

PROJECT AFFIRMATION

*A Report on the Experiences
of Sexual Minorities*

SYSTEMS FAILURE

*in Ontario's Health-Care
and Social-Services Systems*

FINAL REPORT

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COALITION FOR LESBIAN & GAY RIGHTS IN ONTARIO

*Funded by Health Canada
Health Promotion & Programs Branch – Ontario Region*

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A Report on the Experiences of Sexual Minorities
in Ontario's Health-Care and Social-Services Systems

The Final Report of Project Affirmation

CLGRO: Project Affirmation, 1997

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Project Affirmation

Sponsored by the Coalition for Lesbian and Gay Rights in Ontario (CLGRO)

Funded by Health Canada, Health Promotion & Programs - Ontario Region

CLGRO: Project Affirmation, 1997

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PROJECT AFFIRMATION

In 1991, the Coalition for Lesbian and Gay Rights in Ontario (CLGRO) organized a provincial conference on education, "Out In The Classroom." One of the issues that came to the fore was the lack of counselling support available to lesbian, gay, and bisexual students. This in turn led to a questioning of the degree of support provided by the broader health-care and social-service systems.

CLGRO decided to pursue this issue and submitted a funding proposal to Health Canada, Health Promotion and Programs Branch - Ontario Region, for a three-year project. In spring 1992, the proposal was accepted. In 1993, due to delays in transfer payments and start-up time, Project Affirmation received an extension of 14 months. Thus Project Affirmation slowly came into its own with volunteers coming on board to form a management committee reporting to CLGRO's steering committee. In January 1993, three part-time staff were hired (two coordinators and an administrator).

The project was to identify and address the health-care and social-service needs of sexual minorities in Ontario. Three phases were time-lined: engaging the communities to help focus the research; developing, producing, and carrying out a needs-assessment survey of these communities and service-providers; tabulating the results, making linkages, and analyzing the outcome.

Public consultations took place across the province with sexual-minority communities. Different means were used to access the different constituencies. A province-wide survey was circulated that focused primarily on lesbians, gays, and bisexuals. Research consultants were employed to ensure contact with Francophone and transgendered people. Service-providers, post-secondary educational institutions, and professional associations were surveyed. This allowed the project to begin to determine levels of inclusiveness of and sensitivity to sexual minorities, to see what knowledge existed and what resources were available, and to ascertain what policies, practices, and guidelines had been developed.

The project then held a provincial conference at which delegates were able to review the preliminary findings and provide feedback and insight.

The confidentiality of project participants was a prime concern. Participants retained control of the decision to use their names or other potentially identifying details.

This report represents a milestone in the attempt to uncover the realities of lesbian, gay, bisexual, and transgendered people with respect to their experiences with the health-care and social-service systems in Ontario. It also provides the opportunity to assess the ability of health care and social services in this province to deliver sensitive and equitable services to these populations. Through both data and narratives this report reveals that a supportive, even-handed, or simply accepting service environment is, too often, hard to find. It begins, we hope, a pathway to understanding and change.

CLGRO

Coalition for Lesbian and Gay Rights in Ontario

CLGRO is a coalition of 20 groups and hundreds of individual members in all parts of the province. Founded early in 1975, CLGRO has concentrated its efforts in the areas of grassroots organizing, public education, and governmental lobbying.

Mission Statement

The Coalition for Lesbian and Gay Rights in Ontario is an organization composed of groups and individuals who are committed to working towards feminism and lesbian, gay, and bisexual liberation by engaging in public struggle for full human rights, by promoting diversity and access within our communities, and by strengthening co-operative networks for lesbian, gay, and bisexual activism.

CLGRO Member Groups

Bisexuals, Gays, & Lesbians at Lakehead (BGLLU, Thunder Bay)
Canadian Union of Public Employees, local 771 (CUPE # 771, Toronto)
Christos Metropolitan Community Church (Christos MCC, Toronto)
Durham Alliance Association (DAA)
Equality for Gays & Lesbians Everywhere (EGALE, Ottawa)
Gay & Lesbian Liberation of Waterloo (GLLOW)
Gays, Lesbians, & Bisexuals at McMaster (GLBAM, Hamilton)
Homophile Association of London Ontario (HALO)
Lesbian & Gay Community Council of Windsor (LGCC)
Lesbian, Gay & Bisexual Association of Kingston (LGBA)
Lesbian, Gay, & Bisexual Youth of Toronto (LGBYT)
Lesbians, Gays & Bisexuals at the University of Toronto (LGBAUT)
Ontario Federation of Labour (OFL)
Options (London)
Parkdale Gays, Lesbians, & Bisexuals (Toronto)
Pink Pathways (London)
Pink Triangle Services (PTS, Ottawa)
Provincial Gay & Lesbian Action Group, Ontario Public Service Employees' Union (OPSEU-PGLAG)
Timmins Area Lesbians & Gays (TALG)
uwOUT (University of Western Ontario, London)

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ACKNOWLEDGEMENTS

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Community Support

Association of Lesbians, Gays, & Bisexuals of Ottawa; Christos Metropolitan Community Church; Department of Public Health, City of Toronto; 519 Church Street Community Centre, Toronto; Hamilton Lesbian & Gay Alliance; Homophile Association of London Ontario; Lesbian, Gay & Bisexual Youth, Toronto; Lesbian & Gay Community Appeal, Toronto; Ontario Federation of Labour; Sudbury All Gay Alliance

SYSTEMS FAILURE

A Report on the Experiences of Sexual Minorities in Ontario's Health-Care and Social-Services Systems

CLGRO: Project Affirmation, 1997

Abstract

In the health-care and social-services systems, lesbians, gay men, bisexuals, and transgendered people are given short shrift - both by the services their tax dollars fund and by professionals who are paid by them.

Discrimination comes in two main forms: systemic and individual prejudice.

Instances of systemic discrimination include: service intake forms that assume heterosexuality; next-of-kin policies that fail to recognize same-sex partners; work environments in which openly expressed homophobia appears to be acceptable to the authorities; service-provider training that routinely omits lesbian, gay, bisexual, or transgendered contexts.

Instances of individual prejudice include: professionals who feel free to make prejudiced and hostile comments or who reduce the standard of their service/treatment on finding out that a client/patient is lesbian, gay, bisexual, or transgendered.

For lesbians, gay men, bisexuals, and transgendered people who belong to other minority groups also, or who are disadvantaged by sexism or by living in under-resourced regions, all these issues are compounded.

Lesbians, gay men, bisexuals, and transgendered people are guaranteed equitable treatment by the *Canadian Charter of Rights and Freedoms*, the *Canadian Human Rights Act*, and the *Ontario Human Rights Code*. Discrimination is illegal.

It seems a little odd to need to say this in 1997 but lesbians, gay men, bisexuals, and transgendered people are human beings who contribute to society and should be treated with dignity and respect.

It is inappropriate to leave the onus for bringing about change on the shoulders of service-users. In all cases, change must happen from the top down. Legislation is in place. Employers, professional associations, and service managers must establish, implement, and enforce non-discrimination policies. They must make the implementation possible by providing appropriate education for service-providers.

Based on an Ontario-wide survey, this report indicates the dimensions of the problems and makes recommendations for change.

SYSTEMS FAILURE

A Report on the Experiences of Sexual Minorities in Ontario's Health-Care and Social-Services Systems

CLGRO: Project Affirmation, 1997

Preface

Project Affirmation's task was to identify and address the health-care and social-service needs of sexual minorities in Ontario. (The term "sexual minorities" was used to encompass lesbians, gays, bisexuals, and transgendered people.) A three-year project certainly could not identify these needs, publicise and educate, as well as carry out the processes needed to bring about change. Therefore Project Affirmation has produced the following report as a foundation to be built on by those who are interested in learning, researching, educating, and carrying out social change to achieve equitable service provision for lesbians, gays, bisexuals, and transgendered people.

The responses received through Project Affirmation's survey and focus groups show systemic failure. There are stories ranging from unbelievable ignorance, insensitivity, and hostility down to institutional stone-walling and incompetence. The system has failed this population by failing to provide appropriate service. The result is that lesbians, gay men, bisexuals, and transgenderists must make the decision whether to disclose the circumstances of their lives; if they do, they risk meeting with prejudice; if they do not, the health-care and social-services assistance they obtain may not correspond to their needs. Many simply avoid even needed health care and social services. Their access to health care and social services is compromised.

i Lesbians, Gay Men, and Bisexuals

It must be recognized as a starting point that lesbians, gay men, and bisexuals are a disenfranchised population. Notions of lesbians, gay men, and bisexuals as dysfunctional, deviant, or deeply troubled are still wide-spread. Homophobia and heterosexism permeate all levels of society, and the health-care and social-service systems are no exception. When lesbian, gay, and bisexual people turn to these systems for help, assistance, or support they are vulnerable to prejudice; the ensuing relationship places the service-provider in a more powerful position.

The project's survey shows that lesbians, gay men, and bisexuals in Ontario are well aware of this situation; they are clearly critical of the health care and social services they receive. It is worth noting that those reached by the survey tend to be "out" (openly lesbian, gay, or bisexual). It is by no means clear that those who are out are the majority of the lesbian, gay, and bisexual population. Given what the out members have to say, the need to be silent felt by the rest should give us pause.

ii Transsexuals and Transgenderists

The lack of recognition, acknowledgment, and acceptance faced by transgendered and transsexual people is even more profound. Transgendered and transsexual people are not only invisible and unwanted; they are incomprehensible to health-care and social-service systems that operate within overly simplistic, rigid, gender-role boundaries. For them, the process of being heard and understood is just at a beginning. The ability these communities have to survive is amazing given the absence of support provided to them.

The transgender/transsexual section of this report was provided on contract by a transgendered research consultant since parts of the transgendered and transsexual communities felt it was inappropriate for a lesbian, gay, and bisexual coalition to be carrying out this work. Indeed, CLGRO has not discussed the issues raised in this section of the report and has taken no official position on them, except that it is clearly crucial and urgent that service-providers develop an understanding of and sensitivity to the needs of transgendered and transsexual people.

Project limitations allowed us to study the needs of transgendered communities only as they reported them; we recommend further study in the area of health-care and social-service providers, educational institutions and professional associations with regard to this population.

iii Sexism, Heterosexism, and Homophobia

Heterosexuals are clearly the targeted constituency of health care and social services in Ontario. Others are mainly invisible. They are noticed only when they assert themselves, or when their needs are so dramatic that they cannot be overlooked (as in the case of gay men and AIDS). Then, what is offered may be well intended, but it is just as likely to be inadequate or inappropriate.

At the very least, these services anticipate that, if people are not heterosexual, they will be heterosexual-like in both appearance and lifestyle. For example, those whose relationships do not fall into the nuclear-family model or members of such communities as leather, drag, or S/M are not accepted. Individual service-providers are often aware of their existence, but the services themselves are not prepared to receive them.

Women have always had a troubled relationship with the medical and social-welfare professions - from unnecessary gynecological surgery to unnecessary "tranquillization" - and have been seen historically by these professions as deviating from the model of a healthy human, that is, a man. Issues of sexism have not been dealt with at length in this report, since the impetus of the women's movement has provided many resources, both grassroots and academic. We focus here on the issues raised by women's sexual orientation, since these have often been overlooked in writing on or work done with women.

Lesbian, gay, bisexual, transgendered, and transsexual people have always been aware of the feelings of fear, anxiety, and anger that arise within the mainstream health-care and social-service organizations they contact for service. Organizations and institutions whose mandate is to help them become unsafe places where they are misunderstood, and definitely not helped. They go away fearful, angry, and mistrustful of a system that has interpreted them as non-compliant, unreachable, and resistant.

iv Service-Providers

Service-providers generally reported that they were open to working with lesbians, gays, bisexuals, and transgendered people and that the services provided were adequate and not necessarily discriminatory. They would be open to further training but were quick to point out the lack of funds to do so. Their responses were in stark contrast to those of the lesbian, gay, bisexual, and transgendered service users. Project Affirmation data point to serious neglect on the part of service-providers. This discrepancy clearly indicates the degree of systemic homophobia and heterosexism that exists.

It is not acceptable to simply profess an open attitude towards the lesbian, gay, bisexual, and transgendered communities. Proactive commitment must be demonstrated through the sensitive, informed, and equitable service provision required for all patients and clients. Certainly, homophobia and heterosexism are insidious, but sub-standard service provision, whether or not it is intentional, is irresponsible in terms of service-delivery standards. If intentional, it constitutes unethical and discriminatory behaviour. If unintentional, providers have lost touch with their responsibility to be aware, sensitive, and informed professionals, attuned to the needs and circumstances of those to whom they provide services.

Future study should also focus on the views and experiences of lesbian, gay, bisexual, and transgendered service-providers within the health-care and social-service systems.

v Post-Secondary Educational Institutions

A sample of post-secondary educational institutions was also surveyed, since they train professionals entering the fields of health care and social services. Curriculum content that is positive towards lesbians, gays, bisexuals, and transgendered people is only minimally in existence and arbitrary at best; this is also true of related placement opportunities. Their existence depends on individual professors. It is possible for individual professors and whole faculties to avoid entirely the issues and needs of the lesbian, gay, bisexual, and transgendered communities. Systemic intolerance may mean that those who wish to address these issues lack the opportunity and that students cannot request inclusive curriculum content or relevant field placement. In some institutions, student request is the only way to raise these issues, which is hardly inviting and potentially risky for the students.

Many educational institutions reported that, though they were open to developing lesbian-, gay-, bisexual-, and transgender-positive curriculum, they were not currently willing to do so because of lack of funding. This demonstrates a lack of commitment, since many materials are already available for use and creative means of adding to the curriculum can be utilized at little cost. Students are willing to undertake research projects and the lesbian, gay, bisexual, and transgendered communities can provide resources.

vi Professional Associations

Most of the professional associations studied had “sexual orientation” in their codes of ethics. It is generally expected of the members of professional associations that patients and clients will be treated sensitively and equitably irrespective of their sexual orientation.

However, the simple listing of the term “sexual orientation” in a code will not achieve the desired result. The experiences described by Project Affirmation survey respondents indicate that its influence is, at best, limited. Professional associations must develop clear guidelines,

policies, education, and enforcement mechanisms, to back up their codes of ethics. They should also provide ongoing training so that professionals are given the opportunity to develop the necessary knowledge, understanding, and sensitivity.

vii Financial and Human Costs

For lesbians, gays, bisexuals, and those in the transgender communities, the very systems that profess to care for people's health and social-service needs can be sources of discrimination and result in a worsening of the situations that led them to seek assistance.

These gaps and inadequacies in the system result in increased costs: financial, personal, and in terms of human resources. The human costs to society include thousands of individuals who are highly stressed, and damaged in their self-esteem; their opportunity to become productive members of society is diminished.

In financial terms, we see the cost of repeating botched or unnecessary medical procedures, emergency intervention because patients have been too discouraged to seek preventive or follow-up care. The Ontario Health Insurance Plan (OHIP), government ministries, and private insurance carriers pay out when people need to shop around for unbiased service. We see the cost of inappropriate mental health assistance, of counselling that is protracted because inadequate, and continuing services to those whose distress is unabated.

viii Conclusion

It is imperative that professionals in these fields receive adequate training to deal appropriately with carrying out their responsibilities when providing services to members of the lesbian, gay, bisexual, and transgender communities. The structures and institutions that support the health-care and social-services systems (government, professional associations, educational institutions) must cease to ignore these communities and begin to work for them and with them.

Post-secondary educational institutions and professional associations can play an important role in developing the necessary knowledge, expertise, and sensitivity. Higher levels of professional expectation and thus higher levels of quality care would be achieved. By making these achievements systemic, heterosexism and homophobia within the health-care and social-service fields will begin to diminish. Those who set social policy, whether in government or not, need to respect diversity in sexual orientation when designing and implementing social support structures.

We hope that this report of the appalling circumstances faced by the lesbian, gay, bisexual, and transgender communities, will lead to the transformation of health-care and social-service systems until they proactively affirm access to equitable service-provision as a fundamental human right. Through responsible change, past neglect can be rectified, current gaps and inadequacies in the system remedied, new approaches developed, and equitable services implemented for a healthier, stronger Ontario.

The work of Project Affirmation confirms what the lesbian, gay, bisexual, transgendered, and transsexual communities have known for a long time: they do not get the service for which they pay and to which they have a right. They are expected to contribute to society, but not to benefit from it. This report calls for much needed changes. It is time for health-care and social-service systems to begin to respect the principles of fair and just treatment - for everyone.

Project Affirmation's data have been stored and can be accessed at the Canadian Lesbian and Gay Archives, 56 Temperance Street #201, Toronto M5W 1G2; (416) 777-2755.

SYSTEMS FAILURE

A Report on the Experiences of Sexual Minorities in Ontario's Health-Care and Social-Services Systems CLGRO: Project Affirmation, 1997

1 Guide to the Report

1.1 Methodology of the Lesbian, Gay, and Bisexual Research

First, a research methodology had to include a strategy to deal effectively with the entire province, identify a data-collection method and process, and plan for data analysis and documentation.

For outreach and data-collection, Ontario was divided into eight areas, according to physical distance from Project Affirmation's Toronto office. For analysis and reporting, the data were then assembled to represent Toronto, other urban settings, central and southern rural communities, and northern communities.

A series of public meetings and an initial provincial tour put a human face to the project and established a network of contact people who helped extend its reach, made resources available, and fed back information on local needs and issues. In this way, the communities under study participated in the ownership of the project.

The initial meetings included two in Ottawa (one in English, one in French), and one each in Kitchener, London, Sudbury, Thunder Bay, Peterborough, Hamilton, and Toronto. Meetings in other communities occurred from time to time, as requested. A second round of meetings in Thunder Bay, London, Sudbury, Ottawa, and Kingston presented early project findings for review and comment. Later, a conference gathered people together to consider the data on a provincial level. Combined, the consultations and conference offered project participants a first-hand chance to participate in the research.

Part of maintaining a network of personal and organizational contacts meant keeping track of them and keeping them informed. From time to time, project participants received a newsletter chronicling our progress.

The data collected for the final report included the information gathered from the public forums, meetings, and other forms of personal contact, but the major component of the data-collection effort was the survey designed and distributed by Project Affirmation.

1.1.1 Survey

Project Affirmation's staff and management committee, in cooperation with a research consultant, designed the survey. The draft survey was reviewed by a number of survey-design specialists. It was then focus-tested with a sampling of potential survey participants.

The main survey tool was a questionnaire, because questionnaires are both anonymous and easy to circulate, giving more people the opportunity to participate. The questionnaire was circulated across Ontario between February and July 1995. Of 6,000 surveys sent out, 1,233 were returned, a response rate of 20.5%. Some were vandalized or removed from the distribution sites. Others were discarded at distribution points after the deadline for return had passed. Because of this, it is unclear how many of the surveys actually made it into peoples' hands.

Ads were placed in local newspapers and newsletters as well as in *Xtra!* and *Capital Xtra!* lesbian, gay, and bisexual newspapers with wide circulation in the Toronto and Ottawa areas. Flyers were posted on bulletin boards of community groups, bars, and libraries. Both ads and flyers included a tollfree telephone number to enable people to phone for a survey. They also announced the location of survey distribution sites across the province. Many community groups distributed the survey to their memberships. Selected bars, social events, and dances left surveys for patrons and guests.

No attempt was made to randomize the sample. Mainly, it represented people familiar with the distribution sites, publications, and venues where we were able to advertise the project. Many people who did not interact with these networks returned surveys, but these surveys moved along the previously described pathway.

1.2 Special Features of the Research

Despite its broad reach, a survey by questionnaire did not offer the best way for many lesbian, gay, and bisexual people to participate. It was lengthy and required both literacy and time to complete. While some people felt safe disclosing personal experiences in this format, others did not. Most of the survey data reflect a group that is out, well educated, economically privileged, and, by their own designation, white. Between a quarter and a third of survey participants were people who in one way or another do not represent that group. However, analysis can extend the data to cover the perspective of many marginalised people.

Unless otherwise indicated, subgroups are compared with the sample overall, and the sample overall always includes all subgroups.

If a participant overlooked or chose not to answer a question, this was recorded as a missing response and the sample size for that question was reduced accordingly.

Some people did not report their age, income, relationship status etc. Others did not indicate their gender, so the total of men plus women in the sample is less than the total number of survey participants. This affects the subtotals for some questions but is a justifiable deviation.

Also, for example, people who had never seen a counsellor or therapist were told to skip the questions on counsellors and therapists. Then only the responses for people who indicated that they had been in counselling or therapy were considered in developing statistical information about experiences with counsellors or therapists.

The decisions on how to arrange the findings have some important implications. There are interrelationships between many forms of discrimination, and many participants felt that homophobia interacts with sexism, racism, ableism, classism and other forms of oppression.

You might consider sexism more generally. I have a PhD, I'm white, and yet male doctors still talk to me like I'm an idiot. I can't imagine how hard it is for women who don't speak English, aren't white, or don't have socially sanctioned educational credentials.

In some interaction it is impossible to identify which form of discrimination is having the greatest effect.

I'm not sure, as a woman, whether there is a gender bias and just poor treatment as a result of that vs. other issues [like] paternalism within [the] medical model.

Race, ethnicity, and culture were determined in a fashion described in the chapter of the same name; the intent was to present the perspective of those who define themselves as being outside the (white) majority group of survey participants.

Sometimes, it is obvious that an individual belongs to a particular group. For example, race and sex are often apparent. When a member of a marginalised group is visibly identifiable, it is easier to establish a causal link between negative experiences and bias based on membership in that group. Sexual orientation is often invisible.

Survey participants were asked if they had told service-providers that they are lesbian, gay or bisexual. Throughout the report, information is given also about the group that had not disclosed their orientation. However, a third party may tell service-providers that someone is lesbian, gay, or bisexual. And service-providers (correctly or incorrectly) often assume that a client is lesbian, gay or bisexual without being told. A person's appearance, living situation, or style of communicating may conform to stereotypes that influence service-providers' perceptions. Information gained in these ways is not reliable, but it may still shape the beliefs of service-providers.

On the other hand, service-providers may not realize that a client is lesbian, gay or bisexual even though the client believes they have given some very direct hints about their sexual orientation. An opposite-sex person accompanying a patient to a medical appointment might be assumed to be a spouse, while in the same situation a same-sex partner may be assumed to be a friend or relative.

Therefore, although aspects of this report describe people who do not consider their sexual orientation to be known to their service-provider, all that can really be certain is that they did not volunteer any information.

1.3 Notes on Presentation

A brief outline of the contents of this report follows. The first two chapters cover methodology and an overview of survey findings and are essential reading. Subsequent chapters provide a more detailed breakdown of the findings by issues and communities and can be selected according to the reader's interests and needs.

This report includes comments from the survey questionnaires which appear indented and in italics. No identifying information is given except where the sex of the individual is necessary to ensure clarity of meaning; then the symbols & (female) and % (male) are used.

1.4 Notes on the Findings

Although we feel that there is no hierarchy among oppressions (sexism, racism, anti-Semitism, ableism, homophobia, or any other form of oppression), different elements can predominate at different times. Discrimination can be extreme or subtle, systemic or perpetrated by individuals. These feelings and behaviours can be found among heterosexuals and also within lesbian, gay, and bisexual communities (Icard 1986).

In “Health-Care and Social-Service Delivery,” four mini-reports address the degree to which health-care and social-service organizations, educational institutions, and professional associations influence service, education, and standards of practice. One report considers the efforts of a number of Toronto services characterized as positive in their response to lesbian, gay, and bisexual people. This work was completed by two university students who were placed with Project Affirmation as part of their course work.

“Transsexuals and Transgenderists” is excerpted from “Access Denied,” a larger report written by Ki Namaste and commissioned by Project Affirmation. In this shorter form, we highlight information specifically relevant to the mandate of Project Affirmation.

1.5 Conclusion

Project Affirmation's research methodology enabled staff to gather data that could give an overview of many of the health-care and social-service problem areas for lesbian, gay, and bisexual people in Ontario. It made it possible to assemble information according to certain issues and groups and by geographic regions. It allowed for the identification of survey participants according to a broad range of demographic criteria.

Even so, this report only samples the data. There are many more ways to group survey participants than are accounted for here. Whether to delve more deeply into existing report topics or to take a fresh perspective, this report is very much a call for further research.

PROJECT AFFIRMATION SURVEY

DIFFERENCES BETWEEN WOMEN AND MEN RESPONDENTS

	Women	Men
Number of respondents	556 (45%)	669 (54%)
On Social Assistance	134 (24%)	155 (23%)
Income		
\$0-9,999	104 (19%)	104 (16%)
10-19,999	96 (18%)	128 (19.5%)
20-29,999	96 (18%)	91 (14%)
30-39,999	91 (17%)	98 (15%)
40-49,999	62 (11.5%)	90 (14%)
50-59,999	45 (8%)	62 (9.5%)
60-69,999	27 (5%)	49 (7.5%)
70 +	20 (4%)	33 (5%)
Have Dependent(s)		
1 or more	137 (25%)	89 (13%)
Have Child(ren)		
yes	140 (26%)	78 (12%)
no	405 (74%)	576 (88%)
All or Some of My Children Live with Me		
yes	86 (63%)	24 (33.3%)
Relationship Status		
not in relationship	139 (25%)	276 (42%)
opposite-sex relationship	11 (2%)	3 (0.5%)
same-sex relationship	393 (72%)	369 (56%)
both same- and opposite-sex relationships	4 (1%)	10 (1.5%)

2 Health Care and Social Services: Survey Overview

2.1 Introduction

The Project Affirmation survey sought information about a broad range of health-care and social-service providers, educators, and professional associations. What is described in this report is of vital importance to them because it is their responsibility to deal with and correct the problems presented by their systems.

Doctors and hospitals are focal points in the medical model and figure in almost everyone's health-care history. This section includes information about the experiences of lesbians, gays, and bisexuals with doctors (particularly general practice or primary-care physicians) and hospitals.

A brief overview of social services is also offered here. However, compared with health services, there is no similar focal point. There are many kinds of service-providers and many different settings for service delivery, and they are examined in more detail in subsequent chapters.

2.1.1 Profile

Of the 1,233 surveys returned to Project Affirmation, 556 were from women and 669 from men. Eight people did not indicate their gender.

For both men and women, 80% were aged 26-54, 15% were younger, and 5% were older.

For both men and women, 70% were employed; 44% earned \$20-50,000 a year; 36% earned less and 20% earned more; 24% received some form of social assistance.

For both men and women, 51% had completed community college or had an undergraduate degree; 28% had up to a high-school diploma, and 21% had graduate degrees; 15% reported that they were students.

Most men (98%) and women (91%) had been sexually active during the previous year. Almost 66% overall were in a same-sex relationship (75% of the women and 58% of the men); of those in relationships, 75% of the women and 61% of the men lived together.

26% of the women and 12% of the men had children; 63% of the women and 33% of the men had their children living with them.

11% of survey participants described themselves as generally not having come out, and this is true for slightly more women than men. 42% of the women and 35% of the men felt it unsafe to be out in their daily lives.

PROJECT AFFIRMATION SURVEY

Overall Summary

Total survey sample: 1,233

Breakdown of survey respondents by percentage:

Women	45%
Men	54%
Aged 26-54 years	80%
Employed	70%
Earned \$20,000+	64%
Earned less than \$20,000	36%
On social assistance	24%
Post-secondary education	72%
Sexually active in previous year	95%
In a same-sex relationship	66%
• Women	75%
• Men	58%
Parents	18%
Women with children	26%
of these, children live with them	61%
Men with children	21%
of these, children live with them	31%
Disabled or had chronic illness of more than 6 months in duration	21%
• almost evenly split between men and women	
• 50% of the men HIV positive or living with AIDS	
Self-identified as bisexual	5%
Self-identified as	
• First Nation	4%
• East Asian, South Asian, Middle Eastern, Black, Hispanic, or Jewish	9%
• Francophones	3%
• Youth	15%
Not out as lesbian, gay, bisexual	11%
Not safe to be out in their communities	
• Men	35%
• Women	42%

Regional profile of respondents

Ontario Urban	50%
Metro Toronto	33%
Ontario North	10%
Ontario Rural	5%

Age profile of respondents

Over 54	5%
26-54 years	80%
Under 26	15%

Education profile of respondents

Graduate degrees	21%
Undergraduate degrees or community college	51%
High school or less	28%

Income profile of respondents

Over \$49,000	20%
\$20-49,000	44%
Under \$20,000	36%

Significant findings - all respondents

- 23% reported being **physically assaulted** because of their sexual orientation
- 71% reported being **verbally harassed**
- 52% believe their sexual orientation will be **viewed negatively by health-care providers**
- 74% have **disclosed their sexual orientation to their physicians**
- 24% of women and 39% of men said their **doctors asked about their sexual orientation**
- 89% of respondents stated that **mental health professionals (social workers, psychologists, psychiatrists, etc) need training to better deal with lesbians, gays and bisexuals.**

2.2 Health Care

2.2.1 Stories

The survey provided space for people to tell their stories. In interviews, public forums, and a variety of informal contacts people did the same. Project staff harvested accounts of wrenching experiences and heartfelt concerns relating to mistreatment from health-care services and service-providers. No more eloquent voices for the issues dealt with here could be found than those.

Some participants have experienced outright violence as a result of homophobia.

I did experience what a later doctor described as speculum rape - by a female doctor who seemed quite hostile to my sexual orientation - had a very painful experience during annual routine pap smear, and only after my yelling did she finally admit she did have a smaller speculum, after initially denying this.

Some participants spoke of a dramatic change in the way they were treated after hospital staff discovered their sexual orientation.

I have a tattoo of 2 womyn symbols in the area that the staff was attending to and I knew they treated me different after they saw it. They told my mom that I should be tested for STDs and it didn't even involve that area!

5% reported homophobic comments from their doctors, and some were denied treatment when their doctor became aware of their sexual orientation.

I was having a physical ... dressed in the gown and everything, and the doctor asked if I had sex. I said yeah, and she said "Do you use birth control." So I decided to come out and said, "Well, no, I'm a lesbian." She put down her instruments and walked out without a word. I was just sitting there in that gown, and finally I just got dressed and left.

Some service-providers reacted more subtly: they were abrupt, unfriendly, or uncomfortable once sexual orientation had been disclosed. Others seemed less concerned, spent less time with the individual, or were just less responsive. Subtle indications of discomfort or insensitivity on the part of a physician can have a dramatic effect on the comfort and trust a patient may feel. A patient is left wondering if their doctor will really give them attentive, thorough care.

I am sure that the kind of treatment I get is affected but not verbally expressed by my doctor.

It could be my imagination but since I told my doctor I'm gay, I feel his concern for me as a patient is less. I stay with him only because it is hard to find doctors who will care.

I felt as though everyone looked down at me, although nothing rude was said.

Dirty looks. No privacy for personal moments. Stares, glares and whispers. Some nurses think you'll pounce on them or something.

20% of participants reported that their doctor remained silent about the fact that they were lesbian, gay or bisexual.

We told our doctor that we are a [same-sex] couple. The doctor never commented on it, never brings it up. When we brought it up again. We were told, "Who you are isn't an issue."

Making a decision to disclose can be the biggest decision faced by a patient; it requires great courage to disclose. Physicians who neither acknowledge nor consider the information risk the trust of their patients.

Many lesbian, gay, and bisexual people didn't get treatment they required because doctors either assumed patients to be heterosexual or didn't incorporate knowledge about lesbian, gay, and bisexual issues into their diagnosis and treatment procedures.

He assumed that I was straight when I first came to him. I was in need of bowel and bladder repair and a hysterectomy. After having five pregnancies the opening to my vagina was large. After the hysterectomy and repairs, the opening was considerably smaller and I was very upset about this. He indicted (again, not knowing that I was a lesbian at that time) that my husband ... and I would find more pleasure with a tight vagina. I was very shaken and distressed.

I have been mis-diagnosed by a straight doctor who had never heard of gonorrhea of the throat in gay men and therefore kept telling me that I had a simple sore throat even though I had an STD ... it was a gay doctor who understood oral sex between men who immediately identified my STD and stomach parasites.

It can be disillusioning, distressing, or frustrating to come out and then find that you are faced with stereotypes and the need to educate your physician about lesbian, gay, or bisexual health issues (Stevens 1992; Stern 1993; Winnow 1991).

[My doctor] is poorly informed about health issues/risks specific to lesbians. My Dr. told me that as a lesbian I had a lower than average risk of cervical cancer and therefore do not need an annual pap test. Also, he did not question me about number of male partners or age of first heterosexual intercourse in making his judgement.

More than 10% of participants reported that their doctor made incorrect assumptions about them on the basis of their sexual orientation. In addition to being unable to get treatment they did need, some lesbian, gay, and bisexual people reported being forced to accept treatment they didn't need. For example, one woman reported being required to have an HIV test before surgery because her GP (general practitioner) assumed that lesbian women are at high risk and required the test for the protection of hospital staff.

Sexism and homophobia lead health-care providers to assume that women's sexual health concerns focus solely on issues of reproduction (Zimmerman 1987.) Lesbian and bisexual women repeatedly reported that health-care providers assumed that the only sexual issues relevant to them were birth control and pregnancy.

*When asked *do I need information about birth control*, I answered *no*. No other questions were asked - ie. *Are you sexually active in same sex relationship*.*

*The question *are you sexually active* was too vague. Yes I am [but] not if it would lead to pregnancy. My friends laughed at me for not understanding the question - but I didn't get it. Then the doctors acted like I'd told them some overly intimate and private thing by saying I'm a lesbian.*

Many women reported that pregnancy was the first line of inquiry for a diagnosing physician despite the patient's explanation that they had not been in contact with sperm. Serious health problems, such as appendicitis, were incorrectly diagnosed as being associated with pregnancy, while the real nature of the patient's health concern went untreated.

I was hospitalized due to severe pain in connection with passing a kidney stone. The admitting physician kept insisting that I must be pregnant even though I stated that it was not a possibility. When I told her I had not had intercourse with a male in seven years she was rude and hostile and insisted on giving me a vaginal examination anyway. The vaginal exam was extremely painful and when I told her it was painful (she was rough) she said there must be something wrong with me and that it shouldn't hurt (ie. all I needed was a good fuck?). I had been telling her all along that I believed my pain to be the result of a kidney stone. Finally she agreed with my diagnosis and then left me for 45 minutes before providing pain killers.

Many survey participants felt disadvantaged in hospital and unable to demand their right to appropriate treatment.

