who receive services and supports for their children/youth/young adults into this calculation.
12. If you provide targeted services to trans, two-spirit, intersex, or gender diverse people, do you have a waiting list?  Yes  No. If yes, how long do clients wait for service?
13. Have you received training to provide services for trans, two-spirit, intersex, or gender diverse people?  Yes  No. If yes, what training(s) have been received?
14. What services for trans, two-spirit, intersex, or gender diverse people would you like to provide but are not able to? Why are you not able to provide these services?
15. Are you connected in any other way with other agencies or private practitioners that provide services that address the needs of trans, two-spirit, intersex, or gender diverse populations? If yes, who?
16. Is there anything that you would like to add that will help support our planning process?
17. Would you like to be kept informed of this process? If so, how?

## Appendix C



# Engagement Session with Two-Spirited People in the Ottawa Region

## Agenda

### 1. Introductions

### 2. Safety Agreements

### 3. Background on Regional Planning Table

### 4. “Pathways to Care”

- What services are you aware of in Ottawa for two-spirited people?
- How did you find out about these services?
- Have you accessed these services? Were they relatively easy to access?

### 5. “Pathways through Care”

- What were your experiences accessing services?
  - Did you feel safe? Understood?
- Can you identify a negative experience you have had with a service provider regarding your identified gender/sexuality?
  - What do you identify as the reason behind why you had a negative experience?
- Can you identify a positive experience you have had with a service provider regarding your identified gender/sexuality?
  - What do you identify as the reason behind why you had a positive experience?
- Do you believe that being Indigenous has impacted the care you have or have not received? In what way?
- Have there been barriers to receiving culturally competent care?

### 6. “Future Pathways”

- What would service providers need to know in order to meet the needs of two-spirited individuals?
  - What cultural knowledge would be important?

- What type of positions could be created to assist two-spirited individuals navigating the health system in Ottawa?
- What types of services would you like to see implemented in the future?

## **7. Next Steps and Community Feedback**

## Appendix D



# Focus Group/Interview Questions for the Trans, Two-Spirit, Intersex, and Gender Diverse Community Engagement Sessions

## Agenda

### 1. Introductions

### 2. Safety Agreements

### 3. Background on Regional Planning Table

### 4. “Pathways to Care”

- What services are you aware of in or around Ottawa for trans, two-spirit, intersex, or gender diverse people?
- How did you find out about these services?
- Have you accessed these services? Were they relatively easy to access?
- If you have accessed these services, how easy were they to access?

### 5. “Pathways through Care”

- What were your experiences accessing services?
  - Did you feel safe? Understood?
- Do you believe that being trans, Two Spirit, intersex or gender diverse has impacted the care you have or have not received? In what way?
- Can you identify a negative experience you have had with a service provider regarding your trans, two-spirit, intersex, or gender diverse status?
  - What do you identify as the reason behind why you had a negative experience?
- Can you identify a positive experience you have had with a service provider regarding your trans, Two Spirit, intersex or gender diverse status?
  - What do you identify as the reason behind why you had a positive experience?
- Do you believe that being Indigenous has impacted the care you have or have not received? In what way?
- Have there been barriers to receiving culturally competent care?

## **6. “Future Pathways”**

- What would service providers need to know in order to meet the needs of trans, two-spirit, intersex, and gender diverse people?
  - What type of positions could be created to assist trans, two-spirit, intersex, and gender diverse people navigating the health system in Ottawa?
- What types of services would you like to see implemented in the future?

## **7. Next Steps and Community Feedback**

# **Community Engagement Background Documents**

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**April 28, 2017**

Report Submitted By Benny Michaud

## Two-Spirit Focus Group: Report Back

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### Background

The two-spirit focus group took place on March 9, 2017 from 6:00-8:00pm at Kind Space in Ottawa, Ontario. There were eight (8) two-spirit individuals who provided feedback during the focus group and all were contacted through snowball networking. The session began with an explanation as to how the Trans, Two-Spirit, and Gender Diverse Regional Planning Table came to be, and that the purpose of the focus group was to identify gaps and opportunities within the current medical and mental health systems in Ottawa. Additionally, two (2) individual interviews were completed with two-spirit community members who could not attend the focus group.

### “Pathways to Care”

#### Summary

- *{What services are you aware of in Ottawa for two-spirit people?}*

When asked about two-spirit specific programming in Ottawa participants were aware of a few programs having existed in the past but which were no longer operational. These programs included a two-spirit trans-masculine support group that was run by Ontario Aboriginal HIV/AIDS Strategy out of Wabano, a two-spirit group run by Minwaashin Lodge, and a group run by Pink Triangle.

Participants believed that groups were no longer running because there is a lack of continuous and specific funding to support them. The lack of targeted funding has meant that two-spirit programs are often included in broader programs and provided no dedicated human resources.

Additionally, participants believed that the lack of medical and mental health supports for two-spirit people was due to mainstream agencies not having awareness around the existence of the two-spirit community, nor the specific health needs of two-spirit people.

There was also acknowledgement of the lack of support from within Indigenous communities and, particularly by knowledge keepers. Participants noted that often elders will speak of the traditional roles of men and women in our communities without acknowledging the traditional role of two-spirit people. This was attributed to the imposition of Christianity in Indigenous communities through the residential school system and other colonial policies.

- *{How did you find out about these services?}*

Participants had no knowledge of two-spirit programs currently running in Ottawa.

- *{Have you accessed these services? Were they relatively easy to access?}*

Participants did have knowledge of some medical and mental health supports provided that were not two-spirit specific, however, identified a number of barriers to accessing culturally competent care. Some participants felt that the onus was always on them to educate service providers about two-spirit issues and said the task seemed overwhelming, as it was perceived that some service providers were not even familiar with broader queer issues. As one participant put it: “If I need to educate someone about trans and non binary then forget even beginning a conversation about being two-spirit”.

The process of educating and teaching therapists and doctors about Indigenous issues was described as exhausting, draining and a reason some participants had not utilized services in the past. One two-spirited individual explained that prior to beginning treatment with a mental health worker they provide the worker with a particular book about Metis people. Only once the worker has read it do they begin their work together. The participant found this to be empowering and a way of sharing the burden of educating.

It was identified that health professionals are a product of academia and that universities and colleges lack the ability to fully comprehend Indigenous issues, let alone the needs of two-spirit people.

The hesitancy to seek care through Indigenous run programs in Ottawa was emphasized by all participants but one. Participants overwhelmingly felt as though maintaining confidentiality when accessing services was extremely difficult. Multiple examples were provided of participants witnessing breaches in confidentiality.

As one person put it: “Breach of confidentiality is a big issue in Indigenous-run services. Everyone is too close-knit. The community likes to talk so you can’t go for counselling, especially around gender and sexuality. There ends up being conversations and things get out.” For this reason most participants sought medical and mental health services elsewhere.

## **“Pathways through Care”**

### **Summary**

- *{What were your experiences accessing services? Did you feel safe? Understood?}*

When asked about experiences with medical staff and mental health professionals most participants identified negative interactions. When asked what they attributed to be the cause of these negative interactions they indicated a lack of understanding around the various intersectionality that comes with being a two-spirit person. Participants explained that while some service providers were knowledgeable about the queer community, and others were knowledgeable about Indigenous issues, very few seemed to understand the complexity of being both queer *and* Indigenous. Generally, participants felt misunderstood by practitioners.

Participants felt there wasn’t an appreciation of how difficult it can be for two-spirit people to access traditional ceremonies and spiritual teachings- something considered key to health and well-being. Participants wanted practitioners to understand more fully the challenge faced by two-spirit individuals wanting to access spirituality and the role that colonization has had on diminishing the traditionally valued role of two-spirit people in Indigenous communities. It was explained that many traditional elders and

ceremony-makers had been greatly influenced by their time in residential school where Indigenous understandings of gender fluidity were replaced by Christian notions of a gender binary.

Participants specified the fundamental need for Indigenous service providers to maintain lists of Elders who welcome two-spirit participation in ceremony and respect the unique needs of two-spirit individuals. This includes not “skirt shaming” or asking that two-spirit women wear skirts while attending ceremony and allowing participants in fasting camps or in other ceremonial spaces to take medications. These medications may include hormones, anti-depressants, anti-psychotics and anti-anxiolytics that are critical to maintaining physical and mental health.

This difficulty accessing ceremony and key elements of spirituality was understood to have had negative impacts on the overall health and wellbeing of participants.

- *{Do you believe that being Indigenous has influenced the care you have or have not received? In what way?}*

All participants believed that being Indigenous had influenced their care in some way. Most referenced the continuing impact of stereotypes about Indigenous on how they are perceived by practitioners. Some participants voiced the hurt that came with having their Indigeneity challenged by non-Indigenous practitioners because of the lightness of their skin. These participants believed that because they did not fit the stereotypical image of an Indigenous person, they were treated as though they were making it up, or referencing an intersectionality that didn't exist. Practitioners demonstrated this by asking questions such as, “what's your blood quantum? What percentage are you?” and making comments like “you would never know you are Indigenous”.

Other participants discussed the frustration at having experienced frequent micro-aggressions. These included assumptions being made about them based on stereotypes about Indigenous people and addiction, or stereotypes about Indigenous people and poverty. One participant explained an instance where she told a doctor she couldn't afford something and he responded by saying “yeah, that makes sense”.

- *{Have there been barriers to receiving culturally competent care?}*

There was consensus in the group that all present had trouble finding service providers who had some Indigenous cultural competency. Lack of cultural competency was the major concern for participants who felt that this was more prevalent than providers not being familiar with how to meet the needs of the queer community in general.

Participants stated the need for service providers prioritizing the need for Indigenous cultural competency training for staff. There was consensus that there was a need for greater awareness and education around the particular experience of two-spirit people in relation to Indigenous communities and the broader non-Indigenous community. Participants stressed the need for non-Indigenous service providers to acknowledge that they, too, have a responsibility to serve two-spirit people and not rely solely on referring to Indigenous programs.

Participants emphasized the need for healthcare providers to recognize and acknowledge the unique health needs of two-spirit people. According to those present, particular health needs should be understood from a medical as well as mental health perspective.

Another barrier to accessing culturally appropriate care was the lack of a dedicated space for two-spirit people to gather. The lack of opportunities to come together further hindered the ability of two-spirit participants to share information on which services/service providers they considered “safe” and which to avoid.

