# TRANS AND NON-BINARY CHILDREN AND YOUTH:

## A ROADMAP FOR IMPROVING SERVICES IN ONTARIO

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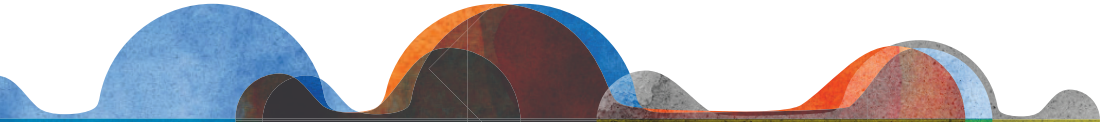

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# Executive summary

## INTRODUCTION

Awareness of trans and non-binary children and youth is increasing, both socially and among service agencies. However, despite legislative and regulatory progress in trans rights, the specific needs of trans and non-binary children and youth remain largely unaddressed. Many agencies looking to strengthen their supports for this vulnerable group and their caregivers don't yet know how, leaving trans and non-binary children and youth to encounter avoidable problems.

Rainbow Health Ontario (RHO), a program of Sherbourne Health, led a needs assessment to learn about ongoing concerns and challenges faced by trans and non-binary children and youth; their parents and caregivers; and their service providers. Evidently, significant barriers remain for these children and youth to have access to needed health care in a timely way, and to fully participate in their families, communities and broader society.

In this report, we review the current literature on trans and non-binary children and youth and share their perspectives, along with those of their caregivers, on their health and social needs. We also offer evidence for policy and service development in support of these populations, and provide cross-sectoral recommendations for public and community sector agencies to better address the needs of these youth and their families.

**The specific needs of trans and non-binary children and youth remain largely unaddressed.**

# METHODOLOGY

This report was guided by an advisory committee of parents and youth, and professionals whose work supports these families. We collected data through surveys, key informant interviews and a focus group. Our three Phase 1 surveys were addressed, respectively, to trans and non-binary children and youth aged 9-17, their parents or caregivers, and service providers who support them—including some working in school boards.

In Phase 2, a second survey was circulated to service providers, to explore knowledge needs in supporting trans and non-binary children and youth. Also in Phase 2, to ensure intersectional perspectives on the issues identified in this report, our key informant interviews addressed gaps we saw in our Phase 1 responses. These focused on the needs of trans and non-binary youth who are Indigenous, from newcomer communities, racialized, Francophone, and/or living in rural or northern communities.

# LITERATURE REVIEW

Most trans and non-binary children and youth don't feel supported at home, at school or socially. They face climates that are hostile towards their identities, where rigid social gender norms are reinforced, and where the very existence of trans people may be denied. Non-binary children and youth face especially prevalent denial of their identities compared to trans youth with binary identities. They frequently encounter harassment and lack of access to facilities.

Indigenous and/or racialized trans children and youth experience racism, colonialism, and other forms of discrimination in addition to that related to their gender identities or expressions, causing even more severe disparities for these populations. Meanwhile, transfeminine children and youth—particularly those who are of colour—are more frequent targets of hostility and violence than their transmasculine peers.

These detrimental external factors for trans children and youth are associated with negative health, including mental health, and poor overall quality of life outcomes—such as high rates of depression and anxiety, low self-esteem, substance abuse, self-harm and suicide, among others. These same factors also contribute to lower academic success, a lack of a sense of safety or belonging, and hopelessness about the future.

There is, however, a path forward: the literature review revealed that when trans children and youth are supported by the people and environments in their lives, their health and well-being is comparable to their cisgender peers. Gender-affirming support from parents is the most significant protective factor.

In medical settings, gender-affirming care is the most likely contributor to positive health outcomes and overall well-being. In schools, social service and community support settings, initiatives such as trans-inclusive policy, comprehensive training for staff and trans-specific supports are integral to creating safer environments.

# WHAT RESPONDENTS TOLD US

Our service user respondents (children and youth, and their parents or caregivers) identified many access needs, including reducing long waitlists for transition-related care. They also said they need:

- information;
- gender-affirming support;
- knowledgeable and gender-affirming health and mental health providers;
- timely access to physical and mental health care;
- supportive and welcoming school environments;
- gender-affirming spaces for social participation; and
- programs and services to ensure and foster good parental support.

Service providers identified many similar issues, including with reducing waitlists for transition-related care, and the need to build capacity in gender-affirming care and support throughout Ontario. They pointed to an exponential increase in the number of children and youth seeking support around gender identity issues over the last five years, with waitlists for specialist and mental health services in particular being unacceptably long.