*You always fear that you will get inferior treatment if you *come out* in a hospital. I work in a hospital and I know - I wouldn't be out unless I was seriously ill or dying! I also provide care to lesbian clients in hospital and have been actively advocating for them in labour and delivery wards - as long as lesbians, gays, and bisexuals have supportive people with them, direct physical, verbal abuse is minimized but being in hospital is by definition an extremely vulnerable position to be in and most people do not have advocates/support people with them ever most of the time.*

2.2.2 Doctors

Most survey participants saw doctors more often than any other health-care provider. Doctors have considerable prestige and authority both within the health-care system and in society. This creates

a power imbalance that can limit communication between any patient and doctor. Often the point of entry into the health-care system, doctors have a positive or negative impact at a crucial point. Because doctors play such an important role, it is essential that they are able to deal with lesbian, gay, and bisexual patients in an intelligent, sensitive, and informed manner.

Fearing negative treatment, 51% of survey participants indicated they don't always come out to health-care providers. About 15% believe this has a direct effect on their health because their doctor is the service-provider they cannot tell. A relationship of trust and respect with a doctor enables a patient to confide personal and intimate details. Honest communication and understanding the context of a patient's life allow a doctor to make an accurate diagnosis and develop an appropriate health-care plan.

In the survey, 91% of participants found it important that their regular doctor is comfortable acknowledging their sexual orientation. Yet only 74% of all participants disclose. Women were asked about their sexual orientation much less frequently than were men. 39% of the men but only 24% of women had been asked by their regular doctor about their sexual orientation. 33% of women but only 26% of men reported they could not talk openly to their regular doctor about sexual issues affecting them.

I purposely had to seek out a gay-positive doctor, which took some time. It's extremely important that my doctor acknowledges my homosexuality in a positive manner.

Of survey participants, 84% as being involved in lesbian, gay, and bisexual community organizations, and 77% described themselves as being generally out. Across the province, services such as AIDS committees, lesbian, gay, and bisexual groups, and women's groups and services provide informal screening of health-care providers for homophobia.

Many lesbian, gay, and bisexual people consulted others on the way to finding a doctor receptive to lesbian, gay, and bisexual patients. This *Agrapevine* approach increases the likelihood that consumers will avoid most discrimination and insensitivity and may account for the relatively large number who had satisfying encounters with their personal physicians.

It may be, then, that most disclosure occurs because of the individual's efforts to find lesbian-, gay-, or bisexual-positive physicians. Of those who are out to their doctor, most reported they initially visited more than one in order to find a doctor comfortable with lesbian, gay, or bisexual patients.

My partner and I interviewed physicians to find one who would provide the health care we wanted and on our terms as a couple. We talked with other lesbians prior to interviewing, so we were dealing with physicians known to be lesbian-positive.

Those who are not generally out do not have access to the information circulating in lesbian, gay, and bisexual networks and are less likely to find lesbian-, gay-, or bisexual-positive professionals.

23% of survey participants had not told their doctor about their sexual orientation. Many felt it would have a negative effect on the professional relationship. In spite of avoiding the stress of disclosure, they felt at increased risk of inappropriate health-care treatment. A doctor's assumption that they were heterosexual resulted in inappropriate treatment for 7%; only 3% of those who were out to their doctor reported inappropriate treatment. Some endured unnecessary pregnancy tests or unwanted birth control counselling while real concerns were not addressed.

A host of ordinary questions suddenly became risky (*Could your wife help you put on this cream?* *Who is your next of kin?* *What does your husband think about your child's illness?*)

I was going to visit my partner who was working in Mexico. She had just contracted a tropical disease, and I wanted to be inoculated. They refused to because they said I'd only be in casual contact with my friend so I wouldn't need it. So I had to come out to them. The third Dr. I saw was cool, she kind of jumped a bit at the news I was a lesbian but then got herself under control and was very professional.

Of those participants who were not out to their doctor, 66% reported they had not voiced concerns or asked questions about health issues because they feared that knowledge of their sexual orientation might negatively affect the way they are treated. They were often left with incomplete information related to their sexual health.

Because I'm afraid to come out to my GP I'm not sure I'm getting proper advice ie: can I spread a yeast infection or other infection to my partner.

My partner was told to Arefrain from sex@ for a time after her hysterectomy. She was too embarrassed to ask whether that meant refrain from all sexual contact ... or only refrain from vaginal penetration.

Often a health-care crisis forces a decision about coming out to one's physician. Women who are considering pregnancy or anyone diagnosed with HIV or other sexually transmitted diseases must come out to their physician in order to receive appropriate medical information and service. At that point, a physician/patient relationship based on secrecy faces a difficult transition.

I've been seeing my doctor (GP) for approximately 13 years. Until it was noted through tests I was HIV+, he didn't speak of any sexual orientation. Once notifying me of my HIV status he then began to make negative gay comments.

2.2.3 Factors Influencing Coming Out to Doctors

Supportive health-care providers make it safe for patients to come out. It is very important that future research examines the relationship between doctors' inquiries about sexual orientation and patients' decisions to come out.

It is much safer for lesbian, gay, or bisexual patients to come out if the doctor is known to be lesbian, gay, or bisexual or if service-providers do not impose assumptions of heterosexuality. Unnecessary references to heterosexual norms (AAre you married yet?@ AWhy doesn't a woman like you have a boyfriend?@ AMaybe your wife could drop off this paperwork@) are alienating.

Signs that a doctor is comfortable with lesbian, gay, and bisexual people help patients to disclose their sexual orientation. For example, doctors who do not assume the gender of a sexual partner but use inclusive pronouns convey the message that they are aware of and comfortable with a lesbian, gay, or bisexual sexual orientation.

If, when I was sitting in my doctor's office or hospital waiting area, there were homophobia-awareness posters and the forms asked me to identify my same-sex partner, I wouldn't have to live a lie.

Doctors who ask about sexual orientation send the message that they are aware that they may be with a lesbian, gay, or bisexual patient. In cases where doctors did ask, 99% of lesbian, gay, or bisexual patients came out. If doctors did not ask, only 60% came out.

I wish my doctor would ask if I am a lesbian because most patients will answer truthfully but not volunteer the answer.

Doctors who provide an opportunity to disclose sexual orientation on intake forms increase the likelihood that consumers will disclose their sexual orientation. Almost all participants (97%) who were given an opportunity to disclose their sexual orientation on intake forms did choose to come out. Otherwise the number fell to 70%.

Despite the fact that both direct questioning about sexual orientation and intake forms which discuss sexual orientation increase the likelihood that consumers will disclose, both of these are relatively rare. Unfortunately, doctors asked only 32% about their sexual orientation. About 13% found intake forms which gave them the opportunity to disclose their sexual orientation.

It made it easy that my doctor asked me about my sexual orientation. In the past, doctors assumed I was straight and I wasn't comfortable telling them I wasn't.

However, lesbian, gay, and bisexual people will only come out if they trust that the information will be handled respectfully. Many are concerned about the confidentiality of their personal information. In smaller communities or in social situations, a health-care provider may know family members or work associates. Lesbian, gay, and bisexual people worry about the control of information. Even trust in a health-care provider does not overrule the fear that health-care records could be discovered and misused.

In my community, intake forms that identify people as gay/lesbian/bisexual could place individuals at risk of discriminatory, inappropriate or abusive treatment. Many professionals in this area are quite homophobic and/or ignorant of gay/lesbian issues. Many still believe that homosexuality is an illness or at best immoral. Coming out to health-care professionals is always risky - this is a small rural community - confidentiality is not always maintained.

2.2.4 Hospitals

While 70% of participants reported that their family doctor treated with respect the fact that they are lesbian, gay, or bisexual, there were many hospital situations in which lesbian, gay, or bisexual people were treated poorly.

54% of survey participants had been hospitalized or treated in hospital in the previous five years. About 20% were in hospital or receiving hospital treatment at the time of the survey.

Just over 40% of survey participants felt it important that hospital staff were comfortable with lesbian, gay, and bisexual patients. Of those who dealt with a hospital, only 13% actually disclosed their sexual orientation; of these, 44% of participants reported that it was not comfortable there to be openly lesbian, gay, or bisexual.

70% of those who had been in hospital found it important that hospital staff are comfortable acknowledging their sexual orientation. In focus groups the initial response was the same, but those who had never been in hospital often revised their opinion as they heard the horror stories from those who had. Those who have not reflected on the possible implications of service-providers= homophobia may underestimate the impact such bias could have on them. Of those who had used hospital services just under 23% disclosed their sexual orientation to hospital staff.

PROJECT AFFIRMATION SURVEY

SURVEY RESPONSE SHEET

HEALTH-CARE SERVICE IMPROVEMENTS

Of 1233 respondents

Do you think that health-care services and practices need to be improved to better meet the needs of gay, lesbian, and bisexual people?

Yes: 1139 (96%)

Do you think that health-care service for gay, lesbian, and bisexual people in Ontario would be improved if the following were provided:

- | | |
|--|-------------------|
| •same-sex spousal benefits | Yes: 1142 (92.6%) |
| •same-sex extended health-care benefits provided by employers | Yes: 1140 (92.5%) |
| •education for doctors on gay, lesbian, and bisexual issues | Yes: 1127 (91.4%) |
| •education for other health-care providers about gay, lesbian, and bisexual issues | Yes: 1123 (91.1%) |
| •intake forms allowing for people to identify as gay, lesbian, and bisexual | Yes: 904 (73.3%) |
| •intake forms that allow people to identify that they have same-sex partners | Yes: 960 (77.9%) |
| •gay-, lesbian-, and bisexual-positive images in doctor's offices and other health-care settings | Yes: 998 (80.9%) |
| •equal recognition for same-sex partners | Yes: 1151 (93.3%) |
| •more information and referral lists for gay-, lesbian-, and bisexual-positive health-care providers | Yes: 1095 (88.8%) |

2.2.5 Effects on Access to Health Care

Fearing or experiencing negative treatment related to sexual orientation diminishes lesbian, gay, and bisexual people's access to health care. Many spoke of delaying or compromising their health care because the possibility of negative treatment presented such a powerful obstacle.

Overall, 15% reported that they had not gone for regular physical checkups because they believed that homophobia might negatively affect the way they were treated; for those who were out, the figure was 63%, and for those who were not out it was over 38%. 18% had not gone back for necessary follow-up visits.

Doctors, especially older male doctors do not know anything about the needs of lesbians. They assume you're straight. If they do suspect, they always have a sneering or smug look on their face. That is why I try not to ever visit a doctor's office.

I have not been to my doctor for about two years, since just after I came out. Partly this is due to her knowing me as straight and assuming that I still am. In the one time I saw her, I was not courageous enough to correct her assumption ... I haven't been back (two years since my last physical) and this is in part - but not completely - because I face the task of correcting her assumption about me.

Survey participants generally saw coming out to health-care providers as important, but many people still choose not to - almost always on account of fearing homophobic consequences.

Subsequent chapters discuss some of the above findings in the context of special subgroups and special issues.

2.3 Social Services

2.3.1 Overview

47% of lesbians, gays, and bisexuals who reported using a social service went to a generic counselling/therapy service. Most others went to welfare services or public health nurses, or specifically to lesbian, gay, and bisexual services.

In descending order, people saw psychiatrists, psychologists, social workers, medical doctors, and guidance counsellors. A small number of people saw volunteer workers and religious leaders. As well, others saw someone whose exact qualifications they did not know.

77% of survey participants had had or were having dealings with a social-service provider of some sort and 94% had disclosed their sexual orientation. Yet 34% felt that the context of their lives as lesbian, gay, or bisexual people was neither understood nor dealt with respectfully.

Psychiatrists and religious leaders provided most problems. Of those dealing with psychiatrists, 39% saw them as the least respectful. Of those dealing with religious leaders, 28% described negative experiences; 22% reported negative responses from psychologists, 20% from social workers, and 19% from doctors.

The main reason for seeing a therapist was for help with coming-out problems. Self-esteem issues, loneliness and isolation, family problems, and childhood sexual abuse provided the other major concerns mentioned.

Survey participants identified specific barriers to getting much-needed help. Unlike most medical services, social services are often provided by private practitioners for a fee; many people do not have the money to pay. In large cities or towns, a range of agencies is free to the public, but many smaller communities do not enjoy the same variety of services. One possible reason more people reported seeing psychiatrists rather than other professionals would be that psychiatrists are commonly covered by Ontario's health insurance plan (OHIP).

Other common barriers were not knowing where or how to find the required service, having to wait long periods for an opening, fears about confidentiality or prejudice, and unavailability of the service needed.

Nearly all survey participants said there was a need for mental-health professionals (psychiatrists/therapists/counsellors) to have greater knowledge and sensitivity where issues related to being lesbian, gay, or bisexual are concerned (69% felt this strongly and 20% agreed somewhat). Over 94% felt that social services (such as those provided by mental-health professionals, welfare workers, Children's Aid workers, etc.) must be improved to better meet the needs of lesbian, gay, and bisexual people.

3 Regions

3.1 Introduction

Although the survey was anonymous, participants were asked to include the first three characters in their postal code to offer a method of identifying their general location. In this section, Ontario is divided into four geographic regions largely related to population distribution: Ontario North; Ontario Rural; Ontario Urban; Metro Toronto.

Although Ontario constitutes 412,582 square miles, most of its 11 million inhabitants are concentrated along the shores of Lakes Erie and Ontario and the St. Lawrence River. Fewer people are found by Lakes Huron and Superior and at the head of the St. Lawrence Seaway. The smallest number of people lives rurally, outside cities and large towns; they form the smallest regional group in this study.

Ontario North comprises communities from North Bay east to the Quebec border north of Pembroke, west to Manitoba, and north to James and Hudson Bays.

Ontario Rural comprises places outside Ontario North where the postal code indicates a rural address.

Ontario Urban comprises those places not included in Ontario North, Ontario Rural, or Metro Toronto, such as Ottawa, Kingston, Peterborough, Hamilton, Kitchener, London, and St. Thomas.

One third of all survey responses came from Metro Toronto. Metropolitan Toronto has the largest and most visible lesbian, gay, and bisexual communities in Ontario; it is a centre for social and political activity.

3.1.1 A Demographic Comparison

Ontario Urban survey participants provided 49% of the 1,233 surveys returned, Metro Toronto 34%, Ontario North 12%, and Ontario Rural 6%.

Women constituted 75% of the responses in Ontario Rural, 45% in Ontario North and 47% Ontario Urban but only 39% in Metro Toronto. Notably, in the outreach conducted by Project Affirmation, rural lesbian groups hosted more meetings than men.

Survey respondents who identified themselves as coming from racial, cultural, and ethnic minorities are represented least in the north (2%). The numbers increase through rural and urban communities to a high of 12% in Metro Toronto.

The majority of responses overall came from those aged 26-54. Surveys completed by those over age 54 hovered at around 5% of the sample of any given region, though retired people are found in greater numbers in Ontario North and Metro Toronto. People under 25 made up 21% of the sample in Ontario North, 17% in Ontario Urban, 11% in Metro Toronto, and just over 6% in Ontario Rural.

Most of those currently at educational institutions were from Ontario North and Ontario Urban; fewest were from Ontario Rural and Metro Toronto. In terms of completed education, Ontario North survey participants are better represented at the high-school and community-college end of the scale. Educational levels move up in Ontario Rural and Ontario Urban. In Metro Toronto survey participants were more likely to be at the university (under- or post-graduate).

In Ontario Rural 76% and in Metro Toronto 73% of survey participants work either full- or part-time, 66% in Ontario Urban and 63% in Ontario North. Unemployment is low in the survey group with a 7% high in the Ontario North and a 3% low in Ontario Rural communities.

Ontario North and Ontario Urban report the lowest income levels, Ontario Rural and Metro Toronto the highest.

Social assistance in the form of financial supplements is spread out unevenly among payments from Unemployment Insurance, welfare services, Family Benefit Assistance, longterm disability, workers= compensation, and sources identified as Aother.@ Notably, the number of people who receive no assistance is very much the same across the board averaging 75%.

3.1.2 Special Features of Regional Groups

This chapter is a comparison by region of health care and social services generally. Subsequent chapters of this report deal with their topics both in more detail and as compared with the sample overall.

Time and space constraints do not permit such an analysis region by region, though this information could be extracted from the survey data. Future research must make a detailed analysis of specific health-care and social-service issues and populations for each region.

3.1.3 Identity and Relationship-Status

Lesbians account for 69% and gay men 22% of respondents in Ontario Rural. In Ontario Urban 42% are lesbians, 48% gay men. In Ontario North lesbians are 41% and gay men 53%. In Metro Toronto lesbians are 36% and gay men 60%. The proportion of survey participants who describe themselves as lesbians or gay men follows the regional breakdown for gender.

Bisexuals, for whom gender is not an indicator, are fewest in Metro Toronto at 3%, higher in Ontario North (5%), Ontario Rural (6%), and Ontario Urban (7%).

The number of lesbian, gay, and bisexual survey participants who reported that they had had sex during the previous year is consistent across the regions, averaging 91%.

In each region, an average 66% of survey participants were involved in same-sex relationships. Just 1% are in opposite-sex relationships only and 2% are in both same- and opposite-sex relationships.

For same-sex relationships, a duration of one year or over is more common. This is true for 63% in Ontario Rural, 50% in Ontario Urban, 47% in Metro Toronto, and about 42% in Ontario North.

Ontario Rural reported the greatest proportion of parents (32%), all of whom were women; in other regions, most were women. Ontario North reported 20% of survey participants were parents, and Ontario Urban was 19%. Metro Toronto reported the smallest proportion at close to 14%. In each region about 50% of parents have children living with them.

Disability was a factor in the lives of 18% in Ontario North, 19% in Metro Toronto, and 22% in Ontario Urban. In Ontario Rural, 27% reported a disability.

Ontario North reported 4% as HIV-positive, Ontario Rural just under 6%, Ontario Urban 8%, and Metro Toronto 10%. Greater access to health care and the greater chance of anonymity may account for the higher figures in Metro Toronto and Ontario Urban. It must also be noted that AIDS committees and public-health nurses controlled the primary distribution of surveys in those regions reporting the lowest numbers.

The degree to which lesbian, gay, and bisexual people described themselves as out is quite high in all the regions, ranging from 64% in Ontario North, through 65% in Ontario Rural, and 74% in Ontario Urban, to 86% in Metro Toronto.

However, feeling safe and being safe do not go hand in hand. In areas where people felt less safe, they also reported less violence. Conversely, where people felt most safe, they reported most violence. This may be a function of increased caution on the part of the wary, or increased visibility on the part of those who feel safer. The central issue is that violence must be stopped.

To help combat violence against lesbians, gays, and bisexuals, violent acts need to be reported, so that systemic preventive measures can be implemented and professional response improved. However, the professionals to whom reports must be made must be educated in how to respond. Hospital, social-services, and police personnel often give the impression that they believe lesbian, gay, and bisexual people provoke assault by being too visible.

It is asking a lot to expect people who have just experienced homophobic violence to stand alone and challenge a system that is at best disbelieving and at worst uninterested. Reporting systems must fully support the survivor; personnel must be trained in understanding of the issues involved and must be seen to oppose homophobia.

3.2 Health Care

3.2.1 Doctors

Most survey respondents see a GP (general practitioner) at least once a year. In Ontario North 55%, in Ontario Urban 72%, in Ontario Rural 73%, and in Metro Toronto 82% told their doctor about their sexual orientation.

In Ontario North 35% and in Ontario Rural 36% could not talk to their doctor about sexual issues. In Ontario Urban this figure dropped to 23%, in Metro Toronto to 17%.

For many of those who disclosed their orientation, doctors' responses were unsatisfactory. 34% of northern and 30% of rural survey participants reported that their doctor was silent on the issue; 19% in Ontario Urban and 17% in Metro Toronto reported the same.

54% of survey participants from Ontario North and 65% from Ontario Rural, 68% in Ontario Urban, and 80% in Metro Toronto reported that doctors treated their disclosure with respect. This was about the same as the proportion that felt they could talk openly to their doctor.

Most survey participants indicated that they feel somewhat comfortable with their physician. However, most also indicated they had travelled outside their area and shopped around for a doctor before settling on one. Perhaps this means that many people find their way to the few lesbian-, gay-, and bisexual-positive doctors, rather than that many positive doctors exist.

3.2.2 Hospitals

In Ontario North 60%, Ontario Urban 57%, Metro Toronto 54% and Ontario Rural 52% of survey participants had been hospitalized or treated in hospital during the previous five years. 35% in Ontario North and around 45% of the rest (Ontario Rural 47%, Ontario Urban 44%, Metro Toronto 43%) felt that it was not comfortable to be openly lesbian, gay, or bisexual in hospital. The reasons people reported for feeling uncomfortable included inappropriate behaviour and treatment as well as hospital visiting policy.

[I was] treated like dirt, they were very rude, called me names, did not take care of me while I was so ill, they thought I was a deviant, snapped at me.

Treated poorly ... and my partner was ignored, homophobic comments made during two different hospital stays. I took action with Physicians AComplaint Board. @ It was a stressful experience!

Distrust and discomfort affect health-care decisions. Across the regions, 16% acknowledged that, as a result of concerns over how they will be treated as lesbian, gay, or bisexual patients, they do not go for regular physical examinations. Many fail to return for necessary follow-up visits, do not voice concerns about sexual-health issues that affect them, and do not disclose their sexual orientation to health-care providers.

3.3 Social Services

77% of all survey participants had been in counselling or therapy at some point in their lives: in Ontario North 65%, in Ontario Rural 70%, in Ontario Urban 77%, and in Metro Toronto 81%. In Ontario North 35%, Ontario Urban 36%, and in Metro Toronto 30% indicated that they felt their lives as lesbian, gay, and bisexual people were not understood and respected by counsellors and therapists. In Ontario Rural the figure rose to 43%.

In all regions people cited similar reasons for social-services involvement: coming-out issues; self-esteem and self-confidence issues; loneliness and isolation; family problems related to sexual orientation; sexual abuse as a child.

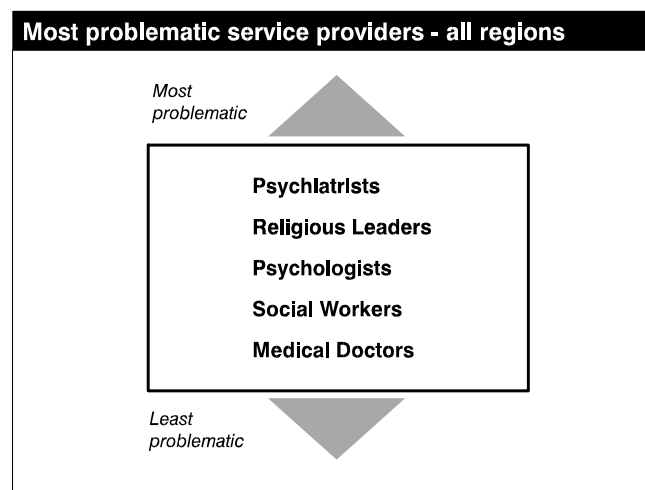
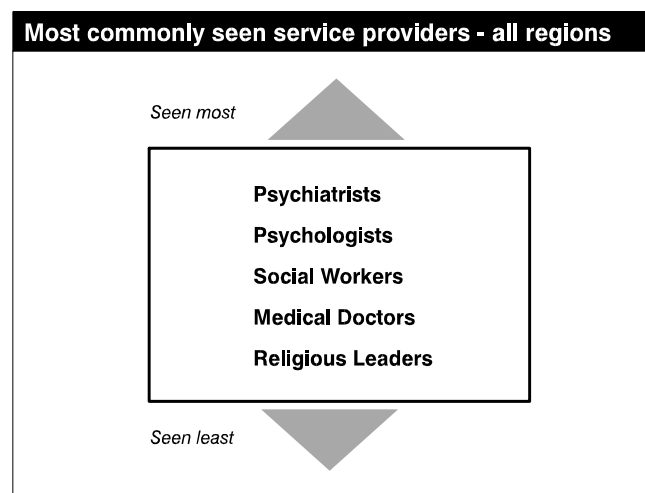
Survey participants were asked to indicate which services they had used and whether they received a negative or positive response. Across the regions, the same services were the most commonly used: generic counselling and therapy services; lesbian and gay services; welfare services; and public-health services. Welfare evoked the most consistently negative responses from lesbian, gay, and bisexual users; this was reported by 25% of people who used welfare services in every region. The next most unwelcoming service was provided by public-health departments across the province; in every region negative experiences were reported by 16% of those who used the service. Generic counselling and therapy services fared somewhat better; negative experiences were reported by 7% in Ontario North and Ontario Rural and 12% in Ontario Urban and Metro Toronto. In Ontario North 11% and in the other regions 7% reported feeling negatively received by lesbian, gay, and bisexual services. Lesbian, gay, or bisexual services were certainly less easily available than other services; expectations of them may well have been higher.

In addition, survey participants were asked what type of service-provider they had seen and whether that experience had been positive. In descending order, the most commonly seen service-providers were psychiatrists, psychologists, social workers, medical doctors, religious leaders, and volunteer counsellors. In each region, psychiatrists and religious leaders were the most problematic mental-health practitioners - for as many as 50% of the people they saw. The lowest figures for negative experiences, averaged at 12%, were those for volunteer counsellors. Clearly, service-providers need to improve in their dealings with their lesbian, gay, and bisexual clientele, a fact agreed upon by over 90% in every region.

Responses about barriers to access to social services were consistent across the regions, the cost of many services being the leading barrier. The second most prevalent barrier was inability to find a lesbian-, gay-, or bisexual-positive therapist. Lastly came fear of breached confidentiality and homophobic reactions on part of service-providers.

3.4 Conclusion

Some demographic differences are very distinct. The survey highlighted trends, similarities, and differences that were not always explicable. There was greater variation in health-care than social-



service concerns between regions. Clearly, the response to the mental-health system is more uniform across the province.

Dividing the population into geographic regions is only one way to examine the results of this survey. Economic, political, and social divisions are also valid. Future research must take these and other divisions in to consideration in analyzing these and other data.

Clearly, the examination of the issues by region supports a call to action. All the data show that lesbians, gays, and bisexuals are receiving less than adequate care. A provincial strategy should be adopted to combat poor social services. In addition, many health-care strategies will have to be developed locally because priorities differ in different parts of the province.

In the strongest possible terms, lesbian, gay, and bisexual people in Ontario must confront mediocre or poor service delivery. The tax dollars of lesbian, gay, and bisexual people in Ontario support these services, and the *Ontario Human Rights Code* guarantees service equity for lesbians, gay men, and bisexuals.

4 Francophones

This chapter was commissioned from La Coopérative Convergence and written by Lyne Bouchard in French. An English translation provided by Marie Bouclin was then edited and shortened to provide this chapter. The full French report is available from CLGRO. The Francophone chapter is based on the profile of 39 Francophones who answered Project Affirmation=s French questionnaire and on material from two focus-group discussions held in French in Ottawa and Sudbury. The document, *Les francophones tels qu'ils sont* [Francophones as they are], was also used to provide perspective (Gilbert 1994).

4.1 Introduction

Because the survey sample is so small, comments are made principally when responses differ significantly among themselves or differ markedly from the survey responses overall. The small sample makes generalizations difficult, though the group discussions were helpful in clarifying the results.

Of all the returned Project Affirmation questionnaires, 3.2% were from Francophones. Statistics Canada cites Francophones as 4.9% of the total population of Ontario.

Please note that Francophone racial and ethnic minorities can be difficult to identify if their members have not specified that French is their mother tongue.

4.1.1 Profile

Though women comprise 52% of Ontario=s Francophone population and 45% of Project Affirmation survey respondents overall, 67% of Francophone survey respondents were men, only 33% women.

Of respondents, 33% identified as lesbians, 64% as gay, and 3% (one man) as bisexual; 67% have been identifying themselves thus for more than 6 years. Some 49% had had previous heterosexual relationships.

*Je vis mon lesbiannisme depuis plus de dix ans mais j=suis sortie du * closet + vis-à-vis ma famille cette année; au bureau tout le monde le sait depuis quatre ans. [I=ve been living as a lesbian for ten years but told my parents only this year; everyone at work has known for four years.]*

*Cette année j=ai dit à mes parents que je suis lesbienne, par lettre, et leur réaction a été très bonne. Je regrette un peu ne pas l=avoir dit plus tôt mais l=important c=est de se bâtir une confiance en soi, une bonne image de soi, alors que la société nous projette une image négative des gais et lesbiennes. Depuis mon * coming out + j=ai une tonne d=enlevé sur mes épaules et maintenant je me sens prête à affronter n=importe qui qui vient souiller les gais et lesbiennes. [I came out to my parents this year by letter, and they reacted well. I regret I didn=t do it sooner but it is important to build your self-confidence and self-image, because society gives you a negative picture of gays and lesbians. Since I came out, I feel as if I've lost a weight from my back and now I feel I can take on anyone who disparages gays and lesbians.]*

The lesbian, gay, and bisexual Francophone survey respondents came from urban Ontario (56%), northern Ontario (31%), Metro Toronto (10%), and rural Ontario (3%).

Almost 95% were Awhite@; 5% were First-Nations people.

The average age of respondents was 34.

60% worked full-time; of these, 41% earned \$30-50,000 a year, an average income.

Just over 71% had no children, 26% had biological children and 3% were parenting their partner=s child(ren); 70% of parents had their child(ren) living with them. These figures are about the same as the survey sample overall.

21% of parents had told their children about their sexual orientation and 5% had told the children's other care-providers (other parent, etc).

One of the Francophone men surveyed was HIV-positive (5%); no conclusions can be drawn in this area.

74% declare themselves proud to belong to the gay, lesbian, and bisexual communities. 82% reported they were active in gay, lesbian and bisexual community organizations, and 53% said they felt safe when disclosing their sexual orientation in the community they live in.

In the Sudbury discussion group, people saw no connection between their Francophone and sexual identities. However, in Ottawa, participants clearly defined a close connection between being Francophone and gay, lesbian or bisexual. At the same time, these people were aware that the way services were organized (no French language or no recognition of sexual orientation) forced them to choose between services appropriate to their language and those appropriate to their sexual orientation.

Ça fait drôle quand certaines personnes font la distinction entre mon handicap, mon orientation sexuelle et ma langue. Pour moi, c'est lié; il n'y a pas moyen de les séparer.

[It's strange when people make a distinction between my disability, my sexual orientation, and my mother-tongue. For me, they are connected; there is no way to separate them.]

4.2 Health Care

Of Francophone survey respondents, 51% have a health plan on top of the Ontario Health Insurance Plan (OHIP). 77% consider their health excellent or very good; 59% consider their life somewhat stressful. Among survey respondents overall, these figures are 67% (state of health) and 61% (level of stress).

11% had difficulty finding a general practitioner they could trust, and 51% were stressed by the fact that they had to conceal their sexual orientation. 26% of Francophones felt unable to disclose their sexual orientation to their doctor. This is comparable to survey respondents overall.

Difficulté à trouver un médecin qui soit ouvert et qui accepterait mon orientation sexuelle sans être menacé [Difficult to find a doctor who would be open and accept my sexual orientation without being threatened.]

Both men and women felt their stress level was increased by homophobia in society, family, or work environment. Women also mentioned that having to decide whether or not to disclose their orientation to health professionals increases their stress levels when they are ill.

*De décider constamment devant chaque professionnel si je vais * le dire + ou pas est un stress additionnel lorsque je suis malade.* [Constantly having to decide whether to tell each professional is an added stress when I am ill.]

Although this was not the consensus in Sudbury, the group discussion in Ottawa clearly indicated that the constant stress experienced by lesbians, gays, and bisexuals had a direct effect on their health.

4.2.1 Visits to Health-Care Professionals

Francophone respondents visit their GPs less often than the survey sample overall: 46% see their doctor once or twice a year, compared with 63% of the sample overall. Few other professionals (nurses, hospital staff, native healers, etc) are consulted, though dentists are among the most visited health-professionals (67% see them once or twice a year; 74% of survey respondents overall). Also, 17% of Francophones (compared with 12% of the survey overall) pay no visits at all to other types of health professionals.

The Ottawa group believed the reason for this is that few professionals can deal well with people who are either Francophone or lesbian, gay, or bisexual, and none can cope with the combination. In Sudbury, the group felt that the lack of French-language services was the biggest factor. Both groups agreed that each individual has to choose where to direct their energy: ask for adequate services in French or work to have their sexual orientation accepted.

Lesbian, gay, and bisexual Francophones had been exposed to homophobic comments. For example, an Ottawa lesbian had been told to try [** essayer +*] to have sexual relations with a man to help solve her *Aproblem*; a gay man from Sudbury reported that no one had asked him whether he was gay and he heard hospital staff telling each other *Aqueer jokes*. [*farces de * tapettes +*]. Yet 65% of the Francophones surveyed reported that they had been respected as lesbian, gay, and bisexual individuals.

4.2.2 Coming Out to Health-Care Professionals

Francophones and survey respondents overall feel much the same about coming out to their doctors. Of Francophones, 87% found it important their doctor both feel comfortable with and openly acknowledge their orientation, and 69% (compared with 73% overall) had disclosed their sexual orientation to their doctor. However, only 61% of the Francophone group feel they can freely discuss sexual issues with their doctor.

In the Sudbury discussions, several people reported that they disclosed their sexual orientation only when sexuality was directly related to the health issue at hand; others said they never mentioned it. In the Ottawa group, everybody reported that their GP was aware of their sexual orientation. However, people agree that those choices are hard to make.

Asked if it is important that health professionals other than their GPs generally recognize patients' sexual orientation, 87% of Francophones and 91% of the survey overall were in favour.

Although 57% had not disclosed their sexual orientation to health professionals they consulted, Francophone respondents generally felt that the quality of services or treatments they received was not affected by their sexual orientation. Yet one of the most common facts mentioned is the amount of shopping needed to find a doctor they can feel comfortable with. This shopping around seems to have as much to do with being a Francophone as it does with being gay, lesbian, or bisexual. In the Sudbury group, the participants were clear that they had needed to visit several doctors (and some had needed to travel to another city) to find a good GP.

*Mon omnipraticienne a une large clientèle lesbienne puisqu'on se passe le mot qu'elle est * gay-positive +.* [My GP has a large lesbian clientele because we pass the word around that she's gay-positive.]

For the 50% of Francophones who had been admitted or received treatment in a hospital, supportive GPs were important: knowing who the key people are, they could facilitate the involvement of the patient's significant others.

Être ouverte avec mon omnipraticienne sans être explicite à l'hôpital a permis qu'elle tienne ma partenaire au courant. [Being out to my GP without coming out at the hospital meant she could keep my partner informed.]

Hospital intake papers that use the term *Asignificant other* [* *personne significative* +] as opposed to the term *Aspouse* [* *épouse ou époux* +] were found a great help.