### **“Future Pathways and Recommendations”**

- {What would service providers need to know in order to meet the needs of two-spirit individuals?}
  - What cultural knowledge would be important?
  - What type of positions could be created to assist two-spirit individuals navigating the health system in Ottawa?
- {What types of services would you like to see implemented in the future?}

They type of knowledge needed by service providers to provide culturally appropriate care for two-spirit clients has been outlined above. In addition, participants created a list of resources that they believe would assist two-spirit people in accessing culturally appropriate care in the Ottawa area. The list of recommendations are as follows:

- **One-time contract funding for the creation of a two-spirit resource guide** for distribution within the Ottawa area to service providers and the community. The consultant should be a two-spirit person willing to engage the two-spirit community throughout the process. The consultant should also have experience in curriculum and resource development.
- **Continuous funding for dedicated space** out of which two-spirit social and support-based programming could operate. Participants emphasized the need for a dedicated space separate from other queer spaces and housed outside of an Indigenous organization. Continuous funding would ensure program stability. The space should also be smudge friendly.
- **Full-time dedicated position for education and outreach** whose responsibility it would be to work within the community and with Indigenous and non-Indigenous service providers.
- **Part time Indigenous MSW therapist** that is covered by Non-Insured Health Benefits.
- **Funding for the creation and maintenance of a two-spirit specific** website to act as an interactive communication tool for two-spirit folks looking for culturally competent care in Ottawa.

## **FRANCOPHONE FOCUS GROUP**

### **Focus group details:**

18 March 2017, 1:00 pm & 4:00 pm  
via teleconference (toll-free number given)

### **Total participant time required:**

90 minutes

### **Focus group facilitator and note taker:**

Maëlys McArdle

### **Number of focus group participants:**

1 focus group participant, 1 other participant via email

### **Focus group objectives:**

- Identify strengths and weaknesses of current health services for trans, Two Spirit, intersex and gender diverse people in the Champlain Region;
- Develop community recommendations for how to improve health services in the Region;
- Record community vision for health services in the Region;

### **Focus group agenda:**

- 1) Facilitator and participant introductions
- 2) Background on Regional Planning Table
- 3) Demographics sheet highlighting that questions are optional
- 4) Questions before beginning the interview
- 5) Begin interview (topic guide below)
- 6) Wrap up, recommendations to improve process, follow up

### **Overview:**

The focus group was held by teleconference. A toll-free number was provided for participants to connect to. Those with high speed Internet connections could also connect with their computer if they so desired, by way of a provided link.

The event was scheduled for 4 pm on March 18th. The Facebook page erroneously indicated a time of 1 pm. As such, the focus group was held at both the erroneous time of 1 pm and the otherwise advertised time of 4 pm, to ensure that no one was missed.

There ended up only being a single participant. As such, the format was altered on the fly to be more amenable to an interview format. Afterwards, a second individual who showed interest in the focus group but that did not attend answered the focus group questions via email.

The lack of participation means that the original report represented no more than a single interview - the email correspondence of the other participant was not received until after the report was completed and

submitted to the Regional Planning Table separately. While the engagement was tremendously valuable and deeply appreciated, I would not characterize this report as community engagement.

The report was submitted to the Champlain Local Health Integrated Network. It was condensed to highlights when released to the public as the original information was too identifiable. The email correspondence was also incorporated at this time.

**Demographics:**

Demographic data was removed as it risked identifying the participants due to the limited participation.

**VISIONING**

- General practitioners informed on trans healthcare.
- Greater numbers of care providers as to reduce wait times.
- Remove the need for a general practitioner to refer to an endocrinologist.
- Establish ethical decision making processes to assure the respect of trans individuals.
- A symbiotic relationship where cisgender individuals are in solidarity and each other's skills and limits are respected.

**RECOMMENDATIONS**

- Online lists of specific endocrinologists, mental health providers, etc. that are involved in the end-to-end care of trans patients should identify which of those are francophone; perhaps with a secondary list.
- Endocrinologists that require trans clients to see a psychologist should have a clearly identified list of the accepted mental health providers so that clients don't end up spending money on a mental health provider that isn't accepted by the endocrinologist.
- Provide training to pharmacists on off-label use of HRT medications.
- Have trans people work for service providers.
- Connect with the local trans community as resources to run training.
- Have real involvement from the trans community at all levels, including posts with decision making power.

# **Focus Group Summary Report:** *Eastern Champlain*

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*Part of the Regional Planning Table on Health Services for  
trans, Two Spirit, intersex and gender diverse people*

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**Focus Group Date: Sunday, 19<sup>th</sup> March 2017**

Prepared by **Rika Moorhouse and Jaina Tinker**

## **Acknowledgements**

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Thank you to Stephanie Hemmerick for logistical support and for making Seaway Valley Community Health Centre (CHC) available to us on a Sunday afternoon. Thanks also to the RPT's Community Representatives for their countless hours discussing, designing and delivering the community engagement portion of the RPT. Finally, a very special thank you to the Eastern Champlain focus group participants who volunteered their time, personal stories and wisdom to the discussion. Your contribution to this summary focus group report is greatly appreciated.

## **1.0 Background**

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### **1.1 Health Services for Trans, Two Spirit, Intersex, and Gender Diverse People**

Trans, Two Spirit, gender diverse, and intersex people in the Champlain Region are marginalized and underserved populations. Many health and social service providers in Ottawa and surrounding counties have made efforts to address service gaps for these communities. However, in recent years the demand has increased dramatically and placed pressure on providers to meet these communities' expectations of timely, competent and culturally appropriate gender-affirming care. Trans, Two Spirit, gender diverse, and intersex people themselves have not been substantively involved in the design or delivery of these services and continue to voice the need for responsive programs that are informed by community knowledge.

Centretown Community Health Centre (CHC), Children's Hospital of Eastern Ottawa, Family Services Ottawa, Champlain Local Health Integration Network, Royal Ottawa Mental Health Centre, Seaway Valley Community Health Centre (CHC), Youth Services Bureau of Ottawa, and Trans Health Information Ottawa (THIO) have worked together to form a Regional Planning Table (**RPT**) to improve access to culturally appropriate gender-affirming health care; services and programs for mental health, addictions and concurrent disorders; and social services across Ottawa and the surrounding region (also known as the Champlain region) for trans, Two Spirit, intersex, and gender diverse people. The RPT included an equal number of representatives from these communities. The RPT was active from December 2016-April 2017.

### **1.2 Background on Community Focus Groups**

The RPT received a Health System Improvement Proposal (HSIP) grant from the Champlain LHIN to produce three deliverables: a map of existing services; recommendations for improvements to existing services; analysis of gaps in knowledge, training and services that require resources.

Focus groups were held in Ottawa and Cornwall as part of the RPT's community engagement. In the limited time available, RPT community representatives were able to facilitate three focus groups: Two Spirit and Indigenous Trans, Eastern Champlain, and Youth. Priority consultations that did not take place were Parents and Guardians, Western Champlain, On Reserve (*Pikwàkanagàn* and Awkwesane), People of Colour, and people assigned male at birth (AMAB).

### **1.3 Objectives of the Community Focus Groups**

1. Identify strengths and weaknesses of current health services for trans, Two Spirit, intersex, and gender diverse people in the Champlain Region;
2. Explore possible improvements to existing services and new services needed for trans, Two Spirit, intersex, and gender diverse people in order to address weaknesses in current health services in the Champlain Region;

3. Describe community vision for culturally safe and gender affirming health services for trans, Two Spirit, intersex, and gender diverse people in the Champlain Region.

## 2.0 Methods

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### 2.1 Focus Group Instrument Development

The focus group guide and questions were developed by the RPT's community representatives through a series of face-to-face meetings and emails in February and March 2017. The focus group guide was divided under three section headings: **Pathways to Care**; **Pathways through Care**; and **Future Pathways**. Open-ended questions were listed under each section heading so facilitators could encourage discussion and direct the conversation to sub-themes (see attached focus group guide). The focus group framework (i.e. three sections and sub-themes) allowed the facilitators to identify content for all three of the deliverables described in the HSIP grant (see RPT meeting minutes).

### 2.2 Eastern Champlain Sample and Recruitment

The Eastern Champlain focus group was a convenience sample of people who signed up to participate and/or who showed up on the focus group date. The LGBT Lead at Seaway Valley Community Health Centre, Stephanie Hemmerick, circulated promotional material through the following channels: Seaway Seaway Valley CHC's general Facebook page and its LGBT Facebook group; Diversity Cornwall; direct outreach. There were two trans-identified focus group facilitators: Jaina Tinker (RPT Community Representative) and Rika Moorhouse.

Before the focus group began, participants were asked to fill out an optional quantitative demographics form and a consent form. Completed consent forms and demographic forms were submitted to Seaway Valley CHC (Stephanie Hemmerick). Volunteers were compensated for their time and contribution with \$50 gift cards. Focus group interviewing was carried out in the meeting room/kitchen of Seaway Valley CHC.

### 2.3 Analysis

Focus group discussion was recorded using a digital audio app. Hand written notes were also kept by both facilitators. Both facilitators analyzed data and wrote up the final report. Focus group participants were invited to review focus group findings to ensure accuracy of the facilitators' interpretation of the data.

## 3.0 Demographics

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### 3.1 Participant Characteristics

All participants (N=7) lived in the Eastern Champlain region of the Champlain LHIN, were Canadian citizens, and report English as their mother tongue. The median age among of these participants was 23 (range 16-70). Four participants were assigned male at birth (57%). All other participants were assigned female at birth. One participant was Indigenous/Aboriginal (14%), four participants were of white/European descent (57%), two participants were ethnically/culturally mixed Indigenous and white (29%), and one participant was Black/African and white (14%). The majority of participants identified as bisexual or pansexual (n=5; 71%), whereas the remainder identified as either straight or questioning (28%).

## 4.0 Findings

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### PATHWAYS TO CARE

#### 4.1 “What services are you aware of in or around Cornwall (Eastern Champlain) for trans, Two Spirit, intersex, and gender diverse people?”

Respondents indicated that there are **no trans health services in Cornwall**. Instead, one has to commute to Ottawa. A respondent explained, “in Akwesasne, I went to regular doctors. I got no real answers. I then went on a CAMH waitlist. I have not heard anything from them. And Centretown [Community Health Centre] has long wait lists.” Ottawa-based providers listed were Drs. Douek, Seidl, and Visram. CHEO and CAMH’s gender clinic were also mentioned (“CHEO shouldn’t be the only option for youth- a hospital?!”). Akwesasne- function on a federal level; education for providers; I have an ohip card so I can go to Cornwall.

Respondents were aware of a few **social and peer support programs** available to trans people: Gender Mosaic (“they used to have a 24 hour phone line”), Kind Space, and Seaway Valley Community Health Centre’s LGBT group. One participant stated that many people don’t know about the LGBT group at Seaway Valley Community Health Centre and it may be helpful to promote it. There is a staff at SafeZone in Akwesasne. But needs to be more. There were no known LGBT support groups in Hawkesbury.

While the providers with trans health care experience are located in Ottawa, participants were aware of **some local providers who have taken training or have experience** with trans clients/patients. There are two primary care providers (i.e., nurse practitioner and physician) at Seaway Valley who have completed training to do hormone starts and maintenance and are able to follow clients for a gender affirming process. One participant stated that there are two nurse practitioners at the Glengarry Nurse Practitioner Led Clinic that have taken some training in trans health. A well liked counselor was mentioned a few times but apparently is now a manager. There is a sexologist in Hawkesbury who has written letters for one focus group participant. One participant has a psychologist who now lives abroad; he is not experienced with trans health but has a good ear and a good mind. There are no known providers who do hormone starts or maintenance in Hawkesbury.

