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Crossing to Safety: Transgender Health & Homelessness

Persons who identify with a gender that differs from the sex assigned to them at birth are at high risk for social isolation, physical and emotional trauma, chemical dependency, infectious disease, and discrimination limiting their access to employment, housing, and health care. Homelessness compounds these risks. The following articles were written to enhance understanding of gender variance and to illustrate ways in which clinicians can provide a safe and comfortable "medical home" for transgender clients who are otherwise homeless.

Dani, Stout Street Clinic, Denver, Colorado

Among the most marginalized of homeless people are those whose gender identity transgresses cultural norms. "Transgender individuals experience homelessness for all of the same reasons that other people do — lack of affordable housing, mental health and addiction problems, physical abuse, and estrangement from families," says **Jenny Scanlon, FNP**, Colorado Coalition for the Homeless. But their social isolation and stigmatization are disproportionately high. They often end up on the street as a direct result of job or housing discrimination, with fewer legal protections than other sexual minorities have. As many as 60% have been victims of harassment or violence, and 37% have experienced economic discrimination.[1]

ROOTS OF DISCRIMINATION

"Homophobia motivates most overt discrimination against transgender persons, especially by men," says mental health practitioner **Marc Potter, MSW**, of Harborview Medical Center in Seattle. "Variations in gender expression don't disturb women as much as they disturb men," he observes — perhaps because males have a much narrower range of "acceptable" gender expression in our society than females do.[2]

"Society's response to gender variance with fear and hatred rather than understanding and compassion is often more disruptive to transgender peoples' lives than the psychological struggle to express their internal gender identity," notes **Jay Sheffield, LCSW**, who coordinates a disability evaluation assistance program for the Tom Waddell Health Center in San Francisco.

BEYOND STEREOTYPES

"There is a continuum of gender identity and its expression along which people fall in different places," explains Sheffield. Some transgender individuals choose to dress in a unisex manner to protect their safety and security; others are comfortable cross-dressing. Still others feminize or masculinize their bodies medically and/or surgically to match their internal experience. The general public often confounds this range of expression into a single stereotype embodied by male-to-female transsexuals who have had complete sexual reassignment surgery. But that is as mistaken as assuming that all homeless people live in alleys. Although often presumed to be homosexual, transgender persons may be attracted to the same or opposite sex, to both, or neither. In short, gender variance defies stereotypes, like most human ways of being.

"We see a tremendous variety of clients at the Tom Waddell transgender clinic," says **Robyn**

DEFINITIONS[2]

Sex: a biological label ascribed at birth on the basis of genitalia - male, female, intersexed.

Gender: appearance and behaviors based on socially constructed concepts of masculine and feminine that vary from culture to culture and among individuals within a given culture.

Transgender: gender variance or blurring of cultural gender norms; individuals who feel a "disconnect" between the sex they were assigned at birth and their psychological gender identity.

FTM (female-to-male): born with female genitalia but see themselves as partly to fully masculine.

MTF (male-to-female): born with male genitalia but see themselves as partly to fully feminine.

Gender dysphoria: a clinical term for unhappiness or discomfort experienced by individuals whose external sex characteristics do not match their internal gender identity.

Transsexual: individuals who feel a need to change their external sex characteristics through hormones and/or surgery to match their internal gender identity.

Sexual orientation: the sex to which one is erotically attracted – opposite (hetero), same (homo), both (bi), none (a).

Stukalin, LCSW. "Their ages range from 18 to over 60. Many are from countries where transgender people are severely persecuted; these clients frequently qualify for political asylum. Some individuals have been aware of a disconnect between their sex and gender from their earliest memory; others experienced it much later in life."

The majority of **Marc Potter's** transgender clients are in their late 40's. Admitting their gender identity became an imperative for them as they matured. Most waited to come out until after their marriage ended and children were grown. One client is a Vietnam veteran. "Most of my clients are heterosexual men trying on their stereotypes of women," explains Potter. "Over time, that calms down."

MULTIPLE STIGMAS

Transgender persons who are homeless are members of multiple disenfranchised groups, observes Stukalyn. Besides being poor, they may be ethnic or linguistic minorities, estranged from their families and often from their country of origin. Coming out may also preclude support from religious communities. Isolation deprives them of role models. "Many of our clients have never met people who have successfully transitioned, are still employed or in school, and are going on with their lives," she says.