*La possibilité d'avoir la * personne significative + à mes côtés (comme politique de l'hôpital) me permet d'avoir ma partenaire auprès de moi sans être obligé de * sortir + lorsque je suis vulnérable physiquement et émotivement.* [It was hospital policy to allow me to have a *Asignificant other* at my side, so I was able have my partner with me without needing to come out at a time when I was physically and emotionally vulnerable.]

4.2.3 Improvements Needed in Health-Care Services

Over 63% of Francophones said that doctors should be aware of lesbian-, gay-, and bisexual-related issues and 53% felt that hospital staff should be aware of these issues.

Notre situation va s'améliorer si les professionnels deviennent plus ouverts aux autres diversités. [Things would get better if professionals were more open to diversity.]

100% of Francophones stated that health services should be improved to better meet their needs; the percentage is almost the same for the lesbians, gays, and bisexuals surveyed.

Plus de services / obtenir des changements dans les lois pour avoir une équité [Provide more services or change the law to bring about equity.]

4.3 Social Services

Family services, hostels, crisis hotlines, etc., were used by only 10% of Francophone lesbians, gays, and bisexuals. Is this under-use because services are not available locally, not available in French, or because they do not reflect gay, lesbian, and bisexual realities?

The services most commonly used are lesbian, gay, and bisexual services (41%) and general therapy and counselling services (36%); next come welfare services (18%) and family benefits (13%). The percentages are roughly the same among the survey respondents overall, except for family benefits (overall 7%).

The Ottawa group felt this was because of the way the agencies offering social services are organized, so that lesbians, gays and bisexual individuals in need of therapy services have to turn to private organizations. General services were perceived to meet the needs of the heterosexual population only. Most people surveyed had not even attempted to obtain free services, since they did not feel entitled, although they pay all the health deductions that maintain these services.

The Sudbury group identified as the major problem the smaller number (and longer waiting lists) of French-language social services in northern Ontario.

4.3.1 Social-Service Providers: Counselling and Therapy

Of Francophone survey respondents, 21% were undergoing therapy at the time of the survey, compared with 27% of the sample overall; of these 10% of Francophones and 23% overall were seeing psychiatrists. 70% of Francophones and 77% overall had seen a counsellor at some time.

Most of the Francophones (89%) as well as the respondents overall (88%) believed that mental-health service professionals need to be better informed and have greater awareness of issues related to gays, lesbians and bisexuals.

4.3.2 Experiences Leading to the Use of Therapy or Counselling Services

The two main types of experience that lead people to counselling are coming-out issues (46%) and feelings of loneliness and social isolation (46%). Over 36% of Francophones mentioned the problems resulting from dealing with homophobia generally, and 28% had experienced relationship difficulties caused by homophobia. The stresses of living with AIDS or a chronic illness can also lead people to seek help from counsellors or therapists.

62% reported experience of verbal abuse, 18% reported physical assault; all those reporting physical abuse and all the perpetrators were men. In all but one of these cases, the perpetrators were unknown to the victim.

La personne qui m=a agressé a pris un deux-par-quatre qui avait un clou de quatre pouces au bout et m=a frappé avec juste en bas de l'épine dorsale. [My assailant hit me at the base of the spine with a 2x4 which had a four-inch nail sticking out.]

J=ai été attaqué dans un parc de l=arrière. On m=a jeté par terre, dévalisé, puis j=ai reçu un coup de poing à l=œil gauche. [I was attacked from behind in a park, thrown to the ground, robbed, and punched in the eye.]

None of the victims reported it to the police.

J=ai pas dit rien à la police parce que le certain individu m=a dit que si je disais ou si j=allais à la police qu'il me trouverait et me me mettrait six pieds sous terre et j=ai rien dit parce que j=avais peur qu'il me trouve après ça. [I didn=t tell the police because the attacker said, if I did, he would find me and put me six feet under; I was afraid he would.]

Je ne l=ai pas fait, donné: 1 - mon emploi; 2 - mon orientation sexuelle; 3 - éviter la publicité (journaux, rapports, enquête). [I didn=t tell the police, given 1) my job; 2) my sexual orientation; and 3) to avoid publicity.]

Where violence is concerned, only childhood sexual abuse and opposite-sex domestic violence led people to therapy, although 5% reported same-sex domestic violence. Francophones are beginning to break the silence surrounding the violence between same-sex partners. Social services have yet to respond appropriately.

4.3.3 Barriers to Accessing Services

The major obstacle to accessing services is being unable to find an appropriate professional (41% of Francophones; 28% of the sample overall). This may be the result of the double-minority situation of Francophone gays, lesbians, and bisexuals. Other barriers include: money (about 26%, compared with 42% of respondents overall), anticipation of homophobia on part of service-providers (23%), and fear of breach of confidentiality (21%).

Every Francophone surveyed indicated that mental-health professionals need training to deal better with lesbians, gays and bisexuals.

4.4 Conclusion

Although most of the quantitative data compiled for the Francophone survey respondents was similar to that of the rest of the respondents, the qualitative data reveals differences in both experiences and perspectives based on geographical location.

In the Ottawa discussion group, Francophones felt a strong link in identity between their sexual orientation and being Francophone. Often, they were forced to choose between one or the other and thus felt that health-care and social services failed them.

In the Sudbury discussion group, Francophones felt their sexual orientation did not pose a problem but felt shortchanged in getting services in French. Not receiving a service as vital as health-care or social services in one's first language can be frightening and risky.

When service-providers fail to deal effectively with the sexual orientation of clients/patients, those in need will either be silenced or receive inappropriate responses or treatment.

5 Bisexuals

5.1 Introduction

Bisexual people have affectional and/or sexual relationships with both/either men or women; ways of being bisexual vary as much as the individuals concerned - this is also true of hetero- and homosexuality. Yet people profess themselves very puzzled by bisexuals.

Bisexuality suffers in the attempt to define it. It is neither the great wasteland inhabited by everyone not heterosexual or homosexual, nor is it an exact balancing point in between two poles. Among bisexuals themselves there is no consensus definition (Dynes 1990). Challenging the bipolar perception of sexuality, bisexual people attribute a fluidity to their sexual preferences not exhibited by lesbian, gay, or straight people.

Some bisexual participants felt alienated from both heterosexuality and homosexuality.

I'm afraid it would count against my (opposite sex) partner if my bisexuality was known - as if I would corrupt his children (he has custody).

Others feel it to be safer than homosexuality.

I prefer the bi-sexual label as I am open and this is more socially acceptable than Agay. @

5.1.1 Special Features of this Group

Survey participants who identified themselves as bisexual reported much prejudice from straights, gay men, and lesbians. Members of a bisexual women's focus group described a broad spectrum of negative responses specifically aimed at bisexuals: that they are confused, immature, or unstable and can't make up their minds; that they crave sex with anyone; that they spread AIDS to straight people.

These responses lead bisexual people to feel that they do not fit in anywhere. Services designed for lesbian and gay people frequently leave bisexual people feeling as though no one quite knows what to do with them. Phone counsellors on lesbian and gay support lines are often uncomfortable dealing with bisexual issues.

Both in and outside of bisexual communities, there is a special need for bisexual-specific education, including both sex- and relationship-based information.

5.1.2 Profile

Bisexuals comprised about 5% of survey respondents (65 people) both for men and for women. On average, they were younger than respondents overall. More are students and slightly more are unemployed. Overall they figure more at the lower end of the income spectrum and make more use of financial assistance programs.

Naturally, they are more likely than other survey participants to be sexually active with both sexes. They were also twice as likely as the sample overall not to have had sex within the past year or be in a current relationship.

SURVEY FACT SHEET

BISEXUALS

- 65 respondents, 5% of the total sample
- on average, younger than respondents overall and more are students
- 84% had been in counselling or therapy; 53% of these believed their lives were neither understood nor respected by the person they saw
- 42% had come out to their doctors compared with 74% of survey respondents overall

Most commonly used services

*Most
commonly
used*

Generic counselling and therapy
**Specialized lesbian, gay,
and bisexual services**
Public-health nurses
Suicide/crisis lines
Addiction services

*Least
commonly
used*

Most problematic services

*Most
problematic/
negative*

Suicide/crisis lines
Addiction services
Generic counselling and therapy
Public-health nurses
**Specialized lesbian, gay,
and bisexual services**

*Least
problematic/
negative*

Of bisexual survey respondents, 28% were in same-sex relationships, 16% in opposite-sex relationships, and 13% in relationships with both sexes. Their relationships were of shorter duration than those of respondents overall, and they were less likely to live with their partner.

They are more likely to be parents than survey participants overall; their children are as likely to live with them.

54% reported that they had disclosed their sexual orientation compared with 75% of the total sample. They felt somewhat less safe than the total sample in being open in their communities and experienced much less verbal abuse and marginally less physical abuse than the total sample but tended to report assaults at a higher rate.

5.2 Health Care

5.2.1 Doctors

Physically, health was reported by 97% as fair to excellent. This is roughly equivalent to the sample overall, as is the rate at which they saw their GPs. Compared with 75% of respondents overall, 42% of bisexuals had disclosed their sexual orientation to their doctors and 37% felt unable to talk openly to their GP.

At a university health centre, I had a terrible experience when I went in with a yeast infection. I was with a woman at the time and did not feel welcomed to be Aout@ when the intake nurse assumed I was straight and was aghast when I said I was using no birth control. The intake questions were completely geared to straight people. I felt extremely uncomfortable, then humiliated when I asked the doctor what could have caused the infection, and she snidely answered AYour sexual practices,@ in an accusing voice. After that I was very reluctant to be out at all to doctors.

My former family doctor did not respect confidentiality on any matter, and spoke to my senior family members; therefore, I no longer have a doctor. All of my town's queer-positive doctors have huge waiting lists and pass vacancies by word of mouth. I am outside the loop - therefore no MD.

19% feel that although their doctor knows they are bisexual, s/he is silent about the fact; this is the same for the sample overall.

Although 52% had needed to visit more than one doctor to find one with whom they are comfortable (much the same as with the total sample), bisexuals reported less support from their doctors than the sample overall.

5.2.2 Hospitals

72% of bisexual survey participants had stayed in hospital or received treatment in hospital in the previous five years. This is higher than for the total sample who reported their hospital involvement at 56%. Only 31% of bisexuals felt comfortable with the services, compared with 43% of the total sample.

While at hospital I felt isolated and scared, and my friend only visited once because she felt negative vibes.

When I was hospitalized, the nurses, thinking that I was heterosexual, told everyone under their care that saying you are bisexual is a cop-out for being a lesbian or homosexual.

9% had travelled outside their area to get health care compared with 20% of the total sample, though 48% chose not to voice their concerns and more than half had not come out to health-care providers.

5.3 Social Services

5.3.1 Services

84% had been in counselling or therapy at some point, more than in the total sample. However, only 47% felt the context of their lives was understood and dealt with respectfully by their counsellor or therapist, compared with almost 66% overall. 59% saw counsellors or therapists; 43% went to lesbian, gay and bisexual services; 15% saw public-health nurses; and 14% used suicide/crisis phone lines and addiction services.

Problems arose most often with suicide/crisis lines and addiction services where about 50% reported negative treatment. About 25% reported negative treatment at the hands of public-health services, counselling and therapy services, and lesbian, gay, and bisexual services.

5.3.2 Service-Providers

Psychologists were the most-used service-providers, but 17% of clients felt they did not receive good service. Psychiatrists saw slightly fewer people but left 48% feeling ill-served. Social workers saw fewer still and left 12% dissatisfied. Volunteer counsellors saw the least number of people, and here 27% did not feel understood or dealt with respectfully. Doctors who counselled people were seen as least offensive (6%).

5.3.3 Issues

Difficulty with coming out was a common experience (75%) and 37% of those coming out were assisted by a counsellor or therapist. Feelings of loneliness and isolation troubled 71%, but 52% of these sought help. Similarly, 65% identified (lack of) self-esteem as an issue, and 55% of these saw a counsellor or therapist. Relationship concerns troubled 52%, and 29% of these looked for help. Of those who had experienced childhood sexual abuse (43%), 50% later sought professional help.

Some barriers to getting help were practical considerations such as a lack of money, not knowing how or where to find an appropriate service-provider, and long waiting lists. Many were concerned that they could not count on confidentiality or would be rejected because of their sexual orientation. 69% of the people in this sample felt mental-health professionals need more knowledge and sensitivity to their issues, and 92% felt social services should be improved to better meet their needs.

SURVEY FACT SHEET

BISEXUALS

Most commonly seen service-providers

*Most
frequently
used*

Psychologists
Psychiatrists
Social workers
Doctors seen as counsellors
Volunteer counsellors

*Least
frequently
used*

Most problematic service-providers

*Most
problematic/
negative*

Psychiatrists
Volunteer counsellors
Doctors seen as counsellors
Psychologists
Social workers

*Least
problematic/
negative*

6 Transsexuals and Transgenderists

This chapter comprises edited excerpts from *Access Denied*, a report on the experiences of transsexuals and transgenderists with health-care and social services in Ontario written for Project Affirmation by Ki Namaste, July 1995.

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

6.1.1 Acknowledgements

Ki Namaste would like to thank Xanthra Philippa and Mirha-Soleil Ross of genderpress; Sonny Wong of Asian Community AIDS Services; Kara of Maggie's; Wayne Travers of SOS; Carol-Anne O'Brien; Maxine Petersen of the Gender Identity Clinic; and all who agreed to meet and speak with her about their experiences, even when this was not always an easy thing to do.

6.1.2 Summary

Access Denied documents the discrimination faced by transsexuals and the transgenderists in Ontario with regard to health-care and social services. Interviews with 33 transgendered people and numerous service-providers formed the basis for research outlining some of the main problems faced by transgendered people in this area. Specific topics include: safe, informed access to hormones; gender identity clinics; experiences in hospitals, shelters for the homeless, and alcohol/drug rehabilitation programs.

6.1.3 Résumé en français

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

6.2 Introduction

Access Denied provides an overview of health-care and social services for transgendered people in Ontario. The word *transgender* is used as an umbrella term to include all individuals who live outside normative sex/gender relations. The following groups of people are included within the category transgender:

Transgenderists: those who live in a gender other than the one assigned to them at birth on the basis of their biological sex; for example, those who were born male but who live as women; in this chapter, the terms *transgender*, *transgendered*, *transgenderist* are sometimes abbreviated to TG.

Transsexuals: those who live in a gender other than the one assigned to them at birth; like transgenderists, they take hormones to change their physical appearance; transsexuals also have sex-reassignment surgery which for male-to-female (MTF) transsexuals, involves the creation of a vagina, and for female-to-male (FTM) transsexuals includes the removal of breasts, reconstruction of the chest wall, removal of the ovaries and womb; FTMs may also have phalloplasty (creation of a penis); in this chapter, the term *transsexual* is sometimes abbreviated to TS.

Cross-dressers: those who wear the clothing associated with the *opposite* sex; for example, men who dress as women; a synonym is the term *transvestite*; cross-dressers choose when and where they will present themselves in their chosen gender.

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

Transgendered people live their lives in a variety of ways, however, and the above categories are in no way mutually exclusive; for example, some identify both as drag queens and transsexuals. Others take hormones but still live in the gender assigned to them at birth. Many people cannot be classified within this framework.

Due to the limitations of the project, this research focussed primarily on the issues of transsexuals and transgenderists. This does not detract from unique situations of drag queens, cross-dressers, and other transgendered people when it comes to health-care and social services; further research is recommended. An in-depth examination would analyze intersexuality, transsexuals in prison, mental illness, HIV/AIDS legal complications faced by transsexuals and transgenderists, relations with welfare and FBA (disability), suicide, and the many surgeries transsexuals and transgenderists have. These issues must await future research.

This present research reveals systemic barriers to health-care and social services. The most important issues raised by the interview participants included: safe, informed access to hormones; experiences with hospitals; gender-identity clinics; addictions; and homeless women and battered women.

6.2.1 Methodology

Interviews were conducted with transsexuals and transgenderists, with a focus on their health-care and social-service experiences, the issues they identified as important, and their suggestions for change. The decision to interview transgendered people is particularly significant, given the lack of control transsexuals and transgenderists have over their own bodies, desires and identities. Other people habitually pass judgement on the genders of transsexuals and transgenderists and grant or deny them services accordingly. Therefore, it is absolutely crucial to employ a research methodology which acknowledges that transsexuals and transgenderists are the experts on their lives.

Individuals were contacted via: support groups; advertisements in transsexual/transgender publications; a notice distributed at the Gender Identity Clinic of the Clarke Institute of Psychiatry; contacts made through social-service agencies; word-of-mouth; direct outreach in bars and on the street; and snowball sampling (an individual interviewed was asked to provide the name of a TS/TG friend who could also be interviewed).

The total sample consisted of 33 individuals, aged from 20 to 60 years.

Nineteen were enrolled in the Gender Identity Clinic at the Clarke.

There were seven people of colour: Black, First-Nations, and Métis. Asian transsexuals are not represented in the sample. Four of the individuals had a mother tongue other than English (French in three cases, Spanish in one instance.)

Fourteen identified themselves as something other than heterosexual, including bisexual, lesbian, queer, polysexual, and asexual.

Six of the MTF transsexuals interviewed were post-operative.

Twelve people in the sample (36%) were sex-trade workers; some of these individuals worked on the streets, some over the telephone out of their homes, and some both on the street and over the phone.

Two individuals were FTM transsexuals. Although the sample is predominantly MTF transsexuals and transgenderists, this chapter attempts to outline some of the specific issues of FTM transsexuals and transgenderists. Further research on FTM issues is necessary.

Due to limited resources, almost all the people contacted were from the Metropolitan Toronto region. Metropolitan Toronto is the largest city in Ontario, and transgendered people there still have many problems accessing health-care and social services. These difficulties can only be exacerbated in smaller cities and the rural parts of Ontario.

Project Affirmation provided honoraria of \$20 for each of the interview participants. The researcher felt that remuneration of \$20 was an important factor in the decision of many transgendered people to meet. Interviewees were met in places chosen by them (cafés, bars, parks, and private homes) and were free to end the interview at any time. Participants were informed that they had control of the situation and were the experts on their lives. The interviewer's job was merely to record their experiences. With the participants' informed consent, interviews were audiotaped and important sections transcribed; this is the source of the quotations in this chapter.

Each participant was asked about demographic information (race/ethnicity, age, mother tongue); gender and sexual orientation; hormones (where they got them from, whether they had any negative side-effects and knew about the longterm side-effects of hormones). Other questions were on: primary-care physicians; the Gender Identity Clinic at the Clarke Institute of Psychiatry; surgery; experiences with hospitals and/or emergency rooms; and stays in shelters.

Various service-providers were also contacted, although less energy was devoted to this task; they told very different stories from the transgender service-users. These contradictions suggest some useful avenues for change at the level of agency policy (staff training, anti-discrimination policies, etc.).

SURVEY FACT SHEET

TRANSGENDERISTS AND TRANSSEXUALS

ACCESS TO HORMONE TREATMENT

- getting access to hormones was extremely difficult
- means of acquiring hormones were:
 - illegally, off the street
 - through a doctor
 - through the Gender Identity Clinic of the Clarke Institute of Psychiatry
- finding a doctor who is transgender-positive and willing to prescribe hormones was very difficult; some transsexuals resorted to going to doctors who had “questionable” reputations or were known as “pill-pushers”
- transgender people often had to educate their doctors about hormone treatment or other medical issues

GENDER IDENTITY CLINICS AND HOSPITALS

- the Clarke's Gender Identity Clinic's policy of requiring a person to cross-dress for one year before receiving hormone treatment was determined to be arbitrary and stressful
- the treatment of transgendered people by hospitals was characterized as being “absolute contempt,” ranging from ridicule and disdain to insistent use of inappropriate pronouns

SERVICES FOR HOMELESS PEOPLE

- there were few resources for transsexuals and transgenderists who were homeless
 - youth shelters
 - were generally unsympathetic to transgendered youth
 - were hostile and unsafe places for transgendered people
 - had staff members who refused access to transgendered people or told them how to dress and act, subjected them to unfair treatment and blamed them for the violence or hostile attitudes of other shelter-users
 - women's shelters
 - generally had one of the following policies, all problematic
 - refusal to admit
 - acceptance of post-operative male-to-female transsexuals only
 - acceptance if the individual could provide documentation of undergoing a gender transition
 - in some situations, housed male-to-female transsexuals in motel rooms

ALCOHOL, DRUG, AND SUBSTANCE ABUSE

- the long and difficult process through which transgendered people come to terms with their gender identity can lead them to alcohol- and drug-abuse to escape confusion, pain and suffering
- survey respondents reported that traditional forms of support available for people dealing with substance abuse were not welcoming of transsexuals; they could only “deal with” their abuse problems if they hid the transgender issues which were part of them

6.3 Hormones

6.3.1 Overview

Hormones are an integral part of the daily lives of transsexuals and transgenderists. They change one's physical appearance and increase one's level of comfort with one's body. For female-to-male transsexuals and transgenderists, testosterone produces dramatic effects such as lowering the voice, developing facial and body hair, and ending menstruation. For male-to-female transsexuals and transgenderists, estrogen redistributes fat tissue throughout the body, softens the skin, and promotes breast development.

Hormones can also have serious side-effects, including nausea, vomiting, headaches, mood swings, blood clots, liver damage, heart and lung complications, and problems with one's blood circulation and veins (Kirk 1992), so it is important that those taking hormones are regularly monitored by a medical doctor.

Despite the central role hormones play in the lives of TS/TG people and the value of being monitored for their side-effects, TS/TG people encounter serious difficulties in obtaining safe access to them. Further, TS/TG people are generally more knowledgeable than their doctors about how hormones will affect their bodies. Finally, many of those interviewed reported that they often obtained their hormones from doctors without undergoing regular physical examinations and bloodwork. Each of these issues deserves more discussion.

6.3.2 Access to Hormones

Interviewees noted that it was extremely difficult to obtain hormones. As a rule, they were obtained in three ways: illegally; through a doctor; or through the Gender Identity Clinic of the Clarke Institute of Psychiatry.

Hormones acquired surreptitiously were obtained either from a family member (often unknowingly) or through an underground market. Some transsexuals told me that they would get a female friend to get a prescription for birth control pills, which the transsexual would proceed to take regularly, or they would take the medications prescribed for their wives and mothers:

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

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

More commonly, however, transsexuals and transgenderists would buy their hormones off the street. The usual procedure was that some transsexuals would obtain multiple prescriptions and would sell hormones to any individuals interested - friends or strangers.

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

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

There are several reasons why transsexuals obtain their hormones on the street. It is extremely difficult to find a doctor who is willing to prescribe hormones.

I bought hormones off the street for a year and a half before I attempted to go to my family practice ... I went to him [my doctor] and told him that if he doesn't give them to me, I'm going to continue buying them off the street. So he took it in his own hands to monitor me, and put me on them legally ... He believed in me.

For some, obtaining their hormones from a doctor is not an option; for example, transsexuals who do not have access to health care in Canada, such as illegal refugees.

Hormones can have serious side-effects, and those who bought their hormones on the street did not consult with doctors. HIV/AIDS research has suggested that in the context of American inner-city transsexual communities, transsexuals may share needles with their lovers and friends in order to inject their hormones (Bockting et al. 1993; Elifson et al. 1993). This puts them at increased risk of contracting HIV, as well as other health complications such as hepatitis.

Since transsexuals had great difficulty in locating a doctor who would prescribe hormones, some went to doctors with questionable reputations. They knew that they could get a prescription for

hormones, but they did not expect any follow-up work to maintain their general health. Nor did they necessarily expect these doctors to prescribe their hormones indefinitely.

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

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

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

A: *Yeah*

Q: *You were 18, 17?*

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

While some were able to obtain hormones from pill-pushers,⁶ many recounted stories of being flatly refused hormones by their general practitioners. People reported that their doctors knew little or nothing about transsexuality and expressed little interest in pursuing the topic. Their doctors feared legal repercussions if they initiated hormonal treatment. Doctors would either refer their transsexual patients to the Gender Identity Clinic of the Clarke Institute of Psychiatry or refuse the hormones without further discussion. In some instances, doctors would prescribe hormones if they had a letter of recommendation from a psychiatrist, presumably to protect them from any future legal action. This creates a situation in which transsexuals must consult other doctors and specialists before beginning hormones.

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

Q: *And you'd spoken for how long?*

A: *About four or five minutes, maximum.*

Transsexuals often needed to prove⁷ themselves as really⁸ transsexual in the eyes of their psychiatrists and doctors; transsexuals shared the names of psychiatrists who would assist them in the provision of letters and supporting documentation.

Some doctors did not insist on letters from psychiatrists but decided for themselves whether a particular individual was really transsexual. One story illustrates how much doctors relied on the visual presentation of transsexuals to determine gender identity.

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

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

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

This anecdote reveals both the arbitrary judgements to which transsexuals are subjected when they request hormones and the implicit sexism of the doctor, who judged women and men almost exclusively on their physical appearance.

Transsexuals and transgenderists took an active role in the maintenance of their own bodies and wanted to work with doctors to monitor their health. The two quotations below are from male-to-female transsexuals who were taking hormones through an underground market: one had her hormones mailed to her from the United States; the other bought them from a transsexual friend. Both indicate that there were important psychological benefits to being monitored by a doctor on hormones.

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

Q: Right. So you could be monitored?

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

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

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

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

The transsexuals and transgendered people interviewed told each other which doctors would prescribe hormones, but increasingly these doctors have large case-loads and cannot accept new patients. Thus even when transsexuals are interested in working with doctors to monitor their health, they cannot find a sympathetic caregiver.

These and other barriers worked to prevent honest, direct communication between many transsexual patients and their caregivers. Some were afraid that, if they told their doctors everything about their lives, they would no longer receive hormones. Several admitted that they took more hormones than the prescribed dosage. Some obtained hormones from their doctors as well as from an underground market, but only mentioned their ‘legitimate’ hormones in the health-care setting. Other people did not tell their physicians if they had stopped taking their hormones, in case their doctors judged them to be unbalanced or not ‘true’ transsexuals and left them without a source of hormones. One interviewee comments that she would start and stop hormones based on how she felt she was being treated in her primary relationship.

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

The same interviewee withheld this information from her doctors:

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

6.3.3 Knowledge about Hormones

Doctors were less reluctant to prescribe hormones if a patient demonstrated knowledge about the drug and its effects on the body.

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

Many transsexuals also found that they were far more knowledgeable than their doctors and would provide them with the appropriate documentation.

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

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

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

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

One interviewee summarized the biases of medical professionals and how these prevent adequate health care for transsexuals:

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

6.3.4 Maintenance and Follow-up

In addition to finding a transgender-positive doctor and/or a doctor who is knowledgeable about the effects of hormones on transsexual bodies, participants revealed that their caregivers frequently neglected to do bloodwork to verify blood-sugar and cholesterol levels or liver functions. One person who had been taking hormones for more than 16 years commented that ANo one [doctor] has ever insisted that I have blood tests. @ Another said she gets her bloodwork done only periodically Aand I have to bug him [my doctor] about it. @

Since breast cancer is an issue with hormone-users, they were asked if their doctors examined their breasts and/or if they performed self-examination. More than half replied they did not do breast self-examination. Only about 25% said these issues had been addressed by their doctors. One stated that her Ahormone doctor never once asked if there was a family history [of cancer]. @

Female-to-male transsexuals experience similar health-care and maintenance problems. In particular, they face issues of getting proper gynecological care while living as men. One informed me he had only one gynecological exam in more than 13 years with the same physician.

6.4 Gender-Identity Clinics

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

The GIC at the Clarke has about 300 active clients (people who consult them at least once a year); on average, they see one new patient every week. The GIC's established guidelines for eligibility for sex-reassignment surgery demand that the individual must live in the chosen gender (the opposite sex) full-time for at least two years and provide written documentation supporting this claim. People can work, study, or do volunteer work full-time, or engage in a variety of these activities (equivalent to full-time work) in order to meet this requirement. This guideline is commonly referred to as the real-life test (Clemmensen 1990).

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

Strictly speaking, the GIC does not approve people for surgery. It makes a recommendation that the individual in question has been assessed, is of sound mind, is diagnosed to be transsexual, and will not suffer any adverse effects from sex-reassignment surgery. The GIC makes this recommendation to OHIP, which in turn decides whether or not the procedure will be covered through provincial health-insurance plans. (In fact, a representative at OHIP stated, this is a rubber-stamp procedure, since they always follow the recommendation of the GIC). Staff at the GIC reported that six or seven individuals are recommended for surgery each year; OHIP confirms this.

There is some mistrust and misinformation with regard to the GIC. Many people interviewed mistakenly believed the GIC works with a quota system and recommends only one or two individuals for surgery each year. However, it is useful to think about some of the social relations which underlie this misinformation. The people I interviewed who were enrolled in the GIC voiced dissatisfaction with the services offered there. In particular, they felt that GIC staff did not offer them much information about transsexuality.

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

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

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

One post-operative transsexual woman who had been recommended for surgery by the GIC found inadequate the surgical information she was given.

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

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

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

Refusal to provide information about resources for transsexuals could be particularly stressful when the GIC presented its assessment of a candidate. One person who was not recommended to begin the real-life test expressed confusion as to how to proceed.

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

Interview participants also took issue with the GIC's policy that individuals must cross-live for one year before they begin hormone treatment. Staff at the GIC justified this policy on the grounds that hormones have profound and lasting effects on female-to-male transsexuals, so they needed to be sure that the individuals were truly committed to living in the chosen gender. Then, they felt, it would be unfair to give MTFs hormones after an initial diagnosis while FTMs had to wait a year. Concerns were also expressed about the possible health-risks involved in taking hormones and a 'snowball effect,' which occurs when individuals begin hormones too early (in the opinion of staff at the GIC) and become heavily invested in having surgery soon after.

AEGIS raises the important point that 'health' includes one's psychological state:
The result of failed hormonal therapy is at worst some physical characteristics which run counter to type and which may be difficult for the individual to explain. The result of a failed real-life test is a life in shambles. Family, friends, and employers cannot be untold about transsexualism, marriages and family life are unlikely to be regained. A non-passable appearance, which is likely if the individual has not been on hormones for a significant period, can be highly stigmatizing, and can place the individual in danger in this era of hate crimes. Furthermore, a failed real-life test can result in a high potential for self-destructive behaviour, including suicide. (AEGIS 1992)

The GIC and many other clinics feel the year=s delay is reasonable (Petersen & Dickey 1995). However, the gender-identity clinic in Vancouver, which performs the same functions of assessment, diagnosis, and treatment as the GIC in Toronto, does not delay hormones to individuals diagnosed as transsexuals, and this policy follows the international 'Standards of Care' of the Harry Benjamin International Gender Dysphoria Association (HBIGDA). The standards are reproduced in Denny 1994.

Interestingly, the GIC did not expel people in the first year of their 'real-life test' who obtained hormones outside the GIC (and staff estimated this was 30-50%). It seems somewhat contradictory to maintain a policy that people must cross-live for a year without hormones, while at the same time disregarding the high number who initiate hormone treatment outside of the GIC during this period.

Both MTF and FTM transsexuals objected to the year=s delay before hormone treatment. They understood the necessity of ensuring an individual was serious about undergoing a gender transition, but they did not agree with a delay once a diagnosis had been made.

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

The interviews made it clear that transsexuals and transgenderists who objected to the GICs hormone policy were informed about how health care is organized for transsexuals both in Toronto and elsewhere. In short, then, transsexuals and transgenderists hold erroneous assumptions about the workings of the GIC, while GIC staff enact policies with little regard for the input of transgendered people.

Open dialogue would allow transsexual and transgender clients to work in tandem with the GIC to develop innovative, responsive solutions to this stalemate and create the very best in health care.

6.5 Hospitals and Emergency Rooms

Interviewees had numerous stories of their experiences in hospitals and emergency rooms. In most instances, transgendered people were treated with absolute contempt by hospital staff, and this continued from the initial intake to the formal discharge.

The required documentation provided a dilemma for TS/TG people in a hospital setting. The most recent OHIP cards have a photograph of the bearer. For pre-operative transsexuals and those who have no interest in surgery, there is a discrepancy between the gender of the person in the photograph and the sex indicated on the card. One MTF transsexual commented that the AM@ on her card caused her considerable anguish:

It's going to certainly make me feel very reticent about going for medical care anywhere.

Another participant reported that a hospital had refused to issue her a hospital card in her female name, although her transsexual friend, who was also pre-operative, had precisely such a card issued by the same hospital. It was often the case when transsexuals sought health care, that policies and practices were inconsistent even within the same institution. At best, transsexuals were left to hope for a sympathetic employee.

In the emergency room, transsexuals and transgenderists were treated badly. One participant arrived in intense pain, was seated in an emergency room and asked to disrobe and put on a hospital gown. She was able to remove her clothes but was too ill to put on her gown. A nurse came into the room and told her AYou're not sick. Get your clothes on and leave.@ There were numerous stories of this kind of contempt.

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

When a male-to-female transsexual had accompanied a transsexual friend to the hospital:

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

Sometimes, though the reception stopped short of ridicule, it was less than hospitable. One MTF sex-trade worker recalled the examining physician asking her to explain her body, since she had breasts and a penis. She informed him that she was transsexual. This information seemed to only make matters more confusing for the doctor. This physician, in her words,

was an idiot. He thought I was a sex change into a man. He thought I had a breast reduction. He was really stupid.

Other participants received medical attention but with an attitude of reluctance and disdain: *... they weren't really as helpful with me as I would have liked. They saw me and everything, but it was one of those, they put on two sets of gloves and stuff just to come in the room and feel my throat, and it was really, I thought quite bizarre.*

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

Hospital staff repeatedly and consistently - despite repeated requests - referred to transsexuals and transgenderists with inappropriate pronouns (Ahe@ in the case of MTF transsexuals; Ashe@ in the

case of FTM transsexuals.) The use of inappropriate pronouns persisted even when an individual had legally changed her/his name and even when this new name appeared on the hospital card.

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

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

One nurse talked about a MTF transsexual who had entered the hospital as a result of a drug overdose and had been given activated charcoal to induce vomiting and rid the body of toxins. No nurse in the previous three shifts had helped the woman clean herself. When this nurse talked to her, cleaned her up, and washed her hair, the woman began to cry.

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

Transgendered people are treated as less than human within the hospital setting. Staff ridicule them, deny them basic services, address them with the wrong pronouns, and limit their interactions with them at all times.

6.6 Shelters for Homeless Youth and Women

This research concentrated on youth shelters, shelters for homeless women, and drop-ins for street people. It focused on the policies and positions of staff members and needs to be supplemented with the voices of transgendered people speaking about their experiences with these agencies.