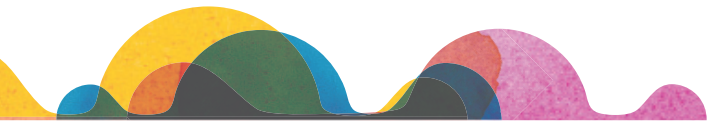
Many of the respondents to our Phase 2 provider survey said they had seen trans youth. The majority, however, did not feel knowledgeable or comfortable in providing their care. As a result, a substantial portion reported “always” referring trans children and youth to other providers. The majority identified service gaps related to access and capacity, particularly in rural and northern communities.

Our key informant interviews showed many common needs among more acutely underserviced trans and non-binary youth, including those who are pre-pubertal, transfeminine, non-binary, newcomers and/or racialized, Indigenous, Francophone, or living in rural and northern communities. Age-appropriate, community and geographically accessible resources for gender-affirming support are needed for these populations. Additionally, some have unique needs related to linguistic barriers, trauma and lack of services close to home.

For other acutely underserviced trans and non-binary children and youth, such as those with disabilities, in care or in custody, the lack of data is significant and we point to the need for further research.

# RECOMMENDATIONS TO IMPROVE ACCESS AND EQUITY FOR TRANS AND NON-BINARY CHILDREN AND YOUTH IN ONTARIO

These 26 recommendations are intended to improve access across many sectors, and are designed to strengthen communities, individuals, families, and research and evaluation. While they focus on the needs of trans and non-binary children and youth, their implementation will strengthen the inclusion, safety and well-being of a broader population of children and youth across the province.



## Support children, youth, and their families and caregivers in all areas of life

1. Develop and expand caregiver support activities and peer support networks. Within this, ensure that Indigenous people, racialized and ethnocultural communities, newcomers, faith-based communities and Francophones have access to supports specific to their communities.

2. Ensure non-gender-specific facilities are universally available in spaces that have historically been sex-segregated, including but not limited to: washrooms, change rooms, shelter spaces, summer camps, university dorms and other overnight accommodations.

3. Create, maintain and promote accessible and local sources of information in various formats and multiple languages for children and youth, parents and caregivers, and others.

4. Provide system navigation supports to help children, youth, families and service providers across the province get the support, services and training they need.

## Create and support social inclusion in schools

5. Train and provide professional development for school staff.

6. Encourage school boards to adopt and implement gender-affirming policy and protocols that support students' gender identities and expressions and respect their other intersecting identities—including making facilities accessible to non-binary students.

7. Ensure dedicated staff resources to work with school boards, children and youth, families, educators, and administrators to address the needs of trans and non-binary students and their families.

## Improve physical and mental health care

8. Develop clinical practice guidelines to support primary care and mental health providers in providing competent, evidence-based care for trans and non-binary children and youth.

9. Develop capacity-building opportunities for primary care providers in gender-affirming approaches, as well as hormonal care. Similarly, build capacity in relevant elements of physical, social and emotional childhood development.

10. Ensure equitable and timely access to treatment and support in primary care contexts throughout the province, while also reducing financial, geographic and cultural barriers.

11. Boost the capacity of specialist services and hospital-based clinics to provide transition-related care—including for complex cases—and to provide consultation as needed to primary care providers.

12. Increase the number and proportion of mental health clinicians, such as social workers, counsellors, psychologists and psychiatrists, who are trained in and can provide gender-affirming care for children and their families and caregivers.

13. Ensure equitable access to general and targeted mental health care, including at children's mental health centres, by reducing barriers that are financial, geographic, cultural and otherwise.

14. Increase the availability of crisis supports for children, youth and their caregivers.

15. Monitor service use to ensure that staffing and service delivery models keep pace with need.

## Bolster community and social service settings

16. In municipalities, adopt and implement gender-affirming policy and protocols that support gender identity and gender expression along with other intersecting identities.

17. Ensure the availability of inclusive and targeted sport and other recreational and social activities for trans and non-binary children and youth and their family members, such as siblings, caregivers and parents.

18. Promote inclusion of, and targeted supports where necessary for, trans and non-binary children and youth in child welfare and shelters.

19. Create and provide educational opportunities for child protection services and family court officials and workers to ensure that trans and non-binary children are afforded respect and self-determination in all settings.

20. Explore needs in sectors such as substance use and addiction and criminal justice, where vulnerable youth are known to be over-represented.

## Foster cross-sectoral work

21. Develop mechanisms to improve inter-professional and community collaboration and referral, such as planning tables and communities of practice.

22. Develop culturally and linguistically appropriate information and supports.

23. Support the recruitment, training and employment of individuals from underserviced communities to improve representation and culturally competent service provision, for instance with more Indigenous and racialized service providers.