"Don't ask, don't tell, don't look" is the basic policy for sexual minorities in Omaha, Nebraska — just like the Army, says **Marilyn Wegehaupt, MSN, RN**, one of two nurses with the Visiting Nurses' Association who provide primary care at seven area homeless shelters. They are careful not to let shelter providers know if any of their clients is gay, lesbian, bisexual or transgender (GLBT). If shelter residents obviously deviate from sexual or gender norms, they may be asked to leave, says Wegehaupt, who can remember only one adult transgender client in the last seven years — a male-to-female who had difficulty obtaining shelter and was "totally ostracized." The nurses are just beginning street outreach to runaway and homeless teens, "who do lots of experimenting with gender and sexual identity." Few transgender homeless people stay long in Omaha, Wegehaupt surmises. "It is not an open community with respect to GLBT issues."

HEALTH RISKS Unable to gain or maintain employment, many transgender individuals turn to survival sex, which increases their risk for violence and sexually transmitted disease. Denied shelter or forced to live with persons of the same anatomical sex, they are frequently harassed or physically abused by shelter residents. Unable to obtain hormonal therapy within a controlled clinical setting, many individuals resort to purchasing black-market hormones of variable quality and quantity, which places them at increased risk for complications from inappropriate dosage and for HIV and hepatitis from shared needles. High rates of addiction, depression, anxiety, and suicide among transgender people attest to the psychological burden of discrimination, isolation, and victimization. Especially unwelcome in small or homogeneous communities, they gravitate toward large urban areas to find greater anonymity or peer support.

CLINICAL BARRIERS Despite their serious health risks, homeless people with atypical gender identities experience even greater obstacles to health care than do other impoverished and homeless people. Many transgender patients report unpleasant experiences with medical providers who are judgmental, unsympathetic, and poorly informed about gender variance, which is often treated as pathological or immoral. Especially troubling is evidence of denied screening and care for life-threatening diseases, such as cervical cancer in FTMs and HIV infection in MTFs.[1]

Even where discrimination is not a factor, lack of health insurance seriously limits health care access for the vast majority of homeless, transgender persons. Because of these barriers to primary care, they often wait until their health problems are acute and present at emergency rooms, where they are frequently mistreated.

Most health care providers lack even basic information about gender variance, observes **Samuel Lurie**, transgender trainer and advocate who works with the New England AIDS Education and Training Center, based in Boston. "Scientific information about transgender care is scarce, and few healthcare providers have had much clinical experience with transgender patients. These clients need an ally in any clinic. Provider hostility is the main reason they don't seek care."

WHAT CLINICIANS CAN DO

There are some basic things that every clinician can do, Lurie says. "Most importantly, talk to clients in a respectful way. Address them according to their presenting gender, and use the name they wish to be called. Negotiate gynecological care with those who identify as male but are physiologically female. Gender variance is everywhere, however hidden, and these people are desperate for care." Knowledgeable clinicians and advocates offer more advice, summarized in the box on this page, to those who are less experienced but willing to create a safe and comfortable medical home for underserved transgender people. ■

CREATE A TRANSGENDER-FRIENDLY CLINIC

- **Educate yourself and your staff about gender variance.**
  - Schedule regular in-service training on transgender issues.
  - Include resources about gender variance in your agency's library.
- **Create a safe and comfortable environment.**
  - Hire a diverse staff with whom clients can identify.
  - Don't tolerate homophobic remarks or actions by clients or staff.
  - Provide unisex (not just same-sex) bathrooms.
  - Display posters and literature supportive of sexual minorities.
- **Use GLBT-sensitive language.**
  - Address clients by their presenting gender. When in doubt, ASK.
  - Use appropriate pronouns -"she/her" for MTFs, "he/his" for FTMs.
  - Avoid personalizing body parts -"the" (not "your") penis for a MTF.
- **Provide respectful, compassionate care.**
  - Treat each client as a unique individual.
  - Be non-judgmental. LISTEN.
- **Incorporate hormone therapy into primary care.**

