Canadian Human Rights Tribunal **Tribunal canadien des droits de la personne**

BETWEEN:

SYNTHIA KAVANAGH

Complainant

- and -

CANADIAN HUMAN RIGHTS COMMISSION

Commission

- and -

ATTORNEY GENERAL OF CANADA

Respondent

- and -

THE ZENITH FOUNDATION

and

TRANS/ACTION

Interested Parties

REASONS FOR DECISION

T.D. 11/01

2001/08/31

PANEL: Anne Mactavish, Chairperson

Grant Sinclair, Tribunal Member

Sandra Goldstein, Tribunal Member

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[1] Canada's federal corrections system is organized into male and female institutions. At issue in this proceeding is the Correctional Services of Canada's policy regarding the placement of pre-operative transsexual inmates, as well as its policy prohibiting access to sex reassignment surgery for incarcerated individuals.

I. INTRODUCTION

[2] Synthia Kavanagh was born with male anatomy. From her earliest childhood, however, she understood that there was something different about her - that something was not right. She was ultimately diagnosed as suffering from Gender Identity Disorder, a condition where her biological or anatomical sex did not correspond to her gender identity, that is, her subjective sense of herself as a woman.

[3] Ms. Kavanagh is currently an inmate in the federal corrections system, as a result of her 1989 conviction for second degree murder. Ms. Kavanagh was initially sentenced to life without possibility of parole for fifteen years. On appeal, her period of parole ineligibility was reduced to 10 years.

[4] At the time of her incarceration, Ms. Kavanagh was living as a woman. She had been taking female hormones from the age of thirteen, and had been conditionally approved for sex reassignment surgery. In passing sentence on Ms. Kavanagh, the judge presiding at her trial recommended that she be allowed to serve her sentence in a female institution.

[5] Notwithstanding the trial judge's recommendation, Ms. Kavanagh was sent to Millhaven Penitentiary, a maximum security institution for men in Kingston, Ontario. Over the ensuing eleven years, despite repeated, albeit inconsistent, requests that she be placed in a female institution, Ms. Kavanagh was held in a variety of maximum and medium security male institutions in Ontario and British Columbia.

[6] Ms. Kavanagh's incarceration affected the treatment she received for her Gender Identity Disorder. She was initially prohibited from continuing with her hormone therapy. This resulted in Ms. Kavanagh losing many of her female secondary sex characteristics, and caused her great distress. Ms. Kavanagh's access to hormone therapy was reinstated in 1993. In addition, despite her repeated requests, Ms. Kavanagh was not permitted to proceed with sex reassignment surgery.

[7] As a result of these events, Ms. Kavanagh filed complaints with the Canadian Human Rights Commission in relation to the withholding of hormone treatment, the denial of sex reassignment surgery and her placement in a male institution. Each complaint alleges discrimination on the basis of sex and disability.

[8] Ms. Kavanagh's individual complaints against CSC have been settled. Subsequent to the settlement, Ms. Kavanagh underwent sex reassignment surgery and is now incarcerated in Joliette Institution for Women, a medium security female institution.

[9] Access to hormone therapy is now provided to transsexual inmates under CSC's Health Services policy, on the recommendation of a recognized Gender Identity Disorder Clinic. There is no issue now before the Tribunal with respect to access to hormone therapy. What remains in issue is CSC's policy regarding the placement of pre-operative transsexual inmates, as well as its policy limiting the availability of sex reassignment surgery to incarcerated individuals.

II. INTERESTED PARTIES

[10] Two organizations providing assistance to the transsexual community sought and were granted interested party status in this proceeding. Despite having been provided with notice of the hearing, Trans/Action did not appear at the hearing on the merits of these complaints. The Zenith Foundation did appear, and provided a useful perspective on the difficult issues raised by this case.

III. GENDER IDENTITY DISORDER

[11] Evidence with respect to Gender Identity Disorder and the appropriate treatment thereof was provided by Dr. Diane Watson on behalf of the Canadian Human Rights Commission, and by Dr. Robert Dickey, Dr. Stephen Hucker and Maxine Petersen, on behalf of CSC. Doctors Watson, Dickey and Hucker are all psychiatrists with expertise in the field of Gender Identity Disorder and related fields, whereas Ms. Petersen is a psychologist with a similar expertise. Dr. Dickey and Dr. Hucker also have expertise in forensic psychiatry.

[12] According to the experts, 'Gender Identity' describes an individual's subjective sense of maleness or femaleness. Dr. Watson referred to this as one's 'brain sex', as opposed to one's anatomical or chromosomal sex.

[13] 'Gender Identity Disorder' is a broad term, encompassing a variety of conditions relating to gender identity. Some individuals may feel the need to manifest certain attributes of the opposing sex through behaviours such as cross-dressing, without ever feeling the need to actually become a member of the opposite sex. Others suffer a more extreme form of the disorder: they have normal internal and external sexual characteristics, but are convinced that they belong to the other gender.[(1)] These individuals are described by Dr. Watson as suffering from 'high intensity' Gender Identity Disorder, a term utilized by Dr. Watson, but one apparently not in general use within the medical community. Gender Identity Disorder is a recognized medical syndrome, classified as such in the Fourth Edition of the Diagnostic and Statistical Manual.

[14] Dr. Watson previously diagnosed Synthia Kavanagh as suffering from 'high intensity' Gender Identity Disorder. Dr. Hucker concurs in the diagnosis of Gender Identity Disorder, without adopting Dr. Watson's 'high intensity' terminology.

[15] 'Gender Dysphoria' describes the distress felt by transsexuals who are unhappy with their biological sex. Various witnesses describe the tremendous torment, including the social ostracism, suffered by individuals who perceive their bodies as incongruent with their subjective sense of who they really are.

[16] The weight of professional opinion favours a biological cause for Transsexualism. Recent studies suggest that one of 11,900 males and one in 30,400 females are transsexuals, although there may be a somewhat higher prevalence of Transsexualism in the inmate population.

[17] Gender identity is quite distinct from sexual orientation. That is, an individual's subjective perception of their own maleness or femaleness operates independently from the individual's sexual preference. A transsexual may therefore be homosexual or heterosexual. Sexual preference does not change. As a result, a biologically male transsexual who is attracted to men will remain attracted to men, should that individual be surgically reassigned as a woman.

[18] Male heterosexual transsexuals tend to be masculine in appearance, and do not ordinarily have a history of early feminisation.[(2)] These individuals develop an attraction to female anatomy, specifically female anatomy on themselves. Heterosexual transsexuals or 'autogynephiles' are attracted to women, and become lesbians after sex reassignment surgery. In contrast, homosexual male transsexuals tend to be more highly feminized than heterosexual transsexuals, and manifest feminine characteristics and symptoms of Gender Identity Disorder earlier in life. Male homosexual transsexuals remain 'androphilic', or attracted to men, after sex reassignment surgery.

IV. TREATMENT OF TRANSSEXUALISM

[19] The experts agree that careful assessment is required in order to properly identify individuals suffering from Transsexualism, as there are many other conditions that can contribute to confusion with respect to gender identity, and mimic Transsexualism.

[20] Once an individual has been diagnosed as suffering from Transsexualism, there are several types of treatment that may be appropriate in individual cases. Psychotherapy may assist the transsexual in setting realistic life goals, and in identifying and alleviating conflicts that may have undermined the patient's lifestyle. In addition, psychotherapy and drug treatment may be required for co-existing mental health conditions such as depression.

[21] Hormone therapy also plays an important role in the gender transition process. Through the controlled administration of opposite-sex hormones, individuals can start to acquire some of the secondary sex characteristics of the desired gender. For example, biological males treated with estrogens will start to experience a decrease in body hair, breast growth and redistribution of body fat. Biological females taking male hormones will have a deepening of the voice, an increase in facial hair and breast atrophy, amongst other effects.

[22] Properly prescribed, hormone therapy can improve the quality of life for transsexuals, helping them to feel more like members of their preferred or target gender.

[23] Sex reassignment surgery is a recognized and appropriate treatment for properly screened candidates. All of the experts testifying at this hearing recognized the importance of properly identifying suitable candidates for sex reassignment surgery, having regard to the invasive and irreversible nature of the procedure. To this end, efforts have been made to develop a standard international protocol for the treatment of transsexuals. The Harry Benjamin International Gender Dysphoria Association is an international professional organization devoted to the understanding and treatment of Gender Identity Disorders. This organization has developed generally accepted Standards of Care, which establish minimum eligibility requirements for sex reassignment surgery.

[24] The Harry Benjamin Standard stipulates that in order to be eligible for sex reassignment surgery, candidates must be of the age of majority, must usually have had twelve months of continuous hormone therapy, and have successfully completed twelve months of a continuous, full-time 'real life experience' living in the target gender. In determining whether an individual's real life experience is sufficient to satisfy the requirements of the Harry Benjamin Standard, the Standard stipulates that consideration be given to the individual's ability to maintain full or part-time employment, to function as a student or as a community-based volunteer, or some combination thereof.

[25] According to the Harry Benjamin Standard, the real life experience '... tests the person's resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports. It assists both the patient and the mental health professional in their judgments about how to proceed.'

[26] Sex reassignment surgery is not a right to be granted on request, according to the Harry Benjamin Standard. Patients should not be allowed to receive sex reassignment surgery without meeting the minimum eligibility criteria, including the successful completion of the real life experience. The Standard does say, however, that departures from the Standard may come about as a result of 'a patient's unique anatomic, social or psychological situation, an experienced professional's evolving method of handling a common situation, or a research protocol.'

[27] Once a patient has met the eligibility requirements for sex reassignment surgery, the Standard requires that the candidate obtain two letters of recommendation from mental health professionals, in order to permit them to receive surgery.

[28] In the case of male to female sex reassignment surgery, the process includes the removal of the penis and testicles, and the creation of a vagina, clitoris and labia. Other surgical procedures, such as breast implantation may also take place. These procedures are irreversible.

V. CORRECTIONAL SERVICE OF CANADA POLICIES REGARDING THE TREATMENT OF TRANSSEXUALS

[29] Evidence with respect to the history of CSC's policies concerning the treatment of transsexual inmates was provided by Jane Laishes. Ms. Laishes is the Senior Project Manager for Mental Health at CSC, and manages a group of psychologists and social workers. Ms. Laishes is responsible for policy development and consults on complex mental health cases. During her career with CSC, Ms. Laishes has been involved in the development of CSC's policy dealing with transsexual inmates.

[30] According to Ms. Laishes, CSC first examined the issue of how to manage transsexual inmates in 1980, when it commissioned a report from Dr. F.C.R. Chalke to assist it in formulating a policy for dealing with the medical aspects of inmates seeking sex reassignment. Dr. Chalke recommended that no form of treatment be initiated while inmates are incarcerated, but that inmates who had already started taking hormone therapy prior to their incarceration be dealt with on a case by case basis. According to Dr. Chalke, sex reassignment surgery should only be undertaken near the end of an inmate's sentence.

[31] In 1982, CSC promulgated its first policy on the subject, which policy mandated that each transsexual inmate be dealt with on an individual basis. In accordance with Dr. Chalke's recommendation, the policy stipulated that treatment was not to be initiated while an inmate was incarcerated. Hormones could be provided to those already under treatment at the time of incarceration, if it appeared that the inmate would continue with sex reassignment after release. The policy made no provision for sex reassignment surgery during the period of incarceration.

[32] A further report was prepared for CSC in 1982, by Dr. Betty Steiner and Dr. Hucker, amongst others. This report recommended that inmates be 'frozen' at the stage of feminization or masculinization they were at when they were incarcerated. Inmates would be placed in male or female institutions, in accordance with their anatomical structures. Hormone treatment could be provided, but sex reassignment surgery would not be performed during the period of incarceration.

[33] CSC's policy was again revised in 1987. The 1987 policy permitted the administration of hormones up to nine months before release, and made no mention of sex reassignment surgery.

[34] In 1992, Dr. Yvon Lapierre was asked for advice with respect to CSC's policy. Dr. Lapierre recommended that transsexual inmates not receive any treatment while incarcerated, as 'the side effects of treatment will add to the burden of care'. Dr. Lapierre was of the view that behavioural results of the treatment would cause difficulties in the management of these inmates. He did not elaborate on this. CSC also consulted with several other experts in the field at this time, including Dr. Watson and Dr. Hucker, and in 1993, CSC's policy was revised to permit hormone therapy throughout the period of incarceration. 'Sexual <u>reconstructive</u> surgery' was permitted, but no mention was made of sex <u>reassignment</u> surgery. In 1995, the policy was amended to expressly permit sex reassignment surgery, with the approval of the Regional Deputy Commissioner and the Commissioner of CSC.