Participants included 14 representatives of different agencies: four shelters for homeless youth in Toronto, three shelters/drop-ins for youth in the Ottawa area, and one women's shelter in Ottawa. Staff members were asked: whether their organizations accepted transgendered people; whether transgendered people had been or presently were among their clients; whether the agency had an anti-discrimination policy that included transgendered people; and what training staff members received on transgender issues.

There are few resources for transsexuals and transgenderists who are homeless. Shelters lack anti-discrimination policies that include TS/TG people; staff lack training on transgender issues. This section documents some of the attitudes and beliefs which underlie the exclusion of transsexual and transgendered women from youth and homeless shelters.

6.6.1 Shelters for Youth

None of the agencies had a written anti-discrimination policy that included transgendered people. Staff receive inadequate training on transgender issues, and one staff member stated that transgender issues were Anot a training priority.@ Only one agency sought out training on transgender issues and invited outside facilitators to do presentations on transgender issues.

Representatives of shelters and agencies which work with homeless youth were generally ignorant of transgendered people. Staff are often unaware of the way compulsory sex/gender relations can make home, school, and traditional work-environments unsafe for transgendered youth, leaving only the street and sex-work as places where they can live in their bodies as they choose. One staff person interviewed claimed

it [transgender identity] is a case for people in their 20s.

In several cases, staff members asked for a clarification of the term Atransgender.@ When this research project was explained to one worker, she responded:

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

Representatives of these agencies claimed that anyone was welcome to use their services, the shelters were environments Afree from oppression@ where people were Aasked to keep their prejudices to themselves.@ Transgendered youth, however, report discrimination. For example:

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

Q: So they wouldn't let you in?

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

By forcing a homeless transgendered youth back onto the street, these staff members claimed to be protecting this individual's safety. The comment, 'We don't want any trouble here,' shifts the focus of the situation profoundly: the issue is no longer that of a social-service agency refusing its services to a client; nor is the 'trouble' associated with any shelter residents who may attack this person; it is now about a client causing 'trouble.'

Youth shelters are segregated according to gender. Staff reported that transsexuals would be housed according to their biological sex, not the gender in which they live. Staff interviewed admitted that perhaps the shelter would not be a safe place.

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

Some staff were asked: if MTF youth were located on male floors due to their biology, would FTM youth - who lived, identified, and interacted as men - be housed with young women? Unfortunately, this question was not answered since a great deal of time was spent trying to explain the concept of female-to-male transsexuality to the staff.

In the event that a transgendered youth is admitted into a shelter, staff demand strict adherence to their idea of masculinity and femininity. Transgendered youth challenge these boundaries and meet with an unsympathetic reception.

The staff just looked at my [MTF cross-dressing] friends and went, 'Hmmmph!'

Q: Did they say anything?

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

Shelters are unsafe and hostile places for transgendered youth. Staff members refuse them access, tell them how to dress and act, subject them to unfair treatment (e.g., placing them in hallways), and blame them for any confrontations caused by transphobic shelter residents. Transgendered youth use these services only as a last resort.

The following is an excerpt from a conversation with four young, transgender, sex-trade workers asked if they had ever used a women's, youth, or homeless shelter.

A: No. You go to the bathhouse.

B: Exactly. The saunas.

C: Someone else's house.

D: Exactly. Or the crack house.

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

6.6.2 Shelters for Women

Staff members of shelters and drop-ins for homeless women were generally more familiar with transgender issues than those working with homeless youth. Many said they had worked with transsexual clients in their agency. Some noted that the question of MTF transsexuals in shelters for homeless women had been raised as an important issue in recent years.

In certain situations a short-term solution would be adopted, such as housing an MTF transsexual in a motel room. However, this does not address the necessity of developing clear policies and guidelines on transsexual and transgender issues. In general, the shelters held one of at least three different positions on the question of admitting transsexual women:

- outright refusal;
- acceptance if the individual was post-operative; and

- acceptance if the individual could provide documentation (such as a letter from the Clarke or a doctor) that they were undergoing gender transition.

Both the outright rejection of transsexual women and the justification of post-operative status mesh badly with the feminist belief that one's biological sex and one's social gender are not necessarily the same thing.

Some shelters which admitted post-operative transsexual women cited the safety and comfort of the other women residents in refusing admittance to pre-operative transsexual woman. Other women would not feel safe due to the presence of the transsexual woman=s penis. It is interesting to note the confusion of the penis of a transsexual woman and her gender identity; it suggests a belief that one's genitals and one's gender are the same. This would presumably mean that transsexual men who still have vaginas could use the services of a women's shelter, as long as they do not yet have a penis. And yet the safety and comfort level of women residents would most probably be challenged by the presence of a female-to male transsexual, even with a vagina.

The acceptance of only post-operative transsexuals is questionable for four other reasons. First, issues of race and class thus figure centrally in who has access to sex-reassignment surgery since the procedure costs \$7-25,000. The only way to have sex-reassignment surgery paid for through health insurance is to enrol in a gender-identity clinic which works against sex-trade workers and those with criminal records (see above). Second, this stance assumes that all MTF transsexual and transgendered women want to have genital surgery, which is not the case: many live quite happily with their penises. Third, surgeons will not operate on transsexuals who are seropositive, who would thus not have access to shelters when they were homeless. Finally, gender-identity clinics do not recommend individuals for surgery who are younger than 21. MTF transgendered people are routinely denied access to youth shelters; if they are excluded from women=s shelters, they are forced to live on the street.

Some agencies accepted pre-operative transsexual women who provided documentation as to their commitment to a transgender lifestyle. This policy ignores the reality of health care for transsexual and transgendered people who find access to supportive medical personnel difficult at the best of times and may not have official documentation. Moreover, doctors generally charge fees to provide written documentation of a patient's medical status; one of the reasons transgendered people are homeless, of course, is because they are poor.

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

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

Again, the criterion of physical appearance is disconnected from the everyday realities of transgendered women, especially those who are poor and living on the streets. For example, the removal of facial hair costs \$35-75 an hour; most transsexuals need at least 100 hours= treatment. It follows that some transsexual women who live on the street will have visible facial hair and be disqualified from shelter. Thus it makes little sense to accept only those transsexual women who look feminine.

Moreover, the psychological effects of being refused admittance to a woman's shelter should not be underestimated. Transsexual and transgendered women want to change their bodies and work to do so. To be refused admittance into a woman's shelter on the basis of one's physical appearance can reinforce the hatred that transsexuals feel for their bodies, decrease self-esteem, increase alcohol/drug consumption and suicide attempts. In this complex way, the denial of services to transsexual women has repercussions beyond their immediate housing needs.

Like homeless transgendered youth, transgendered people do not access these services or make use of them only as a last resort. One MTF transsexual said that, although she was homeless for a few months upon her arrival in Toronto, she did not even attempt to access shelter services because of her gender presentation:

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

In the current situation, shelters do not have written anti-discrimination policies that include transgendered people; staff have little or no training on transgender issues. They consistently address the issue of service to transgendered people on a case-by-case basis, and this creates a situation in which the issue is individualized, so that a particular transgendered person arriving at the shelter is perceived as the cause of the problem. Although many shelter staff stated that their facilities would not be safe for transgendered people, few addressed the responsibility of the agency to create, provide, and maintain a safe space for transgendered people in need of assistance. As one staff member of a drop-in for homeless women remarked:

No one thinks it's [the provision of services to transgendered people] their responsibility.

The policies and practices of shelters for battered women and homeless women and youth do not address the needs of transgendered and transsexual women. This type of discrimination is not acceptable.

6.7 Alcohol, Drug, And Substance Use

The use of alcohol, drugs, and/or illicit substances was a topic that arose frequently in this research. While more research is needed in this area, the information contained here may be of use to people working in the field of addictions, and/or to those interested in offering social services to transgendered people.

Interviewees spoke at great length about the long and difficult process through which they came to terms with their gender identities. Like other groups, some transgendered people had used alcohol and drugs as a way to escape their confusion, pain, and suffering. One difference in the experience lies in the barriers transgendered people faced once they attempt to access alcohol/drug rehabilitation programs.

Several participants reported that the traditional forms of support available for people dealing with substance abuse were not welcoming of transsexuals. One participant had been a regular attender of Alcoholics Anonymous (AA) and received a great deal of support. When it was discovered that she was transsexual, AA members were less than hospitable.

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

When transsexuals enrolled in more formal alcohol/drug rehabilitation programs, they often felt alone and isolated. Several had gone through rehabilitation programs in the gender assigned to them at birth (MTFs with men; FTMs with women). This made the process of recovery even more difficult and stressful.

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

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

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

I just kept it [transsexuality] my little secret.

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

Things were not necessarily much better for transsexuals who received services in their chosen gender. One MTF transsexual interviewed was housed in a women's detoxification program where she overheard the staff make disparaging comments about transsexuals. A FTM transsexual interviewed went through a recovery program with men:

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

In neither situation - treatment as the gender assigned at birth or as the chosen gender - is it safe to declare one's transsexual status.

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

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

Further, although his counsellor was pleasant, she was ignorant of transsexuality.

She's very nice, even if she doesn't think I should do this [transition] ... She thinks I'm trying to mutilate my body. I said, "Dear, I have scars all over me. I'm trying to take care of me now. I don't want to do that anymore." She (my counsellor) said she'll support me (to transition and live as a man), but she doesn't want me to do this. We've had long talks about it, like she just, it freaks her out. She wants me to try and just be gay. (laughter!)

Transsexuals and transgenderists have to deal with counsellors who are ignorant of TS/TG issues. In many cases, this redefines the counselling situation. This FTM had to spend time educating his counsellor about the ways in which his addiction and gender issues are related: while living as a woman he hated his body and how he was perceived, and so used alcohol to deal with that pain. His decision to live as a man decreased this anxiety and thus lessened his need to consume alcohol. (This is not to suggest that when transsexuals with addiction-issues begin transition, they will suddenly no longer have any drinking or substance abuse problems.)

Locating resources that accept transsexuals is difficult. Finding a transgender-positive addictions-treatment program or counsellor is a formidable challenge. Finding support where the staff have knowledge of transsexual and transgender issues is even less likely. These problems of access are compounded when questions of race and ethnicity are considered.

6.8 Conclusion

Currently, transsexuals and transgenderists face systemic barriers with regard to health-care and social services in Ontario. This research clearly documents that transgendered people are habitually

refused the services they seek to live in their bodies as they choose. TS/TG people lack informed, safe access to hormones, are mistreated by the staff of hospital and emergency rooms, face rejection from traditional alcohol and drug rehabilitation programs, and are denied entry into youth, homeless, and women's shelters. It is particularly ironic that such exclusionary practices continue in social-service agencies designed to aid people with few resources.

In all these areas, basic access is denied.

7 Race, Ethnicity, and Culture

7.1 Introduction

This chapter is about the health-care and social-service experiences of those who are self-identified as other than Awhite.® Race, ethnicity, and culture are often difficult to categorize (Blumenfeld & Raymond 1988); nevertheless, they can be important markers of identity and are factors in the response people receive from service-providers and society generally.

Project data could be used to study specific racial, ethnic, or cultural subgroups, but here, due to the limitations of the project, the broadest possible view is taken. At the same time, we must acknowledge that there can be much overlap because of parentage, geography, and social status, just as there is tremendous diversity in religion, politics, and social customs, let alone in definitions of homosexuality, if that is a concept accepted in the culture in question.

The Project Affirmation survey offered participants an opportunity to identify themselves racially, ethnically, and culturally in their own words by offering two open-ended questions:

The ethnic/racial background from which I (and my ancestors) come is: (for example, Native/Aboriginal, white, South Asian, etc.) ...

and

I also ethnically or culturally identify as: ...

People used many terms to describe themselves: Black, East Asian, Hispanic, Jewish, Middle Eastern, South Asian, South East Asian. A very common term was Awhite.® People who reported being Canadian, American, Australian, or northern European were designated as white unless they included another term to indicate they were not.

Lesbian, gay, and bisexual members of racial, ethnic, and cultural minorities deal with racial discrimination as well as homophobia and biphobia. Where racism is concerned, they can receive support from their families or communities, but sometimes coming out puts this support in jeopardy. Predominantly white lesbian, gay, and bisexual groups cannot guarantee the absence of racism. Fortunately there are a number of lesbian, gay, and bisexual groups organized within racial groupings.

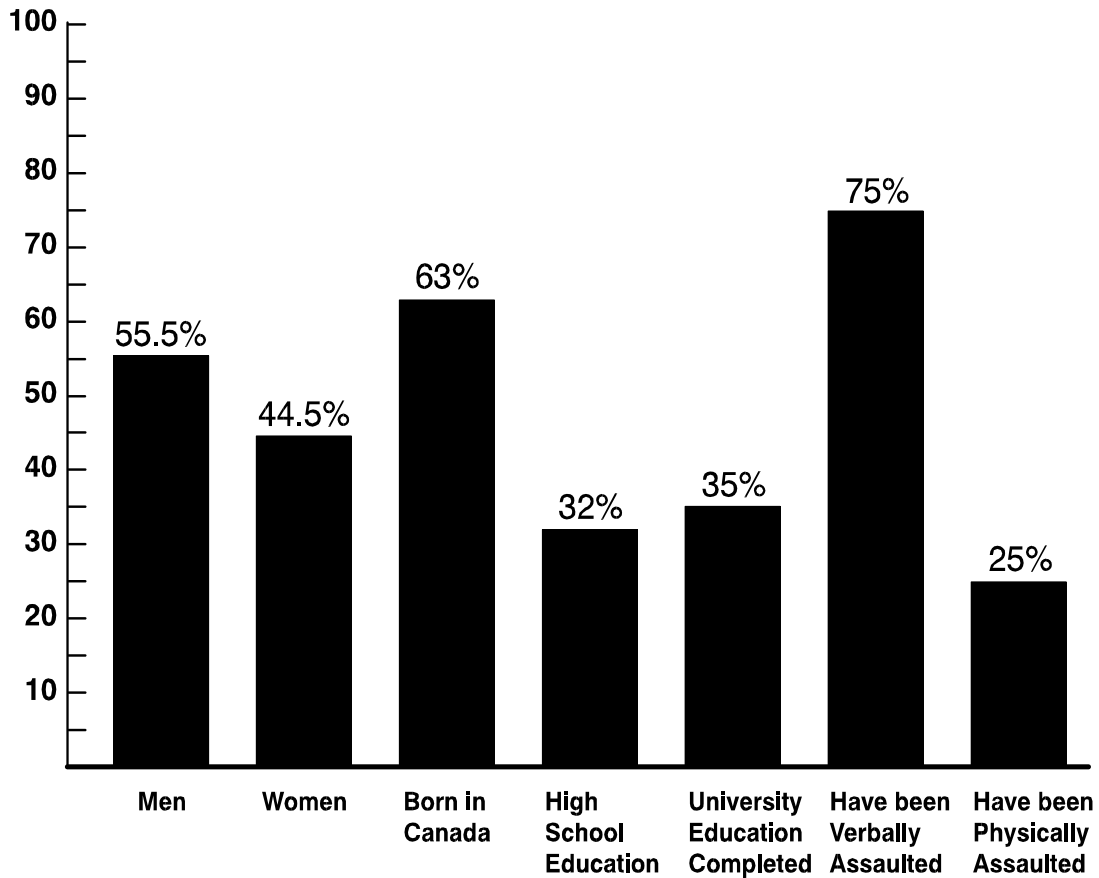
7.1.1 Profile

The sample comprises 129 people (57 women, 71 men, one unidentified by gender), just over 10% of survey participants overall. Of the 129, 63% were born in Canada. 32% had high-school education or less, and 35% have completed university. There are more students and more unemployed than in the sample overall. With respect to income, they are over-represented at the bottom of the scale and are as likely to be receiving social assistance as the sample overall.

Compared with the total sample, slightly fewer had children, but proportionately more had their children living with them.

Profile of survey respondents: race, ethnicity, and culture

Per cent of total
(129 respondents)



Total included: 129, or just over 10% of the total of 1233 survey respondents.

Includes all those who self-identified as: East Indian, South Asian, South-East Asian, Middle Eastern, Black, Hispanic, and Jewish.

Compared with the sample overall, the percentage of bisexuals in this group is slightly higher, as is the number of people who chose the survey category *Other* rather than lesbian, gay, bisexual, or heterosexual. Slightly fewer describe themselves as lesbian or gay. The proportion of those who had sex during the last year is much the same as for the sample overall. 41% were not in relationships, a little higher than for the sample overall. Of those in same-sex relationships, 58% lived together compared with 70% of the total sample. 34% indicated their relationships were less than one year in duration which is higher than in the sample overall.

25% reported a disability. Nine men were HIV-positive (13% of the men); two indicated they were living with AIDS (3% of the men). 52% of this sample had an employee-benefit package beyond OHIP.

80% were generally out as lesbian, gay, and bisexual people; 62% considered it safe to be out.

I think it's important for me to be out and seek support from others, I think being closeted affects one negatively, re: self-esteem.

At the same time, 75% had been verbally assaulted and 25% physically assaulted; of these last, 28% reported the assault to the police.

I was jogging past these two individuals when one of them tripped me. I fell to the ground, whereupon both proceeded to kick and call me names related to my sexual preference. I was able to get back on my feet and outrun them because of their state of inebriation.

SURVEY FACT SHEET

RACE, ETHNICITY, AND CULTURE

- over-represented at the bottom of the income scale
- no more likely to be receiving social assistance than the overall sample
- more students and unemployed than overall sample
- slightly higher percentage of bisexuals than the overall sample
- slightly higher percentage of those who identified "other" rather than lesbian, gay, bisexual, or heterosexual than the overall sample
- 80% had been in counselling or therapy at some time; 27% of these felt their lives were neither understood nor respected by the person they saw
- 66% cited coming-out, loneliness, and isolation issues
- 42% identified racism as a problem for them, and 33% had entered into counselling or therapy to deal with the resulting problems

7.2 Health Care

7.2.1 Doctors

Most people in this sample enjoyed fair to excellent health, and 68% had disclosed their sexual orientation to their doctor. 25% could not talk openly to the doctor they saw most and 12% said their doctor was silent about the fact that they are lesbian, gay, or bisexual. 10% said their doctor did not treat their sexual orientation with understanding and respect.

[Experienced] telling a doctor that I am gay and receiving judgemental reactions, e.g. body language and quieter voice.

I have been very selective about the doctors I have seen. If they are at all homophobic I wouldn't be a regular patient. I shop around for a doctor who meets my needs.

7.2.2 Hospitals

49% had been hospitalized or treated at a hospital at some point in the previous five years. Of these, 46% felt uncomfortable as lesbian, gay, and bisexual people in hospital.

I have had positive experiences while accompanying my partner to the hospital for treatment. However, it was Women's College Hospital, and I would have expected no less. I know all hospitals are not the same.

Feeling that homophobia might affect the quality of health-care service, 10% didn't go for regular physical checkups. 48% went to more than one doctor to find one with whom they were comfortable. Some travelled outside their area to get health care, and 38% had not voiced health-care-related concerns that reflected on their sexual orientation. 54% had, at some time, chosen not to disclose their sexual orientation to health-care providers.

7.3 Social Services

7.3.1 Services

The service most often used was counselling and therapy (45%); 19% of users reported negative experiences.

Lesbian and gay services were used by 37% but concerns about services were indicated by only 6%. 28% had had dealings with welfare services; of these, 33% felt badly treated. 10% had used suicide/crisis lines and Family Benefits Assistance; 31% of these felt they had received negative service because they were lesbian, gay, or bisexual.

Welfare and Family Benefits is stressful at the best of times but home visits were scary because of the books and posters in my apt. In one home visit, these were noted in my file.

7.3.2 Service-Providers

80% had been in counselling or therapy; 27% of these felt that their lives were neither understood nor respected by the service-provider.

I mentioned to a therapist that I was thinking seriously of exploring a lesbian relationship. She acted as if I hadn't said anything.

The most frequently seen service-providers were psychiatrists. Seen by 46%, they left 38% of these feeling they had received negative treatment. Psychologists fared better; they saw 44% but only 16% of these felt they had received negative treatment. 41% saw a social worker; 21% of these felt negatively treated. Doctors counselled 34%, of whom 21% reported negative experiences. Religious leaders were seen by 17% and left 33% of them feeling negatively treated.

I come from a fundamental, evangelical christian background (by my own choice as opposed to Aheritage®). They see homosexuality as abnormal, deviant, evil behaviour that one can either chose to shun or that one can be healed of. My unwillingness to forsake the lesbian lifestyle specifically sexual intimacy with a woman, caused me to be expelled from the church I was attending. The counselling had been an attempt to Acure® me of homosexuality by identifying possible causes. There was just too big a gap in our positions/ideologies for there to be any compromise or understanding reached.

7.3.3 Issues

The most common issues in counselling and therapy were coming out, loneliness, and isolation (66%). 58% cited self-esteem and 53% of these saw a counsellor or therapist; 48% cited relationship issues and 40% of these saw a counsellor or therapist. Racism was reported as a problem by 42%, and

33% of these entered into counselling or therapy to deal with the resulting problems. Almost all (92%) agreed that mental-health professionals need more knowledge and sensitivity around lesbian, gay, and bisexual issues.

7.3.4 Barriers

The most common barrier to getting adequate mental-health services was lack of money (42%). Next was lack of knowledge of how to locate a lesbian-, gay-, or bisexual-positive service-provider (33%). Finding a counsellor or therapist sensitive to racial, ethnic or cultural needs was hard for 20%, and 19% were deterred from seeking help because they anticipated a negative reaction to their sexual orientation. Long waiting lists were also a deterrent for 16%

7.4 Conclusion

In many respects, the problems this group faces in getting appropriate services are similar to those facing the survey sample overall, but they are compounded by the effects of living in a racist society. They live with more unemployment and more violence, and report less comfort with physicians, hospitals, and the range of mental-health services and service-providers. It is clear that there is a great need for more support from within their own communities and less prejudice from others.

8 First-Nations People

8.1 Introduction

Canada's First Nations are the people who lived in Canada before the European invasion of this country. As a result of their dispossession, the degree to which First-Nations people are able or eager to retain their traditions varies considerably. Lesbian, gay, and bisexual First-Nations people are sometimes known as two-spirited people; like others, they struggle to harmonize the spiritually based beliefs of their native cultures with the behaviour-based ones of the imported, largely European majority.

A Toronto group, Two-Spirited People of the First Nations, convened a focus group on behalf of Project Affirmation. This section is based on their report as well as survey responses.

8.1.1 Profile

First-Nations or aboriginal people comprised 4% of the survey total (32 men and 21 women). About 75% were aged from 26-54; none were over 55.

I am a homosexual, but I am [name], see me. I am a Canadian, I am a tax-payer, I've been in Inuvik/Hinterland since 1500s.

Most were from Ontario Urban (as defined in the chapter on regions). 28% had attended community college, compared with only 20% of the total sample. Fewer people in this group than in the total sample had undergraduate or graduate degrees; 21% were in school. 57% were employed.

Almost all (91%) had been sexually active during the previous year; 46% were in a same-sex relationship, and 63% of these were living together.

Nearly all reported their health as good to excellent; 46% were covered by an employee-benefit health package.

74% described themselves as out and 94% reported they take pride in their sexual orientation.

Was aware of sexual orientation since childhood but just came out recently.

I feel I have been gay all of my life ... I am very open about my sexuality.

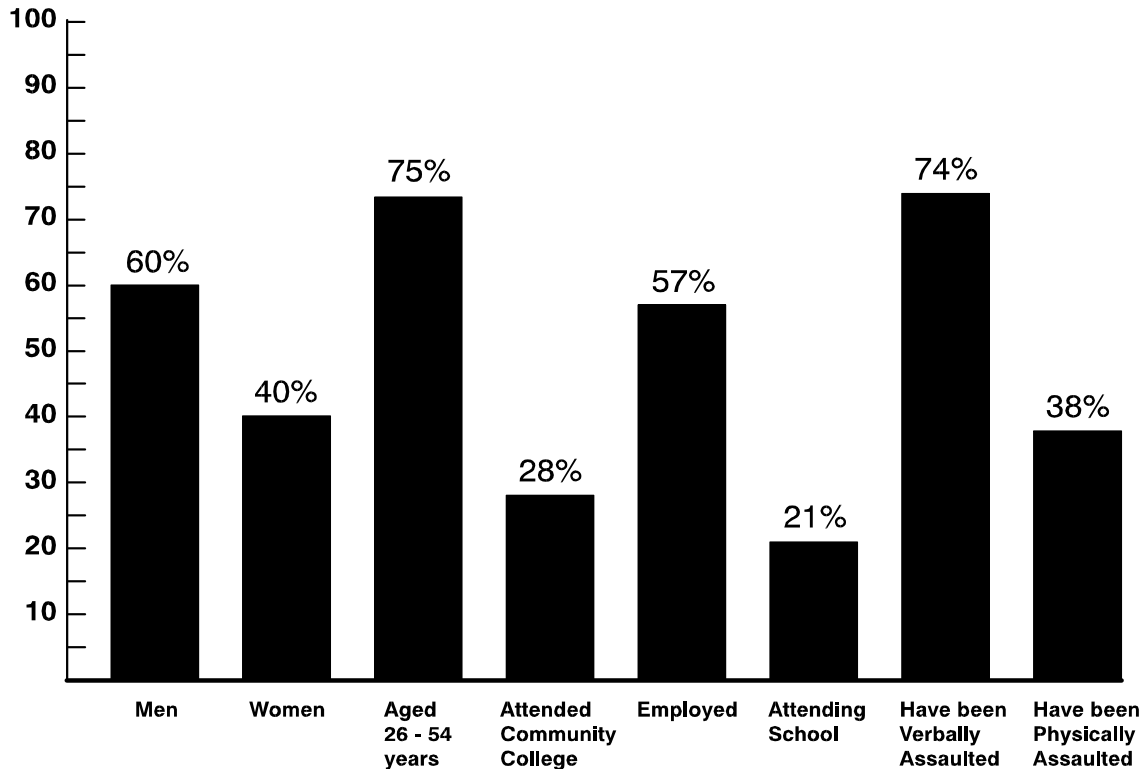
I identify myself as being a lesbian because I am proud of it, I'm not ashamed, I just wish more people would accept it.

54% felt it was safe for them to be out in their communities. 89% described their lives as stressful. Verbal assaults had happened to 74%, physical assaults to 38%; of these, 30% had reported the assaults to the police.

I was walking home and accosted by 5 youths who verbally and physically assaulted me - punches, kicks, and a 2" x 4" piece of wood.

Survey Profile: First Nations / Two-Spirited People

Per cent of total
(63 respondents)



8.2 Health Care

8.2.1 Doctors

86% saw a doctor at least once a year. 53% had been asked by a doctor whether they had a partner; 20% had been asked whether they wanted their partner included in decision-making and 12% whether they wanted their partner present during hospital treatment.

[I=m] afraid that I will not be called to my partner if something were to happen, and I would not be there for someone I love very much.

33% were not out to their doctors and 27% were unable to talk with them about sexual issues.

My current doctor is excellent and I have had her for 10+ years. Previously, my experience was very different, and I would have answered these questions very differently.

69% had a doctor who had asked them if they practised safer sex, but only 41% of the whole group had been spoken to by the doctor about safer sex practices.

Inappropriate assumptions were experienced by 12%, inappropriate treatment plans by 12%, and inappropriate comments by 6%; 12% felt their doctor did not treat their sexual orientation with respect. 61% thought their doctor needed to be more knowledgeable about issues related to their sexual orientation.

My original GP would not discuss my sexuality at all with me. My neurologist had to be beat over the head with it before I could get answers out of him. He also made the mistake of assuming that lesbians don't want children, therefore I had to force him to discuss pregnancy and the dangers to a person with epilepsy.

22% see a traditional native healer. Of these, 36% felt it important that their healer know about their sexual orientation, but only 16% had told them; 47% felt healers need more sensitivity and knowledge about their sexual orientation.

I believe all medical and professional staff need to be educated so that they can identify their internal homophobia and identify their limitations and abilities.

8.2.2 Hospitals

67% had stayed in or been treated in hospital, and 13% feel their treatment was affected negatively by homophobia or biphobia. 50% felt it uncomfortable to stay in hospital; 17% said it was difficult for their friends to visit.

I noticed a varying degree of behaviour, from warning my female lover that my grandparents had arrived so she would stop holding me ... other staff members ranged from complete neutrality to actually sloppy work.

No special effort was made to help my partner cope with the situation or to keep her updated on what would happen, on decisions to be considered. They directed all of these comments to my parents. Despite the fact my lover's name was on the form to be contacted in case of emergency.

8.2.3 Barriers

Most reported that they go back for follow-up treatment as necessary. However, 42% had shopped around for a doctor before finding one with whom they were comfortable. A few travelled outside their immediate area to get health care. 32% said there were times when they had not spoken about health-care issues affecting them; 56% reported there were times when they did not let health-care providers know about their sexual orientation.

Aside from the practical consideration that they can't always afford medication, 24% felt their health was adversely affected because they didn't have a doctor they could talk to about their sexual orientation. Also, their health was affected by the stress of having to hide their sexual orientation (45%) and concern over negative comments or actions (59%).

I do not feel comfortable revealing my sexual orientation to my doctor - I wish I could find out which doctors in my area are gay-positive.

8.3 Social Services

8.3.1 Services

78% had been in counselling or therapy; 30% reported negative experiences.

I was treated with ignorance as to why I was bisexual and was told that I am just confused and that I'm really a het.

They asked if I thought something was wrong with me to be lesbian ... that I'm being immature.

Could not understand my pride in being lesbian, focused on my being out to everyone more than the issue that brought me to counselling.

Negative experiences were reported by 35% of those who used welfare services, 30% of Family Benefit Assistance service-users, and 10% of those who went to lesbian, gay, and bisexual services. Few had had involvement with public-health nurses, and they reported no incidence of negative experience.

8.3.2 Service-Providers

Of those who had seen a counsellor/therapist, just over 33% had seen a psychiatrist. Psychologists and social workers were seen by just under 33% and doctors by just over 20%. Of those seeing psychiatrists, over 33% reported problems; of those seeing social workers, over 20%; of those seeing doctors, 10%. Psychologists were not identified as problematic by anyone.

Psychiatrist I saw said I was basically Astuck@ with being gay, implying something negative about this. Psychologist was interested in helping me try to Achange@ my

orientation (I was 15 years of age), again implying that there was something wrong with it.

70% of this sample indicated they had had problems with coming-out issues; 54% of these sought counselling or therapy. 66% reported feelings of loneliness and isolation and 43% of them had sought help. 62% reported self-esteem problems; 58% of these saw a counsellor or therapist. 49% described relationship difficulties; 46% of these got professional help.

Another common problem for which members of this group sought help was childhood sexual abuse; it was the second-most-common problem for women, the sixth-most-common for men.

The most common barrier was the cost of services (47%), the next most common finding a service-provider positive towards lesbians, gays, bisexuals, and two-spirited people (36%). Others feared their confidentiality would be breached, a few feared they would face a negative reaction for seeking services at all. Finally, some didn't know how to find a therapist who would be racially and culturally sensitive to them.

I'm unsure whether same-sexual-orientation health-care providers including physicians are needed. I think as long as you are knowledgeable and sensitive to the needs of your client, gay or straight, is really the issue. It is really making health-care services more humane and compassionate for all involved.

SURVEY FACT SHEET

FIRST-NATIONS PEOPLE

- most were from Ontario Urban
- fewer had graduate or undergraduate degrees than the overall sample
- only 54% said it was safe to be out in their communities
- 12% experienced inappropriate treatment plans from doctors, 12% experienced inappropriate assumptions, and 6% experienced inappropriate comments
- about 22% saw a traditional native healer; only 16% of these had disclosed their sexual orientation to their healers
 - 47% reported that native healers need more sensitivity and knowledge about sexual orientation
- 78% had been in counselling or therapy at some point
 - 54% had sought counselling or therapy for coming-out issues; 66% felt lonely and isolated
- 62% had experienced self-esteem difficulties; 58% of this group had sought counselling or therapy
- 35% reported experiences with welfare services as negative; 30% reported Family Benefit Assistance services as providing negative experiences
- childhood sexual abuse was the second most common problem for which women in this group sought help and was also cited by a significant number of men

Almost all of this group thought that social-service practitioners as a group needed to have more knowledge and show more sensitivity to their issues. As many felt that the service systems also needed improvement.

8.4 Conclusion

Historically, Canada's various levels of government have assumed financial and custodial responsibilities for and over First-Nations people based on treaty rights and policy decisions. This relationship textures all issues differently for this group than for any other.

As a First-Nations lesbian, I would like more respect for me and my culture.

Where cultures have clashed, they have also mingled. The extent to which First-Nations people have become distanced from their original cultures varies. Interpretation of the findings reported here is affected by the many issues which challenge First-Nations people in this province. Culture-clash and economic and social marginalisation all have influence.

Being lesbian, gay, or bisexual used to be revered by my culture. When the Europeans came with their christian-based prejudice, things changed.

People who are not of the First Nations have not been particularly willing to learn about and understand these cultures. Service-providers need to learn about First-Nations identity and about the identity of two-spirited people in addition to learning how society is structured for First-Nations people now. This needs to work with education about lesbian, gay, and bisexual people and how they are (or should be) treated in the health-care and social-services systems generally. More targeted study is necessary in order to understand the implications.

9 Youth

9.1 Introduction

Like all youth, young lesbians, gays, and bisexuals must establish a sense of self-worth, find role models, seek areas of interest, move towards finding careers, and learn to form intimate relationships. These issues are more complex for lesbian, gay, and bisexual youth. In addition, however, they must come to terms with a sexual identity for which there is often little or no support.

Many lesbian, gay, and bisexual youth try to hide their sexual orientation. Since young people mostly lack the wherewithal to live independently, they are particularly vulnerable. To use health-care and social services, youth must trust their advice and their offers of confidentiality. Health-care and social-service systems can severely threaten closeted youth whose families may be involved in their support and health care.

Most of the young people surveyed tried to access support services; their experiences suggest that services and service-providers could do a better job.

9.1.1 Special Features of this Group

Most survey participants were found through groups frequented by lesbian, gay, and bisexual young people and through youth agencies. Probably because of this, 72% reported social-service use, and 86% reported membership in lesbian, gay, or bisexual organizations.

With these contacts, it would be reasonable to assume they were well informed about lesbian, gay, and bisexual issues and had support systems in place. Yet 31% feared a negative reaction at health-care and social services if they were known to be lesbian, gay, or bisexual, 14% felt embarrassed and ashamed to seek social-service help because of their sexual orientation, and over 10% felt they would be unable to see a counsellor or therapist because of this.