Jenny Scanlon, Denver, Colorado; Marc Potter, Seattle, Washington; Samuel Lurie, Boston, Massachusetts; Jay Sheffield, San Francisco, California

The Rationale for Hormone Therapy in Primary Care

Seven years ago, the San Francisco Public Health Department's **Tom Waddell Health Center** started Transgender Tuesdays, a four-hour per week primary care clinic providing multidisciplinary care for self-defined transgender people, under the direction of **Barry Zevin, MD**, medical director of the homeless program and assistant clinical professor of internal medicine at UCSF School of Medicine. "Our initial reason for establishing the clinic was because we were seeing many homeless transgender people who were not getting medical care, or who reported very appalling stories of discrimination in medical settings," recalls Zevin. It was also clear that these individuals were at high risk for serious health conditions, including HIV, which clinicians hoped to reduce through improved access to primary medical care.

A 1997 study conducted by the San Francisco Transgender Health Project, including the Tom Waddell clinic, confirmed this risk. They found that 32% of 515 transgender participants had prior exposure to injected, illicit drugs excluding hormones, over 50% had used injected hormones outside conventional medical settings, and 48% had engaged in sex work. In addition, 35% of MTF participants were infected with HIV, and among African Americans, almost two-thirds (63%) were HIV positive.[3] Other studies have corroborated high rates of HIV infection among transgender women in California, even surpassing those for bisexual and homosexual men.[1]

HARM REDUCTION In response to the urging of Tom Waddell clinicians, community AIDS organizations and transgender activists, the Health Department decided to offer a range of primary care services including the possibility of hormonal therapy. Their rationale was harm reduction — specifically, to prevent HIV transmission and reduce other health risks for the general public and for transgender individuals, by increasing their access to primary and preventive care. It was clear that without access to hormone therapy in a controlled medical setting, transgender people would continue to use injected hormones purchased on the street or from medical providers who did not monitor their use. The clinic does not provide sex reassignment surgery or psychiatric approval for surgery.[4]

Tom Waddell clinicians developed detailed Protocols for Hormonal Reassignment of Gender. The protocols, which are available online, specify laboratory tests and health care required prior to initiation of therapy, recommended medications for MTF and FTM gender reassignment, contraindications and precautions for their use, adverse effects, and expected outcomes of therapy.[4] These protocols have significantly influenced transgender care in San Francisco and several cities across the United States.

"We have done a lot of educating, including HIV treatment providers and medical staff at the county jail," says Dr. Zevin. "We even get requests for the protocols from physicians in the private sector, who are becoming more comfortable with hormone therapy for sexual reassignment." Another positive outcome is increased medical monitoring of practitioners in San Francisco. "Patients now know they have the alternative of coming to Tom Waddell, instead of relying on black-market hormones or those prescribed by unscrupulous medical practitioners who will prescribe anything for a price without monitoring health or therapeutic outcomes."

TOM VS. HARRY The standard for prescribing hormones at Tom Waddell is "informed consent of self-identifying transgender individuals with the mental capacity to understand possible risks as well as limits to therapeutic benefits."[4] This standard diverges somewhat from the traditional Standards of Care for Gender Identity Disorders of the Harry Benjamin International Gender Dysphoria Association (HBIGDA), which until recently recommended a psychiatric diagnosis of gender identity disorder, a documented real-life experience of at least three months living in the preferred gender, and three months or more of psychotherapy for all patients before hormone therapy is initiated.[5]

Dr. Zevin has three main objections to the Harry Benjamin SOC: **First**, requiring patients to have a psychiatric assessment and psychotherapy prior to treatment "undermines patient autonomy." Informed consent is the highest standard, he insists. **Second**, the HBIGDA standards "discriminate against poor people." Mental health care for poor people is in extremely short supply; even severely mentally ill patients don't have the option to receive the mental health treatment they need. Given limited health care resources for indigent people, these patients should receive priority. **Finally**, contends Zevin, these standards have been "oriented more toward protecting physicians and

EVALUATION PROCESS FOR HORMONE TREATMENT

- **1st visit**: psychosocial intake with social worker, refer to mental health IF indicated.
- **2nd visit**: physical exam, labs, discuss risks, benefits, client expectations.
- **3rd visit**: re-discuss risks, benefits, client expectations; review labs; obtain informed consent (written).
- Can take more than three visits.