[35] CSC's current policy (known as Commissioner's Directive 800), was promulgated in 1997. It is this policy, and, in particular, Sections 30 and 31 thereof, that is under consideration in this proceeding. The relevant provisions provide:

> <u>Policy Objective</u>
>
> 1. To ensure that inmates have access to essential medical, dental and mental health services in keeping with generally accepted community standards.
>
> <u>Essential Health Services</u>
>
> 2. Inmates shall have access to screening, referral and treatment services. Essential services shall include:
>
> > a) emergency health care (i.e. delay of the service will endanger the life of the inmate);
> >
> > b) urgent health care (i.e. the condition is likely to deteriorate to an emergency or affect the inmate's ability to carry on the activities of daily living;
> >
> > c) mental health care provided in response to disturbances of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life. This includes the provision of both acute and long-term mental health care services....
>
> 3. Inmates shall have reasonable access to other health services (ie: conditions not outlined above) which may be provided in keeping with community practice. The provision of these services will be subject to considerations such as the length of time prior to release and operational requirements.
>
> <u>Non-Essential Inmate-Requested Services</u>

26. All inmate-requested services deemed non-essential by the institutions [sic] physician will be at the inmate's complete expense including consultation fees and at the discretion of the institutional heads, any associated escort costs. Health Services shall be responsible for the coordination of arrangements for all inmate-requested services.

Gender Dysphoria

29. If an inmate has been on hormones prescribed through a recognized gender program clinic prior to incarceration, they may be continued under the following conditions:

a) that the inmate be referred to and reassessed by a recognized gender assessment clinic; and

b) that continuation of hormone therapy is recommended by the gender assessment clinic.

30. Unless sex reassignment surgery has been completed, male inmates shall be held in male institutions. [(3)]

31. Sex reassignment surgery will not be considered during the inmate's incarceration.

[36] According to Ms. Laishes, medical treatments classified as 'essential services' are provided to incarcerated individuals, at CSC's expense. This is done consistently on a nation-wide basis, regardless of whether or not the particular service in issue is a listed service under the provincial health care plan for the province where the inmate is being held. Non-essential services are provided at the inmate's expense. According to Ms. Laishes, the decision as to what constitutes an 'essential service' is a medical decision made by the institutional physician. The institutional physician is also responsible for referring the inmate to outside specialists for assessment, where it is necessary to do so. The institutional physician would ordinarily refer the inmate to the 'most available' specialist. In the case of inmates seeking sex reassignment surgery, Ms. Laishes says, the assessment is paid for by CSC.

[37] CSC's actual practice with respect to inmate access to hormone therapy is somewhat different than that contemplated by Section 29 of the policy. According to Ms. Laishes, CSC provides access to hormone therapy for transsexual inmates, as long as the therapy is recommended by a recognized gender clinic. CSC does not insist that the inmate have been on hormone therapy at the time of incarceration. Even though it views hormone therapy as an elective service, Ms. Laishes says, CSC pays for such treatment, on a gratuitous basis.

[38] Dr. Dickey, Dr. Hucker and Ms. Petersen all agree that sex reassignment surgery is an elective procedure, and does not constitute an 'essential service' within the meaning of CSC's policy. Dr. Watson did not address this issue directly in her testimony. She did, however, emphasize the disabling torment that can be suffered by individuals with untreated

Transsexualism. The issue of the elective or essential nature of sex reassignment surgery is also addressed in the Harry Benjamin Standard. The Standard states that "**Sex reassignment is not** 'experimental', 'investigational', **'elective'**, 'cosmetic', **or optional in any meaningful sense**. It constitutes very effective and appropriate treatment for Transsexualism or profound GID." (Emphasis added)

[39] Ms. Laishes explained the reasons for eliminating the possibility of sex reassignment surgery in the 1997 policy. Ms. Laishes says she reviewed the practice in a number of other jurisdictions, including the United States, the United Kingdom, Australia and New Zealand, and determined that the only time that sex reassignment surgery was allowed was where it had been court-ordered, or was paid for by the inmate. Eliminating the possibility of sex reassignment surgery, Ms. Laishes says, brought CSC more in line with other jurisdictions.

[40] Another reason for eliminating the possibility of sex reassignment surgery was to prevent an inmate from pinning his or her hopes on what was, in reality, a practical impossibility. Ms. Laishes explained that there is only one place in Canada that performs sex reassignment surgery - the Ménard Clinic in Montreal, which creates logistical problems. There were also real concerns with respect to the ability of inmates to obtain the necessary approvals to qualify them for the surgery, given the profound divergence of views within the medical community as to how to best manage incarcerated transsexuals. This divergence in views had recently been highlighted by Ms. Kavanagh's case.

[41] Ms. Laishes suggested that providing sex reassignment surgery to inmates, at CSC's expense, when this procedure is not always available in the community at public expense, could create some incentive for people to commit crimes.[(4)] According to Ms. Laishes, CSC provides a higher level of dental treatment that is ordinarily available in the community, and there is anecdotal evidence that people have committed crimes so as to be able to access dental treatment. This concern has not, however, caused CSC to modify its policy with respect to the provision of dental treatment.

[42] Dr. Diane Watson is a Clinical Professor of Psychiatry at University of British Columbia, and a consulting psychiatrist at the Centre for Sexuality, Gender Identity and Reproductive Health at the Vancouver Hospital. Dr. Watson is also the co-founder and a former Director of the Gender Dysphoria Clinic at the Vancouver Hospital. According to Ms. Laishes, in January of 1997, Dr. Watson and her team at the Gender Dysphoria Clinic approved Synthia Kavanagh for sex reassignment surgery. Ms. Laishes then consulted with Dr. Dickey, who was the Head of the Gender Identity Clinic at the Centre for Addiction and Mental Health (Clarke Division) in Toronto. Dr. Dickey was familiar with Ms. Kavanagh, having seen her once, some ten years before, and was firmly of the view that Ms. Kavanagh was not a suitable candidate for sex reassignment surgery. In an effort to resolve the issue, Ms. Laishes then retained Dr. Hucker for a third opinion. Dr. Hucker is a Professor of Psychiatry and Academic Head of the Forensic Psychiatry Division of the Department of Psychiatry and Behavioural Neurosciences at McMaster University, as well as Medical Director of the Forensic Program at St. Joseph's Health Care and the Centre for Mountain Health Services. Dr. Hucker also acts as a consultant to the Gender Identity Clinic and the Sexual Behaviours Clinic at the Centre for Addiction and Mental

Health (Clarke Division). Dr. Hucker examined Ms. Kavanagh at Mission Institution, and concluded that she was not an appropriate candidate for surgery.

[43] According to Ms. Laishes, this left CSC in a very difficult situation. Ms. Laishes was very concerned about proceeding with treatment that was profoundly life-altering and irreversible, in the face of expert medical opinion that such treatment was not appropriate. Not only was Ms. Laishes concerned about the potential outcome of the surgery for Ms. Kavanagh: In addition, she was concerned about potential liability on the part of CSC.

[44] Faced with these concerns, the decision was made to revise CSC's policy, removing the reference to sex reassignment surgery being permitted, and adding the express prohibition of such surgery reflected in Section 31 of the 1997 policy. Ms. Laishes testified, however, that in making this change to the policy, the intention of the working group charged with revising the policy was to leave open the possibility that sex reassignment surgery could be permitted in exceptional cases, where it qualified as an essential service. This reflected the group's understanding that there could be situations where an inmate was an appropriate candidate for sex reassignment surgery, which view was evidently based upon advice from Dr. Dickey. The working group was later advised that the policy, as worded, did not reflect the authors' intent, and that the express prohibition on sex reassignment surgery in Section 31 of the revised policy precluded inmate access to sex reassignment surgery under any circumstances.

[45] Consideration was also given to having CSC retain the Clarke Institute to assess all of the transsexual inmates within CSC who were seeking either hormone therapy or sex reassignment surgery. Ms. Laishes explained that Dr. Dickey and the Clarke Institute's conservative approach to these issues was well known, and that referring all transsexual inmates to the Clarke Institute would ensure consistency in CSC's approach. This would also limit the number of inmates approved for sex reassignment surgery, and the attendant operational, logistical and liability problems that such approvals could create. However, this suggestion was never accepted.

[46] Ms. Kavanagh underwent sex reassignment surgery, at her own expense, in 2000. Although CSC's policy prohibits inmates from undergoing this procedure during their incarceration, Ms. Laishes testified that an exception was made in Ms. Kavanagh's case, as CSC was in the process of reviewing its policy, in the wake of the settlement with Ms. Kavanagh. Ultimately, however, no changes to the policy were made, as a consequence of advice received from a medical ethicist, and disagreement as to the extent of the duty of care owed to inmates by CSC. Further complicating the matter were the divergent views within the medical community with respect to the appropriateness of providing inmates with sex reassignment surgery, and the difficulty associated with identifying suitable doctors to provide two concurring opinions, given the very limited number of doctors with expertise in this field.[(5)]

[47] Ms. Laishes testified that there is an ongoing recognition within CSC that changes are necessary to the policy, in order to bring it up to what she described as 'practice standards'. Despite this recognition, however, no changes have been made to the policy regarding access to sex reassignment surgery since the 1997 revisions.

VI. SEX REASSIGNMENT SURGERY AND INCARCERATED INDIVIDUALS

[48] Each of the expert witnesses was questioned extensively about whether, and under what circumstances, incarcerated individuals could be suitable candidates for sex reassignment surgery. There appear to be two principle points of disagreement between Dr. Watson, on the one hand, who favours a more liberal approach to the issue, and Dr. Dickey, Dr. Hucker and Ms. Petersen, on the other hand, who take a more conservative view of the matter. These areas of disagreement relate to whether the real life experience can be satisfactorily carried out within the carceral setting, and the need for psycho-social stability in a candidate for surgery.

A. Real Life Experience

[49] As a general rule, Dr. Watson says, prison is not an appropriate setting for transsexual individuals to make irreversible decisions. For this reason, the requirement that the real life experience take place in society is not an unreasonable one, in most cases. However, the implications of denying sex reassignment surgery to individuals serving lengthy sentences are more serious. In Dr. Watson's view, the real life experience can satisfactorily be carried out for these inmates within the prison setting, so as to enable the inmate to qualify for sex reassignment surgery.

[50] Dr. Watson says that the real life experience stipulated in the Harry Benjamin Standard is not a rigid rule, but rather a guideline to care. Every case has to be assessed on its own merits. The determining factor for Dr. Watson is the intensity of the gender identity issues, rather than what she refers to as 'life-style issues'. Ultimately, it is the patient who is in the best position to determine the need for sex reassignment, and not the medical professionals. Dr. Watson stated that it 'is not only presumptuous but impossible' to believe that anyone other than the individual concerned can determine whether or not sex reassignment surgery is a necessary procedure in any specific instance. According to Dr. Watson, it is ultimately a 'self-selecting process': That is, no one would go through all of the obstacles and losses [of family, friends etc.] that are experienced as part of sex reassignment, unless it was something that they truly needed.

[51] The prison environment can, in some ways, provide an even better real life experience than can the outside community, according to Dr. Watson. Inmates are under much closer observation in prison, and thus in a better position to be assessed in relation to the consistency and spontaneity of the manifestations of their male or female gender identity. Being accepted by other inmates is, in many ways, the 'hardest test', says Dr. Watson.

[52] Dr. Watson acknowledges that the experience of male to female transsexual inmates attempting to live as females inside a male penitentiary would not be the same as the experience would be in the community at large - the prison environment being very different from the world outside the prison walls. This is one reason that she does not recommend that individuals serving short sentences attempt to move towards sex reassignment surgery while incarcerated.

[53] The majority of male transsexual inmates that Dr. Watson has dealt with form relationships with other men, while being held in male prisons. The partners of male transsexuals are often otherwise heterosexual inmates.[(6)] While Dr. Watson was not prepared to concede that the

absence of biological women in male prisons makes transsexual inmates more appealing as potential sexual partners for otherwise heterosexual inmates, she did acknowledge that transsexual inmates are dealing with a 'captive audience' and do not face any competition from other women.