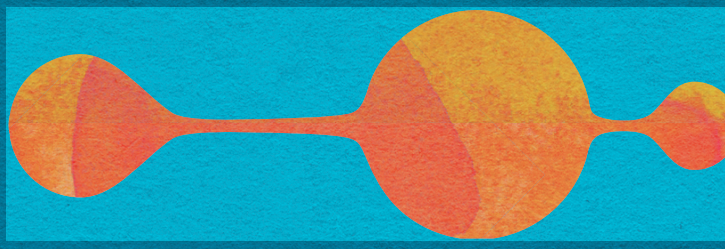
## Encourage research and evaluation on the needs of trans and non-binary children and youth

24. Implement gender-affirming data collection mechanisms in public and community data systems. Additionally, ensure trans and non-binary people have roles in data collection beyond being respondents.

25. Support research initiatives to address the knowledge gaps identified in this report—especially among underserved communities and for children ages zero to six.

26. Perform ongoing evaluations of implementation initiatives to ensure equitable access and outcomes.

# introduction



Awareness of trans and non-binary children and youth is increasing, both socially and among service agencies.

However, many agencies looking to strengthen their supports for this vulnerable group and their caregivers don't yet know how, leaving trans and non-binary children and youth to encounter avoidable problems.

At a policy level, advocacy by trans people has resulted in positive legislative and policy progress, but in many cases, action on implementation remains needed. Additionally, with law and policy forming only part of the picture for health, well-being and social inclusion, many of trans children and youth's critical needs (< 18 years) have yet to be addressed.

Rainbow Health Ontario (RHO) has heard from young trans and non-binary people; their parents and caregivers; and service providers alike about their concerns for the health, well-being and social inclusion of trans children and youth in Ontario. These concerns, among others, are for these children and youth's experiences of harassment and the implications of inequitable health and social outcomes for their chances in life.

Trans children and youth experience harassment through denial of their identities, reinforcement of gender norms, and through bullying and physical violence—compounded with other forms of social exclusion they may face, such as racism or colonization.

Inequitable health and social outcomes arise for trans children and youth through exclusion from their families, schools and communities, and due to barriers to health care. The latter can contribute to poorer mental health outcomes, such as depression and suicidality, as well as increased rates of health-risking behaviours.

We have also heard about a lack of access to appropriate and timely health care, including both primary care and transition-related services.

These concerns led to RHO conducting a needs assessment and developing this report.

**RHO has heard from young trans and non-binary people; their parents and caregivers; and service providers alike about their concerns for the health, well-being and social inclusion of trans children and youth in Ontario.**

## The primary objectives of this report are to:

1. identify the specific health and social needs of trans and non-binary children and youth in Ontario;
2. share the diverse perspectives of trans and non-binary children and youth and their parents and caregivers;
3. provide evidence to support the development of policies and services to improve the availability and accessibility of care and support for trans and non-binary children and youth in Ontario; and
4. make recommendations to various public and community sectors on how to address the needs of trans and non-binary children and youth and their families.

## The secondary objectives of this report are to:

1. outline the current range of supports and services for trans and non-binary children and youth in Ontario;
2. inform the development of capacity-building initiatives in gender-affirming care of children and youth for health, mental health and allied providers; and
3. share information with community groups, academics, human rights practitioners and others to support research and advocacy activities around gender diversity, transphobia, social justice, and health and social equity.

# BUILDING ON AN EXISTING FRAMEWORK TO BETTER SUPPORT ONTARIO'S TRANS AND NON-BINARY CHILDREN AND YOUTH

Building on the 2012 specific inclusion of "gender identity" and "gender expression" in *The Ontario Human Rights Code,* the Ministries of Health and Long-term Care, Education, and Children and Youth Services, among others, produced policies and strategies calling for improved service provision to trans and non-binary children and youth.

This report builds on these initiatives, and aims to create a roadmap to providing the full and equitable services that are called for by their policies. The evidence shows that when clear, comprehensive, evidence-based policies are accompanied by comprehensive training and specific practices, including gender-affirming support and care, positive mental and physical health outcomes can be achieved.

Several legislative, regulatory and programmatic changes have been implemented to further the improvement of the broader trans community's social and health outcomes, including:

- the addition of gender identity and gender expression as protected grounds under the *Ontario Human Rights Act*;[1]
- changes to the regulations governing gender markers on health cards and drivers' licences,[2] birth certificates[3] and passports;[4]
- changes to the regulations governing access to OHIP-funded gender-affirming surgeries[5] and
- the creation of the Trans Health Expansion, a collaboration of Sherbourne Health including RHO, Women's College Hospital (WCH) and the Canadian Centre for Addiction and Mental Health (CAMH), to increase the accessibility of transition-related surgeries and aftercare.

Trans and non-binary health is also receiving more research attention in Canada than ever before. For example, since 2014, the Canadian Institutes of Health Research and Social Sciences and the Humanities Research Council of Canada have funded several research studies looking at trans health needs and service use. However, there is still a shortage of research specifically focused on trans and non-binary children and youth.