## 4.0 Findings

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### ...continued, PATHWAYS TO CARE

#### 4.2 “How did you find out about these services?”

Respondents explained that they discovered services by **trial and error**: “You have to knock on every door, and repeat your personal story again and again until you find what you need.” It can take several years to find and/or access the right services. “I was in a dark place self destructive. I was told come back in two weeks. All contributed to

depressive episodes. No one understands. Only two years ago. Never gonna get to where I need. U go through so many people to find my path. Three evaluations. Had to open so many doors; no help even from family.”

One respondent clarified that the main issue is not that there are no services but there needs to be easier access to existing services: “On the internet you often can’t find what you need or else the information is misleading. You will get information for, like, the Leather men’s Club.” Another participant declared: “How the hell do you know where to go?”

A key theme that emerged is that there is **no one to coordinate services** (“There is nobody to put it all together”) in Cornwall or in Ottawa. Participants noted that there is no central service or phone number where you can get the information you need. Respondents described the Internet as “hit or miss” as a source of trans health care information.

## 4.0 Findings

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### PATHWAYS THROUGH CARE

#### 4.3 “What were your experiences accessing services?”

One of the key access issues described by respondents in the Eastern Champlain area is **distance from services**: referrals for trans healthcare are made to providers in Ottawa as this is where trans-knowledgeable providers are located for the most part. For those outside Cornwall but within the Eastern Champlain (e.g. Hawkesbury), the commute to Cornwall is an hour- the same length of commute as Hawkesbury to Ottawa. Even those with access to a vehicle need to pay ~\$40 in gas to travel for care. With regard to the distance, one participant enquired: “Is it a funding issue? Can’t they bring people here to Cornwall? It would be great to have a crew come here. Like, a mobile clinic...to provide support through the whole process.”

One respondent noted that it is **especially hard as a teenager**- you can’t commute easily and you can’t even get a binder let alone health care.

Another respondent expressed an interest in eVisits (video conferencing over the internet; similar to Skype) with their endocrinologist but wasn’t sure if the endocrinologist would be willing. There was also confusion about whether patients needed to commute to an OTN site (e.g. hospital) in order to access telemedicine.

One respondent noted that **local resources and infrastructure are so limited** in Akwesasne that **celebrities have been brought in from the United States** in order to fill the gap in visibility and social programming around trans issues. Specifically, a family wellness program had an LGBT event where Katie Hill was invited to speak. Hill is a trans teenager from the United States whose story went viral on the internet.

The issue of **trusting local providers** came up for some respondents. One person was nervous that providers in Cornwall will misgender them. It was noted: “When people with authority intentionally misgender you, it is a form of violence. Laverne Cox (transgender LGBT Advocate) talks openly about this. The World Health Organization (WHO) has redefined violence as ‘causing harm intentionally.’” There was also a concern that if local providers don’t understand trans people then they may not be able to provide high quality care: “I wouldn’t trust doctors here. Are they giving me the right dosage?” Another respondent described how they went to a psychiatrist who was highly transphobic and pathologized their trans identity. Another respondent noted: “People look at you like a piece of garbage. ‘Is it a trend for you?’...people are so arrogant.” Respondents discussed how trans people are thrown out of homes- in particular, privately run homes for seniors. Participants explained that respecting trans rights cannot be optional if you work in the health sector. They emphasized **the need for education** of program managers and nurses and anyone else involved with health work.

In addition to education on trans peoples’ right to freedom from discrimination, providers require training on how to deliver gender-affirming care. This training is needed from first point of contact to frontline workers (“It is embarrassing to be called out- ‘that’s a blood test for a woman!’”) to the providers themselves (“My family doctor knew nothing about testosterone or top surgery. The doctor thought I needed a hysterectomy in order to have testosterone.”)

Another concern related to trust is **privacy**. A participant noted: “I can’t switch doctors. I have kids and a wife. I need a separate pharmacy...what if they know my daughter?”

**Safety** was a concern for some respondents. A respondent explained that a provider can put you in the path of danger by outing you in a public space (i.e. office waiting area). She said, “Will someone follow me to the parking lot? Violence is scary and providers don’t know about that and how their actions may make you a target of violence. With all women, being victimized all too often a reality...let alone being a trans woman.” Further, the lack of services for trans people in Cornwall makes the city feel unsafe for one participant. This individual will only go out as [name] when in Ottawa.

A final theme was the **functional availability** of health services. More than one participant stated that being suicidal is the only way to get help: “suicide or threaten to take medication [hormone replacement therapy] by yourself is the only way to get care.” “I go to the hospital for everything- I had to go: ‘Help me now!’ It was a 2-year process...on the wait list for a GP. I lost my pediatrician at age 16. I have been on a wait list for a GP since then. I’m now 23 years old. I had to threaten to hurt myself in order to get help.”

## **4.0 Findings**

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### **FUTURE PATHWAYS**

#### **4.4 “What types of services would you like to see implemented in the future?”**

Respondents spoke about a number of **program areas that are needed**: support for self-acceptance; supports for parents; trainings for local service providers (e.g. pediatricians); a confidential information line where people can identify services. It was also acknowledged that some people enjoy peer groups (“Peer support would be great so we are not alone”) while others only feel comfortable accessing services one-on-one. It was emphasized several times that people need local safe spaces (“It is better when there are people you know”) that are **sensitive to the privacy** of participants/clients.

Some respondents noted that more **outreach** is needed in order to connect the community with existing resources. Promotional materials for services also need to clearly describe the privacy precautions that have been taken (e.g. “we do not keep your phone number, the call won’t be traced, we won’t call you back.”)

The focus group respondents are looking for a few critical **characteristics in providers**: knowledgeable (or willing to learn and do research), understanding, non-judgmental, accepting of the patient as they are, ability to work with trauma. Some participant quotes on this include: “At cancer institute, when they ask ‘*what name would you like?*’ *it feels good*” and “[My provider in Ottawa] *affirmed my gender. It’s a nice feeling. It’s like: ‘Yes I will come back; I feel safe here.’*”

One respondent asked that a trans-knowledgeable endocrinologist be made available in Hawkesbury.

Comments made throughout the focus group point to possible health services for the future.

## **5.0 Summary of Findings and Implications**

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Focus group respondents seemed generally satisfied with the trans healthcare they received in Ottawa. However, it can be extremely difficult to locate these services in a timely way. Searching for referrals through providers who are uninformed or transphobic has caused significant distress to some respondents living in the Eastern Champlain. Once the appropriate services are located, there are challenges related to the ~100km distance between the Eastern Champlain and Ottawa. For adults, there are costs associated with transportation. For youth, it may not be possible to travel for care at all depending on one's support system and access to funds. There was a strong desire for local services- health care, social programs, and coordination of both. Local services must pay close attention to trust, privacy, and respect for patients.

## 6.0 Recommendations

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**Recommendation 1:** Boost promotion of existing LGBT groups at Seaway Valley CHC.

**Recommendation 2:** Provide funding for Seaway Valley CHC specifically for a) primary care needs of trans population and b) to provide information on trans health care, to help patients navigate the health care system, and to build local capacity for health care and social programs in the Eastern Champlain.

**Recommendation 3:** Organize and fund medical transportation into Ottawa for trans health care appointments for all ages (including for the patient's support person).

**Recommendation 4:** Identify primary care providers and specialists in the Eastern Champlain who are interested in providing trans health care.

**Recommendation 5:** Deliver education and training on trans health care to primary care, specialist care, and mental health providers in the Eastern Champlain, and offer ongoing professional supports.

**Recommendation 6:** Fund targeted low barrier and culturally appropriate mental health services for trans, Two Spirit, and gender diverse people in the Eastern Champlain.

**Recommendation 7:** Develop protocols for safeguarding privacy of transgender patients/clients, especially in the context of smaller counties and towns.

**Recommendation 8:** Convene trans youth in Eastern Champlain to identify their unique needs with special attention to social transition supports, parent and school system supports, patient advocacy, transportation, and preferred health care settings for receiving trans health services.

**Recommendation 9:** Convene trans and Two Spirit people on reserve (Akwasasne) to identify unique care needs with special attention to culturally appropriate services.

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## **7.0 Limitations**

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Focus group attendees were self-selected and group composition was skewed toward those who live in Cornwall. This is likely because Seaway Valley CHC is located in Cornwall and outreach focused on Seaway Valley CHC's network. The perspectives of those who were not represented in our focus group remain unknown, and may differ from those of focus group participants. For these reasons, inference should not be made from this report. The limitations noted here must be considered when interpreting focus group findings.

Trans, Two Spirit, Intersex and Gender Diverse Youth  
Focus Group on Health Care

March 18th, 2017

Facilitated by Kaeden Seburn  
Assistance and Note Taking by Rika Moorhouse

Report by Kaeden Seburn

## **Executive Summary**

As part of the work for the Champlain Regional Planning Table for Trans Health Services, community engagement in the form of focus groups, a survey and 1 on 1 interviews were held with the goal of furthering our understanding of the experiences and needs of trans, Two Spirit, intersex and gender diverse people and communities. The youth focus group was open to trans, Two Spirit, intersex and gender diverse people under the age of 18 or who had accessed youth services within the last five years and nine individuals between 15 and 23 participated. Six of the participants were transmasculine, while three were transfeminine. None of the participants were Two Spirit and only two of the participants indicated that they were unsure if they were intersex. Additionally, none of the participants had accessed services while living outside of Ottawa. As such, the views expressed in this report most accurately reflect those of trans and gender diverse youth living in Ottawa.

The focus group discussion was divided into three parts: “Pathways to Care,” which looked at access and barriers to accessing services, “Pathways through Care,” which looked at negative and positive experiences that participants had had with services, and “Future Pathways,” which discussed participants ideas for improving the trans, Two Spirit, intersex and gender diverse health system in the Champlain Region.

In the “Pathways to Care” section, participants were asked to list the services they were aware of for trans, Two Spirit, intersex and gender diverse youth in the region, and describe how they found out about these services and what barriers they had experienced while accessing them.

The majority of services available in the region for youth are drop-in and social groups with far fewer specialized health or mental health services for trans, Two Spirit, intersex or gender diverse youth. Many of the health and mental health services that do exist are for those over the age of 18 and/or do not specialize in services for trans, Two Spirit, intersex or gender diverse youth. Several youth mentioned that there are many more services in other locations such as Toronto and Vancouver and that they were surprised by the lack of resources or information on transition-related services in Ottawa.

Youth often had difficulty getting accurate information about the services that were available and the most efficient pathways to care. Many youth found that the only way to get the information they needed was by word of mouth through other members of the community. When youth did find the services they needed, they experienced many barriers to accessing care, most notably related to wait times, financial barriers and difficulty accessing family doctors for a variety of reasons. The majority of the participants in the group were over the age of 18 and/or had parental support, but it is also acknowledged that younger youth without parental support face very significant additional barriers in getting to services, as many youth may not have parental permission to attend.