[54] In Dr. Watson's view, pre-operative male to female transsexuals in an advanced stage of hormonal reassignment should be placed in female institutions and allowed to complete the real life experience in that environment.(7)

[55] Dr. Dickey, Dr. Hucker and Ms. Petersen are all of the view that the artificiality of the prison environment does not allow for a true real life experience, and would provide a distorted picture of the inmate's suitability for sex reassignment surgery.

[56] One of the basic principles governing the conduct of physicians, Dr. Dickey says, is that they should 'first do no harm'. According to Dr. Dickey, while sex reassignment surgery has been shown to benefit some, well-selected individuals, the indicators of suitability are not that clear. If a potential benefit cannot be demonstrated in a given case, then the physician must consider whether the proposed treatment will in fact cause harm to the patient. In this case, the treatment under consideration (ie: sex reassignment surgery) is both highly invasive and irreversible, and has, as well, a host of psychological and social consequences for the patient.

[57] According to Dr. Dickey, incarcerated individuals are not suitable candidates for sex reassignment surgery, because they cannot properly fulfill the real life experience aspect of the selection criteria in the artificial environment of the prison setting. Dr. Dickey testified that the incidence of facultative homosexuality in the carceral setting provides pre-operative transsexual inmates with a level of acceptance that they would not experience in the community at large. In other words, a pre-operative male to female transsexual living as a woman in a male prison may achieve a degree of status or acceptance that would not be achieved, were the individual living in the community. This positive reinforcement may provide the inmate with a distorted perception of their ability to live successfully as a member of the opposite sex. At the same time, the inmate would have limited ability to interact with women, and to assess their ability to fit in. The unique circumstances of the prison environment also make it very difficult to properly assess the degree or strength of the inmate's Gender Dysphoria.

[58] Dr. Dickey illustrated these concerns with anecdotal examples of transsexual inmates he had treated who had moved from the prison setting back into the community. In one case, a male transsexual lived as a women while in prison, and expressed a strong desire for sex reassignment surgery. After being released from prison, the inmate was no longer certain about pursuing sex reassignment surgery. In another case, a highly feminized inmate lived as a woman while in prison, and wanted sex reassignment surgery. According to Dr. Dickey, within a week of this individual's release from custody, the individual had reverted to the male role.

[59] All of this said, Dr. Dickey testified that he could envisage situations where an incarcerated individual might be a suitable candidate for sex reassignment surgery. He stated that he would have no hesitation in referring an inmate patient for sex reassignment surgery where, for example, the inmate was generally pro-social, had committed one crime (such as a crime of

passion) and was unlikely to re-offend, and had completed some portion of the real life experience prior to incarceration. For this reason, Dr. Dickey says, some flexibility in CSC's policy is desirable.

[60] Dr. Hucker's testimony was largely consistent with that of Dr. Dickey. Dr. Hucker states that most reputable clinics require that candidates for surgery spend between one and two years living in the community in their target gender role. Because he does not run a clinic, but deals instead with individual cases, Dr. Hucker says he can be a little more flexible in his approach. Nevertheless, Dr. Hucker would still insist that the patient spend at least one year living in the community as a member of the target gender, so as to determine whether the patient can deal with the negative reactions that they are bound to encounter along the way. People with whom the patient is in contact may be appalled by what the patient is trying to do. This reaction can result in the loss of employment, as well as estrangement from family and friends.

[61] Dr. Hucker agrees with Dr. Dickey's view that the real life experience cannot be properly carried out in the prison environment, citing many of the same reasons given by Dr. Dickey for this opinion. Dr. Hucker also mentioned the deep need that male to female transsexuals have to interact with other women - to be 'one of the girls' - and noted that there would be limited opportunity for this kind of contact in a male institution.

[62] Despite these reservations, Dr. Hucker shares Dr. Dickey's view that there could be situations where an incarcerated individual would be a good candidate for sex reassignment surgery, although he says that this was 'highly hypothetical' and that he had yet to come across such a person.

[63] Ms. Petersen, (who identified herself as one of the relatively few experts in the field who is herself a transsexual), gave testimony that was largely consistent with that of Dr. Dickey and Dr. Hucker. Ms. Petersen emphasized the controlled nature of the prison environment, observing that a patient's interaction with other people in the prison setting would be highly regulated, unlike the more random encounters that would be experienced in the community setting.

[64] Ms. Petersen also noted that people who have a lot of time on their hands can become depressed, and may fixate on the idea of sex reassignment surgery as a kind of 'magical cure' for their problems. The prison environment would be conducive to this effect.

[65] Like Dr. Dickey and Dr. Hucker, Ms. Petersen noted that the sexual attention that male transsexual inmates are bound to attract in a male prison will be highly reinforcing, encouraging individuals to see sex reassignment surgery as the preferred solution to their unhappiness, whether or not this is, in fact, the case. A male to female transsexual is unlikely to receive this kind of positive reinforcement when presenting as a woman in the community.

[66] Ms. Petersen also reviewed the literature dealing with the ability to conduct a satisfactory real life experience in the prison setting, referring in particular to a paper published by Doctor George Sturup, a Danish Endocrinologist. Dr. Sturup treated several transsexual prisoners, including one patient who had received hormone therapy, and was ultimately surgically castrated, while still incarcerated. Following the patient's release from prison, the individual

lived as a woman for a brief period of time before becoming involved with a female partner, and reverting back to a male role. Dr. Sturup was unable to account for his misperception of the situation, and concluded that no final decision should be made with respect to sex reassignment surgery for inmates until the individuals have returned to the community.

[67] It is noteworthy that the Harry Benjamin Standard specifically addresses the question of the administration of hormones and psychotherapy for incarcerated individuals, stipulating that persons receiving such therapy for Gender Identity Disorder should continue to receive treatment during incarceration, as required. This is done to prevent or limit emotional lability, undesired regression of hormonally-induced physical changes, and the sense of desperation that can lead to anxiety, depression, and suicidality. The Standard makes no mention, however, of sex reassignment surgery for the incarcerated, nor does it address the issue of the real life experience in the carceral setting.

B. Psycho-Social Stability

[68] The second major point of disagreement between the experts in this case relates to the need for a base level of psycho-social stability as a pre-requisite to sex reassignment surgery, and the related question of whether a history of criminality contra-indicates such surgery.

[69] In Dr. Watson's view, policies which emphasize lifestyle, social acceptability and mental stability discriminate against transsexuals who are not middle class, employed, financially secure, free of concurrent psychiatric disorders or behaviourally compliant. A diagnosis of Gender Identity Disorder requires that the patient display evidence of 'clinically significant distress or impairment in social, occupational or other important areas of functioning'.[(8)] It is therefore unreasonable, says Dr. Watson, to expect a chronically marginalised individual to demonstrate complete social integration and the capacity to work or study, simply by living in the target gender role.

[70] The published selection criteria used by the Centre for Sexuality, Gender Identity and Reproductive Health at the Vancouver Hospital, with which Dr. Watson is affiliated, lists as exclusion criteria for its Gender Dysphoria program "Any medical or psychiatric condition in which the individual's behaviour is sufficiently unstable and unpredictable such as to pose a substantial acute or ongoing risk of harm to self or others". According to Dr. Watson, this means that patients with active drug use, active psychosis, or any behavioural situation that is completely out of control should not be considered for treatment.

[71] According to Dr. Watson, many transsexuals have psychiatric problems, along with their Gender Identity Disorder. Problems such as anxiety, depression, substance abuse, suicidal ideation and self-mutilation can be secondary to unresolved Gender Identity Disorder. Dr. Watson testified that patients may have difficulty addressing these problems as long as their core Gender Identity problem remains unaddressed. Dr. Watson agrees that criminality is not alleviated by treating an inmate's Gender Identity Disorder, but she states that treatment may result in a reduction of manipulative, acting out behaviour on the part of the inmate.

[72] Insofar as sex reassignment surgery for inmates is concerned, Dr. Watson asserts that there are no studies supporting the contention that such surgery is an inappropriate treatment for individuals involved in a criminal life-style. Indeed, Dr. Watson says that it is not realistic to think that incarcerated transsexuals will be able to make any progress towards their rehabilitation until such time as the incongruency in their core identity is addressed.

[73] One type of psychiatric phenomenon discussed by the experts is psychopathy or anti-social personality disorder. Psychopathic individuals may have longstanding histories of deviant or criminal behaviour, they may lie frequently, and do not have a conscience. Dr. Watson testified that she does not test patients for psychopathy.

[74] Dr. Dickey is of the opinion that psycho-social instability contra-indicates sex reassignment surgery. Dr. Dickey is not alone in this view: According to a 1995 international survey of gender clinics conducted by Dr. Dickey and Ms. Petersen,(9) one hundred percent of the clinics surveyed indicated that they would consider ongoing psycho-social instability as a contraindication to proceeding with sex reassignment. Sixty-four percent of the clinics surveyed reported that ongoing criminal behaviour would also be considered a contra-indication for surgery.

[75] Dr. Dickey explained that the necessity for psycho-social stability ties into the requirement of the real life experience: Someone who is psycho-socially unstable would be unlikely to be able to fulfill the requirement of the real life experience.

[76] According to Dr. Dickey, additional concerns arise out of the higher level of psychopathy seen in inmates, many of whom suffer from anti-social personality disorder. As noted earlier, psychopathic individuals may lie frequently, and do not have a conscience. The inmate population has a much higher incidence of psychopathy than does the general population, with inmates scoring an average of 22 out of a possible 40 on the Hare psychopathy scale,(10) in contrast to an average score of 4 out of 40 in the general population. This is significant with respect to the assessment of inmates with Gender Identity Disorder, as it may raise questions as to the reliability of the inmate's description of their history. Physicians are reliant on their patients when amassing data concerning the individual's history, as part of the assessment process, although some attempt will be made to verify that history by independent means. Dr. Dickey says that patients seeking sex reassignment surgery may exaggerate the degree of femininity in their histories, in an attempt to make them appear more suitable candidates. When coupled with the psychopath's propensity to lie, Dr. Dickey says, this creates a 'double whammy', making it even more difficult to trust what the patient is reporting. Misrepresentation by the patient could result in unnecessary or inappropriate surgery being administered, which would not only not provide any benefit, but could actually harm the patient. This raises concerns about the expenditure of public monies on unnecessary surgery, possible regrets on the part of the patient, and potential litigation.

[77] There is no treatment for psychopathy at this time, says Dr. Dickey, and thus no way to bring the psychopathic inmate to the point where they can safely be provided with sex reassignment surgery.

[78] While Dr. Dickey acknowledged that there could conceivably be situations where he would be prepared to dispense with the necessity of the real life experience, before approving a patient for sex reassignment surgery, he stated that he would be very reluctant to do so in a patient with a history of serious criminality. He testified that there is little evidence that Gender Identity Disorder causes criminal behaviour, noting that most of the transsexual patients that he sees live what he calls 'pro-social' lives. Similarly, Dr. Dickey stated that the denial of treatment to transsexual patients does not cause criminality or suicidality. While there is a higher rate of suicide in the transsexual population, it has not been demonstrated that the rate is lowered in those who have undergone sex reassignment surgery.

[79] While Dr. Dickey is prepared to concede that it is possible that Gender Dysphoria may cause the psychological upheaval that contributes to the problems of transsexual inmates, he is categorical that sex reassignment surgery will not alleviate these problems.

[80] Finally, Dr. Dickey notes that some patients will appear to be more psycho-socially stable than they really are, in the highly structured environment of a prison. The structure of the prison setting may act as a kind of 'glue', holding the inmate together in a way that would not occur if they were living in the community.

[81] Dr. Hucker and Ms. Petersen's testimony on this issue largely corroborated that of Dr. Dickey. Dr. Hucker said that the majority of individuals who have been treated with hormones and sex reassignment surgery are subjectively happier afterwards, and he agreed with Dr. Watson that the intensity and persistence of a patient's Gender Identity Disorder is one of the indicators for surgery. However, he agrees with Dr. Dickey's opinion that the psychopath's propensity to manipulate and tell lies makes such individuals very difficult to properly assess as candidates for surgery. Dr. Hucker further noted that published studies also suggest that psychopaths tend to have poorer post-operative outcomes. As a result, Dr. Hucker says, psychopathy is a criterion for exclusion.