In other sectors, various social service agencies, community organizations and public institutions have developed. These have grown to support and ally with gender-diverse communities, including gender and sexuality alliances (GSAs) in schools, positive and safe space initiatives in community organizations, parental supports such as PFLAG, or informal peer support networks—to name but a few. However, the specific needs of trans children and youth have been largely overlooked. While often assumed to be grouped in with lesbian, gay, bisexual and queer youth, sexual orientation and gender identity are distinct from one another.

Given the progress and growing momentum regarding the well-being of trans and non-binary people, significant opportunities exist to advance the specific needs of trans and non-binary children and youth, and to address gaps in services and supports for them.

## REPORT OVERVIEW

We've organized this report by first situating the needs assessment in the context of both RHO's mandate and past work in relation to trans and non-binary children and youth. Next, we describe the methodology used in the needs assessment, followed by key needs and issues for trans and non-binary children and youth as identified in the literature.

In the report's following sections, we describe specific findings from our research conducted with stakeholder groups of children and youth; parents and caregivers; service providers and underserviced populations.

The report concludes with a summary of findings and recommendations aimed at improving access to information and supports, as well as strengthening communities, individuals and families.

**Significant opportunities exist to advance the specific needs of trans and non-binary children and youth, and to address gaps in services and supports for them.**

# trans and non-binary youth in RHO's context

Rainbow Health Ontario (RHO) is a unique, multi-faceted knowledge hub and capacity-building program of Sherbourne Health, designed to create opportunities for the health care system to better serve LGBT2SQ communities.

RHO's work in relation to trans children and youth began in 2012, when RHO prepared a literature review and developed a series of brochures for parents on trans and non-binary children. RHO also organized a day-long session for parents and trans children and adolescents, and hosted a two-day national meeting to explore research needs.

This led to the development and implementation of a trans youth and child skill and community building project called Animazing, and three research projects funded by the Canadian Institutes of Health Research (CIHR) and the Social Sciences and Humanities Research Council (SSHRC):

1. Transgender youth in clinical care: A pan-Canadian cohort study of medical, social and family outcomes;

2. Transgender youth in clinical care: A qualitative investigation of trans youth and family well-being; and

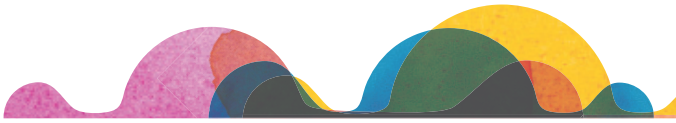
3. Digging beneath the surface: An intersectional investigation into the diversity of trans youth experience.

Additionally, RHO developed and continues to offer a full-day training program for mental health providers on working with trans and non-binary children and youth.

RHO's work in this area, including the current needs assessment, has been guided by an advisory committee (AC) composed of trans and non-binary young adults, parents of trans and non-binary children and youth, and professionals whose work supports these families.

Following Kimberlé Crenshaw's statement, "if you don't have a lens that's been trained to look at how various forms of discrimination come together, you're unlikely to develop a set of policies that will be as inclusive as they need to be,"[6] RHO sought to find members for the AC who could assist with ensuring an intersectional lens was taken to this project. Members of the AC joined from across Ontario and spanned a range of ethnocultural and social locations.

Professionals on the AC worked in a diverse range of sectors, including education, mental health, physical health and social services. A list of advisory committee members who gave permission for their names to be shared is in Appendix 1.



**if you don't have a lens that's been trained to look at how various forms of discrimination come together, you're unlikely to develop a set of policies that will be as inclusive as they need to be.**

# methods: the consultation

The findings presented in this report are based on a two-phase, mixed-methods needs assessment conducted by Rainbow Health Ontario (RHO) between January and June 2016, and June and September 2017, respectively.

The use of a mixed-methods design that included both qualitative and quantitative approaches increased the assessment's rigour and reach, and allowed for data to be triangulated from various sources to support the report's final recommendations.

Area committee (AC) members provided input into the development of data collection instruments, promoted the needs assessment across their own communities and networks, and reviewed and provided feedback on draft versions of this report.

## Phase 1 of the needs assessment

In Phase 1, data was collected through three surveys, respectively addressed to trans and non-binary children and youth between the ages of 9 and 17, their parents or caregivers, and the service providers that support these groups—including some service providers who work for school boards.

Service providers were eligible to respond to our survey if they had provided services to any trans or non-binary children or youth under the age of 18 in the last five years. Service providers from 33 different organizations in Ontario completed the survey. An additional 18 service providers from seven different organizations participated in interviews or focus groups.