Tom Waddell Health Center Protocols for Hormonal Reassignment of Gender, as adopted and adapted at Stout Street Clinic, Denver, Colorado

PREPARING FOR HORMONE TREATMENT

- Review patient's expectations. Ask: "What do you want from taking hormones?" "What changes do you expect to notice?"
- Straightforward approach is best if expectations are unrealistic.
- MTF: Changes happen slowly, heredity limits tissue response to hormones, and more is not always better.
- FTM: Changes happen quickly, 2-6 months.

Tom Waddell Health Center Protocols, as adopted and adapted at Stout Street Clinic, Denver, Colorado

surgeons than toward providing the best possible treatment for patients."

Nevertheless, clinicians at Tom Waddell admit that the Harry Benjamin standards are more flexible and helpful than they once were, in response to input from transgender advocates. For example, the 2001 version includes the following qualification under 'eligibility criteria for adults':

> *In selected circumstances, it can be acceptable to provide hormones to patients who have not fulfilled [a documented real-life experience of at least three months and a minimum of three months of psychotherapy] – for example, to facilitate the provision of monitored therapy using hormones of known quality, as an alternative to black-market or unsupervised hormone use.*[5]

Other advocates strenuously object to the fact that 23 years after homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders as a mental disorder, transgender identity and expression (particularly for males) are still specified as mental disorders in both the DSM-IV and the Harry Benjamin Standards of Care.[6]

> "Transgendered people do suffer distress and impairment from societal intolerance, discrimination, violence, undeserved shame, and denial of personal freedoms that ordinary men and women take for granted. The psychiatric interpretation of inherent transgender pathology serves to attribute the consequences of prejudice to its victims, neglecting the true cause of distress."
>
> *Katherine K. Wilson, Gender Identity Center of Colorado, Inc., 1997* [6]

CLINICAL CONCERNS Unfamiliarity with transgender patients is the main reason for many physicians' hesitancy to prescribe hormonal therapy, according to endocrinologist **Sydney Westphal, MD**, of the Maricopa County Medical Center in Phoenix, Arizona. "Experience with the patient population is the most important criterion of competence in this area," she says. "Neither medical schools nor endocrinology fellowships typically provide this experience." She confirms the scarcity of scientific information about high-dose hormone therapy and the prevalence or likelihood of complications.

In prescribing high doses of estrogen for physiological males, providers may worry about the risks of pulmonary embolism and deep venous thrombosis — blood clots in the lungs, brain or other parts of the body — notes Dr. Westphal. She says she would also be concerned about homeless clients' access to close monitoring and follow-up care, particularly if they were uninsured. It has been about three years since anyone has come to her clinic with a request for hormone therapy of this kind. She was interested to learn of the Tom Waddell protocols, which, she said, look "helpful and sound."

Dr. Zevin confirms the risk of thromboembolic complications from high-dose estrogens. To reduce this risk, he prescribes transdermal estrogen with aspirin for MTF transsexuals over 40, who are thought to be at higher risk for these complications. This precaution is supported by findings of a study conducted in the Netherlands, 1973–1994, which found a 20-fold increase in the incidence of venous thrombosis and/or pulmonary embolism over the expected rate in 816 MTF transsexuals treated with oral estrogens and anti-androgens. Fewer complications were observed following the introduction of transdermal estradiol in the treatment of transsexuals over 40 years of age.[7] Although he has not conducted a formal study, Zevin reports that of 500 MTF patients treated with estrogens during the past eight years, he has seen only one or two with a prior history of thrombosis, and none who has developed a thromboembolic complication from estrogen therapy. The most significant complications he sees are mood swings when clients are starting, stopping, or changing medications.

"In patients with severe liver disease, we begin with low-dose estrogens and use a transdermal patch, which doesn't have a toxic effect on the liver," says Zevin. "With uncontrolled diabetes, coronary artery disease, or uncompensated cirrhosis, we treat the underlying problems first before beginning hormone therapy. For patients who smoke, we aggressively encourage smoking cessation, although smoking is not by itself a contraindication for hormone therapy." But if a client has a history of thrombosis secondary to hormones, Zevin won't prescribe more hormones. "Ultimately, whether or not to prescribe hormone therapy must be the individual provider's decision, working in the best interest of individual patients," he concludes.