In the “Pathways Through Care” section, participants were asked to describe their positive and negative experiences with providers and services in the Champlain Region

and the negative experiences described by youth far out way the positive ones. Though some individual providers are understanding and/or well-educated, the system as a whole has a long way to go to ensuring that all service providers have a basic level of knowledge, understanding and cultural safety and competency related to trans, Two Spirit, intersex and gender diverse youth.

One major theme identified is the apparent reluctance of providers to trust trans, Two Spirit, intersex and gender diverse youth to make decisions for themselves about their health care. Providers often feel the need to speak to the parents of the client, even in cases where it is inappropriate or unnecessary and often seem to alter their decisions based on those conversations. In addition, providers often ask the same questions repeatedly at different visits, even when the client has not hesitated or varied in their answer previously. This was specifically mentioned in reference to providers asking if youth were “sure about transition” and asking about fertility options, which can be triggering to many people.

Many participants have also described providers asking invasive and unnecessary questions related to early childhood, sexuality, and the transition process among other topics. Many youth also found that it was often left up to them to educate providers who were not familiar with trans identities or transition, only for those providers to become the gatekeepers who get to decide what services the individual is able to access. A last major theme that was discussed during the focus group was the difficulty of many participants to access culturally safe and competent mental health supports. In addition participants described having providers conflate their mental illness with their trans identity, particularly in the case of non binary identities and personality disorders.

Lastly, in the “Future Pathways” section youth were asked what service providers would need to know to best serve them, what positions they would like to see created in trans, Two Spirit, intersex and gender diverse health care in the region and services they would like to see made available in the future.

Their responses further demonstrate that many changes are needed to the health care system in order to meet the needs of trans, Two Spirit, intersex and gender diverse youth. It is vital that providers receive more training so that all providers have at least a basic level of accurate knowledge regarding trans, Two Spirit, intersex and gender diverse identities and experiences as well as the services and resources that are available for trans, Two Spirit, intersex and gender diverse clients. In addition, positions need to be created to hold organizations accountable and ensure that the necessary changes are implemented by organizations and providers. Wherever possible this work should be done by people who are trans, Two Spirit, intersex and gender diverse, including paid positions for youth.

Youth would also like to see a process for better coordinating services with core funding for all of the important services related to health and mental health care as well as social services and youth groups. This would include a centralized, well-maintained website to provide information on available resources and services and to help with

system navigation. Youth imagined a full-time drop in space with resources and services, which also employed queer, trans, Two-Spirit, intersex and gender diverse youth as well as a greater diversity of dedicated groups and events for more specific demographics (eg. transfeminine youth, black trans youth, etc).

Lastly, the participants felt strongly that resources and social services should also be able to provide competent mental health supports, given the large need within the trans, Two Spirit, intersex and gender diverse communities. The youth acknowledged that many youth groups and events are run by other youth or young adults, many of whom do not have the necessary training or support to do the work or to provide peer and crisis support as they inevitably are required to, leading to high rates of burnout among youth leaders. Youth leaders in the Champlain region should be given the appropriate training (e.g. ASSIST, mental health first aid, etc) and the support that they need to be able to do their work most effectively, while also having the ability to take care of themselves.

### **Background**

Trans, Two Spirit, intersex, and gender diverse people in the Champlain Region are marginalized and underserved populations. Many health and social service providers in Ottawa and surrounding counties have made efforts to address service gaps for these communities. However, in recent years the demand has increased dramatically and placed pressure on providers to meet these communities' expectations of timely, competent and culturally appropriate gender-affirming care. Trans, Two Spirit, intersex, and gender diverse people themselves have not been substantively involved in the design or delivery of these services and continue to voice the need for responsive programs that are informed by community knowledge.

Centretown Community Health Centre (CHC), Children's Hospital of Eastern Ottawa, Family Services Ottawa, Champlain Local Health Integration Network, Royal Ottawa Mental Health Centre, Seaway Valley Community Health Centre (CHC), Youth Services Bureau of Ottawa, and Trans Health Information Ottawa (THIO) have worked together to form a Regional Planning Table (RPT) to improve access to culturally appropriate gender-affirming health care; services and programs for mental health, addictions and concurrent disorders; and social services across Ottawa and the surrounding region (also known as the Champlain region) for trans, Two Spirit, intersex, and gender diverse people. The RPT included an equal number of representatives from these communities and received a HSIP grant from the Champlain LHIN. The RPT was active from December 2016-April 2017.

### **Methodology**

As part of the work for the RPT, community engagement in the form of focus groups, a survey and 1 on 1 interviews were held with the goal of furthering our understanding of the experiences and needs of trans, Two Spirit, intersex and gender diverse people and communities. The youth focus group was held on Sunday, March 18th, 2017 from 6-8pm at Kind Space, an LGBTQ+ community centre located centrally in downtown Ottawa. Participants were compensated for their time with a pizza dinner and a \$50 gift card to Tim Hortons.

The focus group was advertised to trans, Two Spirit, intersex and gender diverse youth under the age of 18 or who had accessed youth services within the last five years. None of the participants were Two Spirit and only two of the participants indicated that they were unsure if they were intersex. Additionally, none of the participants had accessed services while living outside of Ottawa. As such the views expressed in this report most accurately reflect those of trans and gender diverse youth living in Ottawa.

Participants were recruited through multiple methods. A Facebook event was created by the facilitator and shared with their personal networks of queer and trans youth (their personal Facebook, to be shared by others; The Lisgar Rainbow Alliance, The High School Student Alliance, and the Gender and Sexuality Alliance Network) as well as the Facebook group FTM Canada. A poster was also created which was circulated to the members of the Regional Planning Table to be shared with their networks and was thoroughly circulated by CHEO through their Diversity Clinic. Participants were asked to contact the facilitator in order to register ahead of time. The majority of them learned about the event through Facebook or from CHEO's mailing list.

The questions asked during the focus group were divided into three sections: “Pathways to Care,” “Pathways through Care,” and “Future Pathways.” The questions were given to the participants upon arrival as part of the Agenda along with some additional information. This document can be found in Appendix A.

The “Pathways to Care” section aimed to learn about the services that youth are aware of in the region as well as their experiences getting information about those services and trying to access them. “Pathways through Care” asked questions about the experiences that youth had when receiving care and positive and negative experiences they have had with services and providers. The last section, “Future Pathways,” looked at participants ideas about what could be done to improve the health care system for trans, Two Spirit, intersex and gender diverse youth and what they would like to see change.

These sections were intended to help verify the RPT's information regarding the services that exist in the region, and to help develop recommendations to improve the health care system for trans, Two Spirit, intersex and gender diverse youth moving forwards.

### **Acknowledgments**

Foremost, thank you to all the community members who attended the focus group and/or promoted the survey in their personal networks as well as the agencies who helped to distribute the poster and information. Thanks also goes to Mikki Bradshaw, Maëlys McArdle, Rika Moorhouse, Serena Rivard, Benny Michaud, Mel Thompson, Jaina Tinker, and Patricia Vincent, the community members who helped to plan and prepare for the focus groups. Special thanks to Rika Moorhouse for their help with note taking and logistics during the focus group as well as their ongoing assistance and mentorship.

## **Demographics**

At the beginning of the group participants were asked to complete a demographics questionnaire. Forms were collected from all participants and they could choose to skip any questions. The questionnaire can be found in Appendix B.

### Age

Nine participants between the ages of 15 and 23 participated in the focus group.

### Legal Status

All respondents are Canadian citizens.

### Sex Assigned at Birth and Gender Identity

Six of the nine respondents were assigned female at birth, while three were assigned male.

Seven respondents said that they were not born with an intersex body, while 2 said that they were unsure.

Eight of the participants chose to respond to the open ended question “What is your gender identity?” Some respondents chose to give more than one response. The answers given were: Male, Non binary, Trans Guy/Trans Man, Transfeminine, Non binary Man

None of the respondents were Indigenous (First Nations, Metis and Inuit), and thus none of them were Two Spirit.

### Sexual Orientation

All nine respondents answered the question on sexual orientation. Some individuals selected more than one option. Results can be seen below.

Number of Participants	Sexual Orientation
12	Queer, Bisexual, Pansexual, Demisexual, Gay, Questioning
2	Straight

### Ethnic and Cultural Groups

All nine participants indicated that they were white.

### Location

Participants were able to check off all sub-regions of the Champlain Region in which they have lived while accessing services. All nine respondents lived within Ottawa.

Number of Participants	Sub-Region
------------------------	------------

6	Ottawa West
2	Ottawa Central
2	Ottawa East

Language

Participants were asked to indicate their mother tongue as well as to state which of Canada’s official languages they were most comfortable in if their mother tongue was neither English or French. All respondents indicated that their mother tongue was either French or English.

Number of Participants	Mother Tongue
8	English
1	French

**Results: Pathways to Care**

*What services are you aware of in or around Ottawa for trans, Two Spirit, intersex or gender diverse youth?*

Below is the list of services named by the youth present at the focus group. These are as-reported and have not been verified by provider organizations.

Health and Mental Health Services:

- CHEO
  - Doctors
  - Surgical referrals
  - Referrals for other transition related services
  - Counselling
  - Hormone blockers
  - Hormone starts and maintenance
  - Social worker
  - Someone is currently training to be able to perform top surgery in the future
- Youth Services Bureau
  - Drop in counselling (not trans-specific)
- Family Services Ottawa
  - Counselling for those over 18
  - May have a counselor specializing in queer and trans issues?
- University of Ottawa
  - Counsellor who specializes in queer and trans issues
- Carleton University
  - Counsellor who specializes in queer and trans issues

- Private counselors
  - Dr. Helma Seidl
- Private doctors
- Private specialists
  - Dr. Hasina Visram (endocrinologist)
- Community Health Centres
  - Counsellors
  - Hormone starts and maintenance for those over 18
  - Surgical referrals for those over 18

#### Social Services

- CHEO
  - Support group
  - Provides information on resources and events (Clients can be on a mailing list to receive information such as the poster for this focus group.)
- Youth Services Bureau
  - Queer and trans drop in youth group (currently on pause)
  - Queer Youth Action Committee (advocates for queer and trans youth within YSB and their outreach programming)
  - Staff are supposed to get trained every year and the board wants to have all of YSB be well-trained on queer and trans issues
- Family Services Ottawa
  - Rainbow families drop in which includes young trans kids
  - Transcend youth social group for youth grade 7-12
- University of Ottawa
  - Pride Centre
- Carleton University
  - Gender and Sexuality Resource Centre
    - Helps connect people with needed resources (available for both students and non-students)
- Western Ottawa Community Resource Centre
  - Queerios - weekly queer and trans youth drop in
- Orleans-Cumberland Community Resource Centre
  - Piloting queer and trans youth drop in
- Kind space
  - Weekly queer and trans youth group
- Ten Oaks Project
  - Summer camps
  - Other events