We conducted focus groups and interviews concurrently with key informants from the Gender Diversity Clinic of the Children's Hospital of Eastern Ontario (CHEO), the Transgender Youth Clinic at Sick Kids Hospital in Toronto, Central Toronto Youth Services (CTYS), Quest Community Health Centre in St. Catharines, and Family Services Ottawa.

These organizations were chosen because they represent some of the few in the province that provide comprehensive services and supports to large numbers of trans and non-binary children and youth. During Phase 1 of our data collection, the clinics at Sick Kids, CHEO and Quest Community Health Centre were the clinics in the province supporting children who had reached puberty to medically transition.

They continue to provide the majority of care for these children and youth in Ontario. While any family doctor or nurse practitioner in Ontario could provide this care, few are, so these clinics continue to serve large numbers of children and youth.

While our needs assessment primarily focused on the health care system, we also asked about the school system as a primary social and institutional location of experiences of affirmation and discrimination affecting health and well-being, as well as a site of services and support. We asked both parents and youth about their experiences with school systems in Ontario, and we invited service providers working within school boards (such as social workers and school counsellors) to participate in our service provider survey.

## Phase 2 of the needs assessment

In Phase 2, we collected two types of data. First, we developed our Provider Capacity Survey to collect data from health and mental health professionals who work with trans and non-binary children and youth under the age of 18. The survey asked about service gaps as well as their experiences, levels of knowledge and comfort, and training needs.

After being piloted by a small group of providers at Sherbourne Health, the survey was published online, with several organizations assisting in its promotion: the Association of Ontario Community Health Centres, the Ontario College of Family Physicians, the Association of Family Health Teams of Ontario, the Sarnia Health Provider Conference and the CAMH-Evidence Exchange Network, among others. Providers on RHO's Trans Health Mentorship Call list also helped with its distribution.

Next, we developed a series of outreach strategies to gather additional data on identities that were underrepresented, or whose needs were not adequately captured in our Phase 1 surveys. As part of this, we conducted 15 key informant interviews with service providers at agencies that specifically serve newcomer, racialized, Indigenous, Francophone and/or northern communities. Additionally, we held a focus group with northern youth and two individual interviews with Indigenous youth.

We analyzed the service data using descriptive statistics (e.g., frequencies, means and medians). We also reviewed and, in some cases, re-coded responses to open-ended questions so they could be ranked. We then analyzed focus group and interview data to identity key themes and extracted information on specific groups from the survey data.

We also updated the literature review conducted during Phase 1.

We have incorporated quotations from survey respondents throughout the report for illustrative purposes. These are identified using demographic information where relevant, like age, gender and location.

# literature review

**This section provides an overview of sex, gender and gender identity in Western society, an estimate of the proportion of children and youth who may identify as trans or non-binary, and an overview of the adverse and protective factors that impact trans and non-binary children and youth's well-being. It also identifies the issues facing specific populations and demographic groups of trans and non-binary children and youth.**

As much as possible, we sought out research from people writing about their own communities, in recognition of their insider knowledge, and as part of supporting communities to describe their own needs.

As previously mentioned, multiple terms are used to describe people whose gender expression and/or gender identity do not match their sex assigned at birth.

We use "trans and non-binary" as an umbrella phrase. However, at times when we are quoting or referencing research, we use the language used in the source material.

# UNDERSTANDING SEX, GENDER AND GENDER IDENTITY

**In Western society, gender has been conventionally viewed as a binary construct based on the assigned sex designations of male or female.**[7]

Western society has assumed that male individuals will express masculinity and female individuals will express femininity, and has fostered the belief that both sex and gender categories are fixed. As a result, people who have stepped outside of these categories have frequently been met with stigma and bias[8] and have been treated as medically or psychologically abnormal—or pathologized[9,10] —rather than having their experiences seen as just another aspect of human diversity.

Societies around the world have historically had, and continue to have, a range of ways of understanding sex, gender, gender identity and gender expression.[11] This may include a different number of possibilities in those categories that we recognize here in Western society today, or it may be different categories altogether.

Even in Western cultures, we are increasingly recognizing that sex categories are less distinct than is usually assumed, and that there are multiple possibilities for gender identity and gender expression. More complex understandings of gender identity and expression are also now being reflected in policy. In Ontario's contexts, The Ontario Human Rights Commission recognizes that there is a broad diversity of gender identities and expressions, and that people have the right to define their own gender identity.[12]

# PREVALENCE

## Gender identity

We don't know exactly how many children and youth in Ontario identify as trans and/or non-binary.[13] In this section, we draw from studies in other regions to create estimates, since we do not yet have Canadian studies that address population sizes.[14,15]