9.1.2 Profile

Young survey respondents (183 under 26 years old; 102 men, 81 women) comprised 15% of survey respondents overall.

79% described themselves as open about their sexual orientation and 92% were proud to be lesbian, gay, or bisexual. In general, 87% also experienced their lives as moderately to very stressful.

90% had had sex during the previous year; 48% were in same-sex relationships; about 40% of those in relationships lived together.

Most were students. 34% were employed or seeking employment; 35% had an employee health-care benefit package. Of benefit packages, 37% were provided by their employer, 60% indicated another (possibly parents), and only 3% said they qualified under their partner's insurance. Almost all (90%) reported good to excellent health.

SURVEY PROFILE

LESBIAN, GAY, AND BISEXUAL YOUTH

- 183 respondents, 25 years or less
- 61% of those who needed to talk to their doctor about health issues affecting them had not done so, compared with about 40% of the overall sample
- 87% reported their lives were moderately to very stressful
- 75% had been verbally harassed
- 22% had been physically assaulted because of their sexual orientation
- only 20% said their doctor asked them about their sexual orientation
- trust was the biggest issue identified in respect of their doctors; youth feared that doctors' first loyalty is to parents
- 72% have sought counselling
- 65% used lesbian and gay services, 50% used generic counselling services, 27% used general welfare, 24% saw public-health nurses, and 9% saw family-service agencies
- 30% of youth who used general welfare assistance reported being mistreated because of their sexual orientation

Verbal harassment was experienced by 75%, physical assault by 22%. Although the incidence of assaults is about the same as for the sample overall, young people reported 20% of incidents to police, compared with 26% for the sample overall. It is understandable that they might want less of the kind of attention that comes with police involvement. They are vulnerable to reactions from parents, school, and community. Commentary from the surveys also indicates an underlying mistrust.

Cops in Kirkland Lake are homophobic and don't care.

I was kicked out of a restaurant for being gay because the owner knew from someone else that I am gay. I called the Timmins Police and they didn't help at all and were rude.

When I was physically assaulted I didn't bother to contact the police.

The police force in my small town unfortunately share the same views on homosexuality as my assailants. I would expect to cause more harm and uproarious activity if I actually did report anything. I did not report it to school for same reason.

9.2 Health Care

9.2.1 Doctors

42% had disclosed their sexual orientation to their physicians; this is about half the rate in the sample overall. About 25% didn't have a doctor they felt they could trust; 24% didn't go for regular check-

ups; 21% of those who needed follow-up visits didn't always go back. This is higher than for the total sample where only 15% skipped physicals and 19% avoided follow-up visits.

Shopping around for a doctor, choosing a new doctor over the family doctor, or travelling outside their home area for medical matters may not be possible for financial or family reasons.

I have never felt comfortable talking to any of my doctors. You can really never tell how they will feel about the subject. I wish it wasn't like that.

I simply haven't come out to my doctor yet. She hasn't made any overt assumptions, but neither has she asked specific questions.

Young people tend to be silent when faced with adults in authority. Physicians fall into this category. In addition, young people may feel that their concerns related to sexual orientation are trivial compared with illness, injury, or other health concerns. Doctors (sometimes because of pressure of work, sometimes for other reasons) may not do anything to enable young people to talk. Of those in the survey to whom it applied, only 20% said their doctor had asked them about their sexual orientation; 30% said their doctor was silent about the fact their sexual orientation after they had come out.

The GP that I have is aware that I'm gay through people in the community - however he does not question/approach me on the issue. It would appear that he is afraid.

She never asked and I never said anything about the fact that I am gay.

*As soon as I tell a doctor I'm gay, he immediately asks if I'm sexually active, even though it is not applicable to the health problem. Upon receiving a *Ayes@* answer he immediately goes on about *A safe sex.@* I say *Agay,@* they say *A safe sex.@* I don't like the implied connection.*

Some felt that they were not seen by doctors as individuals but as part of a huge amorphous collective, focussed on sexual behaviour. Misinformation and misunderstanding adversely affect the quality of health care. Some survey participants felt they were given inappropriate treatment or faced with inappropriate assumptions because they are lesbian, gay, or bisexual.

*I'm a 19 year old woman and she was willing to allow me to not ever have a pap smear or gynecological exam because I wasn't having *A sex@* (intercourse with a penis). I had to request them and convince her I needed them.*

*Once I *A came out@* to my doctor, he tried to include a blood test for HIV in my regular blood work without telling or asking me. I was mad and felt as if he saw me as some *A disease-infected@* freak.*

Of those who need to talk to their doctor about health issues, 61% do not (37% for the survey overall).

In a Project Affirmation focus group, youth identified trust as the biggest issue. Many were apprehensive that doctors would feel their first loyalty was to their patients= parents; youth therefore were worried that doctors would breach confidentiality. Many young lesbian, gay, and bisexual people live with families who know nothing about their sexual orientation and whose positive reaction could not be guaranteed. Negative reactions include sending the youth to ministers and psychiatrists to be cured or throwing them out of the home altogether. The risk is immense.

My father did not know I'm lesbian and when he found out I was sure he'd beat me

9.2.2 Hospitals

Patients have the lowest status in the hospital power structure; young patients have even less and are more likely to lack confidence in asserting their needs.

I think much of the discomfort or poor treatment I received in hospitals was as much related to my young age as to my sexuality.

51% of the sample reported they had either been treated in hospital or they had stayed in hospital. 41% said it was uncomfortable to be a lesbian, gay, or bisexual youth in a hospital, but few felt mistreated or ill-served. On the other hand, 18% said it was difficult for their friends to be with them.

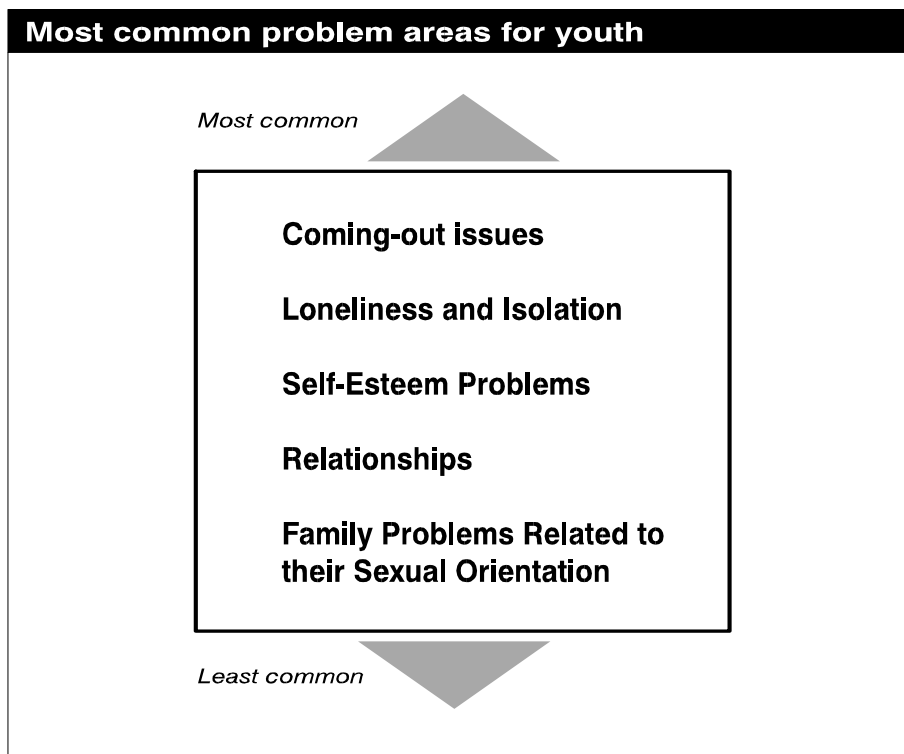
I was in emergency with anaphylactic shock (allergy) and my date (woman) stayed with me. I was afraid they wouldn't let her stay (they kept me overnight). They seemed oblivious to our relationship.

Others said that it was difficult to visit friends or a partner.

Because I'm not considered to be an immediate family member I was not allowed in the emergency room with my partner - I was left not knowing anything. I was asked to leave if I wouldn't cooperate.

In the past, I have been able to ignore stares, unwelcoming restrictions etc. from hospital staff or patients in order to see my friends/lovers. I'm sure others would feel more uncomfortable and blocked by these situations.

27% of those in need of medication felt that financial constraints limited their access to health-care services; 14% of the sample overall reported the same problem. Many young people are financially dependant on their parents, low-paying employment, or social programs; they cannot afford to jeopardise financial and other material supports.



9.3 Social Services

9.3.1 Services

Counselling was sought by 72% of the youth surveyed. Many services were mentioned but the five most-used were: lesbian, gay, and bisexual services (65%); counselling services (50%); general welfare (27%); public-health nurses (24%); family services agencies (9%).

Young people looking for financial aid to help them stay in school or make ends meet are likely to turn to general welfare assistance, where however 30% reported negative treatment due to homophobia or biphobia.

When I identified as lesbian to my welfare worker, she was dismissive and pretended I hadn't spoken. This made me feel completely invalidated and invisible.

Of the 50% of the sample who had used generic counselling services (such as those available from children's aid societies or community centres), about 23% were left feeling negatively treated.

My first counsellor abruptly ended our sessions about six weeks after I told her that I thought I was gay. During the six weeks she was very abrupt and wouldn't tell me what was going on. She still wouldn't talk to me after I went to her supervisor.

14% indicated they were unhappy with the response they received when they disclosed their sexual orientation at public-health departments.

A public health nurse was shocked and uncomfortable when I told her (I was getting a blood test). She didn't say anything but she was obviously distressed.

Lesbian, gay, and bisexual counselling services were the most popular choice for counselling, but still 8% felt they were negatively treated there for coming out.

Family services saw 9%; 6% of these had concerns about the way they were treated.

These reports indicate that, no matter the context in which these young people seek service, there is room for improvement.

9.3.2 Service-Providers

72% of the sample had been in counselling or therapy; almost all (93%) had told their counsellor or therapist about their sexual orientation; 43% felt they were not understood or respected as lesbian, gay, or bisexual people. These numbers are high compared with those for survey respondents overall.

The most commonly seen therapists were psychologists (48%) and school guidance counsellors (47%). Clearly, from the following comments, mistreatment at school is a major problem.

During school days I was suppressing my gay feelings. I came across as being withdrawn and anti-social. Classmates began to label me Aqueer@ or fag. The hardest class to tolerate was gym. If I had known that some of my teachers were also gay or [if I had had someone to talk about my feelings with] it may have been easier.

I was pushed around and insulted more than anything. It happened in high school, Abecause I was different.@

She talked about it with others in her field, breaking guidance counsellor confidence.

The guidance counsellor seemed understanding but was no help and made me feel uncomfortable about being gay. All others made me feel uncomfortable by an unsaid, projected attitude.

Both verbal and physical assaults occur regularly at school.

While at university and in high school I was attacked for being gay even though I was not out. Constant shoving pushing and threats of severe physical violence.

It was a typical day in small town Ontario at a secondary school of only 500. I was called a derogatory name (as usual) and then slammed up against a locker and kneed in the stomach area. It was certainly not pleasant.

48% of the sample had seen psychologists; 17% felt that the therapist was uncomfortable with their sexual orientation.

One of the two counsellors I saw in the past two years told me my sexuality was a phase and not to worry it would pass. The psychologist told me I had chosen my sexuality in reaction to abuse and that when I overcame my past abuse I would also recover from being a lesbian.

46% saw social workers; 25% indicated that the worker did not accept their sexual orientation.

My partner was in the room while I was speaking to my case worker. I identified my partner - and whatever she had to add to the conversation was dismissed.

I went to [university] counselling recently to deal with an abusive relationship but felt a level of discomfort and a sense of them not knowing what the hell they were doing. Also I found as a youth coming out, straight counsellors tended to assume that being a

Ahomosexual@ was about sex and neglected other issues pertinent to a queer identity.

37% saw psychiatrists; of these, 46% felt they were not helped. Psychiatrists were found problematic nearly twice as often as other service-providers.

Health-care professionals - all psychiatrists have told me my panic attacks could or are caused because I'm in a same sex relationship. My mind is all screwed up and gets panicky cause I'm probably straight as they say. It can't handle the fact I could be gay. FIGURE THAT OUT.

I received counselling for my abusive past, and the psychiatrist told me I was abused because I disappointed my family for being gay.

There was a lack of understanding of me as a gay man. The lack of understanding extended to my same-sex relationship at the time. The psychiatrist seemed to feel that somehow abuse in a same-sex relationship is more equal because we're both men. That because I am a man I should be able to defend myself or Atake it@ because we're

Aequals.@

As counsellors, young people saw doctors less often than any other professional. However, 30% of those who saw doctors found them unsupportive.

9.3.3 Issues

The most common problem areas for lesbian, gay, and bisexual youth were coming-out concerns (82%), loneliness and isolation (72%), self-esteem problems (66%), relationship difficulties (56%), and family problems (50%). Over 50% of those facing these problems saw a counsellor or therapist.

Coming out can be a time of confusion, since young people who receive negative responses when they talk about lesbian, gay, or bisexual feelings have few positive images to set against the stereotypes.

I was treated with ignorance as to why I was bisexual and was told that I am just confused and that I'm really heterosexual.

They say I'll snap out of being a lesbian to become straight again.

Young people who want to talk about the meaning of being lesbian, gay, or bisexual need to find supportive service-providers. Even before they are aware that they are in the process of coming out, they frequently feel troubled that something is not quite fitting together in their lives. To help them, service-providers must list coming out on their inventory of possible issues. The need to counsel heterosexual young people about the meaning of their emerging sexual orientation is recognized; it is a much more urgent need for lesbian, gay, and bisexual youth.

I only came out midway through university and mostly needed help before then.

Young people are socialized to see all romantic relationships in a heterosexual context. Young lesbian, gay, and bisexual people often need to talk about what is happening for them to understand themselves and their potential more fully; this can be of particular importance when relationships are not going well.

Gay relationships are very complex and it would be great if more people in the health-care field were up to speed on this.

9.3.4 Barriers

Lack of money was the most common barrier to young lesbian, gay, and bisexual people accessing services. Many others reported that they couldn't find a lesbian, gay, or bisexual positive counsellor or support system.

I was very surprised at the help available to gay persons. The very large problem is how to find it. I had an extremely difficult time finding support groups.

Some sort of media, advertising to let people who are coming out know where to get some help dealing with it. (Whether a therapist or to a social service of some sort). Any positive media about gay/lesbian/bisexual.

More than just a safe place, people are looking for somewhere that is clearly welcoming.

I need a place where I can go and be in a queer environment before I'll feel really safe to talk about my needs.

Many young people were apprehensive that disclosure of their sexual orientation would meet with only negative reactions.

I did not tell my doctor or guidance counsellor. I am too afraid that they will react negatively, or try to Achange@ me or that I will not get adequate help.

The need for more lesbian-, gay-, and bisexual-operated services was recognized, though it is not clear how these can be funded, since government has largely abrogated its responsibility in this area. Concern about waiting lists was often expressed; simply put, there aren't enough positive services to go around.

One of the most common concerns was confidentiality. Family is often involved in regulating young people=s access to physical or mental-health care; if family provide a negative environment, the cost of them finding out can be high. 22% indicated that they were not completely out of the closet; 40% felt it was not safe for them to be out in their community.

This survey represents youth who received and completed the survey. The number of young people who were not able even to do that can never be known. They remain silent facing a future that is uncertain and threatening.

9.4 Conclusion

It is crucial that recommendations be implemented to improve the access to service of lesbian, gay, and bisexual youth. A December 1989 study from the Village Clinic in Winnipeg found that 25% of lesbian and gay youth had attempted suicide, most for reasons related to their being gay. This echoed the slightly earlier finding the US government's Department of Health and Human Resources which estimated that lesbian and gay youth accounted for more than 30% of all US suicides. Subsequent

studies have confirmed the gravity of the situation (Gay & Lesbian Youth Services Network 1989; Hammelman 1993; Gibson 1994).

10 Older Lesbians, Gay Men, and Bisexuals

10.1 Introduction

The people in this group were 54 and over in 1995; they were born 1940 or earlier. Here we find both the early gay- and lesbian-liberation activists and feminists and also those whose lives were lived in silence. In the 1940s, =50s, and =60s, the public stance on homo- and bisexuality was largely condemnatory, though of course there were lesbian and gay social circles and bars, and circles of liberal-thinkers who did not condemn.

Many lesbians, gay men, and bisexuals stayed discreetly in the closet. Some sought public safety by entering into marriages of convenience or taking up stances such as *Athe maiden aunt,* *Athe bachelor,* *Athe career woman.* For most, the best hope was public tolerance, private acceptance.

The fact that I didn't Acome out@ until I was 54 says it all I think. We haven't been allowed to even think of our sexuality if it isn't the Anorm,@ never mind speak of it. I'm thankful to all the men and women who fought for our rights to allow me to be myself - now - finally!

Married in 1962 when I could not find the lesbian community in Ontario. Marriage ended in 1982.

I've always known I was gay since I was a small boy.

The older generation comprises people to whom the concept of social services and mental-health services as a form of social safety-net, let alone as a right, was introduced in their adult years; their expectations of service are probably lower. They also carry the experience of early health-care and social-services systems which, as a whole, saw homosexuality as a deviance to be cured or corrected - and some of these attitudes linger still.

For those who internalized this public homophobia, help was harder to come by.

10.1.1 Special Features of this Group

Ageism (in this case, the prejudice of young people against those who are older) is an additional layer of oppression facing this group. It is supported by the notion that older people are hard to understand and compounded by the fact that for many of the young, these older lesbians, gay men, and bisexuals who are now supposed to be their role models are friends of their parents or, at least, belong to the generation they=ve been rebelling against.

There is a sense that as lesbian, gay, and bisexual people age, they disappear. Certainly they become less visible. For the most part, regardless of sexual orientation, advertising, entertainment, and news media are created by the young, for the young, about the young. However, as the so called baby-boom generation ages, the demographic is shifting.

10.1.2 Profile

This group of 54 lesbian, gay, and bisexual people (32 men and 22 women) over 54 years old comprises slightly more than 4% of survey respondents

Compared with the sample overall, slightly more members of this group completed high school and more hold graduate degrees. 54% are employed; 30% are retired.

68% indicated they are generally out; 92% are proud of who they are, but 52% describe their lives as being stressful.

70% had been sexually active during the previous year and 65% were in relationships; of these, 61% live together. They had more longterm relationships than the sample overall.

43% had children compared with about 18% of survey respondents overall.

The group reported about half the amount of verbal and physical assault of the sample overall; none of them had reported an assault to police (in the sample overall, 26% of those assaulted reported to the police).

68% of this group are out publicly, compared with 76% of respondents overall. The level of trust regarding doctors is about the same for both groups, but, older lesbian, gay, and bisexual people feel better understood by counsellors and therapists.

Isolating this group from the total sample yields a profile that one might expect based on the idea that they have lived both during a period of almost total oppression and one where restrictions have been somewhat relaxed.

10.2 Health Care

10.2.1 Doctors

The majority of this group reported good to excellent health. 62% were covered by an employee health-benefits package (either their own or their partner's). Almost all saw their doctor at least every few years, some as often as every month. Only four people out of the sample of 54 reported that they never see a doctor. 72% had told their primary doctor about their sexual orientation; 70% said they could talk with their doctor about sexual issues.

32% had visited more than one doctor before deciding on one they were comfortable with. A few travelled outside their area to get health care. Anticipating a negative reaction, some do not feel comfortable to voice lesbian, gay, or bisexual health-care concerns to their doctor or ask questions related to their sexual orientation.

59% said that their doctor hadn't asked about safer sex practices; for 74% their doctor offered no advice around safer sex. 23% described doctors as being silent about their sexual orientation. This may have to do with the doctors' discomfort with the idea of older people having sex.

29% reported that their doctor asked if they had a partner; 19% were asked if their partner was to be included in major treatment decisions or be present in hospital

Both my partner and I name each other as next of kin on any form we fill out and have had no problem having this honoured so far.

SURVEY FACT SHEET

DOCTORS SEEN BY OLDER LESBIANS, GAY MEN, AND BISEXUALS

- 59% of the doctors hadn't asked about safer sex practices; 74% offered no instruction around safer sex
- 23% of doctors were described as silent about sexual orientation even when their patients came out to them
- 29% of doctors asked if their patients had a partner
- only 19% of doctors asked if a partner was to be included in major treatment decisions or if a partner was to be present in hospital

Outright negative responses from doctors were rare; very few were seen as making incorrect assumptions because of sexual orientation or offering inappropriate comments or treatment.

As patients, older lesbian, gay, and bisexual people indicated they feel the treatment they receive by doctors and in hospital is acceptable. However, it is noteworthy that their health-care providers fail to ask them for information that could help in providing the best possible treatment.

10.2.2 Hospitals

In this group, 52% have experienced hospital treatment or a stay in hospital, where they felt generally well served. There were no reports of inappropriate behaviour and only isolated examples of inappropriate comments or poor treatment.

I was well supported by hospital staff who recognized me as the primary relation in my late partners life, and they tactfully supported me when her mother tried to by-pass me and step between us.

Some 10 years ago, in hospital, some nurses made sneering comments about visiting rights for my Afriend. @ Others, in the corridor, commented loudly there were too many Afruit flies around here. @

Many felt that hospital staff needed more awareness and training:

I was so busy educating staff about lesbian/gay issues ... there was little opportunity for mistreatment because of my gayness.

If and when I do have to go to a hospital I would feel stressed about having to Acome out@ to staff I don't know, particularly in a gossip small town where Aprofessionals@ are often unprofessional.

People felt their friends had access to them in hospital, but 25% said they were not comfortable there as lesbian, gay, or bisexual people.

People sensed they had been safe both in hospital and with their doctor. Generally, they felt that being a lesbian, gay, or bisexual person had not negatively affected the way they were treated.

About 50% indicated that health-care professionals generally need to be more knowledgeable and more sensitive to lesbian, gay, and bisexual issues; almost all (94%) agreed that health-care systems must improve to better meet their needs.

10.3 Social Services

The most used services were counselling or therapy services (28%); lesbian and gay services (20%); seniors= services (13%); welfare, family-benefits, and public-housing services (6%).

14% reported being in counselling or therapy at the time of the survey; 77% indicated they had sought such help at some point in their lives. Of those who had been in counselling or therapy, 63% saw a psychiatrist, 35% saw a doctor, 30% saw a religious leader, 25% a psychologist, and 23% a social worker. 75% of those who had seen a counsellor or therapist reported that they disclosed their sexual orientation.

Of those who saw psychiatrists, 32% reported they felt that they were not treated respectfully by them; 17% felt the same of religious leaders, 11% of social workers, 10% of psychologists, 0% of doctors. These numbers are somewhat lower than for the sample overall.

One psychiatrist I interviewed (in my search for help) called homosexuality a pathology but claimed he was willing to take me on as a client! I told him I didn't think this would work, thanks just the same!

At best, lesbianism was seen as a non-issue. At the worst, it was seen as a disease to be cured.

The main issues in therapy were: coming-out issues, loneliness/isolation, issues of self-esteem, relationships, and childhood sexual abuse.

The main barriers to accessing service were cost, availability of service, long waiting lists, and fear of breach of confidentiality. A small number declined to seek social services since they anticipated a homophobic response on the part of service-providers.

77% felt that counsellors and therapists need to have more knowledge about and sensitivity towards lesbian, gay, and bisexual issues. Almost all (94%) agree that agencies can improve service and practices to better help lesbian, gay, and bisexual people.

10.4 Conclusion

Older lesbians, gay men, and bisexuals report a lower level of service use and a higher level of satisfaction. Explanations for this vary from the historical (unaccustomed to reliance on service provision), to the psychological (uncritical or more assertive). This is certainly an area which would reward more detailed study than the scope of Project Affirmation permitted.

11 Families/Relationships

11.1 Introduction

Like heterosexuals, many lesbians, gay men, and bisexuals live in relationships or family units. For them as for heterosexuals, their nearest and dearest are a critical component of their health and well-being. Particularly in times of trauma, illness, or injury, it is imperative to have the presence and support of loved ones. Sometimes, lesbians, gay men, and bisexuals use the term *chosen families* to designate our choice of family and family structure which is not recognized by the government or, sadly, by many service-providers.

The relationship issues covered in the data-collection were: inclusion in health-care packages and acknowledgement of partners by primary-care physicians in hospitals. The focus is health care rather than social services; no other information was sought about couples using social services.

The majority of health-care data here focus on hospital experience. Hospitals are particularly important given their role in emergency medical care and the fact that, when patients stay for prolonged periods in hospitals, a same-sex relationship becomes increasingly apparent to hospital staff. Of course, hospitals are not the only health-care facilities where same-sex couples have difficulty.

Research on couple-counselling and relationships was not part of the Project Affirmation study. The only specifically social-service-oriented question was whether people had ever entered into counselling or therapy to work on relationship problems. Some information about perceptions of lesbian, gay, and bisexual parents was collected.

A longterm, co-habiting, sexual relationship with one partner is only one of a range of possible lifestyles. Project Affirmation was limited in the extent to which it could cover the full breadth of relationship configurations and emphasizes the need for further research to detail the diversity within same-sex relationships.

The data presented here reflect the responses of survey participants who are in same-sex relationships. This chapter covers two important dimensions of chosen families: partners (romantic/sexual relationships) and parenting.

11.2 Partners

11.2.1 Special Features of this Group

Heterosexist assumptions (in this case, the mistaken belief that legal or biological relatives and opposite-sex partners are the only true family) affect all people who do not live within the nuclear-family model. For example, when children are parented by two people who are not married or when they are parented by more than two people, their relationships to their parents are not legally protected. In addition, lesbian, gay, or bisexual relationships are often denied the full range of rights that heterosexual relationships enjoy. For example, same-sex partners often do not automatically receive the next-of-kin status.

Often there are rules that serve to ostracize same-sex partners, for example, with respect to next-of-kin provisions, visitor admittance, and access to information. Although people who are unable to act on their own behalf may depend on health-care or social-service support, social services to families usually offer no provision for same-sex spouses.

11.2.2 Profile Of Partners

63% of survey participants overall were in same-sex relationships, 72% of women and 56% of men. About 75% had been with their partner for over a year; 75% of the women and 61% of the men live with their partner.

12% have not told biological-family members about their relationship. Just under 14% found their biological family not supportive of their relationships; 34% reported full biological-family support. 20% reported that they are parents; of these, 53% are living with some or all of their children.

SURVEY FACT SHEET

SAME-SEX RELATIONSHIPS

- 14% reported their families of origin were not supportive of their relationship
- 34% reported their families of origin were supportive
- 19% of those acknowledged by hospital staff as being in same-sex relationships reported that their partner was not welcomed as their support
 - 8% said inappropriate comments were made by staff because their partner was present
 - 34% reported that their partner was not kept informed about medical treatment
- 58% of respondents overall received supplementary health-care benefits through an employer but only 41% of these reported that coverage was extended to same-sex partners
- of those who reported having extended health-care plans through their places of employment, nearly 10% did not disclose a same-sex partner because they did not feel safe coming out at work

11.3 Health Care

24% of all survey participants had partners who had been hospitalized for illness or injury; 6% reported that they were excluded because they were not considered to be "immediate family."

My partner was initially denied off-hours visiting because they did not view her as a spouse. Straight spouses could visit any time. We complained to admin. (loudly) and were grudgingly given permission.

Concern was expressed that loved ones will be denied access during a health-care crisis.

If I was hit by a car and was dying I wonder if they would let my lover in to say good-bye.

And how would she be treated through and after my dying?

Even with legal backing, some anticipated their relationships would not be fully recognized in a time of crisis.

With the recent legislation I have legal access to my partner if he were to be hospitalized and can get his medical power of attorney to make medical decisions; but I know that I'll still meet hostility, resistance and discrimination in trying to be seen as his family.

The risk of being denied access to one's partner is heightened when members of a patient's family of origin (biological family) wish to exclude a same-sex spouse.

His parents refused to let me in. Made things very difficult. After a while the staff and doctors would sneak me in.

Even where same-sex couples are acknowledged, in 19% of cases the partner was not welcomed as support in the hospital, and 8% reported inappropriate comments from hospital staff. 36% reported that their partner was not kept informed about the treatment they were receiving.

The nurses weren't too bad but they weren't as respectful as they have been to a straight spouse and once or twice I was excluded when straight spouses were not.

[The hospital staff] would not speak to her [my partner] even though she sat at my side 10 a.m. to 8 p.m. every day until I could get up again.

My best friend and other close friends have died of AIDS. We were like family but not treated that way. I was there every day for 3 months looking after him until he went to a hospice and died. The hospital treatment was poor, awkward, and inadequate.

Hospital settings often provide little privacy for intimate moments with loved ones. Although touching, holding hands, and hugging are commonplace for heterosexual couples, these same behaviours expose same-sex couples to homophobic reactions from hospital staff.

My partner was in the hospital this year and although no one treated me with hostility, I felt uncomfortable extending her the level of support I would in private, because I was conscious of being watched.

The nurses were down the hall making jokes about the dykes in room 5 saying 'they're practically on top of each other' and 'I don't want to know what they are doing behind those curtains'.

Often participants allowed hospital staff to assume that a partner was a sibling or friend. *We have to lie and say we are sisters or [else] they make you wait in the waiting room [and] it is tough to get information out of them.*

Sometimes even hospital staff themselves advise patients to keep their sexual orientation a secret.

Identified [my] partner as same-sex lover, nurse wrote friend, saying doctor won't give good treatment [if aware of our relationship].

When hospital staff show sensitivity and acceptance towards lesbians, gays and bisexuals, it makes a profound difference in the quality of their experience.

Was treated with respect by all nursing staff. Evening after my surgery I was in intensive care unit. My partner called at 11:00 pm and was told my condition. My nurse then told me he had called to see how I was and that he loved me

Staff wonderful; allowed visits after visiting hours, [and] discusses his health with me as if we are a family; only problem was with department head who treated my talk with him with disdain.

Employer-provided health-care benefits are made available to employees, their spouse and dependent child(ren). 58% of survey participants overall received employee health-care benefits; of these, 41% reported that coverage is extended to same-sex partners. 8% of those living in a same-sex relationship indicated their partner's coverage played either a complete or partial role in theirs. Even where spousal benefits are available to those in same-sex couples, recipients pay tax on them, which is not the case for heterosexuals.

Lesbians and gays pay into these things at the same rate as heterosexuals, but at my company, [they] can only claim for themselves, while heterosexuals very often claim for a spouse. This is unfair.

In addition, employees' access to the benefits is compromised by homophobia in the workplace. Of those with extended health-care plans, 10% did not claim spousal benefits because they did not feel that it was safe to be out at work, and about 10% were not registered on their partner's plan for the same reason.

I would normally not request same sex benefits because of the discrimination involved.

In any case, equitable access to spousal health benefits is beneficial only for those lesbians, gays, and bisexuals who meet all of the eligibility standards for employer-provided insurance. These are based on the nuclear-family model: spouse and/or dependent child(ren). Partners who do not live together or who are not in longterm relationships are excluded; those who have more than one partner cannot extend coverage to even one of these. This discriminates not only against lesbians, gay men, and bisexuals but also against those heterosexuals who do not fit the narrow criteria for eligibility.

Rather than allowing individuals to determine the nature of their committed relationships, this outdated notion of a family unit restricts everyone's choices.

In general I don't believe health care [benefits] should be dependent on anyone's relationship with everyone else. These benefits should be available to all. Politically, I don't believe in pursuing spousal benefits. I don't think the state has any business in relationships. I don't think heterosexual marriage is a good model to emulate.

11.4 Lesbian, Gay, and Bisexual Parents

11.4.1 Special Features of this Group

There are many lesbian, gay, and bisexual parents: some had become parents in an earlier heterosexual marriage; some had stepped in when a sudden death in their family left children parentless; some had adopted; others chose to have children and bring them up alone.

Even in 1997, being a lesbian, gay, or bisexual parent can constitute an excuse for the label "unfit parent" and result in loss of custody and/or access to one's children. Although lesbian, gay, and bisexual families are more common and more visible than ever before, the view that parenting is the exclusive territory of heterosexual couples in a marriage sometimes prevails. Human-rights and legal battles have been won, but attitudes are slow to change.

Your questions do not relate to me though I have children ... I came out just before the first Canadian lesbian got custody and [I] was denied custody.

Homophobic attitudes equate lesbian, gay, and bisexual people with child abusers, although child abuse has been shown to be nearly exclusively heterosexual. A July 1994 American Academy of Pediatrics study showed that in a survey of 249 cases of child abuse, only two offenders were identified as gay. The counterbalancing fear is that children will see being lesbian, gay, or bisexual as a reasonable option and choose it.

Yet lesbian, gay, and bisexual parents are often viewed with suspicion. Many service-providers assume that it is impossible for lesbian, gay, and bisexual parents to provide a healthy environment for a child.

11.4.2 Profile of Parents

18% of survey participants were parents; 64% were women; 53% had some or all of their children living with them.

81% were parenting their own biological children; 15% were parenting the biological children of their partners. 6% had adopted children; 5% were parenting children who did not fall into the above categories.

68% of parents were in same-sex relationships; of these, 78% had been together for one year or more. 78% of those in relationships lived with their same-sex partner.

69% of parents described themselves as generally open about their sexual orientation; this is slightly under the rate of the sample overall. However, almost all the parents report that they have had to hide the fact that they are parenting with a same-sex partner. 14% had not disclosed their sexual orientation to their child(ren).

SURVEY FACT SHEET

LESBIAN, GAY, AND BISEXUAL PARENTS

- 18% of respondents overall were parents
 - 64% of these were women
 - 53% had some or all children living with them
- 87% of all parents were parents of their biological child(ren) and 15% were parenting a partner's biological child(ren)
- 6% of all parents had adopted child(ren)
- 89% of parents reported having had to hide the fact they are parenting with a same-sex partner
- 14% of all parents had not disclosed their sexual orientation to their child(ren)

11.4.3 Health Care and Social Services

Service-providers sometimes find lesbian, gay, and bisexual parents simply incomprehensible. *They always asked [where] the Amissus@ [was and] could not understand two men raising a male child.*

Heterosexism and homophobia on the part of service-providers affects the quality of service provided to parents who choose to disclose their sexual orientation. In fact, lesbian, gay, and bisexual parents often find their problems attributed to the fact that they are lesbian, gay, or bisexual.

When my daughter needed help, some CAS [Children's Aid Society] workers said her Aproblems@ stemmed from the fact that I was a lesbian.

One social worker put the responsibility for our daughter's anger on the fact that she has gay parents only.