FINANCIAL CONCERNS Before last year, virtually no insurance plan in California covered hormone therapy for transgender individuals, reports Zevin, and most insurance plans still exclude sexual reassignment surgery. Since last year, every city employee in San Francisco has had access to insurance that covers a certain amount of medical and surgical treatment for transgenders or transsexuals. Many of the patients treated at the Tom Waddell clinic qualify for MediCAL under SSI or as refugees, and medications commonly used in hormone therapy are included in the MediCAL formulary, Zevin says. Some patients qualify for SSI disability at least in part because of a gender identity disorder, but usually not on that basis alone. Workplace discrimination is considered a disability-related condition, however, which can contribute to functional impairment.

> "It is important to remember that we can reach these people and provide necessary care for them *because* we provide hormones. Otherwise, they would remain a hidden population."
>
> *Barry Zevin, MD, Tom Waddell Health Center, San Francisco, California*

OUTREACH CHALLENGES Clinicians at Tom Waddell report increasing numbers of female-to-males among their patients. Those who first came to the clinic were more likely than male-to-females to be employed, emotionally well adjusted, and eager for services. "Now we're seeing less functional FTMs as well," reports Zevin. "Special efforts are required to connect with this hidden population." ■

TRANSGENDER & HOMELESS: A CASE STUDY

M. is a 36-year-old, male-to-female, transgender person with severe hypertension, diastolic dysfunction, hyperlipidemia, and hepatitis B. She presented to Stout Street Clinic two years ago, after hearing that providers there were prescribing hormones for transgender people.

M. has been homeless since leaving the South and coming to Denver three years ago after the death of her mother, her primary social support. She works at temporary clerical jobs, usually making barely enough to pay for a single-room-occupancy hotel room. On rare occasions, she exchanges sex for money or housing to avoid being on the streets or having to sleep in a shelter, which she considers an unsafe place for "anyone like me."

Knowing since age six that she was "really a girl" despite being told by everyone that she was a boy, M. began dressing privately as a female at age 15, and has been living full-time as a woman since age 22. Injectable estrogen is the only street drug M. has ever used, and she is not sure that was really estrogen. Although she used a clean needle, M. says she knows other transgender people who share needles.

When M. presented to Stout Street, her blood pressure was severely elevated and uncontrolled. She had not sought treatment for her hypertension consistently because she was always treated badly by medical providers, she explained. M. recalls being sexually assaulted by a physician during a physical exam, but did not report the incident because she was sure no one would believe her.

M. has passed as a female for many years. Like most other transgender people, she expresses a strong need for her body to match how she feels inside, which is why she sought hormone therapy at Stout Street Clinic. On her first visit, M. received baseline lab tests, during which hyperlipidemia was discovered, and a psychosocial assessment. After maintaining better blood pressure control, learning about the risks and likely outcomes of hormone therapy, and signing an informed consent, M. began oral estrogen and an anti-androgen (aldactone) under the care of her HCH provider.

After nearly two years of hormone therapy, M.'s blood pressure and hyperlipidemia are well controlled, and she keeps nearly all of her routine medical appointments. She receives health care maintenance including an annual breast exam. M. describes her emotional well being as "100% happier." Though still homeless, she has been employed at the same job for six months. When asked how she feels about receiving hormone therapy and primary care at the Stout Street Clinic, this was M's response: "For the first time in my life, I feel like a person instead of a so-called 'faggot' when I go to the doctor. They listen to me!"