Other services for trans youth in the Champlain Region which were not mentioned during the group include:

- Kind Space
  - High School Student Alliance
- Family Services + Ten Oaks Project
  - Trans Youth Swim Night

“In Vancouver I could name like 18 different services. I got here and people have no idea how to access stuff.” -Focus group participant

*How did you find out about these services?*

Youth found out about services through a variety of methods. The methods named by participants were:

- Referred to CHEO by other providers
  - Some providers didn't know what to do, but did research and found CHEO's clinic
- Staff within CHEO know about the diversity clinic
- GP referred to private endocrinologist who referred to Dr. Seidl
- Most people only found out about services from friends or members of the community
  - Got info from individuals by attending Canadian Centre for Gender and Sexual Diversity conferences
  - Some participants described being really glad that THIO exists, as there was not previously any way to access the information or resources that it provides

“I just had to know queers who knew things. If I didn't know them, I would have been dead in the water.” -Focus Group Participant

*If you have accessed these services, how easy were they to access? (eg. Did you need to get a letter from someone else to refer you? Was there a long waiting list? Was it far away from where you live? Did you/your family have to pay for it?)*

Participants had experienced numerous different barriers to receiving and accessing care. Below is a list of those mentioned during the focus group:

- Not all GPs are willing or able to help and make referrals or provide information
- Not all youth are even able to see their GPs or other service providers as their parents may not agree to take them
- It is much more difficult to go through the transition process without access to a family doctor
- Without private insurance individuals would need to pay for some services, such as counseling to get approval letters for hormones
- Ontario Works covers hormones, but if one does find work and is taken off OW they would no longer have their hormones covered, meaning that they would likely be unable to afford them
- If you age out of youth care or your childhood physician stops practicing it can be very difficult to access your old files
- Many services have very long waiting lists while trying to access care
  - Eg. Even if getting a prescription only takes a few appointments it can still take a year or longer as there is such a long waiting time between appointments

- Lupron is not covered by OHIP and is very expensive. A program called Lupron Cares can cover it, but many participants were not informed about this option until after they had begun paying
  - It was also noted that if a client is not able to afford Lupron without Lupron Cares they can still have their shots administered even before being approved for ongoing coverage and that providers can work with the client to get it covered
- Word of mouth indicates that the process for ageing out of youth care is not very smooth
- Clients may need to be redirected to other services as they can sometimes age out of youth care while on the waiting list as it is so long
- The waiting list for the LGBTQ+ specific counselors on university campuses is so long that if a person needs counseling unrelated to their trans identity they are forced to choose between receiving timely counseling and having a provider who understands trans issues
- University health plans do not cover the cost of hormones and this is a concern for students living on a low disposable income

## **SUMMARY**

The majority of services available in the region for youth are drop-in and social groups with far fewer specialized health or mental health services for trans, Two Spirit, intersex or gender diverse youth. Many of the health and mental health services that do exist are for those over the age of 18 and/or do not specialize in services for trans, Two Spirit, intersex or gender diverse youth. Several youth mentioned that there are many more services in other locations such as Toronto and Vancouver and that they were surprised by the lack of resources or information on transition-related services in Ottawa.

Youth often had difficulty getting accurate information about the services that were available and the most efficient pathways to care. Many youth found that the only way to get the information they needed was by word of mouth through other members of the community. When youth did find the services they needed, they experienced many barriers to accessing care, most notably related to wait times, financial barriers and difficulty accessing family doctors for a variety of reasons. The majority of the participants in the group were over the age of 18 and/or had parental support, but it is also acknowledged that younger youth without parental support face very significant additional barriers in getting to services, as many youth may not have parental permission to attend.

### **Results: Pathways through Care**

*What were your experiences accessing services? Did you feel safe? Understood? Do you believe that being trans, Two Spirit, intersex or gender diverse has impacted the care you have or have not received? In what way?*

Focus group participants described having a mix of experiences when accessing services as outlined below:

- Some GPs don't know anything about transition and will direct the conversation away because they don't know what to do

- Many counsellors don't have any information or resources and are not educated on trans, Two Spirit, intersex or gender diverse identities and experiences
  - If you aren't sure about your identity or transition steps that you want to take it is hard to find someone who you can talk about it with who is educated and is not judgmental if you are still figuring things out
  - Counselling is not helpful if you have to continuously educate your counsellor
- Some counselors do not have specific knowledge on trans, Two Spirit, intersex or gender diverse identities or experiences but they are understanding and open to discussing the topics and can be helpful
  - Some providers are good with using preferred names but still do not use the correct pronouns
  - Many providers don't know about the change in surgery referrals or how to make referrals
  - Demand is skyrocketing but funding and available services are not improving

“There is no process for saying ‘How do we make sure that all doctors in Ontario have trans 101?’ They don't need to be experts but just, like, how to not traumatize people.” - Focus Group Participant

*Can you identify a negative experience you have had with a service provider regarding your trans, Two Spirit, intersex or gender diverse status? Why do you think you had a negative experience?*

The large majority of experiences that participants described related to “Pathways Through Care” were very negative. These are summarized below:

- Many people have to educate their counselors on their identity and do not get to talk about how they were feeling about transition or the issues that they are experiencing
- Many providers and agencies do not consistently use clients preferred names
- Many providers are very adamant about talking to youth's parents
  - This includes youth who do not live with their parents and whose parents are unsupportive of their transition
    - Parents will even sometimes be informed of upcoming appointments, even though it is established that they are not to be contacted
  - This also includes youth who are over the age of 18 and who do not live with their parents
  - Multiple participants noted that provider interactions with their parents appeared to change the outcome of appointments
    - Eg. Being more or less likely to make a referral for the service that the client is seeking after speaking to parents, even when those parents are established to be unsupportive

- Participants also noted that some providers asked a lot of questions that did not seem relevant to their assessment or that were not appropriate (eg. asking a lot of questions about early childhood)
  - Many participants found that providers repeatedly asked them to confirm that they “were sure” about transition
- Clients also often find their genders to be very pathologized when accessing counseling services, particularly in the case of non binary genders and personality disorders
- Participants noted that the questions they were asked when accessing sexual health services were very binary as well as very invasive (eg. Asking: “Do you sleep with men?” “Have you had it removed?”)
- Several participants had also had experiences with providers asking invasive questions regarding non-straight sexualities
  - Eg. Asking a pansexual trans man whether he had slept with men and “how it made him feel”
- Participants recounted very negative experiences with psychologists
  - Being very binary
  - Being fatphobic (e.g. saying “You need to figure out your weight before you can figure out if you’re trans.”)
  - Telling trans kids that they are too young to know if they are trans
  - Saying that it is natural for people to not want to date trans people
- Individuals have experienced having appointments repeatedly cancelled and pushed back, to the point that it seemed like the provider was intentionally avoiding seeing them
- Participants recounted feeling that providers expected them to either be ashamed of their body and therefore not sexual or to be hypersexual
- Providers assume that you are suicidal because of your trans identity
  - Eg. They do not take into account other factors or unrelated mental illness
- Providers expect you to educate them but then become the gatekeepers to decide what services you are able to access
- Providers expect to hear that you have always known that you were trans and that you had traumatic experiences as a child
- Multiple participants found that providers repeatedly asked about fertility options, significantly beyond what was necessary or comfortable for the client
  - Several participants indicated that they are certain they don’t want to biologically have kids and that discussing it makes them dysphoric but that providers continued to ask and make sure at every visit
  - Participants commented that they feel that providers are perpetuating the idea that the only way to have kids is to biologically reproduce themselves
- Doctors feel entitled to your body (e.g. asking invasive questions about the process of transitioning if it comes up in passing, even if they don’t need the information to provide their service)
- Providers seem not to understand social influences (e.g. counselors not understanding that a participant’s depression is related to the fact that they are poor)

- In large organizations, not all parts seem to even have trans 101 training (e.g. crisis line workers not understanding that family conflict is related to parents not accepting trans youth)
- Many youth supports and groups are primarily run by older youth and young adults
  - These youth are volunteers and do not have the training to provide services or to do crisis support, which they often need to do, or create boundaries for themselves
  - The youth providing services and support are still going through the same things as the youth accessing services
  - Youth leaders are sometimes selected by oversight groups (e.g. student committees at universities) that can easily select cis people who are not the most competent people for the role
  - Youth leaders need to split their time between political leadership and providing personal support for other youth and often find it difficult to find an effective balance
- Many people described a lack of coordination between service providers and the services that they provide

*Can you identify a positive experience you have had with a service provider regarding your trans, Two Spirit, intersex or gender diverse status? Why do you think you had a positive experience?*

Though significantly fewer than the negative experiences, most of the youth were also able to identify at least one positive experience that they have had with a service provider. These are listed below:

- Providers who are understanding and relatable
- Experienced and well-educated providers who understand the issues in the system and are able to commiserate with clients over poor experiences with other providers
- Providers who correct themselves when they mess up names, pronouns, etc
- Providers ensuring that clients get the care they need (e.g. prescribing Lupron even if the individual can't afford it and then working with clients to get it covered retroactively)
- Having providers take transition-related care seriously and ensure that clients are able to continue accessing it (e.g. bumping clients up in priority if they discover that they are allergic to the prescribed hormones)

## **SUMMARY**

The negative experiences described by youth far out way the positive ones. Though some individual providers are understanding and/or well-educated, the system as a whole has a long way to go to ensuring that all services providers have a basic level of knowledge, understanding and cultural safety and competency related to trans, Two Spirit, intersex and gender diverse youth.

One major theme identified is the apparent reluctance of providers to trust trans, Two Spirit, intersex and gender diverse youth to make decisions for themselves about their health care. Providers often feel the need to speak to the parents of the client, even in cases where it is inappropriate or unnecessary and often seem to alter their decisions based on those conversations. In addition, providers often ask the same questions repeatedly at different visits, even when the client has not hesitated or varied in their answer previously. This was specifically mentioned in reference to providers asking if youth were “sure about transition” and asking about fertility options.

Many participants have also described providers asking invasive and unnecessary questions related to early childhood, sexuality, and the transition process among other topics. Many youth also found that it was often left up to them to educate providers who were not familiar with trans identities or transition, only for those providers to become the gatekeepers who get to decide what services the individual is able to access. A last major theme that was discussed during the focus group was the difficulty of many participants to access culturally safe and competent mental health supports. In addition participants described having providers conflate their mental illness with their trans identity, particularly in the case of non binary identities and personality disorders.