[82] Ms. Petersen agrees that a level of psycho-social stability is required before a patient could be recommended for sex reassignment surgery. She noted that a number of reports have indicated that people who are psychologically unstable are more likely to express post-operative regrets or have unsatisfactory outcomes after surgery. Ms. Petersen does not agree with Dr. Watson's statement that there is no research regarding the issue of criminal lifestyle and suitability for sex reassignment surgery. Ms. Petersen states that there is relatively little research dealing with the issue, but says that what research there is indicates that patients with a history of criminal behaviour also have significantly less satisfactory outcomes with surgery.

[83] The Harry Benjamin Standard states that to be considered ready for surgery, a patient must have made 'Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health; this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance.'

C. Synthia Kavanagh's Suitability for Sex Reassignment Surgery

[84] Ms. Kavanagh testified that prior to her 1989 incarceration, she had been approved for sex reassignment surgery by a Doctor Hymie Smith in Vancouver. Dr. Smith's approval was, however, conditional on Ms. Kavanagh remaining crime-free. Ms. Kavanagh did not actually have surgery at that time, as she kept getting into trouble with the law.

[85] Dr. Watson approved Synthia Kavanagh for sex reassignment surgery in 1997. According to Dr. Watson, the fact that Ms. Kavanagh's cross-gender identification appeared early in life [(11)], and had been observed as being consistently feminized over a long period of time during her incarceration, made her an appropriate candidate for sex reassignment surgery.

[86] Dr. Watson does not agree that Ms. Kavanagh's stability or lifestyle are factors that should have been taken into account in assessing her suitability for surgery. In Dr. Watson's opinion, there is an element of circularity in requiring that patients be psycho-socially stable. Gender Identity Disorder causes a great deal of distress, which, she says, may lead in turn to depression and anxiety, drug abuse, and criminalized behaviour. According to Dr. Watson, this pattern is perpetuated when the Gender Identity Disorder is left untreated. Dr. Watson says that considering Ms. Kavanagh's record of misbehaviour in the prison setting as a contra-indication of her suitability for sex reassignment surgery ignores the destabilizing effect that her unresolved Gender Identity Disorder has had on her rehabilitation.

[87] In Dr. Watson's view, a patient's psychopathy score would not be particularly relevant. She did not address the issue of Ms. Kavanagh's psychopathy in her testimony, although a report prepared by Dr. Watson shortly before Ms. Kavanagh's surgery notes that her anti-social personality traits were improving. It is unclear how she came to this conclusion.

[88] Dr. Dickey saw Ms. Kavanagh once, in 1989, while she was being held at the Don Jail in Toronto. This was not a formal consultation by the Gender Identity Clinic at the Clarke Institute, but was intended to assist Dr. Dickey in determining what would be appropriate for Ms. Kavanagh, in the short term, in the detention centre setting. Since that time, however, Dr. Dickey reviewed Dr. Watson's report concerning Ms. Kavanagh, as well as reports prepared by other physicians. In Dr. Dickey's view, sex reassignment surgery was not an appropriate treatment for Ms. Kavanagh. According to Dr. Dickey, Ms. Kavanagh's ongoing psycho-social instability and her strong degree of psychopathy[(12)] strongly militate against her being able to successfully fulfill the real life experience in the community.

[89] Dr. Hucker interviewed Ms. Kavanagh in 1997, and has also reviewed her CSC institutional files. Dr. Hucker concurs with Dr. Dickey that Synthia Kavanagh was not a suitable candidate for sex reassignment surgery. According to Dr. Hucker, Ms. Kavanagh's serious psychiatric problems, and, in particular, her extreme psychopathy made her unsuitable for treatment.

[90] Dr. Hucker testified that his major point of disagreement with Dr. Watson and the Vancouver Clinic related to the severity of Ms. Kavanagh's psychopathy. Dr. Hucker says that Dr. Watson saw Ms. Kavanagh's anti-social traits as relatively mild, whereas he saw them as 'very severe'. Dr. Hucker noted that Dr. Watson did not test Synthia Kavanagh for psychopathy, observing that this was not something that would ordinarily be tested for, outside of the correctional setting.

[91] Dr. Hucker also disagrees with Dr. Watson that Ms. Kavanagh's history of acting out in prison was at least in part attributable to her having been denied access to sex reassignment surgery. In Dr. Hucker's view, such a conclusion is 'naive'.

VII. PLACEMENT OF PRE-OPERATIVE TRANSSEXUAL INMATES

[92] Synthia Kavanagh's second complaint alleges discrimination in relation to CSC's policy mandating the placement of pre-operative male to female transsexual inmates in male institutions. The complaint states that CSC's policy does not 'acknowledge the psychological need to be imprisoned with other members of one's psychological sex...'.

[93] It is common ground that in the course of her incarceration Ms. Kavanagh did, from time to time, ask to be placed in a women's prison, although it appears that her wishes may not have been consistent in this regard.

[94] Dr. Watson testified that the decision as to where pre-operative transsexual inmates are placed should be dealt with by corrections and medical staff, on a case by case basis, having regard to where the inmate will be able to integrate most successfully. There is no question, however, says Dr. Watson, that pre-operative male to female transsexuals in an advanced stage of hormonal reassignment should be placed in female institutions. This would permit the inmate to proceed with a real life experience amongst females, and would require the inmate to integrate with and behave like a woman. Similarly, female to male transsexuals who are well advanced in their hormone therapy should be placed in male institutions.

[95] Dr. Watson says that there would be little risk of a pre-operative male to female transsexual inmate sexually assaulting women in prison, as the effect of the female hormones the inmate would be taking would be to render most inmates unable to function sexually. She conceded, however, that this could not be guaranteed. In addition, Dr. Watson says, the majority of male to female transsexual inmates are attracted to men. Insofar as Synthia Kavanagh is concerned, Dr. Watson says that prior to her surgery Ms. Kavanagh was 'exclusively oriented towards men sexually', and thus would not have constituted a risk for sexualized behaviour in a female institution.

[96] Ms. Kavanagh has, in fact had a sexual liaison with a female prisoner while incarcerated at Joliette Institution, although there is some issue with respect to the extent of the relationship.[(13)] Dr. Watson was not aware of this fact prior to testifying, and stated that she had formulated her opinion based upon information provided by Ms. Kavanagh. In light of this additional information, Dr. Watson stated that it was possible that Ms. Kavanagh was bisexual.

[97] Dr. Watson does not anticipate that there would be any difficulty in having an anatomically male pre-operative transsexual inmate accepted in a women's prison. In her experience, Dr. Watson says, women tend to be more accepting of transsexuals than men are. Dr. Watson bases this opinion on her experience with women in therapy groups, and acknowledged that she had little experience with female inmates. Dr. Watson further agreed that there would be a very

different dynamic at work with female inmates, and that she cannot say whether her experience with female patients in therapy groups is transferable to the prison setting.

[98] As an alternative to placing pre-operative transsexuals in institutions corresponding to their target gender, Dr. Watson suggested that there could be some benefit derived from the creation of a specialized treatment centre for transsexual inmates, although this did create a risk of 'ghettoising' these inmates.

[99] There are a number of issues concerning the placement of pre-operative transsexual inmates raised by Dr. Watson's testimony. The evidence regarding the appropriateness and feasibility of each of her suggestions will be addressed below.

A. Physical Risk to Other Prisoners

[100] Dr. Watson's suggestion that pre-operative male to female transsexuals would pose little physical risk to female prisoners was addressed by several of CSC's witnesses. Dr. Dickey, Dr. Hucker and Ms. Petersen all disagree with Dr. Watson's statement that most male to female transsexual inmates are attracted to men: To the contrary, they say, the majority of transsexuals in federal prisons are actually attracted to women. It takes serious criminal activity to qualify a person for a federal prison sentence in Canada. According to Dr. Dickey and Ms. Petersen, homosexual transsexuals do not generally have the degree of aggressiveness or psychopathy necessary to get them into a Canadian federal prison. The transsexuals that Dr. Hucker has encountered in the correctional setting tend, he says, to be 'more ambiguous' in their sexual orientation. Further, Dr. Dickey queries why a homosexual male to female transsexual would want to move to a women's prison. Although it is usually possible to distinguish homosexual transsexuals from heterosexual transsexuals, Dr. Dickey says that there will be cases where it is not possible to do so.

[101] Dr. Dickey, Dr. Hucker and Ms. Petersen all say that they would be very concerned about putting a pre-operative male to female heterosexual transsexual inmate in a women's prison, given the risk that the inmate would prey on female prisoners. Dr. Dickey and Ms. Petersen say that hormone therapy does not provide any guarantee that the transsexual inmate would not have erectile capacity.

[102] Dr. Hucker acknowledged that placement in a women's prison could have an ameliorative effect for some transsexual inmates. He is concerned, however, that inmates who were not truly transsexual would seek to be placed in women's prisons, for sexual purposes. He shares Dr. Dickey's fear that heterosexual male to female transsexuals would pose a risk to female prisoners. While he also questions why a male homosexual transsexual would want to leave a male prison in the first place, he does recognize the deep need that male to female transsexuals feel to associate with women, as one of them. Dr. Hucker agreed that consensual sexual activity as well as sexual violence occur now in the prison setting, on a regular basis.

[103] Ms. Petersen testified regarding the survey she conducted with Dr. Dickey and others with respect to international corrections practices.[(14)] According to Ms. Petersen, this survey disclosed that the general practice world-wide is to have pre-operative male to female transsexuals held in

male prisons. Ms. Petersen agrees with this practice, for many of the same safety reasons cited by Dr. Dickey and Dr. Hucker.

[104] Insofar as the placement of pre-operative transsexual inmates is concerned, the Harry Benjamin Standard does not specifically recommend placement in either male or female institutions, but stipulates that housing decisions 'should take into account their transition status and their personal safety.'

B. Psychological Impact on Other Prisoners

[105] Jane Laishes and Nancy Wrenshall addressed Dr. Watson's suggestion that pre-operative male to female transsexual inmates would be readily accepted in women's prisons. Nancy Wrenshall is the Advisor to the British Columbia Corrections on Women Offenders, and the District Director of the Burnaby Correctional Centre for Women. Ms. Wrenshall was qualified as an expert on the prison system, and issues involving female inmates.

[106] Both Ms. Laishes and Ms. Wrenshall testified with respect to the unique profile of female offenders. According to Ms. Laishes, the placement of pre-operative male to female transsexuals in female prisons would present a great risk of harm to the female inmates, many of whom have histories of having been sexually abused.

[107] Ms. Wrenshall concurred with Ms. Laishes' view, noting that studies have disclosed that over 75% of incarcerated women have been victims of some form of physical, sexual, emotional or psychological abuse, primarily at the hands of men. Some inmates have been so traumatized by their experiences that they are unable to deal with men at all.

[108] In an effort to address these concerns, CSC has taken special precautions with respect to the hiring of male staff for its women's prisons. Acting on a recommendation arising out of the Arbour Inquiry concerning the Prison for Women in Kingston, the Public Service Commission has granted CSC an exemption for the Edmonton Institution, allowing it to staff that women's facility exclusively with females. For all of the other female institutions in the system, CSC is very careful with respect to its male staff, ensuring that any men hired are sensitive to women's issues, and can act as appropriate male role models. Madam Justice Arbour also recommended the appointment of 'cross-gender monitors' to follow-up on certain issues. These monitors have recently recommended that CSC have no male line staff in any of its women's facilities, because of these concerns. In Ms. Wrenshall's experience working with male offenders, and pre-operative male to female transsexual offenders in particular, she has found that inmates do not have the skills necessary to act as male role models.

[109] Ms. Wrenshall denied that the resistance to men demonstrated by female offenders is the result of prejudice. In her view, it stems from fear, although she conceded that some of that fear may be rooted in ignorance and preconceptions.

[110] The presence of pre-operative male to female transsexual inmates in a female institution would also create difficulties with respect to the management of the institution. Ms. Wrenshall shares the concern voiced by other witnesses with respect to sexual activity, whether consensual

or not, between the transsexual inmate and fellow prisoners. Ms. Wrenshall also mentioned the risk of pregnancy presented in such cases. She says that the presence of an anatomical male in a women's prison would be disruptive, as women could become sexually interested in the inmate, leading to jealousies and fights.