The social workers felt because I was a recovering lesbian alcoholic (dry for a year at the time) that I could not be a suitable parent to my children. They felt that I was a sexually perverted person and could not be trusted with the care of my children.

Once a service-provider realizes that a parent is lesbian, gay, or bisexual, they may change their behaviour towards that parent of the child.

Counsellors expressed pity for my poor confused son ... my son's social workers felt I shouldn't live with my partner. His school counsellor felt it didn't matter, but advised me not to Acome out@ to his teachers. She was right! ... once his teachers found out I was gay, they seldom consulted with me again. They would only call if necessary and often did things without my consent. I feel that they Apitied@ my son after that and forever more treated him differently.

Most health-care and social-service workers assume that a parent is biological or adoptive. Same-sex couples find that non-biological parents are not treated equally. Same-sex couples must be constantly on watch to make sure that both parents' rights are respected.

Everywhere I go for service, I am listed as a single mother. Even when they express positive regard for me as a lesbian - they continue to leave out my partner. Since my partner is viewed as a parent only in the home, it is harder for my son to accept and respect her.

I was excluded in the interviews and decision-making meetings with social service because, as a lesbian step-parent, I have no legal or acknowledged rights.

Even if both parents are listed to be called in case of emergency, the child may still not have access to both parents because services will not consider both parents equally.

Hospital emergency did not recognize my partner as a parent for our daughter. I was treated badly because the hospital staff thought my partner was the biological parent.

Lesbian, gay, and bisexual people interested in becoming parents face many obstacles within health-care and social services. Many lesbians and bisexual women become pregnant through alternative insemination; this can make them reliant on a series of health-care professionals whose freedom from homophobia cannot be guaranteed.

I want to get pregnant. Every MD I have ever worked with has expressed discomfort whenever I broach the topic. I have no idea where I will find a very lesbian positive MD for this. It seems a problem even for my otherwise good MD.

Often clinics providing alternative insemination have policies biased against lesbian and bisexual women; some policies are biased against all women who have no male partners. In focus groups and individual consultations, women reported that "psychological" criteria were often enforced which disadvantaged or even disqualified lesbian or bisexual women. In one area, lesbians had sought until they found a psychologist who would administer the psychological tests in a way which did not disqualify them.

In donor insemination clinic treatment is assumed to be only [to] heterosexuals - intake forms leave space for husband's name, characteristic, and even a page for husband to assume father role and responsibility.

We applied to [a] university hospital ... for the insemination program and were told by the ethics committee we were not high on their priority list.

However, some participants reported positive experiences.

My doctor's first reaction when I came out to her was to ask if I was interested in having children. She went on to say that she could refer me to a couple of sperm banks when I was ready to have a baby (for I told her I was interested). I was very pleased that my doctor actually thought it was okay for lesbians to parent children.

11.5 Conclusion

Lesbians, gay men, and bisexuals must have their relationships treated with dignity and respect; they should be accorded the same rights and privileges as heterosexual couples. At the same time, those in non-traditional relationships should not be disadvantaged. The health-care and social-service systems have some way to go.

Children brought up in lesbian, gay and bisexual families show no significant difference from children brought up in heterosexual families - except that their families are treated inequitably and their access to their parents sometimes threatened by homophobia. With rigorous child-protection policies in place, there must be ample room for non-traditional families of all kinds.

12 Disability and Chronic Illness

12.1 Introduction

Lesbian, gay, and bisexual people with disabilities and/or chronic illness are often faced with the choice between services which are sensitive toward their medical condition and services which are respectful of their sexual orientation.

In general, people with disabilities are perceived as asexual. In addition to facing the prejudices of the able-bodied, lesbian, gay, or bisexual people with disabilities either go unrecognized as sexual beings or must come out and also contend with homophobia. (DisAbled Women's Network 1993; Doucette 1989; Anon. 1992) Often, they are seen as doubly disabled: physically/mentally and sexually.

Because I also have a disability I have made some doctors uncomfortable because first they have problems seeing me as a person because of my disability and secondly, I am not supposed to be sexual. Especially not with other women.

Lesbian, gay, or bisexual people with disabilities are often excluded from non-gay events and also from lesbian, gay, or bisexual community events. The lack of accessible public spaces is a problem in general and, on top of that, the number of positive environments accessible to lesbians, gays, and bisexuals is extremely limited. Without access they are isolated from environments which can affirm their sexual orientation.

Lesbian, gay or bisexual people acquiring a disability or chronic illness may face different obstacles. Contending with a health-care crisis or a debilitating condition may require some combination of extensive and frequent health-care or social-service support. They may be dealing with services in a manner entirely new for them. In better health, their need for such services was minimal; now they may be dependent on a system insensitive to lesbian, gay, and bisexual issues.

12.1.1 Special Features of this Group

This chapter covers survey data for those who reported having a disability or chronic illness (longer than 6 months duration); people who fell into these categories were asked to self-identify.

Although the data combine the experiences of those who are visibly and invisibly disabled or ill, the degree of visibility of a disability or illness affects the responses of health-care and social-service providers. When people are confronted with a visible disability or illness, any prejudice they hold will surface. Service-providers must become aware of the extent to which knowledge of a disability or illness, visible or not, affects them, so that they can plan and provide appropriate response and good treatment.

People with lifelong or longer term disabilities and illnesses have much experience with inaccessibility and discrimination; although their backlog of frustration is greater, they are likely to have developed strategies for coping. People facing more recent disabilities or illnesses may be struggling to adjust to a different health status; it can be a dramatic transition.

The data concerning people with disabilities include and are heavily influenced by the experiences of those who are HIV-positive. Of the 141 men who reported having a disability, 50% are HIV-positive; therefore, statistics presented in this chapter are divided by gender.

The Project Affirmation focus group for lesbian, gay, and bisexual people with disabilities was poorly attended. Participants agreed that low attendance epitomized some of the issues facing lesbian, gay, and bisexual disabled people. First, they feel alienated from lesbian, gay, or bisexual organizations. In addition, people with disabilities live in a world that sees them as sexless or just possibly heterosexual. Group participants felt that lesbian, gay, and bisexual people internalize this oppression, and find it difficult to be public about their orientation, even at an event like this. Focus group members also pointed out that information about lesbian, gay, or bisexual events is often not circulated to or within inpatient facilities or residences and organizations for people with disabilities.

The necessity of using Wheel Trans (a Toronto transit system for disabled people) also poses a risk, since Wheel Trans drivers or users may know that the destination is to a lesbian, gay, or bisexual venue.

12.1.2 Profile

20% of survey participants (men and women alike) overall reported disabilities or chronic illnesses. Disabilities reported affected eyesight, hearing, speech, mobility, energy levels, and mental health.

54% of the group (men and women alike) reported that their disability or illness affected their mental and emotional states. Energy levels were reduced by disability for 59% of men and 42% of women. Mobility was affected for 53% of the women and 23% of the men.

70% of survey participants overall were employed, while only 50% of women and 43% of men with disabilities or illnesses were employed. Not surprisingly, people with disabilities or illnesses were almost twice as likely as survey participants overall to be receiving some form of social assistance. 24% of survey participants overall reported that they received social assistance, while 79% of men and over 63% of women with disabilities or illnesses reported that they were receiving social assistance. This is consistent with the links noted between disability, barriers to education, and unemployment noted for people with disabilities as a whole (Statistics Canada 1990; Riddington 1989).

28% of all survey participants and 42% of men and 38% of women with disabilities or illnesses reported that their highest level of education was high school.

Of women with disabilities, 33% reported that they were not in relationships, compared with 25% of women overall. However, men with disabilities or illnesses reported close to the same level of being in relationships as did men overall.

12.2 Health Care and Social Services

People with disabilities or chronic illness can have frequent contact with health-care and social services. There is considerable overlap, particularly in the case of social services that are delivered in a hospital context. Because of this both systems are combined in this section.

58% of men and 45% of women with disabilities or longterm illnesses reported that they saw a doctor once a month or more, compared with 16% of participants overall. Homophobic service-providers, even if their technical service is of high quality, offer an environment of discomfort and stress.

I go to a hydrotherapy pool for physiotherapy. I've been going 2-3 times a week for almost two years. On my first visit the staff were all watching a talk show with some gay men on it. They were all making retching noises and talking about how disgusting gays are. So I've never come out to them. Since I spend so much time there I find it very stressful. They are all friendly and chat to me lots and its hard to always watch what I say ... The one man who worked there (the rest are women) won't speak to me, won't even say hello back to me when we are the only two in the room. He is very talkative to everyone else. I think my hairy legs have given me away - or maybe it was the Aread my lips@ dyke t-shirt I wore by accident one day. When I realized I had it on, I was afraid to walk into the physiotherapy area. It makes me mad at myself as I'm not generally this cowardly ... [but] I can't forget the way they acted my first day there.

In this survey, 67% of women with disabilities reported that they did not come out to health-care providers because they believed this would negatively affect the way they were treated. 59% of women overall indicated they did not come out for these reasons. The data demonstrate this point with respect to women most clearly. The figure for men was much higher. This may be because the situation for HIV-positive men is not typical of people with disabilities or long-term illnesses in general.

Service-providers who make home visits may come across artwork, books, photographs, etc. with lesbian, gay, or bisexual themes. They also see same-sex relationships in their home environment. A pleasant reaction cannot be counted on.

I went through a number of homemakers (Red Cross support workers) before one stayed for more than one visit. Some seemed very uncomfortable with the pride day posters and stuff I had around. But I don't know if it was because I'm a dyke that they didn't come back or not. I always felt very nervous when new workers were assigned. I sometimes Astraightened@ up the house.

When I was completely disabled (about 1 year) the home care worker seemed challenged by my being lesbian, but was thorough all the same. I am sure that my status as university professor was/is influential.

Disabilities or illnesses may necessitate dependence on services. Those using specialized transportation services become like a small community, but getting transportation to locales known or perceived to be lesbian-, gay-, or bisexual-positive may expose a consumer to the homophobic attitudes of drivers or other service users.

I was being picked up (by Wheel Trans) at Buddies (a gay bar) and the driver said "this is a very strange place." I asked why, and he said, "there are guys dressed in leather, holding hands. Is this a gay bar?" I said, "Yeah, and if you have any questions to ask, ask." He said he didn't, but later I know that he talked to other people about me.

In situations where there are few physically accessible services (doctors, dentists, counselling services etc.), consumers do not have the option of going elsewhere once they have received negative treatment or had their confidentiality compromised. It is difficult enough for many physically able lesbian, gay, and bisexual people to find the courage to attend lesbian, gay, or bisexual events or seek out information. Bringing an attendant or relying on a transportation service can add another obstacle or risk.

There is a lack of positive lesbian, gay, or bisexual information openly available at services for people with disabilities or chronic illnesses. This forces them to come out just to get information. It requires that they educate staff and other service users, if receptive, in order to change things.

I was in a ten week chronic pain group at the local hospital. I was out to the group leader but not the other patients. They had a few group discussions about sex and the rest of the group acted so immaturely I didn't want to risk ruining the group for myself by coming out. They had a sex video (straight of course) and a sex manual that was very straight as well. I asked for the lesbian and gay version and the group leader was very apologetic and embarrassed and just told me to take the straight one and ignore the pictures. I did two weeks of research on my own checking the local gay library, university and city libraries, phoning AIDS groups and lesbian and gay health groups in Toronto even. I couldn't find any gay info for disabled people and only a tiny bit of lesbian. I eventually came out in the group and everyone just ignored it. Which I guess is better than being treated negatively.

Difficulty finding appropriate services drives many lesbian, gay, or bisexual people with disabilities or a chronic illness to pay for private service if they can.

It is difficult/impossible to find free lesbian and gay positive help. I pay for my own and my disability pension will not regard it as an "expense" because I theoretically have access to free help at the hospital and clinics I previously tried. I spend more on medical care than I do on housing and food.

48% of those with disabilities or illnesses report that they are unable to pay for counselling or therapy.

12.3 Conclusion

Lesbian, gay, and bisexual people with disabilities or chronic illnesses experience all the prejudice and accessibility problems faced by heterosexuals with disabilities or chronic illnesses. If they come out, they also risk being confronted with the homophobia and heterosexism faced by other lesbians, gays, and bisexuals. They are particularly vulnerable when using services such as attendant care, home visits, or special transportation.

Much more must be done by all service-providers and the lesbian, gay, and bisexual communities to remove barriers, change attitudes, and empower lesbian, gay, and bisexual people with disabilities or chronic illnesses to take control of their lives and express their sexuality as they wish.

13 HIV/AIDS

13.1 Introduction

HIV/AIDS, its close link with gay men, and erroneous assumptions about HIV/AIDS all have a dramatic effect on general attitudes affecting lesbians, gay men, and bisexuals. The blending of the prejudices against homosexuality and against AIDS makes it difficult to know whether homophobia or fear of AIDS is the critical element in any negative experience at the hands of service-providers. Relevant anti-oppression strategies must always be sensitive to the dynamics of both forms of discrimination.

HIV and AIDS have, necessarily, become a rallying point for lesbian, gay, and bisexual activists. HIV/AIDS-related issues are, of course, key considerations, but people living with HIV/AIDS have many important health-care and social-service concerns beyond HIV/AIDS (Canadian AIDS Society 1991).

Project Affirmation did not conduct a survey of services for people with HIV/AIDS but rather focussed on the experiences of HIV-positive people using general health-care and social services.

13.1.1 Profile

The information presented in this chapter was provided by the 96 HIV-positive survey participants, as well as by HIV-positive gay and bisexual men who attended a focus group arranged through the Peterborough AIDS Resource Network, participants at public forums held across the province, and those at other Project Affirmation events.

8% of male survey participants were HIV-positive, and 46% of these reported that they had experienced discrimination because of their HIV status. Only three women reported that they were HIV-positive; one reported discrimination because of it.

In the survey overall, 6% of the men reported having a partner who has AIDS. Three women reported having a partner with AIDS. 11% of all HIV-positive survey participants reported that they are living with a partner who has AIDS.

Because so few HIV-positive survey participants were women, there was insufficient information to make substantial findings concerning lesbian and bisexual HIV-positive women. Other research exists on this topic (Stephens 1993).

HIV-positive survey participants tended to have lower incomes than the sample overall. 45% made less than \$20,000 per year, compared with 36% of survey participants overall. HIV-positive survey participants were also less likely to have full-time employment, and were less likely to be covered by an employee health-benefits package. They were almost three times as likely to be receiving some form of social assistance.

Lower income and lack of extended health insurance has serious consequences for the health-care and social-service access of people living with HIV. 33% of HIV-positive survey participants said that they didn't have the money to buy medication, as opposed to 14% overall.

HIV-positive respondents visit health-care providers much more frequently than do survey participants overall. 69% see their primary-care physician monthly or more frequently, while only about 16% overall see their doctor this often. Similarly, 54% of HIV-positive survey participants see other doctors (specialists, etc.) every month or more, while only 17% overall see other doctors this frequently.

The HIV-positive people were more likely to disclose their sexual orientation to their health-care providers. Almost all (95%) of the HIV-positive survey participants had disclosed their sexual orientation to their regular doctor, in contrast to 74% overall. Similarly, HIV-positive survey participants were almost four times more likely than survey participants overall to have disclosed their sexual orientation to hospital staff. (Service-providers may be aware of an HIV-positive client's sexual orientation even though it has not been directly discussed; also, HIV-positive men are often presumed to be gay or bisexual.)

While most survey participants found it important that their regular doctor be comfortable acknowledging their sexual orientation, HIV-positive survey participants were more likely to believe that it is important that the full range of health-care providers be comfortable acknowledging their sexual orientation.

13.2 Health Care

13.2.1 HIV-Phobia and Health Care

Service-providers who lack accurate information about the risks of HIV transmission seriously compromise the quality of patient care (Henry, Campbell, & Willenbring 1990). Survey participants reported unnecessary delays or denial of treatment because health-care staff were poorly informed about HIV transmission.

There was an AIDS patient on our floor and the nurses didn't want to work with the patient until they had plastic aprons and protective eyewear because they were afraid they would get AIDS. He had a chest tube after surgery but it had stopped draining and there was little chance of contamination if gloves had been worn.

The use of excessive precautions against HIV transmission suggests that a fear of homosexuality or HIV/AIDS can guide the behaviour of health-care professionals. Unnecessary gowning, gloving, and masking in order to treat ailments where HIV transmission is impossible (a minor ankle injury, in one reported instance) serves to single people out and humiliate them.

It is certainly true that some medical personnel require more information concerning HIV transmission (D'Augelli 1989), but even where adequate information is available, unfounded fear can be a thin veneer for discrimination against HIV-positive lesbian, gay, and bisexual people.

I've had a nurse refuse to draw my blood while hospitalized. She was openly treating HIV/AIDS patients very anti-gay

13.2.2 Doctors

53% of HIV-positive survey participants reported that, fearing a negative reception, they visited more than one doctor to find a physician who is comfortable with both HIV-positive and lesbian, gay, and bisexual patients; 28% reported that they travel outside the area in which they live for the same reason.

Generally, HIV-positive survey participants reported good relationships with their doctors. Physicians with large numbers of HIV-positive patients may be more sensitive to both lesbian, gay, and bisexual people and HIV-related concerns. For example, 34% of the HIV-positive survey participants report that their doctor asked if they wanted their same-sex partner included in treatment decisions. Only 15% of HIV-negative survey participants reported the same. Similarly, at 27%, HIV-positive survey participants were more than twice as likely to be asked if they wanted their same-sex partner to be present in hospital with them.

In fact, doctors appeared to base their decision to raise sex-related topics on the sexual orientation rather than on the sexual practices of their client (Canadian AIDS Society 1991). Survey results suggest that doctors are strongly influenced by a patient's sexual orientation in their decision to discuss safer sex practices. One can only speculate how often heterosexuals are asked or advised about safe sex.

Of the HIV-positive people in this survey who are out to their doctor, 81% were asked if they practised safer sex. This was the case for less than 45% of the others. Of those whose doctors knew their sexual orientation, 44% were offered information about safer sex, whereas only 25% of the others were offered that information.

Many focus group survey participants felt that a "gay equals AIDS" mentality led service-providers to assume that they were HIV-positive. There was no effort to establish whether they had engaged in activities associated with HIV transmission. For men, the very fact of being gay or bisexual was automatically associated with being HIV-positive.

My new family doctor thought the reason I was losing weight was because I was gay. They do HIV testing every time I see them.

The assumption that the health complaints of gay and bisexual men are necessarily related to HIV can result in incorrect diagnosis and dangerous delays while the real cause of a health problem goes undiscovered.

In August 1993, my partner developed an acute infection of his sinuses. He has suffered from this chronic sinusitis for years and knows his condition very well. In this particular occasion he became very sick with very elevated temperature ... So we decided to go to the emergency ... in Toronto. Big mistake. My partner was seen and examined and blood work was done. Blood work revealed an elevated white blood cell count because of the sinus infection. However the attending physicians and clerks would not listen to his history of chronic sinusitis and instead arrived at a working diagnosis of AIDS-related infection. We told them that we were both HIV-negative but yet they led my partner to believe that they were not ruling out AIDS. Again they failed to listen to us and examine his sinuses for blockage and infection. We felt discriminated against because we were gay. They immediately assumed we were at risk for HIV ... we left the hospital after 8 hours totally frustrated, used and discriminated against.

13.2.3 Other Health-Care Providers

Many HIV-positive consumers feel that, outside an inner core of well informed HIV professionals, respect and concern for HIV issues as they apply to lesbian, gay, and bisexual people diminishes.

Living in downtown Toronto and knowing where and how to look for what I need is helpful. Once outside that carefully chosen circle of health-care providers (eg. in a hospital or clinical setting) there are still plenty of ill-prepared or uncaring people ... if this is true here in the centre of the city what must conditions be like in more remote areas?

In the bigger city hospital the fact that the nurses didn't seem uncomfortable with my illness made me feel much more secure about the quality of care.

In a focus group of 54 HIV-positive people served by a fairly large urban centre, all decided to commute the 12 hours to Toronto in order to receive specialized health care - despite the fact that some of these services were available in their home town. Their reason

... not dealing with the bull shit.

Of course, as a solution this only works for those in good health, with the necessary means.

I never had trouble when I was hospitalized in the city I used to live in but since I have moved to a much smaller community I have experienced a lot of discrimination from hospital employees due to their ignorance.

People living in rural areas often cannot find appropriate service locally. Either they try to survive without the care they require, make do with generic services which really do not fit their needs, or travel elsewhere for help.

There are very few support groups (if any) in my area I live in. I was in one for about 2 years but all the other [group members=] partners died and the group finished.

13.2.4 Hospitals

HIV-positive lesbian, gay, and bisexual survey participants reported more problems with hospitals than participants overall: they reported inappropriate comments concerning their sexual orientation at almost three times the rate. They were more than twice as likely to believe that they were given poor treatment in hospital because they are lesbian, gay, or bisexual.

In hospitals, patients have little control over the service professionals they see. This puts HIV-positive lesbian, gay, and bisexual patients in contact with people who are committed neither to people living with AIDS nor to lesbian, gay, and bisexual issues.

Having worked in a hospital for over five years (although five years ago) ... I have experienced first hand the ~~A~~lower@ treatment standards used on patients who were known to be gay ... I was particularly appalled by the treatment of patients in the hospital with HIV/AIDS-related illnesses. Even ~~A~~educated@ health-care ~~A~~professionals@ seemed totally ignorant of gay issues and concerns and insensitive to these patients in particular ... from this experience and these ongoing observations, I personally have never divulged personal identity information to any health/social care person.

Friends or family or co-workers would be present in the room and nurses would openly discuss my health issues or question me about personal issues in their presence. What ever happened to diplomacy and confidentiality? ... respect for privacy was not present in this hospital. Not all HIV/AIDS patients reveal their status to all family/friends/coworkers.

13.3 Social Services

13.3.1 Services

82% of this group have been in counselling or therapy at some point in their lives. HIV-positive survey participants used social services more than participants overall. Over 50% attended the most commonly used services, generic counselling and therapy (56%) and lesbian and gay services (55%). This was true for less than 50% of the sample overall. Public-health nurses, welfare, and Family Benefit Assistance services were used less by HIV-positive survey participants but still at almost twice the rate of the sample overall.

Often, generic services are not aware that many service-users as well as staff harbour fear and anger towards lesbian, gay, and bisexual people in general and people with AIDS specifically.

I feel very threatened and unsafe in the metro housing building I live in. I have had anti-gay comments made at me, I have had letters mailed to me saying AIDS is god's vengeance. Once on the elevator I had someone ask me if I was queer. Then he told me he ~~A~~killed a queer once.@ I asked for a transfer and have been denied. I was told that the person in the elevator didn't say he was going to kill me therefore it wasn't a threat.

35% of HIV-positive respondents had had negative experiences at welfare services, compared with 24% of respondents overall. 30% of HIV-positive respondents reported difficulties with family benefit services.

The most upsetting experience [I had] had to do with family benefits. When I first had to go for assistance because I could no longer work I felt I got poor service. I believe that I received minimum welfare benefits because I'm gay.

Department of Public Health nurses provided problems for 10% and generic counselling services for 7%. Lesbian and gay services fared better, presenting problems for less than 2% of the HIV-positive survey participants who used them.

13.3.2 Service-Providers

82% of the HIV-positive survey participants had seen a counsellor or therapist, compared with 77% of participants overall.

84% of this group reported that their counsellor or therapist understood and dealt respectfully with them as a lesbian, gay, or bisexual person. When lack of understanding and respect were reported, religious leaders were cited by 42%, psychiatrists by 23%, and medical doctors by 18% as the most common offenders.

My MD made negative homophobic comments about anal sex and my choice to or not to engage in it.

The psychiatrist made it clear up front that he could not understand gay people or gay behaviours. He disagreed with me and was sickened by those who had relations with men and women ... he was not rude or nasty, just clearly stated his opinions.

Volunteers were cited as disrespectful by 8%, psychologists also by 8%, and social workers by about 5%.

Half of the HIV-positive group indicated that mental-health professionals need more knowledge and sensitivity toward lesbian, gay, and bisexual issues.

13.3.3 Issues

64% of this group identified themselves as living with AIDS and 69% of those saw a counsellor or therapist. Just under 60% of this group struggled with coming out and 35% of these went into counselling or therapy. 55% identified loneliness and isolation as a problem with 51% of that number entering counselling or therapy. 49% had problems with self-esteem and nearly 58% of them saw a counsellor or therapist. Addiction was an issue for 30% and 48% of these sought help.

42% lacked the money to pay for needed services; 16% found waiting lists too long; 11% didn't know where to find services; and 9% reported lesbian, gay, or bisexual services unavailable.

13.4 Conclusion

Findings for this group underline the need for more education and understanding about AIDS in particular and lesbian, gay, and bisexual issues generally. With this group, as with others, it is not always clear which prejudice among many is responsible for the inadequate response from health-care and social-service systems.

Reminders of mortality frighten most people. HIV-positive status inspires that fear not only in heterosexual people but also in lesbian, gay, and bisexual people. This group is therefore especially vulnerable.

14 Violence

14.1 Introduction

This is not an analysis of violence in lesbian, gay, and bisexual communities. The work of Project Affirmation was aimed at general health-care and social-service delivery but there are obvious links between violence and lesbian, gay, and bisexual mental-health issues. Information included here was garnered from answers to specific items on the project survey. In addition, information was culled from meetings, and from the project=s conference session on violence.

14.1.1 Profile

Of the sample overall, 22% (270 people) reported that they had been physically assaulted; of this group, 26% were women, 73% men.

People who have been assaulted represent a cross-sampling of survey participants overall. Most were open about their sexual orientation and, even if not out, reported they were proud to be lesbian, gay, or bisexual people; 71% felt safe in their community and 76% in their workplace. Almost all had completed high school and many had gone on to higher learning. 66% were employed, 13% were students. Their income distribution was the same as the total sample, and 56% were covered by an employee health-care benefit package. Most were sexually active; 60% are in same-sex relationships and in 64% of these relationships the partners live together. Almost all enjoyed good health. Nothing marked them as different from most people - except that they were the targets of assault.

14.2 The Issue

Antagonism towards lesbians, gays, and bisexuals begins early in life. "Fag" and "dyke" may be the most common and least understood insults shrieked across the schoolyard - by children as early as grade one or two. Anti-gay and anti-lesbian humour and graffiti are symbolic assaults that affirm anyone with an inclination to violence and give a clear message that it's OK to hate. 21% of respondents overall and 94% of the group reporting assaults had been subjected to verbal abuse.

Assaults by one or more strangers account for almost 62% of the reports. 9% were assaulted by a classmate, some were attacked by acquaintances, and a few by family members. Co-workers, friends, and partners were at the bottom of the list of attackers. Men constituted 80% of attackers.

Only 26% reported attacks to the police.

14.3 Stories

The following comments were responses to the question "Please say more about what happened when you were physically assaulted."

I was in a café with a straight female friend. A man in a police uniform was staring at us and walking back and forth past our table for about twenty minutes. We were talking leaning forward in hushed tones for privacy. As we got ready to leave, the man knocked over a chair in our direction and began screaming obscenities at us, calling us "dykes," "queer," "women fuckers," and dared us to call the police on him. We were the only women in the café. The other patrons did nothing.

My brother is an abuser under the impression that anyone weaker than him can be his victim - his wife because she's a woman, our father because he's passive and elderly, and me because I'm a lesbian. I chose to move away from Southern Ontario to remove myself from the stress. My ex-husband sexually assaulted me when I came out to him in hopes it would "cure" me.

I was kissed by a physician and felt up by him when in for an appointment for a bladder infection. Good news - suspended license for 2 months - counselling for sex offenders required for him.

As a teenager - my mother read my diary, and letters from a girl friend, and then beat me, saying she was "knocking sense into me." [&]

I came out of gay bar with 3 friends and gang of mixed straights followed us up the street shouting foul language then started pushing and kicking us. We didn't want to fight back but a friend who looked very dyke was picked on so we had to retaliate. [&]

He encouraged my sexuality as long as he thought I might have sex with him and his girlfriend. When after a year, he realized it wasn't going to happen, he started treating me like dirt. He also didn't like the very close friendship between his girlfriend and I.

Eventually he accused us of having an affair, and accused me of pursuing her, and although I know he didn't really believe this, he used it as an excuse to push me into a corner, and pin me there while he made several threats. Physical and emotional. [&]

Three co-workers came to my place of residence and threatened to cause harm to me.

One of these workers then shoved me at work and said, "That I won't live long."

I was assaulted by four skinhead women while waiting for a bus at Wellesley and Parliament. The police did not even take a report.

My partner and I left a women's bar and we were standing waiting for a bus. A car pulled up ... two women got out ... passed us and came back behind us. Hit us on the back of head ... I fell and was kicked in the ribs ... lost two front teeth. My partner was unconscious for a couple of minutes and brought around by an older woman who saw us on the sidewalk. [&]

I was 15 yrs. old and told my best friend that I was gay. His reaction was to punch me in the face, then kick me out of his house. After which I tried to commit suicide.

My brother is concerned with his own orientation and upon discovering my homosexuality became more concerned, forceful and abusive. He broke my arm when I was 12 and

beat me badly enough that I was in hospital for 2 weeks. He is seven years older, and has been abusing me for four years. [&]

These comments reveal something of the complexity of trying to come to grips with violent assault. It can happen anywhere, from almost any source, and can take many forms.

14.4 System Responses

One survey question asked specifically whether assault(s) had been reported. Then, open-ended questions allowed people to say more about why they did or did not report, and the results and treatment they received if they did report assaults.

City police tend to do nothing unless you need an ambulance or a meat wagon. Past experience has reinforced this for me.

I was too embarrassed to report. Police would know it was gay-bashing.

Two officers came to take a report, 1 male 1 female, they were not rude but not sympathetic either. I believe that report went into the garbage when they went back to the station although I don't know this as a fact I certainly felt they were not concerned about it.

I didn't even have the self-confidence to report this to my teachers at the time.

I didn't report it because at the time I was a strong believing pacifist. I felt that recrimination would serve no purpose in the greater scheme of things.

At that time I thought, what was the use. All the people on the street never attempted to help. Why would the police.

I was afraid to report to police because this is a rural area and I do know the police work is confidential but I do know most of the police force. Fear.

I called the RAPE assault line and was told: 'To get off the line, pervert, men don't get raped.' At the Emergency 2 days later the attending doctors also said 'Amen don't get raped' and claimed that I was experimenting [with a] homosexual act and the bleeding should stop on its own.

People did not tell stories of the good experiences they had when turning to the police for help. Although there must be some such stories, there are (as indicated above) just too many examples of the ways in which lesbian, gay, and bisexual people are unsupported to conclude automatically that it is safe to turn to the system for protection.

14.5 Conclusion

Violence can occur anywhere and anytime. Proceedings from Project Affirmation research (a workshop on violence, findings from the survey) clearly show the need for greater understanding of violence and its causes. Only when this need is met is it possible to develop effective strategies for prevention.

Among the data collected in this survey, reports of abuse in same-sex relationships were negligible, but it does occur. The New York City Gay and Lesbian Anti-Violence Project reported that 12-15% of agency contacts were to do with violence in same-sex relationships. (Island & Letellier 1991)

Lesbian/bisexual women who have been raped or sexually assaulted face the myths about rape faced by all women who have been assaulted ('She wanted it,' 'She asked for it,' 'She enjoyed it') plus a few more specific ones ('All lesbians want/need really is a man,' 'She deserved it because she refuses to be normal').

Sexual assault of males by other males, even if reported, provides some unique problems. Health-care and social-service professionals are usually unprepared to deal with it and prefer to dismiss it, sometimes with the myths that men cannot be raped or that men enjoy anything sexual (consensual or otherwise). Bohn (1984) found that of all reported male rapes, 'most are committed by heterosexual men against gay men or youth'; he found it the 'ultimate expression of negating the [gay man's] masculinity' - reducing them presumably to the level of women.

Any violence - sexual or otherwise - reduces people to the status of objects; it denies them their humanity. Experiencing violence reinforces the perception that one is powerless or without rights. In our culture there is much imagery to suggest or support the idea that lesbian, gay, or bisexual people are less important or less real than other people. Endorsing even mild forms of homophobic humour makes

violence more thinkable, reduces the chance that victims of violence will seek help, and undermines the provision of helping services in this area.

Anyone who has been the target of violence needs physical and emotional support. Lesbians, gays, bisexuals, and transgendered people justifiably fear that seeking help will force them to come out and may result in a display of prejudice on the part of the service-provider.

15 Health-Care and Social-Service Delivery

The four surveys (on educational institutions, professional associations, service-providers, and positive steps) presented in this chapter are the result of a research initiative undertaken by two university students who completed a practicum with Project Affirmation.

They reveal a certain amount of support for the principle of equitable and inclusive care, but also clearly indicate that the beliefs and attitudes of administrators, educators, bureaucrats, and frontline personnel often exclude lesbian, gay, and bisexual people. Institutional structures often have not established equity and inclusion for lesbian, gay, and bisexual clients.

15.1 Educational Institutions

15.1.1 Introduction

Post-secondary institutions with departments in the areas of medicine, nursing, psychiatry, psychology, social work, and social-service work were surveyed in order to ascertain the extent to which they included the lesbian, gay, and bisexual communities in their curriculum and practice.

To provide adequate service, professionals must demonstrate sensitivity and awareness of the similarities as well as the differences between the lives of lesbians, gay men, bisexuals, and heterosexuals. They must also consider the unique health-care and social-service needs of lesbian, gay, and bisexual people.

15.1.2 Methodology

Educational institutions were divided into nine areas according to the Ontario Ministry of Health's regional health-unit breakdown of the province. The survey was then applied to a random sample: one university and one college program in each region serviced by more than one university and one college. In smaller regions all educational institutions were contacted. In all, 51 educational institutions were contacted by mail and asked to respond to a brief telephone survey.

15.1.3 Survey Format

The survey investigated three areas: curriculum, resource materials, and practice experience. The aim was to ascertain inclusivity, sensitivity, and exposure to lesbian, gay, and bisexual issues as well as the development of policies, practices, and guidelines. Participants were asked about their departments= plans for constructing or expanding relevant curriculum, resource materials, and practice opportunities.

In addition, participants were asked if their departments had considered or would consider looking to the lesbian, gay, and bisexual communities for assistance in developing their knowledge/resource base.