### **Results: Future Pathways**

*What would service providers need to know in order to meet the needs of trans, Two Spirit, intersex and gender diverse youth?*

This question had already been answered in large part throughout the focus group discussion. Participants indicated that providers should have a better understanding of trans, Two Spirit, intersex and gender diverse identities and experiences. They should also have more knowledge relating to the transition process and options and resources available. Providers should also trust clients to make their own decisions about their health care and should be working to help clients reach their goals, rather than gatekeeping access to services. During the Future Pathways discussion participants added the following points:

- Info about the services available in order to be able to provide info on options
- Providers should be able to provide the care you need or know the right person to refer you to so that you don't get passed around between many different providers who aren't able to help
- Basic competency training on trans and non binary identities as well as sex work
  - Provided by trans people who are paid for their work
  - Training should take an implementation approach similar to that of child and youth mental health

*What type of positions could be created to assist trans, Two Spirit, intersex or gender diverse youth navigating the health system in Ottawa?*

Participants came up with several ideas for positions as can be seen outlined below. The main themes were providing paid positions for trans, Two Spirit, intersex and gender

diverse people and creating positions to ensure that the issues discussed throughout the group would be addressed.

- Implementation agents to ensure that changes are implemented in organizations
- Someone to ensure that all staff implement changes and policies in organizations and provider agencies
- Providers who are trans, Two Spirit, intersex and/or gender diverse
- More paid jobs for trans youth doing the work
  - Have the expertise and need the money
  - Financial stability affects physical health as well
  - Ensure that youth are paid and trained for the work they already do
- More paid jobs generally for trans folks doing the work
  - This would also help to make the community less divided and more professional since there would be more people being paid to do the work
  - Similar to other cities such as Vancouver and Toronto
  - Provider training should be provided by trans people
- Paid position for Rainbow Service Providers Network to coordinate services across the region

*What types of services would you like to see implemented in the future?*

The participants came up with several services and improvements to existing services that they would like to see in the region. They are outlined below:

- Process for coordinating services, mobilizing knowledge, scale it, building relationships between service providers
- Youth leaders could be coming together every quarter
- An accessible everyday drop in space with paid full time positions for LGBTQ+ youth and young adults who get the necessary training (e.g. mental health first aid, ASSIST) that can provide information and resources
  - Resources on how not to burn out
  - Similar to Qmunity Gab in BC
- Centralized website on trans health in the region with information on resources and navigation
  - Paid position for a trans person to maintain it
- Service areas across the province with annualized funding for core services similar to in child and youth mental health
- Resources for parents and families of trans youth
- Social workers for trans youth
- Youth peer facilitators paid to do peer support work
- Ongoing and consistent events and programs
- More dedicated groups and events
  - Black trans youth
  - Transfeminine youth
  - Similar to the 519 in Toronto

- Services need to be able to competently provide mental health services and support as well

“Not one person around me hasn’t had a history of self-harm or suicide. And that is terrifying.” -Focus Group Participant

## **SUMMARY**

Many changes are needed to the health care system in order to meet the needs of trans, Two Spirit, intersex and gender diverse youth. It is vital that providers receive more training so that all providers have at least a basic level of accurate knowledge regarding trans, Two Spirit, intersex and gender diverse identities and experiences as well as the services and resources that are available for trans, Two Spirit, intersex and gender diverse clients. In addition, positions need to be created to hold organizations accountable and ensure that the necessary changes are implemented by organizations and providers. Wherever possible this work should be done by people who are trans, Two Spirit, intersex and gender diverse, including paid positions for youth.

Youth would also like to see a process for better coordinating services with core funding for all of the important services provided, related to health and mental health care as well as social services and youth groups. This would include a centralized, well-maintained website to provide information on available resources and services and to help with system navigation. Youth imagined a full-time drop in space with resources and services, which also employed queer, trans, Two-Spirit, intersex and gender diverse youth as well as a greater diversity of dedicated groups and events for more specific demographics (eg. transfeminine youth, black trans youth, etc).

Lastly, the participants felt strongly that resources and social services should also be able to provide competent mental health supports, given the large need within the trans, Two Spirit, intersex and gender diverse communities. The youth acknowledged that many youth groups and events are run by other youth or young adults, many of whom do not have the necessary training or support to do the work or to provide peer and crisis support as they inevitably are required to, leading to high rates of burnout among youth leaders. Youth leaders in the Champlain region should be given the appropriate training (eg. ASSIST, mental health first aid, etc) and the support that they need to be able to do their work most effectively, while also having the ability to take care of themselves.

## **Conclusion**

As demonstrated throughout these responses, there is much that needs to change in order to improve the health, mental health and social services in the Champlain Region for trans, Two Spirit, intersex and gender diverse youth. Some key priorities developed from this focus group include more training for service providers, as well as better coordinated implementation to ensure that changes are made effectively to best improve client experiences. As well, agencies should hire more trans, Two Spirit, intersex and gender diverse people, including youth, to do work related to trans health. The youth leaders who are already leading youth services should also be provided with the necessary training and support to do this work effectively, including training related to mental health and

crisis support. This will help to ensure that they are able to do their work as effectively as possible, while also reducing the risk of burnout. Lastly, the services provided in the region should be better coordinated, with core funding for all necessary services and a centralized body to help with system navigation and access. This should include a well-maintained website and be run by trans, Two Spirit, intersex and gender diverse people.

**TRANS, TWO SPIRIT, INTERSEX and GENDER DIVERSE YOUTH  
FOCUS GROUP ON HEALTH CARE**

**March 18, 2017**

**KIND SPACE, 6PM – 8PM**

**Facilitator: Kaeden Seburn**

**Note Taker: Rika Moorhouse**

**For more information visit: [ottawatranshealthplan2017.weebly.com](http://ottawatranshealthplan2017.weebly.com)**

If you would like more information or to see a copy of the report written to document this focus group contact Kaeden at [kaeden.seburn@gmail.com](mailto:kaeden.seburn@gmail.com)

**Agenda**

- 1. Introductions**
- 2. Informed Consent and Demographics Sheet**
- 3. Safety Agreements**
- 4. Background on Regional Planning Table**
- 5. “Pathways to Care”**
  - What services are you aware of in or around Ottawa for trans, Two Spirit, intersex or gender diverse youth?
  - How did you find out about these services?
  - If you have accessed these services, how easy were they to access? (eg. Did you need to get a letter from someone else to refer you? Was there a long waiting list? Was it far away from where you live? Did you/your family have to pay for it?)

**“Pathways through Care”**

- What were your experiences accessing services?
  - Did you feel safe? Understood?
  - Do you believe that being trans, Two Spirit, intersex or gender diverse has impacted the care you have or have not received? In what way?
- Can you identify a negative experience you have had with a service provider regarding your trans, Two Spirit, intersex or gender diverse status?
  - Why do you think you had a negative experience?
- Can you identify a positive experience you have had with a service provider regarding your trans, Two Spirit, intersex or gender diverse status?
  - Why do you think you had a positive experience?

**“Future Pathways”**

- What would service providers need to know in order to meet the needs of trans, Two Spirit, intersex and gender diverse youth?

- What type of positions could be created to assist trans, two spirit, intersex or gender diverse youth navigating the health system in Ottawa?
- What types of services would you like to see implemented in the future?

## **7. Next Steps and Community Feedback**

Appendix B - Demographics Questionnaire

Trans, Two Spirit, Intersex and Gender Diverse Youth Focus Group: Demographics Sheet

**1. How old are you?** \_\_\_\_\_

**2. What is your legal status in Canada?**

*Mark only one oval.*

- Canadian citizen
- Permanent resident
- Temporary resident/worker/student
- Refugee
- Undocumented
- Prefer Not to State

**3. What is your gender identity?** \_\_\_\_\_

**4. What was your sex assigned at birth? (What sex was put on your birth certificate?)**

*Mark only one oval.*

- Male
- Female
- Unknown
- Other: \_\_\_\_\_

**5. Were you born with an intersex body?**

*Mark only one oval.*

- Yes
- No
- Unsure

**6. If you are Indigenous (First Nations, Metis and Inuit), do you identify as Two Spirit?**

*Mark only one oval.*

- Yes
- No
- I am not Indigenous

**7. What is your sexual orientation?**

*Check all that apply.*

- Lesbian
- Gay
- Bisexual
- Pansexual
- Asexual
- Questioning
- Queer
- Other: \_\_\_\_\_

**8. To which ethnic and cultural groups do you belong?**

*Check all that apply.*

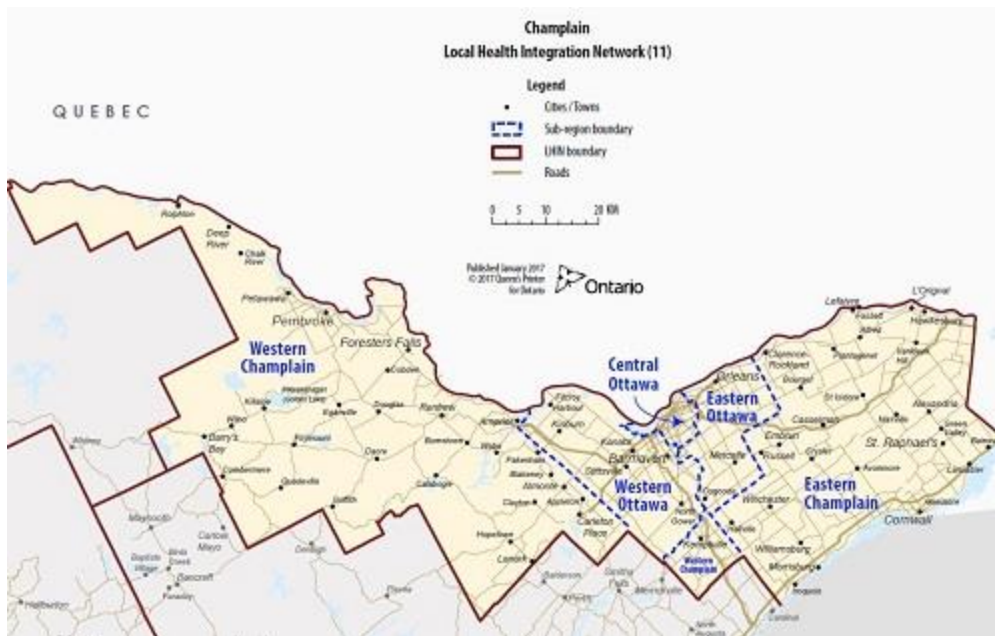
- Indigenous (First Nations, Metis and Inuit)
- Arab
- Black/African
- Chinese
- Filipino
- Japanese
- Korean
- Latin American
- South Asian
- Southeast Asian
- West Asian
- White/European descent
- Other: \_\_\_\_\_

**9. Where have you lived when accessing trans--related services? (Any services related to your status as trans, Two Spirit, intersex or gender diverse, or that you feel are impacted by you being trans, Two Spirit, intersex or gender diverse)**

*Check all that apply.*

- Ottawa - Central
- Ottawa - East (Gloucester, Orleans, Rockland)
- Ottawa - South (Manotick)
- Ottawa - West (Kanata, Constance Bay)
- Eastern Champlain
- Western Champlain
- Other: \_\_\_\_\_

Please find your sub-region(s) below



**10. What is your mother tongue? (the language that you first learned at home in childhood and still understand)**

*Mark only one oval.*

- English
- French
- Other:

**11. If your mother tongue is neither French nor English, in which of Canada's official languages are you more comfortable?**

*Mark only one oval.*

- English
- French

## **Intersex Report**

Mel Thompson

### **1. Describe the participatory community engagement with the community that informed the above recommendations)**

#### **Outreach Attempts: Intersex Medical Patients**

- 1) Electronic dissemination of posters on FB pages, email and websites of groups advocating for sexual minorities.
- 2) Physical distribution of posters in downtown core.