[111] Ms. Wrenshall also takes issue with Dr. Watson's suggestion that female prisoners would likely accept transsexual inmates. Based upon her observation of the treatment accorded to post-operative male to female transsexuals and pre-operative female to male transsexuals in female prisons, Ms. Wrenshall says that pre-operative male to female transsexuals would likely be subjected to ridicule. In her experience, both male and female inmates tend to single out anyone who is different for harassment. As a result, pre-operative transsexual inmates would likely be unable to function in the general female population, and would end up in the institution's Protective Custody unit, where they would have limited access to the educational programs that are otherwise available to inmates.

[112] Notwithstanding the position taken by Ms. Kavanagh in her complaint, her view as to where pre-operative male to female transsexuals should be held appears to have changed as a result of her own experience, and her current familiarity with the environment in a women's prison. Ms. Kavanagh agrees with Ms. Laishes and Ms. Wrenshall that female prisoners would not accept a pre-operative male to female transsexual because of their past experiences of abuse. Ms. Kavanagh also concurs with Dr. Watson's suggestion that a specialized facility be created for pre-operative transsexuals.

C. Creation of a Dedicated Facility

[113] Jane Laishes addressed the operational issues raised by the suggestion that a dedicated facility be created for transsexual inmates. According to Ms. Laishes, as of November, 2000, there were ten pre-operative transsexuals in the federal system, out of a total of 12,500 inmates. Of these ten inmates, four are seeking sex reassignment surgery. A review of the evidence discloses that over the last number of years, CSC has had anywhere from ten to 23 transsexual inmates in custody at any one time. This limited number creates major obstacles to any attempt to create a dedicated facility for transsexual inmates.

[114] There are a large number of 'incompatibles' within the transsexual population, according to Ms. Laishes. Incompatibles are inmates who, for security reasons, cannot be placed together. For this reason, if dedicated facilities were to be created for pre-operative transsexual inmates, it would be necessary to create two or possibly even three such facilities, to allow for incompatibles.

[115] One of the aims of CSC is to try to keep inmates as close to home as possible, so as to allow them to remain in contact with family, to assist in their rehabilitation and reintegration into society. This concern was one of the principle motivations for the construction of five new regional prisons for women: female prisoners had previously all been held at the Prison for Women in Kingston, forcing many to be far from home and family. The creation of a single facility for pre-operative transsexual inmates would have a similar effect.

[116] Ms. Laishes shares Dr. Watson's concern as to the potential 'ghettoising' effect that a dedicated facility would have for transsexual inmates. It would be also unworkable, says Ms. Laishes, to provide programming to such a small number of inmates, each of whom would have their own set of needs.

[117] Although she supports the creation of a dedicated facility for pre-operative transsexual inmates, Ms. Kavanagh testified that she herself has tried to stay away from other transsexuals, both in prison and in the community, stating that she does not feel comfortable with them.

D. How CSC Accommodates Pre-Operative Transsexual Inmates

[118] Jane Laishes described the efforts made by CSC to deal with a pre-operative male to female transsexual inmate in Bath Institution, a medium security male prison in Ontario. According to Ms. Laishes, CSC personnel have made unique and exceptional arrangements in order to accommodate the inmate in that institution. The inmate, who is on hormone therapy, and is described as 'highly feminized', is permitted to cross-dress and wear cosmetics at all times. The inmate has been provided with a separate living area, consisting of a bedroom and private bathroom, but is able to mix with other inmates during the day. The inmate has also been permitted to decorate the living area, and is even permitted to keep a cat. Other inmates are required to live in very small cells on 'ranges'. According to Ms. Laishes, the special arrangements that have been made for this inmate are the source of some resentment on the part of other inmates.

[119] Brenda Lamm testified with respect to the efforts made by CSC staff to accommodate Ms. Kavanagh while she was being held at Kent Institution, a maximum security male prison in British Columbia. Ms. Lamm was the Coordinator of Case Management at Kent Institution during the time that Synthia Kavanagh was incarcerated there. According to Ms. Lamm, Ms. Kavanagh was given preference for single cell assignments, although she acknowledged that there could have been times when the population count in the institution was such that it was necessary for Ms. Kavanagh to share a cell with another inmate. On these occasions, Ms. Kavanagh was allowed to choose her cell-mate. According to Ms. Lamm, Ms. Kavanagh was involved in a relationship with another inmate, and would often choose to room with him. Ms. Kavanagh was generally put in the cell closest to the Security Officer, for her protection.

[120] All inmates at Kent Institution are required to wear blue jeans and a T-shirt during the day. After hours, Ms. Kavanagh was permitted to wear distinctively feminine leisure clothing and cosmetics, which she was able to purchase through catalogues provided to inmates as part of the institutional purchasing process. Ms. Lamm acknowledged that this represented a change in CSC's approach to dealing with transsexual inmates, and that earlier in her incarceration, Ms. Kavanagh would not have been given this latitude.

[121] Ms. Lamm testified that Synthia Kavanagh did not have any significant problems with other inmates during her time at Kent Institution, and that Ms. Kavanagh was well able to take care of herself. Ms. Lamm did say that Ms.Kavanagh spent much of her time at Kent Institution in administrative segregation or protective custody. Ms. Lamm was unsure why Ms. Kavanagh was put in protective custody, but said that her time in administrative segregation resulted from a

combination of Ms. Kavanagh's Transsexualism and disciplinary reasons, arising out of what Ms. Lamm referred to as 'institutional issues'. Ms. Lamm cannot recall whether Ms. Kavanagh ever asked to be put into protective custody or segregation for her own protection.

[122] Allison Dowson has worked with transsexual inmates at both Kent Institution and Mountain Institution, a medium security male institution in British Columbia, where she dealt with Synthia Kavanagh. Ms. Dowson is an Institutional Parole Officer, and is currently an Acting Unit Manager at Mountain Institution. According to Ms. Dowson, Synthia Kavanagh was provided with a single cell in front of the Security Officer while she was at Mountain Institution. This cell was also the cell nearest the showers. Ms. Dowson stated that Synthia Kavanagh did not have much in the way of difficulty dealing with the other inmates at Mountain Institution, who pretty much left her alone.

[123] Ms. Kavanagh was in Mountain Institution immediately before she went to Montreal for her sex reassignment surgery. Before she left, Ms. Dowson assisted Ms. Kavanagh in purchasing female clothing and cosmetics.

[124] Ms. Dowson acknowledged that inmates are searched from time to time. In Ms. Kavanagh's case, she would be 'patted down' by female staff. Ms. Dowson thought that strip-searches would have been conducted by male staff, although she does not recall Synthia Kavanagh ever being strip-searched during her stay at Mountain Institution.

[125] CSC does not appear to provide much in the way of formal training to staff with respect to transsexual inmates and their needs. According to Ms. Lamm, CSC staff who have dealings with transsexual inmates tend to educate themselves. In Ms. Dowson's case, she stated that in the course of her dealings with other transsexual inmates, she realized that she did not know much about what the inmates were going through. She started educating herself, by obtaining information with respect to Gender Identity Disorder from the Vancouver Clinic. Ms. Dowson says that she did attend a CSC workshop for staff dealing with transsexual inmates at the Regional Health Care Centre, and that she passed her knowledge on to other CSC staff who were going to be dealing with Ms. Kavanagh. We were not provided with any other information with respect to this particular program, or any other training in Gender Identity Disorders provided to staff by CSC.

[126] Both Ms. Lamm and Ms. Dowson testified that CSC's attitude towards inmates generally, and transsexual inmates in particular, has evolved significantly over the last ten years, insofar as recognition of the needs of individuals is concerned.

[127] Synthia Kavanagh testified with respect to her experiences at a CSC inmate. Since 1989, Ms. Kavanagh has been held in eleven different institutions in Ontario and British Columbia, moving in and out of several institutions on more than one occasion. Ms. Kavanagh says that most inmates are not moved as often as she was, but that several of the institutions that she was in did not want to keep her because of her Gender Identity Disorder. Ms. Kavanagh acknowledged that her move to British Columbia was taken in order to allow her to consult with Dr. Watson and the Vancouver Gender Clinic.

[128] Ms. Kavanagh stated that shortly after she was incarcerated, Dr. Dickey ordered that her hormone therapy be discontinued. She described in the most graphic terms the pain and the panic that she felt as her female secondary sex characteristics disappeared. Numerous letters written by Ms. Kavanagh to various authorities within CSC were put into evidence, wherein she sought assistance in getting treatment for her Gender Identity Disorder. Ms. Kavanagh's anguish with her situation is palpable in these letters. Ms. Kavanagh stated that she had her gender identity 'pretty well under control' when she was living in the community. Once she was incarcerated, however, and was taken off of hormones, she became consumed with the pursuit of treatment, including sex reassignment surgery. Ms. Kavanagh says that much of her conduct within the institutional setting, including her acting out, self-mutilation, drug use, hunger strikes and attempts at suicide, were acts of desperation resulting from the denial of proper treatment for her condition.

[129] According to Ms. Kavanagh, during her incarceration in male institutions operated by CSC, she was regularly beaten, sexually assaulted and ridiculed. In the course of an earlier federal sentence, Ms. Kavanagh says, she was raped by nine men. Ms. Kavanagh testified that some inmates viewed her as 'a trophy', and pursued her for sexual purposes. Insults from other inmates, who did not like what she was, would lead to violent confrontations. According to Ms. Kavanagh, there was always a great deal of conflict and violence surrounding her. Ms. Kavanagh acknowledged that other inmates are vulnerable to the sort of abuse that she experienced in male prisons, including homosexuals and very young inmates.

[130] While acknowledging that she was able to take care of herself in certain situations, Ms. Kavanagh says that Millhaven 'was like Vietnam'. According to Ms. Kavanagh, had she not been prepared to provide sexual favours to certain inmates, she would not have gotten out of Millhaven alive.

[131] Ms. Kavanagh says that she often asked to be put in segregation for her own protection. When her requests were denied, she would threaten staff or otherwise act out, so as to be placed in segregation, albeit for disciplinary reasons.

[132] During the early years of her incarceration, Ms. Kavanagh says, she was not allowed to wear women's clothes or cosmetics. Since her move to Kent Institution in 1997, Ms. Kavanagh says she has been permitted to wear both female clothing and cosmetics. Ms. Kavanagh notes that this change occurred after she had filed her human rights complaint. Ms. Kavanagh says that she had both single and double cell accommodation during her time in the male prison system. In her last few years in the male system she more often had a cell to herself, although there were occasions when she was forced to share a cell with another inmate. She described her discomfort at sharing a cell with a male inmate, and at having to undress and use the toilet in front of her cell-mate.

[133] After her surgery, Ms. Kavanagh was transferred to Joliette Institution. Shortly thereafter, Ms. Kavanagh attempted suicide, and was transferred to Pinel Institution in Montreal. Ms. Kavanagh states that she had been forced to suppress her emotions throughout her time in the male prison system. Once she was in the safe environment of a women's prison, and her life was no longer at risk, she began to allow herself to feel again. When she started letting herself feel,

Ms. Kavanagh's emotions came out in an uncontrollable rush, and she had what she described as a 'breakdown'. Ms. Kavanagh testified that she has been diagnosed as suffering from post-traumatic stress disorder, caused by the numerous traumas in her life, including her experiences within the male prison system.

VIII. LEGAL PRINCIPLES

[134] Ms. Kavanagh's complaints are brought pursuant to section 5 of the *Canadian Human Rights Act*. Section 5 makes it a discriminatory practice, in the provision of services customarily available to the general public, to deny access to any such service to any individual, or to differentiate adversely in relation to any individual, on a prohibited ground of discrimination. Section 3 of the *Act* designates sex and disability as prohibited grounds of discrimination.

[135] There is no dispute that discrimination on the basis of Transsexualism constitutes sex discrimination as well as discrimination on the basis of a disability.[(15)]

[136] Pursuant to section 15 (g) of the *Act,* it is not a discriminatory practice to deny access to a service to an individual where there is a *bona fide* justification for that denial.