Jenny Scanlon, FNP, Stout Street Clinic, Colorado Coalition for the Homeless

Homeless GLBTQ Youth: Do Ask, Do Tell

Homeless adolescents and youth are susceptible to many negative health conditions.[8] Recent research demonstrates that those who are members of sexual minorities are at even higher risk for physical and mental health problems than are their heterosexual counterparts.[9] Transgender homeless youth, often ostracized even by agencies serving their gay, lesbian and bisexual peers, bear the highest risks of all, according to clinicians and advocates.[8]

Among the factors that increase their health risks disproportionately, if not uniquely, are: *self-injury* (suicide and self-mutilation of genitalia), *substance abuse* (including injection of hormones and liquid silicone without medical supervision to masculinize or feminize their bodies), *high exposure to HIV and other STDs* (from shared needles and unprotected sex in exchange for money to purchase illicit hormones), and *violence* (triggered in individuals who are enraged by obvious divergence from sex or gender norms).[8,10]

Transgender youth who are homeless rarely have health insurance, and few health care systems, even those accessible to indigent populations, are designed to meet their special needs.[8] These economic and system barriers present special challenges to homeless service providers who try to reach these vulnerable young people.

A respectful, trusting relationship with an outreach worker, access to comprehensive health services including health and sexuality education, and case management combined with peer support are said to be the best predictors of positive outcomes for youth who express non-gender conforming behavior or identify as transgender.[8]

The Urban Peak homeless shelter in Denver, Colorado, provides a safe haven for runaway and homeless youth, ages 15–20, including those who are gay, lesbian, bisexual, transgender, or in the process of questioning their gender or sexual identity (GLBTQ). Services include outreach, case management, onsite medical care and behavioral health counseling, in addition to referrals for mental health/substance abuse treatment, and a GED program.

PROTECTING THE SAFETY OF TRANSGENDER YOUTH

- **Create a safe space.** Put up "safe zone" signs to indicate acceptance of diversity. Allow MTF transgender youth to stay in female dorms.
- **Do ask, do tell**. Ask every client, "What is your sexual and gender identity?" Never assume anything.
- **Know your limits.** If you can't ask questions about injection drug use, sexuality and gender comfortably, refer clients to someone who can. Educate yourself to increase your comfort level.
- **Know your agency's policies about confidentiality**. If adolescent under age 18 want to "come out" to you, you can protect their confidentiality, even from parents.
- **Call staff and clients on the use of discriminatory language** (like "fag"). Interrupt it, confront it, address it, don't let it slide. Use nonjudgmental, inclusive language.
- **Educate clients** – about what to say or not to say at their new job; and about the importance of HIV/STD testing regardless of sexual orientation.
- **Promote family and community support.** Try to keep family relationships in tact. Refer clients to mentors and other community resources; help them work with employers.

Allison Hoffman, Urban Peak Homeless Shelter, Denver, Colorado

Part of the intake process for all youth admitted to the shelter is asking about their sexual orientation and gender identity, says case manager **Allison Hoffman**. "This is educational even for 'straight' kids. We send a clear message that everyone is safe and welcome here, regardless of gender identity, sexual orientation or disability. At Urban Peak, acknowledging sexual and gender identity is an important aspect of case management. Staff and clients work together to make our shelter a comfortable, nondiscriminatory place to be."

Adolescence is a very threatening time for transgender youth especially, because their bodies begin to change in ways that are uncomfortable for them, explains Hoffman. As they

get older, girls and boys who emulate behaviors of the opposite sex encounter increasing disapproval and rejection from adults and peers. Many turn to illicit drugs to dull the pain. Prostitution, victimization, and use of illegal hormones are frequent results. Alienation and loneliness compound these threats to physical safety.

Transgender youth comprise 1% of the population served by Urban Peak and 20% self-identify as GLBTQ; 70% of their clients are from Colorado, and 17% are from out of state. One 16-year-old girl hitchhiked to Denver from a small town in Nebraska, which had no social services to offer her.

"GLBTQ youth are everywhere," says Hoffman. "Kids from small communities run to urban areas to find support and services. These young people desperately need support at home, and their parents do too." ■

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Network member **Kathleen Borne-Geary**, 63, Program Director for Open Door Social Services, Springfield, Massachusetts, passed away October 12, 2001. She was a strong and passionate advocate on behalf of homeless individuals, and her loss is felt deeply by clients and staff. She ran Open Pantry Community Services' Open Door Program for the last twelve years, and was especially involved in developing Open Door's substance abuse intervention services. Kathleen's deep commitment to serving disadvantaged individuals, and her generosity of spirit carry on in the program she devoted such a large portion of her lifework towards shaping.

Theresa O'Connor, Social Worker, Open Pantry Community Services, Inc., Springfield, Massachusetts

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