#### **Results: 2 emails, with brief qualifying email conversations.**

**Subject 1** is visiting Ottawa as a student, is diagnosed intersex, and has accessed medical services in Ottawa in the last five years “a couple of times.” However, subject’s intersex status was never disclosed at these consultations because it was irrelevant to their reason for seeking care. Therefore, subject excused self from further participation in study.

**Subject 2** is currently in transition from male to female status. Subject 2 revealed they had no known intersex diagnosis, but disclosed that, as a 13-year-old assigned male patient was told by doctor that their breasts were developing. Subject 2 stated their father and the doctor joked about this breast development during the exam. Subject 2 does not know if this was recorded, or if that record would still exist. No official record of sexual difference or intersex status is available, but subject 2 now suspects possible intersex status. Subject 2 excused self from further participation in intersex study. Subject 2 was referred to Kaeden for trans youth focus group.

**Subject 3** is myself. My difficulties in accessing care are described in ancillary document: “Ottawa Intersex Case Study.”

In brief, the difficulties I experienced have to do with 1) the culture of medicine: a) an unwillingness to disagree with other doctors; b) a well-documented cultural taboo within medicine, a queasy discomfort with and denial of intersex conditions, in favour of promoting the oversimplification of binary sex to describe what in reality is a spectrum of forms that can overlap to any degree and without any obvious outward physical cues; and c) a concomitant dearth of knowledge about intersex conditions within medicine, which puts the profession decades behind the known science, and often espousing long-disproven and inherently discriminatory myths. My difficulties in accessing not only care, but also remediation for abusive encounters with physicians, also expose 2) a lack of credible feedback loops for information within, and 3) a lack of oversight and accountability over the medical profession.

## **2. Detail the services which currently exist in Champlain region**

Between February, 2013 and June, 2015 I consulted with 9 doctors for medical care for my intersex anatomy: 3 G.P.s, 2 gynecologists, 2 urologists, 1 medical geneticist in person, 1 medical geneticist by phone. None recorded my history or concerns correctly, and all refused to make corrections. All disputed my medical history and previous diagnosis, despite stating they were out of scope, or despite the scientific impossibility and inadvisability of making such a claim, and using misinformation that is scientifically baseless and inherently discriminatory to dispute my history and concerns. I also consulted with one emergency department physician without disclosing my intersex status. This doctor also mis-recorded my reason for the consultation, but later did correct my chart notes.

My encounters are described in my ancillary document, “**Ottawa Intersex Case Study.**”

In the fall of 2016, I found 2 G.P.s and 1 gynecologist who were prepared to accept and record my medical history and concerns: One G.P. will follow up on medical investigation for my intersex concerns. The other G.P. has no idea what to do with my intersex concerns: she referred me to a known expert in Toronto, which was refused based on the medical consensus and disputation of my history on the shared information network.

Based on this, as I enter my fifth year of attempting to access health care for my non-binary urogenital system, I would state that affirming care is non-existent or excessively difficult to access for new intersex patients who do not have lengthy medical files available, despite the fact that intersex conditions are neither rare nor generally problematic, according to the last 50 years of scientific research. This is a culture-wide problem, as demonstrated by over 30 years of questioning this medical cultural taboo by intersex rights activists, and as has been extensively documented by academics in medical anthropology, gender studies, women’s studies, sociology and law.

## **3. Provide recommendations to improve client pathways among partners**

- A) Currently, there is no way to include intersex information on health records, as the system is only set up for *either* ‘male’ or ‘female’ sex designations. This proved to be a factor in the invisibility and lack of services for and of intersex patients in all three subjects for this study.

I recommend that the health records and shared information system:

- i) Accept ***both*** ‘male’ and ‘female’ sex designations for patients with aspects of both sexes in their physiology.
- ii) Or, far better medically and scientifically, given that physical sex is no longer strictly definable as a binary system in terms of science:

henceforth exclude an overall designation of ‘male’ or ‘female’ for patients, but rather, **list an inventory of sex organs that may be either or both ‘male’ or ‘female,’** both across and even within different markers. This would mean *either or both ‘m’ or ‘f’ could be chosen for each marker of sex,* whatever the outward appearance and gender identity of the patient, and with the understanding that the markers of a presumed male or female might change as more detailed information or testing becomes available or warranted.

These would include the culturally-determined assessments of **phenotype and genital appearance,** as well as the more precise and measurable determinants of **gonads or gonadal streaks, uterus or uterine structure, hormones, and genes.**

Instead of ‘Sex,’ patients would describe their gender identity: how they would like to be addressed. This might also change.

- B) Provide remedial education to the medical community about the last 50 years of scientific research with respect to the spectrum of human sex and sex-determining genetics.
- C) Educate all caregivers and administrators about their responsibilities in meeting the expectations of the human rights code, and insist and ensure that the human rights of sexual minorities be respected by medical practitioners.
- D) Create or improve accountability pathways to investigate human rights abuses by doctors or other caregivers.

Currently, the health care culture seems to work within the belief that doctors cannot do wrong or be wrong.

The problems I noted were : a) Patient advocacy is entirely inadequate to deal with these abuses, as patient advocates only offer one service: help with correcting chart records (in my case 90% of the doctors refused to correct their chart material to include the raw data as I actually gave it). The issues of discrimination, abuse of power and privilege, and criminality were simply ignored. b) Chart information should be subject to review and endorsement by the patient. I had to go to great trouble and expense to see my own chart materials, only to find that none of the material was recorded as I presented it, or even at all. This is in and of itself abusive and disrespectful treatment. c) Seeking remediation from another doctor (a chief of staff) regarding the abuses of a professional colleague has not, in my experience, borne fruit, and speaks to the collegial protectionism of the medical profession. In my case, this has led only to further complications and retaliatory medical mistreatment d) When I sought remediation for discrimination, incompetence, criminal or unprofessional behaviour by writing to administrators, executives and program administrators, I was met with lack of concern, ignored, was passed on back to patient advocacy, or was pushed away and told ‘nothing further can be done’.

- E) Move towards a culture of collaboration and due diligence in medicine, reducing the relative weight of importance of the unverified (by due diligence) opinion of a medical doctor.

This could be accomplished by using web-based databases to double-check diagnoses or provide alternative or possible diagnoses, as has been done in European medical systems for nearly 30 years. This makes it possible to minimize patient contact with doctors and maximize the possibility of credible and thoughtful diagnoses, another benefit for patients.

- F) Create fillable forms, on paper or computer screens, for patients to enter and verify their raw data, history and concerns.

Rushed intake interviews, whether by nurses or doctors, inevitably creates errors. With no possibility for patients to review this material, important facts are lost, misinterpreted or wholly misunderstood. This is particularly problematic with doctors, who simultaneously record and diagnose according to their limited lens of canonical or allowable possibilities, so much raw patient data is lost or corrupted.

**4. Recommend next steps and priorities for increasing gender- affirming health services capacity in the Champlain region:**

1. Create or lobby for inclusion of either *or both* sex option, or better: create or lobby for exclusion of overall sex designation in medical forms, to be replaced with sex determinant inventory, and self-identified gender, for more respectful and more scientifically credible, realistic care.
2. Educate physicians as to the reality that, in terms of science, we no longer know how to define the terms ‘male’ and ‘female’ anymore, except by cultural agreement. Binary sex is an artefact of culture, not biology, so medicine must cease to be an enforcing arm of this oversimplified legal, cultural and Levantine religious construct, and focus on caring for bodies as they actually are.
3. Improve oversight and accountability over physicians. I was describing criminal activity and human rights violations in my complaints, but was only offered help with chart document corrections, these other concerns rebuffed or ignored by patient advocates, chiefs of staff, administrators, and executives alike. End and prohibit any medical attempts to enforce heteronormativity in patients as a human rights issue and responsibility to the public. Ensure that practitioners and facilities are fulfilling their responsibilities to keep the public safe from discrimination and abuse, and ensuring that it is safe for all members of the public to present at their facilities. There does not seem to be any current mechanism for addressing human rights abuses, especially by doctors, within the system. Make medical doctors subject to the same legal

and professional responsibilities and oversight as any other clinic or hospital employee. Doctors should not be above the law.

4. Mandate that physicians cease providing editorial commentary on their patients that has no basis in science, or is impression-based, and which is, in essence, defamatory and discrediting, and thus obstructive to accessing rational medical care. Mandate that medical diagnoses must provide proof and that due diligence must be undertaken, especially in the much-overused “mental health” diagnosis to explain puzzling symptoms.
5. Bring the practice of medicine into the information age. A web-based information system could provide possible and alternative diagnoses based on patient’s raw data by nurses or doctors. Such systems have been in use in Europe for 30 years. This would offer great benefits to patients and the health care system. The only disadvantage would be bruising of physician’s egos as their relative power is diminished, which is a small price to pay for credible health care. This would also force physicians to be made aware of the same, up-to-date information available to anyone with access to the internet, which they currently lack or refuse to access.
6. Further to this, move towards a collaborative model of health care, with physicians demoted to partners rather than godlike authorities in providing care to the public.
7. Improve or develop, and oversee, feedback loops for physician education. The information relevant to my condition has been known to science for 50 years, but was unknown to the majority of doctors I consulted. It is clear that the CPSO is not adequate to the task, as ‘standards of care’ are woefully inadequate and out of date.
8. Work to rescind the CPSO’s status as the sole authority over medical doctors, and create credible, law-abiding alternatives. (A recent CMA award went to a doctor recommending non-disclosure of intersex conditions, which is fraud.)
9. Develop web-based provider information systems, whereby patients and doctors can research specialists' areas of interest and wait times.

### **Subject 3: Ottawa Intersex Case Study**

#### **1. Describe your experience accessing intersex health care in Ottawa**

I first attempted to access health care in Ottawa specifically for my known and previously diagnosed intersex condition on **February 13, 2013**. I am a 46XX,46XY tetragametic chimera with a non-binary urogenital system. I have never had any problems associated with my condition, so investigations into my difference never went beyond a physical observation of my subtle outward differences, which prompted the blood, nail and skin samples that yielded the above result in a 1969 test.

1. **G.P. #1** at a walk-in clinic stated he had never studied intersex conditions and knew nothing about them, but stated a disproven belief that ‘hermaphrodites are infertile,’ and therefore refused to record my previous diagnosis and history.