POST-SECONDARY EDUCATIONAL INSTITUTIONS TRAINING HEALTH-CARE AND SOCIAL-SERVICE PROFESSIONALS

*Based on 25 responses from departments/faculties of medicine,
nursing, psychiatry, psychology, social work, and social services.*

Current Curriculum

Specific reference in curriculum to health-care/social-service needs of lesbians, gays, and bisexuals	20
Comprehensive development of sources on lesbian, gay, and bisexual issues	3
Minimal inclusion of case examples, at discretion of faculty	17
No specific or formal reference	5

Future Expansion of Curriculum

	Yes	No
Expansion of curriculum in future to include health-care and social-service needs of lesbians, gays and bisexuals	7	18

Reasons for not expanding

- issues already addressed in curriculum	8
- budgetary constraints	7
- no explanation or statement that lesbian, gay, and bisexual issues are included within "minority issues" concerns	3

Availability of Lesbian, Gay, Bisexual Reference Materials

	Yes	No
Currently have resources such as texts, journals, journal articles, audio-visual materials	21	4
Future expansion of these resources	17	7

Guidelines, Policies or Standards of Practice

Specific reference to health-care or social-service needs of lesbians, gays, and bisexuals	
- all students would have to be comfortable working with all clients	25
- students expected to adhere to professional policies and practice guidelines of respective professional associations	25

Practica/Practice Experience

- no way to guarantee exposure to any identifiable target groups	25
- if specifically lesbian, gay, and/or bisexual placements were made available, students indicating interest in such placements would be so placed	25

15.1.4 Results

A number of the appropriate participants (in this case, department heads) were hard to contact, since most departments were conducting a curriculum review caused by new funding limitations. Interviews were completed by 50% of those contacted (25 surveys completed).

15.1.5 Inclusive Curricula

Of the 25 survey participants, 20 said that their departments did make specific reference in their curriculum to the health-care and/or social-service needs of lesbian, gay, and bisexual people. However, the extent of these references varied widely. Three departments described comprehensive courses on lesbian, gay, bisexual issues, while others indicated minimal inclusion of case examples within various courses, left to the discretion of faculty. The remaining 5 reported no inclusion, though they stressed it was possible for case examples to be raised by faculty or students.

As to future expansion of curriculum to include lesbian, gay, and bisexual people, 18 answered *No* and 7 answered *Yes*. Of the negative responses, 8 participants claimed that issues were already addressed, 7 claimed budgetary constraints preventing expansion, and 3 either gave no explanation or cited inclusion in *A minority issue* concerns.

15.1.6 Reference Materials

When departments were asked whether lesbian, gay, and bisexual reference materials (texts, journals, journal articles, and audiovisual materials) were available, 21 answered *Yes* while four answered *No*. Of those who answered *Yes*, some had extensive resources, some share resource materials, and some make students aware of the lesbian, gay, bisexual student groups on campus and in the community. One participant reported that class texts provide all the necessary reference material. Of the four negative replies, two claimed that the institution's library might have resource materials, one felt it was the responsibility of the student, and another indicated that lesbian, gay, and bisexual issues were not *A segmented out for special consideration*.

Seventeen participants indicated that they would not be expanding their resource base (three participants cited lack of money), while seven participants said they would expand at some point in the future.

15.1.7 Guidelines, Policies, and Standards of Practice

The survey asked about guidelines, policies, or standards of practice with specific reference to lesbian, gay, and bisexual people. All participants indicated that students would have to be comfortable working with all clients, and that students are expected to adhere to the professional policies and practice guidelines articulated by their respective professional associations. Two participants indicated that students who could not work with lesbian, gay, and bisexual clients would be removed from the department; one participant identified a set of faculty guidelines that made specific reference to lesbian, gay, and bisexual people.

15.1.8 Practica/Practice Experience

The survey asked about whether faculty helped provide students with practice experience related to issues pertaining to lesbian, gay, and bisexual clients. All participants indicated there was no way of guaranteeing exposure to any identifiable target group. Attempts were made to ensure that, if a student had indicated an interest in specifically lesbian, gay and/or bisexual placement, and such a placement were available, the student would be so placed. In some nursing and medical schools, group-learning methods ensured that students could learn from the placement experiences of others, even though they were not themselves directly exposed to lesbian, gay or bisexual issues. All participants indicated that placements at AIDS hospices or at hospitals treating people with AIDS provided an opportunity of discussing issues of sexual orientation. One participant added that lesbian health issues are not yet as visible and felt that, through HIV/AIDS, gay male health issues are more thoroughly explored.

15.1.9 Lesbian, Gay, and Bisexual Community Input

Finally, participants were asked whether they had looked or would consider looking to the lesbian, gay, and bisexual communities for assistance in developing their knowledge/resource base. Sixteen indicated that either they had or would, while eight stated that they would not, primarily because there were no resources in the immediate community. Asked whether they would be interested in Project Affirmation's findings, all participants replied *Yes*.

15.1.10 Discussion

The majority of survey participants said they were aware of the existence of lesbian, gay, and bisexual people as recipients of health-care and social services. Few departments had translated this awareness into knowledge that could be applied to developing curriculum and resources. There were striking exceptions: some departments offered courses on lesbian and gay sexuality or included lesbian, gay, and bisexual populations within minority discourse. Generally though, neither current nor future plans gave a high priority to curriculum and resource development in this area.

For those including lesbian, gay, and bisexual issues in the curriculum, development of resource materials and placement opportunities appeared consistent with the level of inclusion. Those departments weakest in curriculum development had fewest resource materials and placement opportunities; they also tended towards a generalist approach which tended not to differentiate between the needs of different groups; and sometimes it was indicated that, before the department would act, a student or faculty member needed to come forward and lead a fight against lesbian, gay, and bisexual exclusion.

It appears that, the more isolated the educational institution is from a vibrant lesbian, gay, and bisexual community (on campus or nearby), the less likelihood there is of interaction with or concern about lesbian, gay, and bisexual resources. Lack of direct exposure hampers most departments in providing inclusive educational opportunities to their students. Apart from AIDS issues, many participants did not know of any lesbian, gay, and bisexual health-care and social-service needs.

15.1.11 Conclusion

While there is some evidence of willingness to incorporate a positive approach to lesbian, gay, and bisexual issues, little is actually being initiated. In fact, the onus is placed on lesbian, gay, and bisexual people to promote their own interests. This is an inexcusable demonstration of irresponsibility on the part of institutions whose task is to prepare people for careers in human services. These systems must do more to understand, educate about, and attend to the concerns and needs of lesbian, gay, and bisexual service-providers and service-users.

15.2 Professional Associations

15.2.1 Introduction

This report examines how professional associations contribute to constructing a framework of ethics and practice for medical practitioners, nurses, psychologists, social workers, and social-service workers to use in serving lesbian, gay, and bisexual people.

15.2.2 Methodology

The survey covered only associations administering to entire professions as opposed to associations of specialization within professions. Five professional associations were surveyed with respect to their codes of ethics, policies, standards of practice, and guidelines, as well as any specific recommendations pertaining to lesbian, gay, and bisexual people:

- the Ontario Medical Association (OMA);
- the Ontario Nurses Association (ONA);
- the Ontario Psychological Association (OPA);
- the Ontario Association of Social Workers (OASW); and
- the Ontario College of Certified Social Workers (OCCSW).

The associations were requested to provide any relevant documents, and these were then reviewed to find the extent to which lesbian, gay, and bisexual issues were represented.

15.2.3 Results

The **Ontario Medical Association** (OMA), which is the governing body of both medical doctors and psychiatrists, has adopted a code of ethics established in 1990 by the Canadian Medical Association. This code mentions neither sexual orientation nor lesbian, gay, and bisexual communities. However, a group of Ontario physicians in conjunction with OMA elected officials is working on issues affecting

lesbian and gay doctors and gay patients (Henry 1995). They are establishing a professional working-group of physicians to address specific areas of concern. According to OMA president Michael Wyman, the association recognizes the challenges facing lesbian and gay physicians and patients and is committed to working with

HEALTH-CARE AND SOCIAL-SERVICE PROFESSIONAL ASSOCIATIONS

Based on responses received from selected associations surveyed

Ontario Medical Association

- has adopted code of ethics of Canadian Medical Association (doctors and psychiatrists)
- code of ethics does not mention sexual orientation or lesbians, gays, or bisexuals
- has stated a commitment to working with physicians to provide a forum to examine issues of concern to lesbian and gay doctors, students and patients
- has supported a working group to become more pro-active

Ontario Nurses Association

- promotes development of a work environment free of harassment and discrimination and promotes diversity, including sexual orientation
- includes dealing with incidents of homophobia
- includes gays and lesbians as a "vulnerable group" in a pamphlet on human rights and employment equity
- includes prohibition of discrimination on the grounds of sexual orientation in all collective agreements

Ontario Psychological Association

- adheres to code of ethics of Canadian Psychological Association
- includes in ethical principles and standards explicit reference to sexual orientation in prohibitions on conduct that adversely reflects on the dignity of others
- adheres to policies and guidelines of the American Psychological Association's Committee on Lesbian and Gay concerns

Ontario Association of Social Workers

- has clear and comprehensively stated policy document of lesbian and gay issues
- advocated for same-sex spousal benefits

Ontario College of Certified Social Workers

- code of ethics prohibits discrimination on the basis of sexual orientation

physicians on this issue. The OMA seeks to help provide role models for gay and lesbian physicians and to facilitate the exchange of information. This will provide a valuable resource to the association and its committees with respect to policy matters, educational initiatives, and membership communications. The working group has already suggested a number of areas where the OMA could become proactive: developing resource packages; communicating relevant issues; and proposing legislation, health-care policy, and medical education curricula.

The **Ontario Nurses Association (ONA)** is the collective bargaining voice of nurses in Ontario; it represents all registered and graduate nurses in hospitals, public-health units, nursing homes, and homes for the aged. Its objectives include the promotion of knowledge of nurses in all areas related to their social and economic welfare through education and research and the promotion of the highest standards of health care. The ONA also promotes the development of an inclusive work environment free of harassment and discrimination. It is ONA policy to promote respect for diversity including sexual orientation; policies, activities and structures are expected to reflect the ONA's commitment to equality for all its members; and further, the ONA takes responsibility for resolving all incidents of racism, homophobia, and discrimination.

In 1995, the ONA produced a pamphlet on human rights and employment equity (Lynn and Williams-Shreve 1995) where lesbian and gay people are included in vulnerable groups^a and reference is made to gay-bashing and the recent battle for same-sex spousal legislation in Ontario. The pamphlet cites the *Ontario Human Rights Code's* prohibited grounds for discrimination, including sexual orientation (and the ONA includes reference to these in all its collective agreements). Finally, the pamphlet cites disparaging comments about lesbian and gay people as an example of workplace harassment.

The **Ontario Psychological Association (OPA)** abides by the 1991 code of ethics established by the Canadian Psychological Association whose responsibility it is to help promote ethical behaviour and attitudes on the part of psychologists, adjudicate complaints, and take corrective action when warranted. The code articulates four main ethical principles: respect for the dignity of persons; responsible caring; integrity in relationships; and responsibility to society. The first is to be accorded the highest weight.^a The ethical standards developed from the code make explicit reference to sexual orientation in describing the prohibition of any public statements, presentations, or demeaning descriptions which reflect adversely on the dignity of others.

The OPA also adheres to the policies and guidelines for practice developed by the American Psychological Association's Policy Statements on Lesbian and Gay Issues (APA 1991), which addresses such concerns as discrimination, child custody, employment rights, hate crimes, and AIDS education.

There is also positive correspondence between psychologists and the OPA president on developing an OPA position paper on psychological issues relating to lesbian and gay couples.

The **Ontario College of Certified Social Workers (OCCSW)** is a voluntary regulatory body structured to protect the public. Its 1992 code of ethics governs the conduct of professional social workers and states explicitly that discrimination on the grounds of sexual orientation will not be tolerated under any circumstance.

The **Ontario Association of Social Workers (OASW)** aims at providing education and support to social work practitioners. It publishes a clear and comprehensive 1995 policy document, *OASW Policy on Promoting Equity for Lesbians and Gays*,^a introduced as the logical extension of the association's advocacy of same-sex spousal benefits. It provides a number of examples of the discrimination lesbian and gay people are exposed to in the areas of legislation, policy, and environment. It then describes how the OASW advances equity issues for lesbian and gay people in the areas of legislation, social policy, education, equal employment policies, programs and resources. The statement concludes by recommending that health-care and social-service organizations carry out staff training, development of community resources, the use of inclusive language, and anti-homophobia and anti-heterosexism education. The paper was distributed to deans and directors of schools of social work, health and social-service providers, professional associations, and the media.

15.2.4 Conclusion

Generally, the associations acknowledge the potential for inequitable treatment of lesbian and gay people - although none makes specific reference to bisexuals. The OASW appears to have developed the most comprehensive report documenting forms of discrimination and specific areas of

policy intervention. It must be noted that there are a number of professionals working at informing their respective associations of the issues and concerns facing lesbian, gay, and bisexual people (for example, those in the OPA). Although one code of ethics may be less specific than another, working groups (such as the lesbian and gay physicians) are in the process of generating position papers on lesbian and gay issues. It is impossible to determine yet what impact these may have on individual professions

It is clear that the professional associations must continue to develop awareness around lesbian, gay, and bisexual issues, make strong and informed statements regarding equitable treatment, and see that these are translated into practice.

15.3 Service-Providers

15.3.1 Introduction

The purpose of this survey was not only to gather information but to introduce service-providers to the idea that they may not recognize, and therefore not meet, the needs of lesbian, gay, and bisexual people. It is not enough that frontline workers, management, volunteers and board members are sensitive to and accepting of lesbian, gay, and bisexual people: non-discriminatory programs and services, and their policies, procedures and practices must address specific needs.

15.3.2 Methodology

This qualitative research survey collected data to complement Project Affirmation's major survey on the experiences of lesbian, gay, and bisexual people with health care and social services.

Various health-care and social-service organizations were chosen, based on their ease of contact. Health-care organizations were classified in three groups: public-health units, hospitals, and community-health centres. Social-service organizations were classified as: social services; family-service associations; children's-aid societies; sexual-assault crisis centres; and community services.

Based on the Ontario Ministry of Health's division of the province into nine regional-health unit boundaries, 28 cities and towns were chosen as sites from which to select representative organizations. Because of its size and complexity, the greater Toronto area was excluded. A subsequent survey of several mainstream-service providers in Toronto is covered below under the heading *A Positive Steps*.⁶

In total, 42 surveys were sent to 20 health-care and 22 social-service organizations.

15.3.3 Survey Format

The survey asked about policies, practices and procedures that might adversely affect lesbian, gay, and bisexual patients/clients. It was based on the Ontario Ministry of Community and Social Services' 1994 anti-racism protocol and provided definitions of discriminatory practices, homophobia etc. The survey comprised six sections with both open- and close-ended questions.

Section 1 asked about written policies.

Section 2 asked about (strategies to ensure) balanced representation among board members, managers, staff and volunteers.

Section 3 asked about access to services and programs and included questions about programs without barriers for lesbian, gay, and bisexual people.

Section 4 asked about organizational and structural-change action plans that include reference to sexual-orientation issues.

Section 5 asked whether organizations were willing to follow-up with plans for organizational change, whether they would like to be linked-up with local lesbian, gay, and bisexual organizations and/or receive additional resources.

Section 6 asked for general information about the organization, such as the number of staff (full-time, part-time) and volunteers and the number of clients served per year.

15.3.4 Results

Ten of the 42 surveys were returned. Health-care and social services were equally represented. However, response was stronger from the northeast and southwest of the province and only two

responses came from southeast of Toronto. Section 1 (written policies) and 4 (plans for change) brought the most negative results.

SURVEY FACT SHEET

SERVICE-PROVIDERS OUTSIDE GREATER TORONTO AREA

42 surveys were sent to 20 health-care and 22 social-service organizations in 28 cities and towns outside the greater Toronto area. 10 surveys were completed and returned (25% of those sent out), and they were divided equally between health-care and social-service organizations.

Results of Survey

of Responses

Written anti-discrimination policies that could include lesbians, gays, and bisexuals (not clear whether the policies explicitly include them)

2

Gays, lesbians, and bisexuals represented among clients and staff (only one had a hiring or recruitment strategy to ensure inclusion)

4

No gaps or barriers believed to exist re: access to programs by lesbians, gays, and bisexuals

4

Had begun to address services and programs with sexual-orientation issues in mind

5

Steps Taken to Ensure Effective Communication with Lesbians, Gays, and Bisexuals

- none
- brochures and outreach
- maintain updated list of lesbian, gay, and bisexual press/media
- maintain updated list of available services and resources within lesbian, gay, and bisexual communities

3

3

1

1

Organizational-Change Action Plans Regarding Sexual Orientation

- not begun to develop any
- have developed a plan

9

1

Section 1: only two organizations (both social-services) had written anti-discriminatory policies that could include lesbian, gay, and bisexual people; the first indicated that there exists a non-discriminatory policy⁶ but did not say whether this explicitly included sexual orientation; the second reported that they had no specific employment policies for lesbians, gays and bisexuals, but they did have an anti-harassment policy which includes sexual orientation as prohibited grounds for discrimination.

Section 2: four organizations said lesbian, gay, and bisexual people were represented among clients and staff; only one had an explicit hiring/recruitment strategy to ensure inclusion.

Section 3: four organizations indicated their programs had neither gaps nor barriers to access; five indicated that they had begun to address services and programs with sexual orientation issues in mind; three had taken no measures on any level to ensure communication with lesbian, gay, and bisexual people, though three indicated that they used brochures and outreach to effect better communication, and three others said communication with staff, clients, volunteers, and board members was inclusive and appropriate; only one (health-care) organization had an updated list of lesbian, gay, and bisexual press and media, and used it; only one (health-care) organization had an updated list of available services and resources within the lesbian, gay, and bisexual communities.

Section 4: nine participants reported their organization had not begun to develop any action plans for organizational change; only one (social services) had developed such a plan and even they stated that:

We don't proselytize "gay rights" or take any political stances as the agency serves people with many different values and backgrounds and we must be sensitive and inclusive of all. Taking on a specific stand or political position is counter productive.

Section 5: two indicated that they would not welcome information to assist them in areas of education and policy-writing or introduce them to existing resources and counselling.

Section 6: the number of full-time employees ranged from 2 to 1268; volunteers ranged in number from 2 to 635; the number of clients served per year varied from 250 to 400,000.

15.3.5 Discussion

The educational needs and realities of service-providers cannot be overlooked; this is a field that would repay further study. However, even from this limited survey, certain things emerge clearly. Many participants said they were not aware of lesbians, gays, or bisexuals using their services; many nonetheless suggested that their services are available to all people, regardless of sexual orientation. So perhaps it's true that all their service-users are treated the same - the same as heterosexuals, that is. If lesbians, gays, and bisexuals go unrecognized, their needs are not going to be acknowledged, let alone understood or addressed. Services are designed only for heterosexual people. How can they serve lesbian, gay, and bisexual people equitably?

15.4 Positive Steps: Institutional Change

15.4.1 Introduction

This is a survey of some health-care and social services that have begun to develop policies, strategies and programs for lesbian, gay, and bisexual clients. We hope these case studies will provide examples of how to initiate and implement equitable services within a mainstream (non-specialized) setting.

15.4.2 Methodology

Eight Toronto-based, mainstream facilities with inclusive and/or specialized services for lesbian, gay, and bisexual people were surveyed about initiatives in the areas of policy and practice. Topics covered were inclusiveness, specialized services, agency sensitivity, determination of need, knowledge and skills base, and, internal service review policies and procedures. The organizations were:

- Central Toronto Youth Services (CTYS)
- Children's Aid Society of Metropolitan Toronto (CASMT)
- Street Outreach Services (SOS)
- Catholic Children's Aid Society of Metropolitan Toronto (CCAS)
- Pape Adolescent Resource Centre (PARC)

- Elizabeth Fry Society
- The Wellesley Hospital
- Saint Michael's Hospital

15.4.3 The Interviews

Lesbian, Gay, and Bisexual Youth Program (LGBYP), Central Toronto Youth Services (CTYS)

In 1983, the Ministry of Community and Social Services chose CTYS as the site for the Sexual Orientation and Youth Project, a three-year evaluation and study project. CTYS was chosen for its willingness to consider lesbian and gay youth issues and its proximity to Toronto's downtown core, an area frequented by lesbian and gay youth. In 1986, the ministry funded CTYS= development of the much-used service as a core program. Now known as LGBYP, it is the only core-funded program of its kind in Canada and as such regarded as the "flagship" for research and service provision in the area.

LGBYP works to address gaps in service and raise service-providers' awareness and skill-levels concerning lesbian, gay, and bisexual youth issues. Services include research, resource-development, case consultations, client-advocacy, group-work, and training and consultation to service-providers across the province. LGBYP staff have completed analyses of Toronto residential services and addiction services. Direct services include support, education, and coming-out groups for lesbian and bisexual women, gay and bisexual men, gay and bisexual men with a history of sexual abuse and assault. The groups are facilitated as client-centred, empowerment groups. Staff also offer short-term support, phone counselling, and referral services.

LGBYP regularly reviews policies and programs through internal assessments of individual casework, groupwork and workshops, and through interagency and community dialogue.

Children's Aid Society of Metropolitan Toronto (CASMT)

The Children's Aid Society of Metropolitan Toronto operates a lesbian, gay, and bisexual youth program, which originally evolved out of the efforts of a small group of staff members who met with other supportive staff, shared ideas with key senior staff, then established a broad-based steering committee of frontline and supervisory staff, foster parents, parents of lesbian, gay, and bisexual youth, outside consultants and young people in their care. They searched the literature and attended conferences to develop a knowledge and skills base.

They convinced the agency that it was failing its mandate to serve lesbian, gay, and bisexual clients and showed that the same lack of understanding and support that caused youth to run away from their family was also causing breakdown in CASMT placements. Essential to this process was the testimony of the youths themselves. Once the need was recognized within the agency, emphasis was placed on the development of appropriate and acceptable care to address the particular stresses lesbian, gay, and bisexual youth confront and the systemic nature of barriers to accessing support services.

Systemic barriers that were identified as allowing lesbian, gay, and bisexual youth to remain invisible include: viewing homosexuality as pathological; tolerating anti-lesbian/gay/bisexual behaviour; and denying clients' same-sex relationships. Staff began to recognize ways in which they might be implicated in maintaining systemic barriers.

Voluntary training sessions were initiated throughout the agency. Day-long workshops included presentations by youth and parents and examples of hate-motivated verbal attacks. The intent was to shock staff into recognizing problems and to prompt them to take action. A quarter of CASMT staff (150 people) attended the workshops. To reach the rest of the staff, the Lesbian, Gay, and Bisexual Youth Program then produced (and distributed to each staff person as a resource manual) *We Are Your Children Too: Accessible Child Welfare Services for Lesbian, Gay, & Bisexual Youth*, a 1995 report discussing ways in which an agency may ensure accessibility.

At the policy level, the report recommends that CASMT recognize its lesbian, gay, and bisexual clients, commit to serving them, and openly acknowledge the unacceptability of neglecting their special needs. The recommendations of the report on lesbian, gay, and bisexual youth were passed by the Board of Directors as official CASMT policy and are at various stages of implementation.

The report recommended that all policies be reviewed to ensure they are supportive, with inclusive language regarding sexual orientation and same-sex relationships. All staff, foster parents, and volunteers, as well as other agencies involved, are to provide competent and equitable care and services for lesbian, gay, and bisexual youth. Selection, hiring, and evaluation policies and procedures must be

lesbian-, gay-, and bisexual-positive. CASMT is committed to welcoming staff, foster parents and volunteers who are lesbian, gay, and bisexual. The society is to make all its publications, communications material, posters, etc. inclusive.

The society is encouraged to take a strong advocacy position in the youth-serving community, calling for the elimination of all forms of discrimination against lesbian, gay, and bisexual youth. It includes sharing experience and expertise in the areas of service provision, research, and education. The report encourages the development of child-welfare practices which reflect the particular needs of lesbian, gay, and bisexual youth; this means expanding existing programs and developing new ones. It suggests a support group for lesbian, gay, and bisexual youth. It calls upon foster homes, group homes and other services to offer sufficient options to meet their needs.

Street Outreach Services (SOS)

Street Outreach Services (SOS) was established in 1985 to work with men and women aged 16 to 24 who were on the street and involved in prostitution in Toronto. Counselling services cover human sexuality, and HIV/AIDS education and support. Client-advocacy and on-site legal, medical, and social assistance are also provided. SOS refers clients for educational, employment, or training placement, addiction treatment, and housing assistance. Safer-sex guides, condoms, and dental dams are available; they also operate a needle-exchange service. As part of its AIDS program SOS, has produced a number of information pamphlets and distributes an information manual on working with and caring for street youth who have tested HIV-positive.

SOS has developed its knowledge/resource base primarily from the life experience of clients and the expertise of staff. Staff meetings, interagency resource sharing, and the purchase of various publications and consultations also contribute to the knowledge base. In addition, SOS staff review policies and programs as they become aware of the changing needs of clients and changes in the law and government policies pertaining to prostitution.

Staff are expected to be comfortable with their own sexual orientation and provide role modelling without being judgmental; at the same time, they must maintain appropriate, generally accepted professional boundaries with clients. SOS considers that youth who work the streets have unstable sexual identities, so service-providers must respect they way they identify themselves regardless of their sexual activity.

Staff must exhibit an openness and a high comfort level with all prostitution- and sexual-orientation-related issues clients may present. They are encouraged to work with any client regardless of their own or the client's sexual orientation, are expected to be professional and proficient with good assessment and evaluative skills. An understanding of the specific issues pertaining to lesbian, gay, and bisexual identity and sexual orientation is expected of all staff. Opportunities exist for staff to enhance and develop their knowledge base.

Catholic Children's Aid Society of Metropolitan Toronto (CCAS)

The Catholic Children's Aid Society (CCAS) is responsible for the protection of all Catholic children up to the age of 16 years. The CCAS is in the initial stages of developing an inclusive and equitable environment for its lesbian, gay, and bisexual client population. At the time of the survey, the CCAS had struck three working groups to research policy initiatives, education, and accessibility of services. It has drafted proposals for the inclusion of sexual orientation in a statement of principles as well as a policy statement regarding equity of service, which refers to existing policy on harassment and discrimination in the workplace.

The impetus for policy-development came from both frontline workers and from staff involvement with an interagency street-youth project where other agencies presented issues pertaining to lesbian, gay, and bisexual youth and challenged mainstream services to begin addressing the issues. The CCAS board of directors was responsive and a committee of the board began investigating strategies. Serving lesbian, gay, and bisexual youth within a Roman Catholic agency is problematic. However, those involved in creating these services believe these young people are some of the most vulnerable members of the community and that Catholics must include them in the areas of pastoral care and social justice.

CCAS policy is that all staff, care-providers, and volunteers must be seen as exhibiting a positive attitude toward lesbian, gay, and bisexual youth and families. As part of their ongoing professional development, they must undergo training with respect to lesbian, gay, and bisexual issues. There must

be inclusivity with respect to language, symbols and culture; all public spaces that provide information must include posters, notices, etc. making it clear that lesbian, gay, and bisexual people are welcome. Issues of sexual orientation must be treated with the same respect, concern, sensitivity, and confidentiality accorded to heterosexual youth and their families.

Pape Adolescent Resource Centre (PARC)

The Pape Adolescent Resource Centre assists youth from both the Catholic and Metropolitan Toronto Children's Aid Societies who, on reaching 18 years of age, are no longer eligible for their services. Many remain ill-equipped for independent adult living, and PARC prepares these youth for independence.

PARC developed its programming through its association with the CASMT lesbian, gay, and bisexual youth program, which provided staff training at PARC. PARC recognized the need to provide service to its lesbian, gay, and bisexual client population and has initiated both a lesbian and a gay youth group, hiring lesbian and gay staff as group facilitators. Intake questionnaires and pamphlets have been altered to provide inclusive language. Staff have received sensitivity training and attended workshops on lesbian, gay, and bisexual youth. There is bulletin-board space with information about lesbian, gay, and bisexual groups and events.

PARC maintains a small core staff to facilitate team discussions, information- sharing, and decision- making. All staff have the opportunity to expand their knowledge and practice skills and contribute by building a library on lesbian, gay, and bisexual issues. They ask youth to keep them informed of relevant events, and they consult with their lesbian, gay, and bisexual staff and clients.

Elizabeth Fry Society

The Elizabeth Fry Society provides service to women 18 years and over, who are at risk of becoming, currently are, or previously have been, in conflict with the law. Elizabeth Fry provides counselling, referral, and advocacy services to incarcerated women, as well as a transitional, residential program for women coming out of prison.

While Elizabeth Fry does not offer specific programs to lesbian or bisexual women, their mission statement and various policies are inclusive of lesbians and bisexual women. Antidiscrimination policies address lesbian and bisexual discrimination within the framework of fighting the oppression of women around the prison system. Offices and residential services are expected to be inclusive of lesbian and bisexual women in terms of posters, information, educational materials and books, videos, etc.

The society's Cultural Sensitivity Committee aims to provide and enhance a positive experience of their history and culture for all clients. Staff and volunteers are expected to respond to and advocate on behalf of lesbian and bisexual women. For example, women in relationships in prison receive advocacy and support around issues of segregation or infractions based on same-sex activity. Both staff and volunteers are sensitized to same-sex issues during initial orientation and are expected to demonstrate a lesbian-positive attitude.

The Wellesley Hospital

The Wellesley Hospital is located in an area densely populated by lesbian, gay, and bisexual people. The hospital's HIV unit provides direct health care to those living with HIV/AIDS and also provides space for community services such as counselling and non-traditional types of health care.

The catalyst for change and development at the Wellesley was the threat of closure in 1990. The community agreed to support the continued existence of the hospital if it became more sensitive to the needs of the diverse communities it was serving. This, along with new health-care initiatives regarding community input, led to the creation of the Urban Health Initiative, in which the hospital linked with local community representatives to develop more equitable and appropriate service delivery, educational programming, and research initiatives.

Under this initiative, a number of community advisory panels include lesbian, gay, and bisexual input or discussion of lesbian, gay, and bisexual issues. The Advisory Panel on HIV has representation from local lesbian and gay populations and has influenced staff selection for the primary care unit. The Emergency Department Community Advisory Panel works with emergency department staff to develop protocols around issues such as *outing* and *gay-bashing*. Lesbian, gay, and bisexual issues are raised on the Mental Health Services Advisory Panel and on the Maternal and Infant Care Advisory Panel.

The hospital takes a proactive stance to ensure that staff, volunteers, and others in the hospital community understand lesbian, gay and, to a lesser extent, bisexual issues. For example, intake staff and other care-providers are sensitized around issues of same-sex partners and families. Staff, volunteers, and clients are supported in being open about their own sexual orientation. A complaints committee responds to issues of discrimination within 24 hours of receiving a complaint. The hospital encourages its staff to attend regular lectures and workshops on anti-discrimination and has hired a community worker to investigate access to service for the lesbian, gay, bisexual, and transgendered communities.

Further, the Wellesley Hospital is a teaching hospital affiliated with the University of Toronto. Medical students have been placed in community-based clinics and encouraged to research issues of substance abuse, etc. One student studied the environmental impact of a transition from HIV to AIDS. Opportunities exist for the investigation of issues pertaining to the health of lesbian, gay, and bisexual people.

Saint Michael's Hospital

Saint Michael's Hospital is located in the heart of downtown Toronto. It is a Catholic hospital especially well known for its cardiac-care unit, and it is also recognized as an HIV/AIDS centre.

Management and staff have initiated dialogue with a number of communities served by the hospital. Lesbian, gay, and bisexual issues are raised through the HIV clinic, which is trying to develop a panel of hospital staff and representatives from the AIDS Committee of Toronto and Voices of Positive Women.

Responding to charges of homophobia, the hospital president distributed to all staff and volunteers a letter emphasizing the hospital's inclusive and compassionate mission. The letter included a statement of intent to review all policies and procedures, liaise with the lesbian, gay, and bisexual communities, and educate hospital staff.

Since then, a survey has been distributed to all staff and volunteers asking about experiences of discrimination, including homophobia. Next, the hospital hopes to develop an advisory committee to begin the task of policy and program review.

Given the conflict between the hospital's mandate to be compassionate and the Catholic Church's perceived opposition to lesbian, gay, and bisexual lifestyles, this will be a large endeavour. The impetus for change will have to come from the top level of hospital management, and the process of change will have to be actively furthered.

15.4.4 Discussion

For most of these agencies, consciousness of lesbian, gay, and bisexual issues evolved from concerns raised by clients; it then remained for staff and program people to develop strategies to deal with them. Two primary strategies emerge for soliciting the support of administration and staff. First, issues are presented in an equity-of-service context within the mandate of the agency, identifying inadequate care and gaps in service in order to establish the agency's responsibility. Second, presentations must be made to administrators, management committees, and boards of directors to ensure support and encouragement throughout the agency. Then the important work of constructing a response to service inequities can begin.

One of the more controversial questions surrounding service to lesbian, gay, and bisexual people, indeed to all minority groups, is the extent to which an agency is expected to provide specialized service. Some agencies, like the LGBYP, both have resources and can access the services of lesbian, gay, and bisexual professionals in the field; they can provide relevant forms of service to different groups. Other agencies, like SOS, may place the emphasis on inclusivity; they provide a safe place for youth of all sexual orientations to engage with open, supportive, and informed heterosexual, lesbian, gay, and bisexual staff and volunteers. For agencies that choose not to develop specialized services, knowledge and resource development is imperative in order to provide acceptable and appropriate service.

In any case, health-care and social-service agencies must create an open atmosphere where lesbian, gay, and bisexual clients can feel safe and supported.

16 Systemic Links

16.1 Introduction

The findings of this report reveal a number of issues and concerns. Collecting the relevant data together in this way for the first time underlines both commonalities and differences in various service areas and reinforces the urgent need to provide bias-free services so that the actual issues of service-seekers can be addressed.

This section provides a review of the roles of key organizational players (government ministries, commissions, educational institutions, professional associations, funders, etc.) in maintaining the infrastructure of the health-care and social-service systems.

By addressing the findings of this report and linking with one another to implement them, these bodies can play a vital role in establishing equitable provision of service to lesbian, gay, bisexual and transgendered people in Ontario.

16.2 Ontario Human Rights Code

Formal complaints on the basis of sexual orientation accepted by the Ontario Human Rights Commission (OHRC) have made up an average 2% of all their cases in the last few years. Coming forward to launch a complaint is highly risky for many since it brings the issue of their sexual orientation to the fore, and they may suffer further, in their social circle or at work. Many are not even aware what their rights are.