Internationally, several studies in the U.S. and one in New Zealand have generated estimates. U.S. population-based data estimates that 0.7% of young adults (ages 18–24) identify as transgender.[16] That same report found that "...younger adults are more likely than older adults to identify as transgender."[16] Notably, estimates based on other studies with high school students in both the U.S. and New Zealand have found higher rates.[17]

In New Zealand, a nationally representative sample of 8,166 high school students found that 1.2% of students reported being transgender, 2.5% reported being not sure about their gender, and 1.7% did not understand the question.[17] Similar numbers were found in San Francisco in 2013, where the *Youth Risk Behavior Surveillance Survey* was administered to 2,730 middle-school students (grades 6–8), finding that 1.2% of students identified as transgender.[18] Among smaller studies that measure trans identity among youth using local probability surveys or national convenience samples, the prevalence of trans-identified participants has ranged from 1.3% to 3.2%.[19] Based on census data, a range of 0.7–3.2% would suggest that between 18,796 and 85,928 [20] young people ages 0–17 in Ontario may be transgender or non-binary.

In addition to those who identify as trans, a significantly greater number of children and youth may describe their gender as differing from social expectations.[21,22] They may describe themselves, or be identified by others, as non-binary, sometimes referred to as N.B. or "enby," gender expansive, gender independent, gender non-conforming, genderqueer, non-binary and/or Two-Spirit, among other terms.[21,23]

## Gender expression

Furthermore, many young people do not express their gender in ways that conform to sex-based expectations, although they are comfortable with their sex assignment at birth. The 2012 *Playgrounds and Prejudice* study asked U.S. students in grades three to six about gender conformity, and found that:

"Almost one in ten of elementary school students (8%) report that they do not conform to traditional gender norms—i.e., boys who others sometimes think act or look like a girl, or they are girls who others sometimes think act or look like a boy."[22]

Other studies have found even larger numbers. Sandberg et al. estimated that 22.8% of boys and 38.6% of girls in elementary schools in the U.S. display atypical gender behaviours.[24] The 2015–2016 California Health Interview Survey asked respondents to describe how masculine or feminine they are and compared it to their response to sex. It found that 27 percent of youth ages 12 to 17 in California, or about 796,000 youth, show gender non-conformity by displaying atypical gender behaviours.[25]

All three suggest that a substantial proportion of children and youth are aware that they or others would identify their gender expression as other than expected based on their sex assigned at birth.

Applying the ranges found in the studies of 8%–27% to census data results in estimates that between 214,821 and 725,022 children and youth ages 0–17 in Ontario[20] experience their gender as being outside of normative gender expectations.

# ADVERSE EXPERIENCES, PROTECTIVE FACTORS AND HEALTH OUTCOMES

**Multiple Canadian and international studies indicate that trans and non-binary children and youth commonly experience transphobic incidents** involving experiences of harassment, comments reinforcing societal gender expectations, and experiences where they feel unsafe due to behaviours from their peers, other students, teachers,[26,27] and families.[28]

In the *Canadian Trans Youth Health Survey*, Veale et al. found that trans and non-binary youth ages 14–18 experienced a range of forms of discrimination, violence and harassment (described by the authors as "enacted stigma") in the past year, with the most common experiences being unwanted sexual comments (71%), and harassment based on gender identity (69%) or sexual orientation (63%). In addition, 64% had been bullied, taunted or ridiculed, including at school (52%). In total, 26% had skipped school in the past 30 days due to feeling unsafe. Over one-third (35%) reported sexual abuse.[29] In a separate study, Grossman et al. found that the more gender non-conforming youth were, the more likely they were to experience abuse, both verbal and physical, from their parents.[28]

These experiences often result in high levels of what Meyer describes as "minority stress,"

where "...stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems".[30] In their study on gender nonconformity and school victimization, Toomey et al. found victimization due to LGBT status to be significantly associated with negative psychosocial adjustment.[31] Across the respondent group from the *Canadian Trans Youth Health Survey*, there were significant mental health concerns: in the past year, about three-quarters had self-harmed and more than a third had attempted suicide. In the past 30 days, 45% reported experiencing extreme stress and 28% reported extreme despair.[29]

It is already known that parents and caregivers play an important role in the mental health and overall well-being of lesbian, gay, and bi children and youth.[32]

In fact, the single most protective factor for the well-being of trans youth is family support.[33–35] Data from the *Canadian Trans Youth Health Survey* matches the results from other countries showing that affirmative parental support has a significant impact on the well-being and mental health of trans children and youth.[29,36] Reporting on this data, Veale et al. found family connectedness was generally the strongest protective factor. School connectedness was also protective, especially in relation to extreme stress and extreme despair.