**Results:** referred to CHEO Genetics and a Urologist. Referral wrongly states that I desired to find out “if I might be intersex,” instead of my request for midlife care for my as yet uninvestigated urogenital system, which has elements of both sexes.

Ultimately, in **September, 2014**, releases me from service for refusing to recant my medical history, status, concerns and observations about my intersex health concerns, citing medical consensus and specialists.

Experience provokes rage, despair, terror for my life, suicidal ideation.

2. August 2013 **Urologist # 1** states adamantly intersex conditions did not and could not possibly exist and displayed mockery and disrespect towards me and profound ignorance about the condition at hand. He refused to take research papers I offered him. Subjects me to open mockery, hostility.

**Results:** ultrasound, genetics consult and cystoscopy to rule out obvious causes of problems described. No obvious problems with ultrasound and cystoscopy.

Chart notes do not include my concerns or reasons for visit. Refuses to record or investigate my medical intersex medical history, my empirical observations of my intersex physiology, my concerns for my non-binary system as stated. Disputes my history and empirical observations of my intersex health concerns in my chart notes, despite his admission of being out of scope. Refuses to look for or investigate specific area of concern because “it’s not possible.” Refuses to seek out colleagues familiar with intersex conditions because “there’s no such thing.” Subjected to punitive and deliberately rough cystoscopy, which causes nurse in attendance to gasp, step back and cover his mouth, looking stricken.

Provokes suicidal ideation, triggering of former traumatic events to do with my divergent sexual status.

3. September, 2013 - visit ER at Civic for severe genital pain. Chart documents mis-recorded but later corrected.
4. Sept. 2013 **Medical Geneticist #1** cites disproven and inherently discriminatory beliefs about intersex conditions generally and my condition specifically, and refutes my medical history and concerns, stating it is 'too unlikely' I am correct about my own intersex medical history and concerns because: I am fertile; I am too healthy ("People like that usually have all kinds of health problems and interventions, and a whole lot of paperwork that follows them around their whole, entire lives. If what you say is true, how come you don't have any paperwork to back up your story?"), and genital appearance (states my penis is too small to be a penis, an opinion she seeks out from G.P. #1 and Urologist #1, who are unaware genital appearance does not define intersex conditions and is scientifically irrelevant to my condition or my concerns.)

Subjected to open hostility, mockery, abuse.

Asks me to get another doctor to "agree" that I have what they think looks like a penis in order to receive any further services, consultations, support or advice as an intersex person from CHEO Genetics.

**Results:** Reason for visit, previous dx, history, empirical observations and concerns to do with my intersex status mis-recorded, refuted or ignored. Referrals to knowledgeable specialists refused.

Provokes suicidal ideation, rage, despair, terror for my life, triggering of former traumatic events to do with my divergent sexual status. Leaves me stripped of my own medical history, credibility and ability to access care.

5. Collapse in pain for ~ 1 hour. Unable to move, cry out or call ambulance. Following this, undocumented, uninvestigated second urethral opening is no longer blocked.
6. **Ask Venus Envy bookstore** for medical referrals. Gyne # 1, Centretown suggested. Centretown suggests G.P. # 2 in my catchment area.
7. October 2013 **G.P. # 2** does not record my intersex medical history and reasons for request for referral.

**Results:** Refers to gynecologist #1, reason for consult misstated.

8. October, 2103 **Gynecologist # 1** is familiar with trans population, but states he has never heard of intersex conditions. Mis-records history and concerns as being questioning about my sexual status.

**Results:** MRI. Reviewer does not see “ambiguous genitalia” according to cultural standards. Gynecologist # 1 states categorically I am mistaken about my history and concerns, despite admitting to me he is out of scope. Refuses to accept scientific literature I offer.

Gynecologist # 1 eventually **refuses me further service**, does not state he is out of scope, but does stated I am not intersex, and wrong about my own medical history and empirical observations of my own body.

Experience provokes rage, despair, terror for my life, suicidal ideation.

9. February, 2014 complaints to CHEO yield phone call with **Medical Geneticist # 2**, who orders a genetic blood test for Y chromosomes in response to my stated desire to be able to reclaim my own medical history and status and move forward with my health care for my intersex needs. In terms of science, this is problematic because my condition requires multiple tests from multiple sites and tissue types, are considered tricky to test for, is not necessarily rare, and is considered scientifically wholly unnecessary, given that my condition is already known and diagnosed.

**Results:** Blood test showed no Y chromosomes in that sample. **Medical Geneticist # 2** states this proves I am wrong about my own medical history. I point out to her that multiple scientists I spoke to were shocked that my history was ever disputed, and warned testing would not necessarily yield the same results, pointed out this was a different test, and stated no test can ever disprove chimerism, only prove it, and that this result would in no way nullify my initial results. **Medical Geneticist #2** screams over the phone: “Why does this matter to you so much? What difference does it make?” then hangs up on me.

From chart notes and discussion with G.P. # 2, discover immediately after this phone call, **Medical Geneticist # 2** phones **G.P. # 2** to tell her that it is “simply not possible” for me to be a tetragametic chimera or have a non-binary urogenital system, and states I need to be “booked into the Royal” for a psychiatric assessment.

Experience provokes rage, despair, terror for my life, suicidal ideation.

10. February, 2014 appointment with **G.P. # 2**, who mis-records my intersex history and concerns, and attempts to dissuade me from seeking further care for my intersex health care concerns, and towards psychiatric assessment.

**Releases me from services in September, 2014**, citing medical consensus I am not intersex, but delusional for thinking I am intersex, despite admitting to me she is out of scope for intersex conditions. In office visit, screams at me: “When are you going to stop all this nonsense and admit you’re a perfectly normal female?” Cites medical consensus I am wrong about my history, observations, concerns for my intersex health needs.

Experience provokes rage, despair, terror for my life, suicidal ideation.

11. April, 2014 Complaints to Civic Urology Chief of Staff yields consult with **Urologist # 2**, who states he has never heard of intersex conditions and cannot comment. Refuses stack of scientific literature on the subject I offer him. States he had spoken about me with a psychiatrist the night before, who put forward a possible diagnosis of ‘fixed delusion.’

**Results:** Despite admitting to me he is out of scope, chart notes categorically state I am not intersex, but should seek counselling to address my delusion that I am intersex.

12. April, 2015 Referral to **Gynecologist # 2**. He reveals he is very knowledgeable about intersex conditions, and is aware of the lack of understanding and awareness in the medical profession, but does not wish to take my case. Agrees to send me to knowledgeable gynecologist I have found in Toronto.

**Results:** In his chart notes, he cites, and copies and pastes chart documents I stated were in dispute and should not be used, and which he has revealed he knows are not medically or logically sound and are in error. Refutes my medical history, and states I need psychiatric intervention for my belief in my own medical history and concerns relating to my intersex status. Refers me to Genetics Clinic in Toronto “to find out if I might be intersex”, which is refused, as I stated it would be, as I have already accessed a genetic test in the system.

**Refuses me further services** in writing, citing refused genetic consult and his opinion that my penis is not large enough for me to be a 46XX,46XY chimera, which he has revealed he knows is irrelevant as a determinant of my condition, but which is in agreement with medical consensus. Also states in writing malicious gossip about me, stating he had “heard she had threatened one of the women at CHEO, and has been refused further services there,” a statement which has no basis in fact, but was also verbally imparted to me by **G.P. #1** at our last consult, before he released me from services.

Experience provokes rage, despair, terror for my life, suicidal ideation.

13. June, 2015 Leave the province as a health care refugee for my intersex concerns, being fully convinced I will never be able to access credible, respectful care given the misinformation that is currently on my shared health information file.
14. March, 2016 Return to province. Recent trauma and mistreatment by medical doctors leaves me unwilling to see doctors at all, for any reason.
15. Fall, 2016 Continuing health issues to do with urogenital system prompt visit to Centretown Urban Outreach.

**Results:** Diagnosis of uterine cancer, which I credit to manifestly intolerable stress of being stripped of my medical history and access to care over four years, and of suffering clear human rights violations in attempting to access medical care. I refuse suggestion of immediate removal of all internal reproductive structures.

Referral to knowledgeable gynecologist in Toronto refused, citing medical consensus on shared information network.

16. January, 2017. G.P. # 3, known to be a trans ally, agrees to take on as patient. Correctly records my history and concerns, has knowledgeable specialist in mind to refer me to. Initial check-up March, 2017.

**Results generally:**

- A) Every request I made to correct the material on my chart documents recorded correctly was refused, except the ER visit, in which my divergent status was not mentioned.
- B) Complaints to hospital and clinic administration were ignored, downplayed or rebuffed: most common response to my complaints that I had been abused, and had been stripped of my own medical history and ability to access care was: “We are sorry you did not have a good visit and hope you will have a nicer visit next time.”
- C) Currently have 9 related complaints on file with the CPSO.
- D) Intend to follow up with OHRT, and to seek policy and legal changes to create better oversight and accountability over physicians, not just for members of sexual minorities, but for all stakeholders in our public medical system.

## **PEOPLE OF COLOUR INTERVIEW SUMMARY**

Mikki Bradshaw

The interviews of the three subjects seemed to determine that there has been a severe lack of choice for who their respective service providers would/could be in regards to trans, intersexed, 2spirited, and non binary health care in Ottawa. All participants experienced long wait times when setting up appointments with service providers, and a general "I don't know, and I am not going to touch it!", from most general practitioners seen in Ottawa.

\*Please note and take into account that all of these participants have lived within Ottawa under the last 5 years, but do not reside in Ottawa currently.\*

Another point that came up, appeared that there is no willingness or acknowledgement of colonialist tendencies or lens point that may affect down to a subconscious level, how a service provider interacts with a client who is a person of colour. Also a point that I found interesting, was that interracial traumas and micro-aggression not being factored in or even considered in regards to clients' mental health or physical health.

### **Points for Recommendations and Addressing Gaps**

\* One person suggested that service providers and staff get Black Lives Matters, or another similar organization to give Anti-Blackness workshops. This will allow skills and concepts learned within said workshop, to be transposed with various people of colour, not just those who are black. It is recommended that this be a workshop or training that should be attended at least once every 2 years.

\* The one thing that all participants stated was that within the LGBTQ community, there is a underlying racism at play. But that isn't unusual, as that systemic racism is at play throughout Western society, and the medical profession and care are within those scopes. So it is absolutely necessary that at the very least, an avenue for mental health geared towards people of colour, and specifically immigrants that fall within the spectrum that we are targeting with the RPT.

\* Another suggestion given was that perhaps trans health should be advocated to be added to curriculum for medical students. (I realize that this is out of the scope of the RPT. However, if service providers or the LIHN are able to petition the ministry perhaps in regards to this?).

\* Participants also stated that information on how and where to access health services related to trans, intersex, two-spirited, and gender diverse people, came mostly from peers. But also from community organizations rather than actual clinics and health care providers. I feel that this is important to note, because it supports that access to this

information needs to get to access points outside of the domain of the health care providers, in order to reach much more of the population that need the services.