[137] The Supreme Court of Canada has recently had occasion to revisit the approach to be taken in cases such as this in its decisions in *British Columbia (Public Service Employee Relations Commission) v. BCGSEU* [(16)] ('*Meiorin*') and *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)* [(17)] ('*Grismer*'). The historic distinction between direct and indirect discrimination has now been replaced by a unified approach to the adjudication of human rights complaints. Under this unified approach, the initial onus is still on a complainant to establish a *prima facie* case of discrimination. A *prima facie* case is one which covers the allegations made, and which, if believed, is complete and sufficient to justify a verdict in the complainant's favour in the absence of an answer from the respondent.[(18)]

[138] Once a *prima facie* case of discrimination has been established, the onus shifts to the respondent to prove, on a balance of probabilities, that the discriminatory standard or policy has a *bona fide* justification. In order to establish such a justification, the respondent must now prove that:

> i) it adopted the standard for a purpose or goal that is rationally connected to the function being performed;
>
> ii) it adopted the standard in good faith, in the belief that it is necessary for the fulfilment of the purpose or goal; and

iii) the standard is reasonably necessary to accomplish its purpose or goal, in the sense that the respondent cannot accommodate persons with the characteristics of the complainant without incurring undue hardship.

[139] The term 'undue hardship' is not defined in the *Act*, however, *Meiorin* and *Grismer* provide considerable guidance in determining whether or not an undue hardship defence has been made out. In *Meiorin*, the Supreme Court observed that the use of the word 'undue' implies that some hardship is acceptable - it is only 'undue' hardship that will satisfy the test.[(19)] The Supreme Court has further observed that in order to prove that a standard is reasonably necessary, a respondent always bears the burden of demonstrating that the standard incorporates every possible accommodation to the point of undue hardship.[(20)] It is incumbent on the respondent to show that it has considered and reasonably rejected all viable forms of accommodation. The onus is on the respondent to prove that incorporating aspects of individual accommodation within the standard was impossible short of undue hardship.[(21)] In assessing the adequacy of the respondent's efforts to accommodate, regard may be had to the prospect of substantial interference with the rights of others.[(22)] The adoption of the respondent's standard has to be supported by convincing evidence. Impressionistic evidence will not generally suffice.[(23)] Finally, factors such as the financial cost of methods of accommodation should be applied with common sense and flexibility in the context of the factual situation under onsideration.

IX. ANALYSIS

[140] There are two complaints before the Tribunal, one relating to CSC's policy regarding the placement of pre-operative transsexual inmates, and the other challenging CSC's ban on sex reassignment surgery during incarceration. Each of these complaints will be dealt with in turn.

A. Placement of Pre-Operative Transsexuals

(i) Is There A *Prima Facie* Case of Discrimination?

[141] CSC's policy requiring that anatomically male prisoners be held in male institutions clearly has an adverse, differential effect on pre-operative male to female transsexual inmates. Non-transsexual inmates are placed in prisons in accordance with both their anatomical sex and their gender. Transsexual inmates, however, are placed in accordance with their anatomical sex, but not their gender. Counsel for CSC indeed concedes that the policy is *prima facie* discriminatory, on the basis of both sex and disability.

(ii) Has CSC Discharged its Burden?

[142] Having found a *prima facie* case of discrimination on the basis of sex and disability, the onus shifts to CSC to establish that it has a *bona fide* justification for its policy. There are three elements which must be established in order to demonstrate the existence of a *bona fide* justification.

a) Rational Connection

[143] Using the approach established by the Supreme Court of Canada in *Meiorin* and *Grismer*, in order to prove the existence of a *bona fide* justification for the policy in issue, CSC must first establish that it adopted the standard for a purpose or goal that is rationally connected to the function being performed. The focus at this stage is not on the validity of the standard in issue, but rather on the validity of its more general purpose.(24)

[144] In this regard, counsel for the Canadian Human Rights Commission concedes that CSC's policy with respect to the placement of inmates is rationally connected to its obligation to care for inmates.

b) Good Faith

[145] The second element that must be established by CSC under the *Meiorin* and *Grismer* test is that it adopted its policy in good faith, in the belief that it is necessary for the fulfilment of its purpose or goal. Counsel for the Canadian Human Rights Commission agrees that there is no evidence that CSC has acted other than in complete good faith in the formulation of its policy.

c) Undue Hardship

[146] Finally, in order to establish the existence of a *bona fide* justification, the onus is on CSC to establish that its policy is reasonably necessary to accomplish its goal, in the sense that it cannot accommodate persons with the characteristics of the complainant, without incurring undue hardship.

1. Placement in Target Gender Institutions

[147] Counsel for the Canadian Human Rights Commission contends that CSC has failed to satisfy this aspect of the *Meiorin* and *Grismer* test. According to the Commission, the evidence adduced by CSC to justify its refusal to allow pre-operative transsexuals to be placed in institutions that accord with their target gender is highly impressionistic. The Commission further submits that CSC's contention that pre-operative male to female transsexuals cannot be placed in female prisons because of the reaction of female inmates is extremely troubling, as it gives legitimacy to the prejudicial attitudes of others, which attitudes are based upon fear and misinformation. It is up to CSC, the Commission says, to address these discriminatory attitudes through education, and, if necessary, through improved security.

[148] Ms. Kavanagh observed that, like many female inmates, many transsexuals have had histories of drug use and prostitution, and often share comparable histories of abuse. These commonalities, Ms. Kavanagh suggests, would assist in bridging the gap.

[149] Insofar as the risk that would be posed to female inmates if they were required to share facilities with a pre-operative male to female transsexual is concerned, the Commission says that non-consensual sexual activities occur now in both male and female institutions. These are assaults, they are breaches of institutional rules, and must be dealt with accordingly. It makes no

difference, in counsel's submission, whether the assault is perpetrated by a male prisoner on another male prisoner, or by a pre-operative male to female transsexual on a female prisoner.

[150] The Commission refers to the decision of the British Columbia Human Rights Tribunal in *Sheridan*. Based upon the expert evidence adduced in that case, the Tribunal concluded that: "... transsexuals in transition who are living as members of the desired sex should be considered to be members of that sex for the purposes of human rights legislation.'[(25)] In this case, the Commission says, pre-operative male to female transsexuals should be treated as women, and housed accordingly.

[151] Counsel for CSC noted that the *Meiorin* approach permits consideration of whether a particular method of accommodation would create a substantial interference with the rights of other people. Part of the rehabilitation process for female offenders involves placing them in a safe environment, where they can begin to address the problems that got them into trouble in the first place. This includes teaching them how to deal with men in a more positive fashion. These are disadvantaged women, counsel says, who are dealing with their own issues, and we have to be realistic about their ability to cope. Forcing such women to deal with a pre-operative male to female transsexual in their midst, and the risks that such individuals could pose, is not a realistic expectation, nor is it an appropriate priority.

2. Other Alternatives

[152] Both the Commission and Ms. Kavanagh acknowledge the concerns that arise with respect to the reception that a pre-operative transsexual would receive in a target gender institution. Both suggest that a compromise, such as a transitional facility, or accommodation at Regional Health Centres, is perhaps required. The 'bottom line', the Commission says, is that CSC's current standard does not pass muster, and something different must be done.

[153] With respect to the creation of a dedicated facility for pre-operative transsexuals, the Commission says that all of the reasons put forward by CSC for its inability to create such a facility ultimately boil down to a question of cost. We have no information regarding the cost of creating such a facility, the Commission says, and thus CSC has failed to show that it would constitute an undue hardship to do so.

[154] The Commission and Ms. Kavanagh suggested, in the alternative, that pre-operative transsexual inmates be held in Regional Health Centres during their transition. Counsel for CSC says that this is not an appropriate alternative for several reasons. Regional Health Centres are all maximum security institutions, and it would not be appropriate to house medium or minimum security individuals there for protracted periods of time, having regard to CSC's obligation to house inmates in the least restrictive environment appropriate to the inmate.[(26)] Further, pre-operative transsexual inmates would not be able to access the range of programming necessary for their rehabilitation at the Centres.

(iii) Conclusions Regarding the Placement of Pre-Operative Transsexual Inmates

[155] The first issue to address is the Commission's submission that the evidence with respect to the attitudes of female prisoners was entirely impressionistic, and did not meet the standard prescribed in *Meiorin* and *Grismer*. It is true that there was not a great deal of evidence led with respect to the vulnerability of female inmates as a group, and that more information in this regard would have been helpful. Having said that, both Ms. Laishes and Ms. Wrenshall described the results of the studies that have been conducted of the female inmate population with respect to their life experiences and their needs. Additional information was also provided about the findings of the Arbour Commission regarding the Prison for Women. Finally, Ms. Wrenshall, who was qualified as an expert in issues involving female inmates, provided us with her opinions on the issue. Based upon this information, we are satisfied that there is a legitimate, objective basis for concern with respect to the vulnerability of the female inmate population and the impact that the placement of an anatomical male would have on these women.

[156] The argument that we should not allow the discriminatory attitudes of female inmates to preclude the placement of pre-operative male to female transsexuals in female prisons is an attractive one, at first glance, and one which accords with a line of human rights jurisprudence concerning 'customer preference' as a defence to an allegation of discrimination. It is indeed no defence to a complaint of discrimination that an employer or service provider acted in a discriminatory fashion because of the demands of his or her customers.[(27)]

[157] However, having given this argument careful consideration, we have come to the conclusion that it does not fully take into account the unique context created by the carceral setting. What is being suggested here is that female inmates be asked to live, for extended periods of time, in very close quarters, with a person who is anatomically of the opposite sex. This would happen in a context where leaving would not be an option, were the situation to become intolerable for the female inmate.[(28)]

[158] It also strikes us as overly simplistic to say that the female inmate population would be reacting out of fear and ignorance, and that, with a little education, they could be taught to accept an anatomically male inmate in their facility. The difficulties that female inmates have in dealing with men are based, in part on lack of knowledge, but are also based on painful life experience. It appears from the evidence that many of these women are psychologically damaged, as a consequence of the physical, psychological and sexual abuse they have suffered at the hands of men. Like transsexuals, female inmates are a vulnerable group, who are entitled to have their needs recognized and respected.

[159] In this regard, we note that the conclusion in *Sheridan* that pre-operative transsexuals in transition should be treated as members of the target gender, is one based upon the evidence adduced in that case, and was made in the context of access to washroom facilities in a bar. We agree with the British Columbia Human Rights Tribunal that there may well be situations where it is appropriate to treat pre-operative transsexuals as members of the target gender. In our view, however, the factual situation under consideration in this case is readily distinguishable from that in issue in *Sheridan*, both as it relates to the close living conditions for inmates, and as well, to the particular vulnerability of the female inmate population.

[160] For these reasons we find that CSC has met its burden, and has demonstrated that, having regard to the unique nature of the carceral setting and the needs of the female inmate population, it is not possible to house pre-operative male to female transsexuals in women's prisons.

[161] We have also considered the physical risk that would be posed by pre-operative male to female transsexuals in a female prison. It is apparent from the expert testimony that the sexual orientation of transsexual inmates cannot be determined with any degree of certainty. This point was graphically illustrated by the testimony of Dr. Watson, who was forced to qualify her opinion that Ms. Kavanagh was exclusively attracted to men, in light of the fact that Ms. Kavanagh had been sexually involved with a woman at Joliette Institution. There is also no guarantee that pre-operative male to female transsexuals will be unable to function sexually, notwithstanding their ingestion of female hormones. As a result, pre-operative male to female transsexuals pose a potential risk to female inmates. In our view, this is a factor to consider, although its significance should not be overstated: The unfortunate fact is that non-consensual sexual activity already occurs in the prison setting, although the evidence suggests that it happens less frequently in women's prisons than it does in male institutions.

[162] We agree with CSC that the creation of a dedicated facility for pre-operative transsexuals in transition is simply not feasible. While the Commission approached the issue as solely being one of cost, it is clear that it is the logistics, and not the cost, that create the insurmountable problems for CSC. There are a very small number of transsexual inmates, of whom only a portion will be interested in sex reassignment. According to Ms. Laishes, there are currently four such individuals within CSC. Allowance then has to be made for the issue of incompatibles. Unless several facilities are created, inmates may have to be held in locations that are far away from family and community support systems. Further, although not mentioned by Ms. Laishes, it is clear that the security level of the inmates will have to be taken into account, and maximum, medium and minimum security facilities developed.[(29)] Consideration would also have to be given as to whether it was appropriate to house pre-operative male to female transsexuals with pre-operative female to male transsexuals. The end result would likely be that placement in a dedicated facility could well be tantamount to solitary confinement for the pre-operative transsexual inmate.