The provisions of the *Code* are not complete. It needs to be amended to ensure that lesbians, gays, and bisexuals have the same rights as heterosexuals:

- first: sexual-orientation protection must be added to the harassment sections of the *Code*. Although the OHRC will deal with harassment against lesbians, gays, and bisexuals (using a *poisoned environment* analysis), chances of success are minimal.
- second: the definition of *spouse* must be changed to include same-sex partners. A human rights board of inquiry has already ordered a change to *marital status* (*Leshner*, 1992); spousal recognition is being won piecemeal and expensively, case by case; this is satisfactory neither to the lesbian, gay, and bisexual communities, nor to the government.
- third: the *Code* must allow third-party complaints. Because many individuals are reluctant or unable without significant penalty to come forward, representative groups whose interests are clearly offended by a violation of the *Code* can be effective in seeing to it that violations can be dealt with.

In addition, many are deterred from the lengthy and laborious process of seeing a complaint through by the fact that Boards of Inquiry appointed by the OHRC can only award a relatively small amount of damages in cases of loss of dignity and worth or psychological and/or emotional suffering. The process is long and the reward, if arrived at, not commensurate.

16.3 Legislators, Policy-Makers, and Bureaucrats

Change must take place from the top down. Without protection and sanctions, administrators will hesitate to propose or carry out the changes that are needed to eradicate heterosexism and homophobia.

Policy-makers in government as well as public and private health-care and social-service settings, politicians, executive directors, CEOs, team-leaders, program-directors, coordinators, and others must develop and implement policies, standards, benefits, programs, and services that address the needs and realities of lesbian, gay, bisexual, and transgendered lives. They need to seek the input of the experts: lesbian, gay, bisexual, and transgendered service-users and professionals, as well as other organizations that have already established some measure of change.

On the provincial-government level, a consistent philosophy of social policy needs to be established from the ministries of Health, Community and Social Services, and Education and Training, and Citizenship, Culture and Recreation. The ministries must also ensure that the professionals and bodies they fund follow and promulgate the ethical guidelines established for service-provision. For example, the Ministry of Education and Training could ensure that professional schools and relevant faculties educate future health-care and social-service professionals to be aware of the issues of lesbians, gays, bisexuals, and transgenderists and to provide appropriate, bias-free service.

Professional associations, must then ensure that practice expectations are linked with codes of ethics which govern professionals already in these fields.

The provincial government must introduce and pass a bill amending the full range of Ontario statutes that contain discriminatory definitions of *Aspouse*,[®] *Arelationship*,[®] and *Afamily*[®] to include same-sex relationships. Employment-equity legislation is needed that addresses systemic discrimination against lesbians, gay men and bisexuals in the health-care and social-service fields. (For a fuller description, please see CLGRO=s 1991 brief *We Count: Lesbians, Gay Men, and Bisexuals in Employment Equity*.)

The federal government will need to enact related and complementary measures, principally through Health Canada.

16.4 Lesbian, Gay, Bisexual and Transgendered Service-Providers

Due to limited scope, Project Affirmation could not undertake a systematic exploration of the experiences of lesbian, gay, bisexual, and transgendered people who actually work in the health-care and social-service fields.

However, it is clear that demands by out staff members, patients, and/or clients are the main impetus for change. This can be seen in those hospitals and social-service agencies that had taken positive steps to create a positive environment or to implement inclusive and/or particular programs for the lesbian, gay, and bisexual populations. Though the voices of staff-members, patients, and/or clients speak with special force, to ask them to be the catalyst for systemic change is to put the onus on those in the most vulnerable positions. Staff members can lay themselves open to workplace harassment or charges of inappropriate behaviour; patients/clients can risk reprisals affecting their health care or access to services.

Protective measures must be put in place in the work environment so that health-care and social-service professionals can suggest changes and be given the opportunity to help formulate, implement, and evaluate them.

16.5 Conclusion

Decision-makers must address future work with a consciousness that includes the needs of lesbian, gay, bisexual and transgender communities. In the long run, systemic change is the only economical way to provide service that is equitable to users and not wasteful of resources.

The present Ontario climate of service-cutbacks and elimination brings about a dispirited atmosphere in which to be seeking changes; but many changes require only shifting attitudes and policies rather than the implementation of new, huge, or costly programs.

Under the *Canadian Charter of Rights and Freedoms*, protection from discrimination is promised to lesbians, gay men, and bisexuals. *ASexual orientation*[®] was added to the *Ontario Human Rights Code* in 1986 and to the *Canadian Human Rights Act* in 1996. Discrimination is illegal. Yet it is clear that much work still needs to be done to ensure that protecting lesbians, gay men and bisexuals from discrimination is a) done at all and b) carried out in a knowledgeable and sensitive manner.

17 Recommendations

Introduction

Project Affirmation's findings document the systemic barriers experienced by lesbians, gays, bisexuals, and transgendered people when they seek to access Ontario's health-care and social services. Although more detailed research is required in many areas, it is clear that they face pervasive homophobia and heterosexism, as well as sexism, racism, anti-Semitism, ageism, and discriminatory attitudes towards Francophones and people with disabilities.

Project Affirmation was only a beginning. Its findings are a call to action by:

- federal and provincial governments;
- Ontario government;
- local and regional governments;
- boards of education;
- health-care and social-service providers;
- professional associations and post-secondary educational institutions;
- employers and the private sector;
- lesbian, gay, bisexual, and transgender community groups.

Project Affirmation's research and the recommendations below should be the catalyst for continuing to identify and meet the urgent health-care and social-service needs of Ontario's diverse lesbian, gay, bisexual, and transgendered communities.

GENERAL RECOMMENDATION

- 17.1 Policy-makers, educators, and service-providers in all sectors must develop policies and procedures to:
- (a) address the needs of lesbian, gay, bisexual, and transgendered people as consumers of health-care and social services;
 - (b) eradicate any support for verbal or physical violence against lesbian, gay, bisexual, and transgendered people or their communities;
 - (c) recognize homophobia, heterosexism, biphobia, and transphobia as systemic forms of oppression that must be dealt with proactively;
 - (d) affirm the diversity of the lesbian, gay, bisexual, and transgendered communities, taking into account such factors as gender, age, ability, race, ethnicity, culture, relationship status, income, language, and education, as well as the degree to which people are able safely to disclose their sexual orientation.

FEDERAL AND PROVINCIAL GOVERNMENTS

First Nations/Two-Spirited Peoples

- 17.2 Federal and provincial governments must work in concert to ensure that health-care benefits not covered by the Ontario Health Insurance Plan (OHIP) are available to off-reserve transgendered, lesbian, gay, bisexual, and two-spirited people.

Youth

- 17.3 Federal and provincial governments must provide stable, long-term funding for peer-support groups and services for lesbian, gay, bisexual, and transgendered youth.

Older Lesbians, Gays, Bisexuals, and Transgendered People

- 17.4 Federal and provincial agencies must begin to plan now for future generations of older lesbian, gay, bisexual, and transgendered people; health-care and social-service policy for the aging must acknowledge them, research demographics, and consider their needs.

Families/Relationships

- 17.5 Federal and provincial governments must introduce and pass legislation amending the full range of statutes containing discriminatory definitions of *Aspouse*,[@] *Amarital status*,[@] *Afamily*,[@] and similar terms so that they include same-sex relationships.

HIV/AIDS

- 17.6 Federal and provincial governments must provide adequate funding to:
- (a) continue HIV/AIDS research; specifically, the federal government should introduce an improved national AIDS strategy;
 - (b) maintain and improve community-based AIDS organizations providing education, counselling, and support.

Violence

- 17.7 Federal and provincial governments must conduct continuing research into violence against lesbian, gay, bisexual, and transgendered people in order to identify strategies for education and prevention.

Health-Care and Social-Service Delivery

- 17.8 Federal and provincial bodies that provide funding in the area of health-care and social-service delivery must establish standards of equitable distribution that include lesbian, gay, bisexual, and transgendered individuals and groups.
- 17.9 Health Canada, other federal departments, and their provincial-government counterparts, must ensure provision of funding to:
- (a) carry out further research into the health-care and social-service needs of lesbian, gay, bisexual, and transgendered people generally; and
 - (b) promote greater awareness of the health-care and social-service issues of lesbian, gay, bisexual, and transgendered Francophones, members of racial, ethnic and cultural minorities, and First-Nations people.

ONTARIO GOVERNMENT

Transsexuals and Transgenderists

- 17.10 The Ministry of Health must fund a research-based pilot project on addictions and the transsexual/transgender communities to document the situation (including the extent to which mainstream agencies offer transgender-positive recovery services) and ascertain what is needed to address that situation.
- 17.11 The Ministry of Health must continue to fund the costs of sex-reassignment surgery through the Ontario Health Insurance Plan (OHIP).
- 17.12 The Ministry of Health must provide funding for a transsexual/transgender health-care centre, which would provide informed, safe access to hormones and operate from the philosophy that all transsexual and transgendered individuals can take an active role in their own health care.

Youth

- 17.13 The Ministries of Community and Social Services, Education and Training, and Health must develop bias-free educational materials on issues related to lesbian, gay, bisexual, and transgendered youth for use by high-school guidance counsellors, community workers, and others who counsel or provide services to youth.

Families/Relationships

- 17.14 Ontario laws must be amended in line with recent provincial court precedents so that the adoption of children is available equally to heterosexuals, lesbians, gay men, and bisexuals living singly or in couples; in the case of couples, both partners must have equal adoptive status.

HIV/AIDS

- 17.15 The Ministry of Health must improve the Trillium Drug Plan by reducing the deductible for the working poor and improving the coverage of complementary, experimental, and new therapies.

Health-Care and Social-Service Delivery

- 17.16 Ontario Health Insurance Plan (OHIP) coverage for psychotherapy must be extended to include psychologists, psychotherapists, and social workers.
- 17.17 The Ontario government must ensure that legislation does not prohibit or restrict the ability of individuals to seek out the services of more than one doctor within OHIP.

- 17.18 The Minister of Health must halt plans to close Ontario hospitals that have implemented services and programs to meet the special needs of women, Francophones, lesbians, gays, bisexuals, and transgendered people, or members of other minority communities; instead, the Ontario government must support such hospitals and encourage others to offer similar services.

Systemic Links

- 17.19 The Ontario government must introduce and pass an employment-equity act that includes lesbians, gays, and bisexuals in accordance with the recommendations in CLGRO's 1991 brief, *We Count*.
- 17.20 The Ontario government must amend the *Ontario Human Rights Code* to:
- (a) remove the discriminatory definition of "spouse" and guarantee the recognition of same-sex relationships;
 - (b) add "sexual orientation" to the list of prohibited grounds in the harassment sections of the *Code*;
 - (c) permit third-party complaints;
 - (d) significantly increase the amount that can be awarded by boards of inquiry for damages arising from loss of dignity/worth or psychological/emotional suffering.
- 17.21 The Ontario government must provide the Ontario Human Rights Commission with sufficient funding and other resources to:
- (a) conduct province-wide education about the *Ontario Human Rights Code*, paying special attention to institutions and service-providers;
 - (b) ensure they are proactive on issues of sexual orientation, as well the other grounds of prohibited discrimination.
- 17.22 The Ontario government must
- (a) provide mandatory training on all forms of discrimination including those based on sexual orientation for all arbitrators, board of inquiry/tribunal appointees, and human-rights commissioners;
 - (b) ensure that all government bodies dealing with employment, health care, and social services have openly lesbian, gay, and/or bisexual representatives;
- 17.23 The Ontario government must provide groups for lesbian, gay, bisexual, and transgendered people with funds to:
- (a) conduct a province-wide campaign against homophobia and heterosexism in the provision of health-care and social services, employment, housing and the community at large;
 - (b) develop programs of specialized health care and social services;
 - (c) provide sensitivity training to health-care and social-service providers.
- 17.24 In consultation with lesbian, gay, bisexual, and transgender groups, the Ministry of Education and Training must develop and issue guidelines, policies, and, as applicable, directives, to help colleges and universities accommodate the specific needs of members of those communities and provide inclusive curricula for use in training students entering the health-care and social-service fields.
- 17.25 In consultation with lesbian, gay, bisexual, and transgender groups, the Ministry of Citizenship, Culture, and Recreation, the Ministry of Community and Social Services, and the Ministry of Health must develop and implement guidelines, policies, and directives so that:
- (a) health-care and social-service professionals are informed of their requirement under the *Ontario Human Rights Code* to provide equitable services for lesbians, gays, bisexuals, and transgendered people;
 - (b) professional associations in the health-care and social-service fields will explicitly include in their codes of ethical conduct the requirement that services to lesbians, gays, bisexuals, and transgendered people be provided equitably.

LOCAL AND REGIONAL GOVERNMENTS

Health-Care and Social-Service Delivery

- 17.26 Local and regional governments must implement policies and procedures similar to those recommended for the Ontario government in order to educate those within their jurisdictions about the health-care and social-service needs of the lesbian, gay, bisexual, and transgendered communities and to begin redressing current service inequities.
- 17.27 Local and regional funding bodies must establish standards of equitable distribution that include lesbian, gay, bisexual, and transgendered individuals and groups.
- 17.28 Community programs for youth, older people, people with disabilities, and others must welcome and serve lesbian, gay, bisexual, and transgendered people.

BOARDS OF EDUCATION

Youth

- 17.29 Boards of education must introduce and enforce policies and procedures that:
 - (a) affirm lesbian, gay, bisexual, and transgendered youth and protect them from harassment and violence;
 - (b) foster a positive environment in which lesbian, gay, bisexual, and transgendered people who are students, teachers, and administrators are free to come out in safety;
 - (c) encourage guidance and career counsellors to help lesbian, gay, bisexual, and transgendered students enter the health-care and social-service professions.
- 17.30 Schoolboards must require principals to adopt and enforce standards opposing discrimination and must support the role of lesbian, gay, bisexual, and transgendered parents and of parents who advocate on behalf of their lesbian, gay, bisexual, and transgendered children.

HIV/AIDS

- 17.31 Boards of education must increase and update educational resource materials on HIV/AIDS for elementary and secondary schools, introduce them into schools and ensure there are adequate resources to facilitate their use.

HEALTH-CARE AND SOCIAL-SERVICE PROVIDERS

Francophones

- 17.32 Structural change must be made in the health-care and social-service systems to accommodate the linguistic and other needs of Francophone lesbian, gay, bisexual and transgendered people.

Bisexuals

- 17.33 Health-care and social-service agencies must provide adequate bisexual-specific sex education and other services that recognize that:
 - (a) bisexuality is not an aspect of homosexuality;
 - (b) there are important differences between bisexuality, heterosexuality and homosexuality that must be understood and acknowledged when providing services;
 - (c) biphobia is different from homophobia.

Transsexuals and Transgenderists

- 17.34 All emergency-room personnel and other hospital staff must receive awareness training (including general sensitivity, preferred-pronoun use and specific health-care issues) to enable them to provide equitable service to transsexual/transgender clients; this could be arranged through collaborative work with medical and nursing professional associations and schools.
- 17.35 Doctors must educate themselves about hormone therapy and provide such therapy to transgenderists and transsexuals.
- 17.36 The Gender Identity Clinic (GIC) of the Clarke Institute of Psychiatry must:
 - (a) establish an independent committee to determine what services are needed by transsexual and transgendered people; this committee must be composed of GIC representatives and transsexual and transgender clients reflective of the diversity of the transsexual and transgender communities;
 - (b) conduct a review, preferably by the committee established under (a) above, of the policy insisting on one year's cross-dressing before hormones can be prescribed.

- 17.37 In the absence of shelters established specifically for transsexuals and transgenderists, shelter associations and homeless shelters in Ontario should review current practices and policies to meet the needs of transsexual and transgendered people.
- 17.38 Shelters must:
- (a) assume the responsibility for keeping transsexual and transgendered clients safe from violence, discrimination, and harassment at the hands of other shelter residents;
 - (b) provide a list specifying which shelters will and will not accept transsexual or transgendered people;
 - (c) educate their staff in transsexual and transgender issues, stressing the need for bias-free treatment and the responsibility of the agency to provide equitable services.
- 17.39 Alcohol/drug-rehabilitation services must provide bias-free services to transsexuals and transgenderists; this involves training facilitators and service-providers and making clear to groups that prejudice is not acceptable.

Race, Ethnicity and Culture

- 17.40 Health-care and social-service agencies must provide anti-oppression training to service-providers; this training must be sensitive to the separate dynamics of homophobia, sexism, and racism as well as the additional impact(s) of double or multiple oppression experienced by those who belong to more than one group.

First-Nations People

- 17.41 Service-providers must be given training to develop the cultural sensitivity needed to provide sensitive and equitable service to lesbian, gay, bisexual, two-spirited, and transgendered people of the First Nations.
- 17.42 Native healers must provide support and understanding towards lesbian, gay, bisexual, two-spirited, and transgendered people in their communities; they must acquire more sensitivity to and knowledge about sexual orientation issues.

Youth

- 17.43 Health-care and social-service organizations must train their staff to:
- (a) expect lesbian, gay, bisexual, and transgendered youth as clients;
 - (b) create a climate of trust for lesbian, gay, bisexual, and transgendered youth in which confidentiality is ensured and their gender or sexual identification is respected;
 - (c) meet the special needs of lesbian, gay, bisexual, and transgendered youth and make them aware of positive role models.

Older Lesbians, Gays, and Bisexuals

- 17.44 Service-providers must offer an environment that welcomes and affirms older lesbian, gay, bisexual, and transgendered people; they must recognize that older lesbian, gay, bisexual, and transgendered people may have sexual/loving same-sex relationships.

Families/Relationships

- 17.45 Institutions must provide visiting rights and respect privacy needs for those in same-sex relationships as they do for those in opposite-sex ones.
- 17.46 Programs serving parents and their children must be prepared to include:
- (a) lesbian, gay, and bisexual parents and the children of such parents;
 - (b) positive references to lesbian, gay, and bisexual parents;
 - (c) psychological criteria for the assessment of parenting that are not based upon marital status or sexual orientation.
- 17.47 Lesbian, gay, and bisexual people must have access to the full range of options and services concerning conception, pregnancy, and childbirth; policies, procedures, and protocols for alternative insemination must eliminate bias against women with no male partner and/or with a female partner.

Disability and Chronic Illness

- 17.48 Health-care and social-service organizations serving those with disabilities or chronic illnesses must:
- (a) ensure that their facilities are fully accessible;

- (b) train their staff to expect clients/patients who are lesbian, gay, bisexual or transgendered and acknowledge that their clients/patients may have sexual/loving same-sex relationships.
- 17.49 Health-care and social-service organizations must conduct research on:
 - (a) the degree of hostility, discomfort, or receptiveness of those providing service to lesbian, gay, bisexual, and transgendered people with disabilities or chronic illnesses;
 - (b) the varying degrees of visibility and duration of chronic illnesses or disabilities for lesbian, gay, bisexual and transgendered people; research methods must not force disclosure of sexual orientation or make unrealistic demands on stamina or mobility.
- 17.50 Publicly funded producers of sex- and sexuality-training materials for people with disabilities must include information for/about transgendered people and people of all sexual orientations.
- 17.51 Residential facilities for people with disabilities must develop policies and procedures acknowledging that they have lesbian, gay, bisexual, and transgendered clients and accommodating their special needs.

HIV/AIDS

- 17.52 Health-care and social-service agencies must implement service-provider education that conveys accurate information about HIV/AIDS, for all staff levels and in all service areas.
- 17.53 Service-providers must treat people living with HIV/AIDS equitably and, in particular, must not implement excessive and/or medically unnecessary hygiene measures which isolate or humiliate those to whom service is being provided.

Violence

- 17.54 Service-providers must receive anti-homophobia education to enable them to deal appropriately with lesbian, gay, bisexual, and transgendered people who are the victims of violence; this includes the acknowledgement that both lesbians and gay men are victims of sexual assault by males.
- 17.55 Service agencies must respond proactively to the issue of violence against lesbians, gays, bisexuals, and transgendered people by:
 - (a) establishing services specifically for the victims of homophobic violence;
 - (b) supporting organizations in the lesbian, gay, bisexual, and transgender communities that offer services, programs, support groups, networks, and safe facilities for the victims of violence.
- 17.56 Service-providers must recognize and familiarize themselves with the issues involved in violence within same-sex relationships.

Health-Care and Social-Service Delivery

- 17.57 Health-care and social-service agencies must have and enforce policies stipulating that all diagnostic procedures and personal-history gathering proceed from the assumption that clients may be lesbian, gay, bisexual or transgendered.
- 17.58 Health-care and social-service professionals must show that they are positive towards lesbians, gays, bisexuals, and transgendered people by welcoming the disclosure of a client's sexual orientation, by never assuming the gender of a sexual partner, and by using appropriate and inclusive language; programs run on a heterosexual model must be changed to include lesbian, gay, and bisexual alternatives.
- 17.59 Service-providers must appreciate the differences between identity and behaviour; the fact that a client identifies as lesbian, gay, bisexual, or transgendered does not warrant assumptions about their behaviour or lifestyle.
- 17.60 Health-care and social-service agency boards and senior staff must:
 - (a) establish and maintain training to ensure staff have acceptable levels of knowledge about and sensitivity to lesbians, gays, bisexuals, and transgendered people;
 - (b) assess, maintain, and update policies and programs to meet the needs of lesbian, gay, bisexual, and transgendered people;
 - (c) establish and maintain the program-, resource-, and staff-developments necessary to provide appropriate service;
 - (d) encourage the display of signs, magazines, posters, and other images which affirm lesbians, gays, bisexuals, and transgendered people;

- (e) establish and enforce anti-oppression policies, including those that screen for homophobia on the part of service-providers to whom referrals are made (this must then be documented for use in referral procedures and directories used by staff);
 - (f) develop and implement employment equity plans to employ staff who are lesbian, gay, bisexual, and transgendered, including those who are also Francophones, First-Nations people, members of racial, ethnic and cultural minorities, people with disabilities, and/or people living with HIV/AIDS;
 - (g) encourage and provide a safe environment for lesbian, gay, bisexual, and transgendered staff who choose to disclose their orientation to other staff and clients/patients;
 - (h) involve members of lesbian, gay, bisexual, and transgendered communities within the organization's geographic region, or beyond if necessary, in such initiatives.
- 17.61 Service-providers who are affirming of lesbian, gay, bisexual, and transgendered people must list themselves as such in referral, community, and other directories.
- 17.62 Doctors and other service-providers who are uncomfortable with lesbian, gay, bisexual, and transgendered people and who are not open to becoming sensitized to their needs must, as a minimum, ensure absolute confidentiality and make referrals to positive practitioners.
- 17.63 Funders, sponsors, directors, community advisory bodies, and other stakeholders must hold health-care and social-service providers accountable for the quality of service they provide to lesbian, gay, bisexual, and transgendered clientele.
- 17.64 Medical-history, intake, and other initial-contact forms must use neutral language and encourage clients to identify their sexual orientation and say whether they are in a same-sex relationship.
- 17.65 Intake forms must offer clients the opportunity to designate anyone of their choice (same-sex partners, chosen family members, or friends) as next-of-kin, support people, or contacts in case of emergency; the designated person(s) must be acknowledged and accepted as such by staff; individual and institutional service-providers must respect powers of attorney that name a same-sex partner as a decision-maker.
- 17.66 Information supplied on intake and other initial-contact forms must be treated with sensitivity and used only to the extent necessary to provide required and equitable service addressing the particular health-care or other need(s) of the individual lesbian, gay, bisexual, or transgendered person to whom service is provided; it must be treated confidentially by anyone who has access to those records.
- 17.67 Agencies and services with strong lesbian, gay, bisexual, and/or transgendered programming must:
- (a) monitor community-development initiatives in their service area and be advocates for issues important to lesbian, gay, bisexual, and transgendered people;
 - (b) encourage other organizations which do not provide adequate services to lesbian, gay, bisexual, and transgendered people to implement positive policies and procedures targeted towards those communities.

PROFESSIONAL ASSOCIATIONS AND POST-SECONDARY EDUCATIONAL INSTITUTIONS

Older Lesbians, Gays, and Bisexuals

- 17.68 Gerontology programs in post-secondary educational institutions must incorporate information about the specific needs and contexts of lesbian, gay, bisexual, and transgendered seniors, recognizing that they may be in sexual/loving same-sex relationships..

HIV/AIDS

- 17.69 Post-secondary institutions and professional associations educating and certifying health-care and social-service-providers must ensure that HIV/AIDS awareness, including the particular issues affecting lesbian, gay, bisexual, and transgendered people, are components of pre- and post-certification educational programs.

Health-Care and Social-Service Delivery

- 17.70 Professional associations and post-secondary educational institutions in the health-care and social-service fields must:
- (a) train service-providers to meet the needs of the diverse lesbian, gay, bisexual, and transgendered communities of Ontario;
 - (b) conduct or fund research into the health-care and social-service needs of these communities.
- 17.71 Professional associations must:
- (a) set out in their codes of ethics clear standards of practice which state that negative or discriminatory treatment of clients based on their gender or sexual identification is professional misconduct;
 - (b) establish enforcement mechanisms for dealing with those who contravene such standards of practice;
 - (c) provide adequate support and information to lesbian, gay, bisexual, and transgendered service-users who register complaints about instances of professional misconduct;
 - (d) educate their members concerning their obligation to be respectful of sexual and gender identification issues in their work and to provide equitable service to lesbians, gays, bisexuals, and transgendered people;
 - (e) provide opportunities for lesbian, gay, bisexual, and transgendered service-providers within their membership to contribute to increasing the level of awareness within the profession.
- 17.72 Post-secondary educational institutions must include in the curricula of all programs for health-care and social-service qualification, certification or licensure:
- (a) anti-homophobia and anti-heterosexism training;
 - (b) comprehensive, unbiased information about the health-care and social-service needs of lesbian, gay, bisexual, and transgendered people;
 - (c) practical strategies and techniques for providing equitable services to lesbian, gay, bisexual, and transgendered people.
- 17.73 Post-secondary educational institutions must provide a positive environment in which lesbian, gay, bisexual or transgendered students, teachers, and administrators are free to come out.
- 17.74 Post-secondary educational institutions must provide appropriate practica and practical experience opportunities to students who wish to fulfil such requirements with organizations providing services to lesbian, gay, bisexual, and transgendered people; the availability of such placements must be proactively communicated.

EMPLOYERS AND THE PRIVATE SECTOR

- 17.75 Employers must:
- (a) make extended health-care benefits available equally to same-sex and opposite-sex couples;
 - (b) require that their insurance carriers provide benefits packages equally to same-sex and opposite-sex couples;
 - (c) ensure that employees who are in same-sex relationships can apply for the coverage to which they are entitled without fear of discriminatory repercussions;
 - (d) train those who administer employee-assistance programs to recognize and be sensitive to issues of harassment and poisoned environments for lesbian, gay, bisexual, and transgendered people.
- 17.76 Insurance companies must provide coverage equally to same-sex and opposite-sex couples.

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER COMMUNITY GROUPS

- 17.77 Lesbian, gay, bisexual, and transgender community organizations must be proactive in combatting systemic and personal sexism, racism, anti-Semitism, ableism, ageism, and other forms of discrimination within our communities.

- 17.78 Lesbian, gay, bisexual, and transgender community groups must:
- (a) create/maintain a list of positive service-providers (such as *The Rainbow Book*, which CLGRO and Project Affirmation helped publish in 1995 and 1996);
 - (b) advocate for the implementation of all the Project Affirmation recommendations;
 - (c) through CLGRO, organize provincially around health-care and social-service issues, incorporating local or regional perspectives as they apply;
 - (d) seek funding for other studies on the health-care and social-service needs of our communities, to build upon the beginning made by Project Affirmation.

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Appendix II: Terminology

Common-use meanings for terms that appear in the report; terms relating to transgender issues are more exactly defined in the chapter, *Transsexuals and Transgenderists*

Biphobia - fear or hatred of bisexual women and men

Bisexual - adjective describing men and women whose affectional and/or sexual relationships are with people of either sex

(In the) Closet - used to describe people who choose to conceal or not to disclose their sexual orientation; this is a particularly common experience for lesbians, gays, and bisexuals who may feel the need to protect themselves from the effects of prejudice

Coming out - acknowledging one's lesbian, gay, or bisexual sexual orientation to oneself or to others; often a process rather than an event

Community / Communities - a group of people who live in a shared geographical location; a group of people with a special focus or shared interest/identity; issues and experiences may be shared across communities, yet communities themselves may be a defining factor in varying the experience

Drag - the clothes traditionally thought appropriate to the opposite gender; these can be worn for gender comfort or for entertainment; drag is not confined to gay men

Gay - homosexual; as an adjective, actually includes both men and women but increasingly used to mean just men; when used in the plural, *Agays,* usually means just men

Heterosexism - the view that heterosexuality is the norm for all social and sexual relationships and heterosexual behaviour and experience are the measure for all human, social and sexual activity; the assumption that heterosexuality is the only normal and natural way of being; the assumption that heterosexuality is the only way of being

Heterosexual - adjective describing men and women whose affectional and/or sexual relationships are exclusively or predominantly with those of the opposite sex

Homophobia - fear or hatred of lesbian, gay, and bisexual people

Homosexual - adjective describing men and women whose affectional and/or sexual relationships are exclusively or predominantly with those of the same sex; erroneously used to mean gay men only

Leather community - those who share a sexual interest in wearing leather

Lesbian - adjective describing women whose affectional and/or sexual relationships are exclusively or predominantly with other women

Sexual minorities - used in the by-line of this project in an attempt to include people whose sexual feelings generally fall outside of those that are heterosexual; in practice, lesbian, gay, bisexual, transgender and transsexual people

Sexual orientation - commonly used to describe the state of being homo-, hetero-, or bi-sexual; it is perhaps necessary to recognize that, although for some people, their orientation is stable from early on, for others orientation is a more fluid issue; people can come out at almost any age

S/M (sado-masochism) - consensual sex involving domination or pain

Transgender - people whose chosen gender is at odds with their physical body; they may be heterosexual, lesbian, gay, bisexual, asexual, or nonsexual

Transphobia - fear or hatred of transgender, transsexual, and transvestite people

Transsexual - people concerned with changing their physical body to reflect their chosen gender; they may be heterosexual, lesbian, gay, bisexual, asexual, or nonsexual

Transvestite - people who like to wear clothes which society considers appropriate for the opposite sex; mostly men who like to wear women's clothes, since women can wear *Unisex* or *Men's clothing* to quite an extent without being considered to have crossed the line; they may be heterosexual, lesbian, gay, bisexual, asexual, or nonsexual

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Appendix IV: CLGRO Publications

Order from CLGRO, Box 822, Station A, Toronto M5W 1G3; (416) 533-6824. Shipping costs will be added: \$3 for one item; \$5 for two or more.

<i>Systems Failure</i> , Project Affirmation=s final report	\$ tba
<i>Systems Failure</i> , Project Affirmation=s final report, executive summary	\$ tba
<i>Access Denied: A Report on the Experiences of Transsexuals & Transgenderists With Health Care & Social Services in Ontario</i> , commissioned by Project Affirmation, written by Ki Namaste	\$ tba
<i>Le réalité des gais, lesbiennes et bisexuel-les de l=Ontario</i> , rapport commandé par le Projet affirmation, écrit par Lyne Bouchard	\$ tba
<i>The Spousal Collection</i> , newsclippings on same-sex spousal rights 1989-97, 62pp	\$ 10.00
Selected newsclippings on adoption & parenting issues for lesbians, gays, & bisexuals	\$ 7.00
CLGRO et al., <i>The Rainbow Book: The Ontario Directory of Community Services for Lesbians, Gay Men, Bisexuals, Transsexuals, Transgenderists & Transvestites</i> (Toronto, 1996) is distributed by the 519 Church Street Community Centre, 519 Church Street Toronto M4Y 2C9; (416) 392-6881	-- --
<i>Extracts from the World News</i> , newsclippings, January 1994-July 1995, 6pp	\$ 3.00
CLGRO history 1975-95, <i>Way To Go! A Short History of CLGRO</i>	\$ 5.00
1996 <i>Diary</i> , newsclippings on lesbian, gay, & bisexual rights, 30pp	\$ 7.00
1995 <i>Diary</i> , newsclippings on lesbian, gay, & bisexual rights, 40pp	\$ 7.00
1994 <i>Diary</i> , newsclippings on lesbian, gay, & bisexual rights, 42pp	\$ 5.00
1992 brief, <i>Happy Families: the recognition of same-sex spousal relationships</i>	\$ 8.00
1991 legal guide to relationships recognition, <i>On Our Own Terms</i>	\$ 8.00
1991 brief, <i>We Count! Lesbians, Gay Men & Employment Equity</i>	\$ 5.00
1986 brief, <i>Discrimination Against Lesbians & Gay Men:</i>	
<i>The Ontario Human Rights Omission</i>	\$ 5.00
CLGRO=s educational slideshow/video, <i>Can We Talk</i>	rental \$25.00, purchase \$100.00
CLGRO's guide, <i>Some Notes on Meeting Facilitation:</i>	
<i>A Guide for Meeting Participants</i>	\$ 3.00
CLGRO's organizing manual, <i>The Gay Organizer</i>	\$ 20.00
Package of assorted educational leaflets	\$ 5.00
Leaflet: Young People & Sex: What Can You Do? What Can You Look At? What Can You Read Or Write About (covering Criminal Code / age of consent laws)	free
Leaflet: Washroom & Park Arrests	free
Leaflet: Employment Equity	free
Leaflet: What Is CLGRO?	free

Appendix V: CLGRO Membership

The **Coalition for Lesbian and Gay Rights in Ontario** was founded in January 1975 and, that same year, began its 12-year campaign to have ordinary human rights protection for lesbians, gays, and bisexuals included in the *Ontario Human Rights Code*. In December 1986, the words "sexual orientation" were added to the *Code* as a ground on which discrimination is prohibited.

CLGRO is committed to fighting sexism and supports the women's movement on issues such as employment equity, ending violence against women, and a woman's right to choice on abortion. Similarly, we have a commitment to dealing with racism, anti-Semitism, discrimination against those considered disabled, and other forms of prejudice.

CLGRO is now involved in the relationships recognition campaign to give our relationships with each other and with our children the protection we've finally achieved as individuals. We're working against prejudice at work, for protection from hate literature and from violence.

CLGRO has achieved a great deal. We've produced a book, briefs, a video, a regular newsletter, and more. We have become a lobbying force, a voice for Ontario's lesbians, bisexuals, and gay men. But we need you. You can help us by getting involved: we need your ideas, your support, your work and, of course, your money! Please mail in this form, or call us at (416) 533-6824.

I want to be part of CLGRO!

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- ☐ Here's my \$40 one-year membership fee.
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- Number _____ Expiry date _____
- Signature _____
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