Past-year suicide attempts were lower when there was a higher degree of perception of friends caring. Among respondents 14–18, in worst-case scenarios, when a youth had experienced high rates of enacted stigma and had low rates of family and social support, there was a 72% probability of a suicide attempt in the past year. For youth who experienced high rates of violence, discrimination and harassment, but also high rates of family and social support, the probability of a suicide attempt dropped to 25%. In the best case scenario, where youth experienced low rates of enacted stigma and high rates of family and social support, the likelihood of a past-year suicide attempt dropped to 7%,[36] in line with national averages for Canadian youth.[37]

Unfortunately, many youth do not have access to supportive parents or other adults. The U.S.-based Human Rights Campaign Foundation's survey of gender-expansive youth found that only 43% of these youth reported having an adult in their family they could turn to if they felt worried or sad, and, outside the family, only 59% of gender-expansive youth said they had an adult they could turn to.[21] Grossman et al. found that more than 59% of participants in their study faced negative reactions from their parents as a result of their gender identity.[30] A study conducted in Canada found that trans youth who reported feeling unsafe at home were more likely than those who felt safe at home to report running away in the past year.[38]

However, even the most well-intentioned parent doesn't always know how to support their trans or non-binary child.[39,39] Parents also need to be supported, and to themselves have access to culturally, linguistically and regionally appropriate supportive services.

**The single most protective factor for the well-being of trans youth is family support.**

# Victimization, resilience and support in schools

**Peer-based victimization is one of the best-documented health risk behaviours associated with gender expression.**

Research from convenience samples has suggested that gender non-conformity is associated with bullying and harassment in school[40] and with rejection by peers.[42] Moreover, this victimization is associated with poorer educational outcomes.[42]

The *First National Climate Survey on Homophobia, Biphobia, and Transphobia in Canadian Schools* found that 74% of trans students reported experiencing verbal harassment about their gender expression. These included comments related to a young person "not acting feminine enough" or "not acting masculine enough" in accordance with their assigned sex at birth.[27] Nearly a quarter of gender-diverse students had heard teachers or other school staff use transphobic or negative gender-related language on a daily or weekly basis.[27]

Findings from the Toronto District School Board's *Climate Survey* were recently disaggregated to examine academic, social and health-related outcomes among trans students in relation to the likelihood of attending university, class participation, school enjoyment, sense of belonging, perceived friendliness of their environments, availability of adult/teacher supports, feelings of safety, bullying, health behaviours, mental health and others. With few exceptions, trans students experienced poorer outcomes compared to both the LGBQ and total student populations.[26] It is significant that this climate data showed that trans students experienced higher levels of harassment, physical violence, sexual violence and theft than either LGBQ students as a group, or all students overall.[26] When asked of overall school experience, the *Toronto District School Board Student Census* findings in 2011–12 indicated that only 44% of transgender students felt they belonged, whereas 66% of their cisgender straight peers felt they belonged and 53% of LGBQ felt they belonged.[26]

In the U.S., research by Gender Spectrum and the Human Rights Campaign Foundation found that 40% of gender-expansive youth reported being excluded "frequently" or "often" by their peers.[21] Similarly, among elementary students, the U.S. *Playgrounds and Prejudice* study found that students who did not conform to traditional gender norms were far more likely than others to report being called names, made fun of and bullied "at least sometimes" at school (56% vs. 33%). Students who did not conform to traditional gender norms were also twice as likely as conforming students to report that other students had spread mean rumours or lies about them (43% vs. 20%), and three times as likely to report cyberbullying (7% vs. 2%). Furthermore, students who did not conform to traditional gender norms were less likely than other students to feel very safe at school (42% vs. 61%), and were more likely than others to agree that they sometimes did not want to go to school because they felt unsafe or afraid there (35% vs. 15%).[22]

One piece of Canadian national research identified that "Transgender-friendly alternatives to conventional sex-segregated communal washrooms have been identified as a key component of trans-inclusive school initiatives."[43]

In addition, the presence of GSAs in schools has been associated with less victimization related to their gender expression and greater school safety and school connectedness[44] as well as fewer reports of missing school due to fear.[45]

Toomey et al. found that the benefits of GSA presence in schools continue into later life, and are "...associated with better young adult well-being, and more college-level educational attainment."[46] Research has also shown that safer school climates for LGBT youth can be supported by including LGBT content in curriculum;[47] this has been found to result in less bullying in general as well as less LGBT-related bullying.[47] Other benefits of safer school climates include less harassment, greater acceptance among peers, lower rates of victimization, as well as better academic achievement and decreased absenteeism among LGBT students.[48,49]

## Victimization, resilience and supports in community settings

A 2013 U.S. national study found that only 5% of gender-expansive youth reported "definitely fitting in" to their community, while 30% reported "definitely not fitting in," compared to roughly a third of straight cisgender respondents who felt that they "definitely fit in"—six times more than gender-expansive youth.[21]

What we do know is that, in addition to facing significant violence, discrimination, harassment and exclusion in schools due to their gender identities and/or expressions, trans youth experience similar discrimination when accessing youth-serving organizations, emergency shelters and housing programs.[53]

To avoid these transphobic experiences, trans young people often skip school [26,27,43,] avoid shelters[53,54] and avoid participating in social, recreational and employment programs.[55,56]

Community and social service settings also include child welfare agencies and the criminal justice system. While there is little research about the experiences of trans and non-binary children and youth in either system, research suggests that large bureaucracies and in particular residential settings are often frequent sites of transphobia.[50,51] Knowing the significance of supportive parents as a protective factor for trans children and youth, more research is needed about the experiences of trans children and youth who we know do not have that immediate support.