[163] There are several other reasons for rejecting a dedicated facility as an alternative means of accommodation. CSC's ability to provide programming to these inmates would be negatively affected by the lack of the necessary 'critical mass' for such programs. Several witnesses, including Dr. Watson, also expressed a concern with respect to the 'ghettoisation' that could result from the creation of such a facility. Finally, we must recall the testimony of Synthia Kavanagh herself, who stated that she had always tried to avoid spending time with other transsexuals, as she did not feel comfortable with them. Placing Ms. Kavanagh in a specialized facility for transsexual inmates before her surgery would clearly have not addressed her needs.

[164] If pre-operative male to female transsexuals should not be placed in female institutions or in a dedicated facility, does it then follow that CSC's policy with respect to the placement of transsexual inmates is justified in its current form?

[165] Synthia Kavanagh's descriptions of the treatment she encountered in CSC's male institutions, particularly those in Ontario, is very troubling. We recognize the need to approach Ms. Kavanagh's testimony with some caution, given her history of manipulative behaviour, and her admission that she has frequently lied to authorities to get what she wants. However, we found her to be an articulate and compelling witness, and note that her description of the abuse she says that she suffered within the carceral setting was not seriously challenged by counsel for CSC. Based on all of the evidence, including the testimony of Ms. Kavanagh, we find that pre-operative transsexuals are a particularly vulnerable group of inmates, who require special consideration concerning their placement within the prison setting.

[166] In our view, CSC has not justified its policy with respect to the placement of transsexual inmates in its current form, as the policy fails to recognize the special vulnerability of the pre-operative transsexual inmate population. Although it appears that this is taken into account, at least in some cases, it happens on an *ad hoc* basis, and the approach taken varies from institution to institution. Any policy dealing with this uniquely vulnerable group must recognize the differential effect that housing inmates in accordance with their anatomy has on transsexual inmates. The policy also needs to acknowledge their susceptibility to victimization within the prison system. Finally, it must require the individualized assessment of each transsexual inmate by corrections officials, in consultation with qualified medical professionals, as to the appropriate placement of the individual within the various types of facilities available in the male prison system [(30)], and the steps that are necessary to ensure their safety.

[167] Although it appears from the testimony of Ms. Lamm that there is some training available to CSC personnel with respect to issues relating to Gender Identity Disorder, there does not appear to be any requirement that CSC staff who come into regular contact with transsexual inmates have any kind of training regarding the special needs of this population. Such a requirement should be part of any CSC policy dealing with the placement of transsexual inmates.

B. Access to Sex Reassignment Surgery

(i) Is There A *Prima Facie* Case of Discrimination?

[168] Counsel for CSC contends that the Commission and Ms. Kavanagh have not established that CSC's policy with respect to sex reassignment surgery is *prima facie* discriminatory. According to CSC, transsexual inmates are provided with the same level of health care as are other inmates. Any distinction that is drawn with respect to access to treatment, counsel says, is made because of the inmate's status as federal inmate, and the view of some medical practitioners that inmates are not suitable candidates for sex reassignment surgery, and not because the inmate is a transsexual.

[169] With the greatest of respect, we do not agree that it is the status as an inmate that is the basis for the differential treatment. Dr. Dickey and Dr. Hucker both testified that they could envisage cases where a federal inmate could be a good candidate for sex reassignment surgery. Section 31 of CSC's Health Services policy, however, absolutely prohibits such surgery during incarceration. No other medical procedure is subject to such a blanket prohibition.

[170] There is a dispute in the evidence as to whether sex reassignment surgery is an essential or an elective procedure, within the meaning of the CSC Health Services policy. This issue will be explored later, in the context of our undue hardship analysis. At this juncture, however, we note that even if we were to accept that sex reassignment surgery is a non-essential medical service, CSC's policy treats sex reassignment surgery differently than any other type of non-essential health service. Consideration of the treatment accorded to non-transsexual inmates seeking non-essential medical treatment demonstrates that it is the inmate's status as a transsexual that gives rise to the differential treatment: An inmate who wants to have an elective procedure such as a tattoo removal can obtain a letter from his or her doctors, and will be able to have the tattoo removed at his or her own expense. The same is true of any other type of elective medical treatment, with the exception of sex reassignment surgery. In Ms. Kavanagh's case, she was assessed and approved for sex reassignment surgery by Dr. Watson, but was initially unable to access surgery, because of the prohibition in Section 31 of the policy.

[171] For these reasons, we are satisfied that the Commission and Ms. Kavanagh have established that Section 31 of CSC's Health Services policy is *prima facie* discriminatory, on the basis of both sex and disability.

(ii) Has CSC Discharged its Burden?

[172] Having found a *prima facie* case of discrimination on the basis of sex and disability, the onus once again shifts to CSC to establish that it has a *bona fide* justification for its policy. Each of the three elements which must be established in order to demonstrate the existence of a *bona fide* justification will be considered in turn.

a) Rational Connection

[173] *Meiorin* and *Grismer* require that CSC first establish that it adopted its policy for a purpose or goal that is rationally connected to the function being performed. In this regard, counsel for the Commission concedes that CSC's Health Services policy is rationally connected to its obligation to care for inmates.

b) Good Faith

[174] The second element that must be established by CSC is that it adopted its policy in good faith. On this point, counsel for the Canadian Human Rights Commission again concedes that there is no evidence that CSC has acted other than in complete good faith in the formulation of its policy regarding access to sex reassignment surgery .

c) Undue Hardship

[175] The final issue to be determined is whether CSC has established that its policy prohibiting sex reassignment surgery is reasonably necessary to accomplish its goal, in the sense that it cannot accommodate persons with the characteristics of the complainant, without incurring undue hardship.

[176] It is clear that much of the difficulty that CSC has encountered in its efforts to formulate a policy with respect to access to treatment for transsexual inmates stems from the fundamental differences of professional opinion between the Clarke Institute and the Gender Dysphoria Clinic at the Vancouver Hospital concerning the appropriate treatment of transsexuals in the carceral setting. There is general agreement that the Harry Benjamin Standard represents the 'gold standard' with respect to diagnosis and treatment of transsexuals, including its requirement that candidates for surgery fulfill a real life experience. Where the experts diverge is on the question of whether the real life experience can be properly replicated within the carceral setting. There is also disagreement with respect to the need for psycho-social stability in a candidate for sex reassignment surgery.

[177] Dr. Watson says that an inmate can indeed experience a real life experience in the prison setting, whether it be in a male or female institution. Dr. Watson impressed us as a sincere and compassionate physician, who obviously cares deeply about her transsexual patients. She is also clearly very knowledgeable about Gender Identity Disorders. Although Dr. Watson was qualified as an expert in the treatment of transsexuals in prison, it became apparent from her testimony that she has limited experience with the prison setting. Similarly, Dr. Watson does not have any expertise in forensic psychiatry, unlike Dr. Dickey and Dr. Hucker, both of whom were qualified as experts in this field. Dr. Dickey and Dr. Hucker also have extensive experience working with inmates in the prison setting as a result of their work in the risk assessment and parole context.

[178] We agree with the experts called by CSC that the real life experience requirement of the treatment protocol cannot be satisfactorily fulfilled within the carceral setting. It appears from all of the evidence that pre-operative transsexuals need to be able to interact with *both* men and women in their day to day lives in order to properly fulfill the requirements of the real life experience. We have already concluded that it is not appropriate to place pre-operative male to female transsexuals in women's prisons. Can these individuals then obtain an appropriate real life experience while incarcerated in male penitentiaries? We think not. All of the experts, including Dr. Watson, agree that the purpose of the real life experience is to test the resolve of the patient as it relates to proceeding with sex reassignment surgery, while also assessing the capacity of the individual to live in their target gender. The patient's resolve is tested by requiring the patient to face the potential loss of employment, family and friends, as well as the general social opprobrium that can follow the decision to live as a member of the target gender. Unlike society at large, the artificial environment of the male prison provides both positive and negative reinforcements (31) that can distort the experience of the individual in such a way as to render the real life experience an unreliable test of an individual's 'resolve, the capacity to function in the preferred gender, and the adequacy of social, economic, and psychological supports'. (32) The real life experience carried out in the prison setting is, therefore, an unreliable indicator of the individual's suitability for sex reassignment surgery.

[179] We also prefer the evidence of CSC's experts over that of Dr. Watson insofar as the need for psycho-social stability is concerned, and, in particular, the effect that psychopathy may have on an individual's suitability for sex reassignment surgery. Unlike Dr. Watson, both Dr. Dickey and Dr. Hucker are experts in forensic psychiatry, and both appear to have had considerably more experience working with inmates than does Dr. Watson.

[180] We agree with Dr. Watson that health care providers must be cautious not to impose their own values on a population that is chronically marginalised. It must be kept in mind, however, that all of the experts agree that Transsexualism does not cause criminal behaviour, and that treatment will not render law-abiding otherwise criminally-inclined individuals. We recognize that untreated Transsexualism may interfere with the ability of transsexual inmates to rehabilitate themselves. Nevertheless, having regard to the highly invasive and irreversible nature of the procedure in issue, it seems to us only reasonable that a patient be required to have a basic level of psycho-social stability before taking this final step on the profoundly life-altering journey of sex reassignment.

[181] Although we agree with CSC's experts that the real life experience cannot be carried out in the carceral setting, it does not follow that CSC's absolute prohibition on sex reassignment surgery for inmates is therefore justified. Both Dr. Dickey and Dr. Hucker testified that they could envisage situations where an incarcerated individual might be a suitable candidate for sex reassignment surgery and would benefit from same. One such scenario could arise where, for example, the individual was generally pro-social, and had fulfilled the real life experience component of the selection criteria prior to their incarceration. Both Dr. Dickey and Ms. Laishes acknowledged the need for some flexibility in CSC's policy to allow it to address such cases on an individualized basis.

[182] All of the experts agree that sex reassignment surgery is a legitimate, medically recognized treatment for Transsexualism, in properly selected individuals.[(33)] Counsel for CSC submitted that the blanket prohibition on such surgery was nevertheless justified, as changing the policy to accommodate a theoretical possibility would provide 'false hope' to a lot of inmates who feel very strongly about this issue. Not only does this reflect a somewhat paternalistic attitude towards the transsexual inmate population: It also does not accord with the law in this area. If a service provider is to justify an absolute prohibition on access to a service on a proscribed ground of discrimination, the service provider must be able to demonstrate that *no one* is able to meet the eligibility requirements for the service.[(34)]

[183] For these reasons, we find that CSC has failed to justify its blanket policy prohibiting inmate access to sex reassignment surgery.

(iii) Other Issues

[184] Before moving to the question of remedy, there are several additional issues that need to be addressed, as a result of our conclusion that an absolute ban on sex reassignment surgery is not justified. The first of these issues concerns the question of who should select the physician who will assess the transsexual inmate's suitability for sex reassignment surgery? Considerable time was spent on this issue in the course of the hearing, because of the difference of opinion in the medical community as to the suitability of transsexual inmates for sex reassignment surgery. According to Ms. Laishes, when an inmate is referred to an outside specialist for assessment, the choice of specialist is ordinarily made by the institutional physician. The Commission urges us to allow the inmate to make the choice of physician, given that it is their body that is in issue. If we leave the choice to CSC, the Commission says, CSC will simply refer every inmate to the Clarke Institute, and no one will ever be approved for surgery.

[185] Given our finding that the real life experience cannot properly be carried out in the prison setting, the only way that a transsexual inmate could be a proper candidate for sex reassignment surgery would be if they had already completed the real life experience component of the Harry Benjamin criteria prior to their incarceration. To comply with the treatment protocol, the real life experience has to be carried out under the supervision of a recognized gender identity clinic. It seems to us only reasonable that it be the physicians who have been following the inmate through the transition process who should make the determination of the inmate's suitability and readiness for sex reassignment surgery, unless the inmate and CSC jointly agree to a different choice for the final assessment.

[186] This means that the referral process for sex reassignment surgery may have to be slightly different than it is for other medical assessments. However, it is the essence of the principle of accommodation that it is sometimes necessary to treat historically disadvantaged people differently than others, in order to achieve substantive equality.

[187] Assuming that an inmate meets the eligibility requirements for sex reassignment surgery, and obtains the necessary approvals to proceed with such surgery, the question remains as to who will pay for it. As noted previously, sex reassignment surgery is a legitimate medical treatment for a recognized medical condition. It should be treated like any other medical procedure, for the purposes of CSC's Health Services policy.

[188] Under the policy, essential medical services are paid for by CSC, whereas elective procedures are paid for by the inmate. Dr. Dickey, Dr. Hucker and Ms. Petersen all testified that sex reassignment surgery is an elective procedure, within the meaning of CSC's policy. Although Dr. Watson did not address the issue directly, her description of the distress suffered by those she describes as having 'high intensity' Gender Identity Disorder certainly suggests that there are those for whom sex reassignment surgery might well be essential for their well-being.

[189] We have some concerns about Dr. Dickey's testimony in this regard. Dr. Dickey was very concerned about public monies possibly being expended to provide surgery to inmates, when law-abiding citizens in the community at large may be unable to access surgery at public expense. With the greatest of respect, this appears to be a moral judgment, and not a medical one. Although Dr. Dickey was clearly a knowledgeable witness, we were left with the impression that his concern with respect to the funding issue may have influenced his characterization of sex reassignment surgery as a non-essential procedure.

[190] We have no such concerns with respect to the testimony of Dr. Hucker and Ms. Petersen. Nevertheless, we are concerned about their categorical assertion that sex reassignment surgery was not [and presumably could never be] an essential medical service, in light of the clear statement to the contrary in the Harry Benjamin Standard. It is apparent that different individuals experience varying degrees of distress in relation to their Transsexualism. It may very well be that there are some individuals for whom sex reassignment surgery is an essential procedure, and others for whom it is elective. It seems to us that this is a determination best made, on a case by case basis, by the physicians from a recognized Gender Identity Disorder Clinic, who are supervising the inmate's transition, and are familiar with his or her situation.

[191] If the medical opinion is that sex reassignment surgery is an essential service for a particular inmate, it follows that it should be paid for by CSC, as would any other essential medical service.[(35)] If not, it is the inmate who will have to bear the expense.

C. Conclusion on Liability

[192] We have found that CSC's policy with respect to the placement of pre-operative transsexual inmates has a discriminatory effect on transsexual inmates. While we agree with CSC that pre-operative transsexuals should not be placed in target gender facilities, CSC has failed to establish that it cannot not accommodate persons with the characteristics of the complainant, within the male prison population, without incurring undue hardship.

[193] We have also found that CSC's blanket prohibition on sex reassignment surgery has a discriminatory effect on transsexual inmates because of their sex and their disability, and that CSC has been unable to justify such a blanket policy.

[194] For these reasons, Ms. Kavanagh's complaints are sustained.

X. REMEDY

[195] Having found liability on the part of CSC, it remains to be determined what the appropriate remedy should be.

A. Placement

[196] CSC has demonstrated that it is justified in not placing pre-operative transsexuals in target gender facilities. However, we have found that the application of Section 30 of CSC's Health Service policy has a differential impact on transsexual inmates: In requiring that pre-operative transsexual inmates be placed with other inmates sharing their anatomical structure, CSC's policy fails to recognize the particular vulnerability of this group of inmates, and their need for accommodation within the prison setting.

[197] In our view, it is not necessary to order that CSC cease applying the provisions of Section 30 of the Health Service Policy. It is, however, necessary that CSC take steps, in consultation with the Commission, to formulate a policy that ensures that the needs of transsexual inmates are identified and accommodated.

B. Sex Reassignment Surgery

[198] We have found that Section 31 of CSC's Health Service Policy is discriminatory on the basis of both sex and disability, and that CSC has failed to justify a blanket prohibition on access to sex reassignment surgery. We therefore order that CSC cease applying the provisions of Section 31. This order will be suspended for a period of 6 months from the date of this decision to allow CSC to consult with the Canadian Human Rights Commission with respect to the

formulation of a new policy consistent with these reasons, regarding inmate access to sex reassignment surgery.

C. Retention of Jurisdiction

[199] Within six months of the date of this decision, the parties shall file with the Tribunal copies of CSC's revised policies regarding the placement of transsexual inmates and inmate access to sex reassignment surgery. If the parties are unable to agree with respect to any of the terms of such policies, the Tribunal retains jurisdiction to deal with any outstanding issues.

XI. ORDER

[200] For the foregoing reasons, we declare that Sections 30 and 31 of CSC's Health Service policy discriminate on the basis of sex and disability, and order that:

> i) CSC take steps, in consultation with the Canadian Human Rights Commission, to formulate a policy that ensures that the placement needs of transsexual inmates are identified and accommodated, in accordance with this decision.
>
> ii) CSC cease applying the provisions of Section 31 of its Health Service policy. This order will be suspended for a period of 6 months from the date of this decision to allow CSC to consult with the Canadian Human Rights Commission with respect to the formulation of a new policy that is consistent with these reasons, regarding inmate access to sex reassignment surgery.
>
> iii) The parties shall file with the Tribunal copies of CSC's revised policies regarding the placement of transsexual inmates and inmate access to sex reassignment surgery within six months of the date of this decision. The Tribunal retains jurisdiction to deal with any outstanding issues relating to the terms of these policies

Anne L. Mactavish, Chairperson

J. Grant Sinclair, Tribunal Member

Sandra Goldstein, Tribunal Member

OTTAWA, Ontario

August 31, 2001

CANADIAN HUMAN RIGHTS TRIBUNAL

COUNSEL OF RECORD

TRIBUNAL FILE NO.: T505/2298

STYLE OF CAUSE: Synthia Kavanagh v. Attorney General of Canada

PLACE OF HEARING: Vancouver, British Columbia

(April 2-6, 2001; April 9-12, 2001)

Joliette, Quebec

(July 4-5, 2001)

DECISION OF THE TRIBUNAL DATED: August 31, 2001

APPEARANCES:

Synthia Kavanagh On her own behalf

Daniel Pagowski For the Canadian Human Rights Commission

Donnaree Nygard For the Attorney General of Canada

Stephanie Castle Heal For the Zenith Foundation

1. [1] This latter group of individuals have historically been referred to as 'transsexuals', although this term is no longer used in the Diagnostic and Statistical Manual or 'DSM', the American Psychiatric Association standard classification system. The term continues to be used in the International Classification of Diseases, and was used by most of the witnesses throughout this proceeding to describe those suffering profound Gender Identity Disorder, who desire surgical transformation of their bodies and their social gender status.

2. Given that this hearing arose out of Ms. Kavanagh's complaints, the focus much of the evidence was on male to female transsexuals. The policy issues raised by Ms. Kavanagh's complaints are, however, equally applicable to female to male transsexuals.

3. There is no comparable provision in the CSC policy dealing with the placement of female transsexual inmates. As we understand the evidence, however, pre-operative female to male transsexuals are held in women's institutions.

4. Sex reassignment surgery is covered by provincial health care plans in Alberta, Saskatchewan, Manitoba, Newfoundland and British Columbia. Ontario and the Maritime provinces do not pay for surgery. Québec's Medicare program will fund sex reassignment surgery, provided the surgery is carried out in a public hospital. There are, however, no public hospitals performing sex reassignment surgery in Canada, the Ménard Clinic being a private clinic.

5. Ms. Laishes testified that other than Dr. Watson and the Vancouver Clinic, Dr. Dickey and the Clarke Institute, and Dr. Hucker, the only other medical practioners in Canada providing assessments for sex reassignment surgery are two psychiatrists in Quebec, both of whom are unwilling to consider incarcerated individuals for sex reassignment surgery.

6. The phenomenon of people, who are otherwise heterosexual, engaging in homosexual activity while incarcerated occurs with both men and women, and is known as 'facultative homosexuality'.

7. The issue of the placement of pre-operative male to female transsexuals in women's prisons forms the basis of Ms. Kavanagh's second complaint before the Tribunal. The evidence concerning this issue will be reviewed in greater detail in the section of this decision dealing with that complaint.

8. DSM IV

9. Petersen, M.E. and Dickey, R., (1995) Surgical Sex Reassignment: A Comprehensive Survey of International Centres, *Archives of Sexual Behaviour*, 24, 135-156.

10. The Hare Psychopathy Checklist is an instrument widely used by forensic psychiatrists to test for psychopathy or anti-social personality disorder. The test is used to identify individuals with a propensity for violence, and those at risk of recidivism.

11. According to Dr. Watson, Synthia Kavanagh started taking female hormones at such a young age that she never really went through male puberty.

12. According to Dr. Hucker, Ms. Kavanagh's score on the Hare psychopathy scale puts her in the top 5% of the prison population.

13. Ms. Kavanagh acknowledges that she had a sexual encounter with another prisoner at Joliette, but denies that it constituted 'a relationship'. According to Ms. Kavanagh, she was simply checking to see if she could respond sexually with her post-operative genitalia.

14. Petersen, M., Stephens, J., Dickey, R. & Lewis, W. Transsexuals Within the Prison System: An International Survey of Correctional Services Policies. *Behavioral Sciences and the Law*, 14, 219-229, 1996.

15. See *Sheridan v. Sanctuary Investments Ltd. (c.o.b. B.J.'s Lounge)*, (1999) C.H.R.R. D/467 (B.C.H.R.T), *M.L. and Commission des droits de la personne et des droits de la jeunesse du Québec c. Maison des jeunes*, [1998] J.T.D.P.Q. No. 31 (Qué. H.R.T.), *Ferris v. Office and Technical Employees Union, Local 15*, [1999] B.C.H.R.T. No. 55, and *Mamela v. Vancouver Lesbian Connection*, (1999) 36 C.H.R.R. D/318 (B.C.H.R.T.).

16. [1999] 3 S.C.R. 3

17. [1999] 3 S.C.R. 868

18. *Ontario Human Rights Commission and O'Malley v. Simpson Sears Limited*, [1985], 2 S.C.R. 536 at 558.

19. In this regard the decision in *Meiorin* adopts the decision in *Central Okanagan School District v. Renaud*, [1992] 2 S.C.R. 984.

20. *Grismer*, supra., at para. 32

21. *Grismer*, supra., at para. 42

22. *Meiorin*, supra., at para. 63

23. *Grismer*, supra., at paras 41 and 42

24. *Meiorin*, supra., at para. 59

25. *Sheridan*, supra., at para. 107.

26. Section 28, *Corrections and Conditional Release Act*

27. See, for example, *P.G. Du Québec c. Service De Taxis Nord-Est (1978) Inc.* (1986), 7 C.H.R.R. 3109 (Qué. H.R.T.), *Québec (Commission des droits de la personne) c. Entreprises L.D.Skelling Inc*., (1994), 25 C.H.R.R. D/46 (Qué. H.R.T.), and *Perrett v. Versa Services*, (1990), 11 C.H.R.R. D/435 (B.C.Human Rights Council).

28. It is noteworthy that human rights jurisprudence also recognizes the right to personal privacy and dignity in relation to activities which involve close personal contact. See, for example *Stanley v. Royal Canadian Mounted Police,* (1987), 8 C.H.R.R. D/3799, which dealt with the issue of inmate privacy.

29. Section 28, *Corrections and Conditional Release Act*. The *Act* also requires that CSC provide inmates with access to a compatible cultural and linguistic environment, as well as with access to appropriate programs.

30. Or female prison, in the case of pre-operative female to male transsexuals.

31. It is true that the evidence with respect to this positive reinforcement related to autogynephilic transsexuals. In this regard, we prefer the testimony of Dr. Dickey and Ms. Petersen to that of Dr. Watson, because of Dr. Dickey's greater familiarity with the prison setting, and find that the majority of transsexual inmates are in this sub-group. It should also be recalled that it is not always possible to distinguish autogynephilic transsexuals from the homosexual sub-type with any degree of certainty.

32. Harry Benjamin Standard

33. In this regard, counsel for CSC referred us to the decision of the Nova Scotia Court of Appeal in *Cameron v. Nova Scotia (Attorney General),* 177 D.L.R. (4th) 611, (Leave to Appeal denied [1999] S.C.C.A. No. 531), as authority for the proposition that when we are dealing with controversial new procedures, decisions with respect to access should be left to those administering the plan, which, in this case, is CSC. With respect, we do not find this decision particularly helpful, in light of the medical testimony in this case.

34. *Grismer*, supra., at para. 32. The Supreme Court of Canada noted that the other way that a service provider could justify a blanket prohibition would be if it could demonstrate that individualized assessment was impossible. This is not the case here.

35. It should be noted that while we had some evidence with respect to the cost of sex reassignment surgery, we have no information with respect to CSC's overall health service budget, nor was any real attempt made to justify the prohibition of sex reassignment surgery on a cost basis.