Recently in Ontario, the Ministry of Children, Community and Social Services developed a resource guide to increase capacity within the child welfare sector to respond to the needs of LGBT2SQ youth in the child welfare system, which includes guidelines for service providers on how to best support trans and non-binary children, as well as resources for affirming services that can provide additional supports.[55] It is important to note that data from the U.S. show disproportionate rates of LGBTQ representation within the juvenile justice system,[52] where these youth encounter heightened degrees of discrimination and mistreatment.

## Minority stress, and impacts on mental health and substance use

Perhaps not surprisingly, given our understandings of minority stress, the *Canadian Trans Youth Health Survey* and several other studies conducted in Canada and internationally, which have examined the mental health issues facing trans children and youth, have found that harassment, discrimination and violence against trans youth are closely linked with or contribute to poor mental health outcomes.[47] The specifics include higher rates of depression, self-harm[47] and eating disorders when compared with their peers.[57] Experiences of harassment, discrimination and violence are also known predictors of attempted suicide.[17,57–59]

The *American College Health Association National College Health Assessment*, the largest-ever study of trans student participants on eating disorders, found that trans students displayed increased rates of eating disorder diagnosis (15.8% vs. 1.85%), past-month diet pill use (13.5% vs. 4.29%), and past-month vomiting or laxative use (15.1% vs. 3.71%) compared to cisgender heterosexual women. [60]

Trans youth of any gender were more likely than cisgender boys to have used alcohol, tobacco, marijuana and other illicit substances in the past 12 months. Moreover, trans youth who were bullied were at a higher risk of substance use. [61] Another study found that nearly half of gender-expansive youth (48%) agreed “strongly” or “somewhat” that they have experimented with alcohol and drugs. This rate is double that of their straight, cisgender peers.[21]

# ISSUES FACING SPECIFIC POPULATION AND DEMOGRAPHIC GROUPS

## Pre-pubertal children and their care providers

While gender formation is a lifelong process, children as young as two can have a clear sense of who they are and what their gender is.[62] Young children have less access to supports outside of their homes, and are more reliant on their parents and caregivers for being allowed and enabled to see trans-affirming health care providers,[63] to participate in groups and social/recreational opportunities where their gender is affirmed, and to be exposed to positive depictions of trans and non-binary people.

Research and legislation support and require an affirming model for children of all ages, including those in the early years.[23,64–66] This means more than not engaging in “reparative therapy” (interventions imposed with the intent of promoting a particular sexual orientation and/or gender),[67] and not discriminating; it extends to specifically creating environments that celebrate gender diversity, providing access to people and/or characters who depict a wide range of gender expressions, and helping children develop pride in their identities.[68–71]

## Transfeminine children and youth

Transfeminine children and youth often experience greater hostility and isolation than those who are transmasculine.[72] This may contribute to it being harder for them to come out, seek support or seek transition-related services.[72] In the context of youth services, a Canadian researcher identified that "transgender youth, especially young transgender women of colour, are among the most discriminated against groups of people in housing programs and shelters,"[53] effectively leaving them with no place to go.

While less is known about physical violence experienced by transfeminine children and youth, among adults, trans women—and in particular trans women of colour—are often the recipients of the most extreme transphobic violence, including murder.[73]

## Non-binary children and youth

There are few estimates on the number of children and youth who identify as non-binary, however, within the *Canadian Trans Youth Health Survey*, 41% of respondents who responded to gender identity items in the survey identified as non-binary.[74] Despite this, the needs of non-binary children and youth are frequently made invisible when faced with services that expect all people to be male or female, such as toilets, schools, shelters and recreational programs.[53] This constant experience of being told one does not exist is exhausting and can leave youth feeling like they are facing massive institutional challenges, which can lead to mental health challenges.[61]

Additionally, recent data has shown that:

> "...gender expansive students, including both gender nonconforming and androgynous youth, are at higher risk for a number of health risk behaviors than their more gender conforming peers. Likely due to this higher risk, gender nonconformity among students is associated with reduced academic performance. Moreover, many of these associations are nonlinear, suggesting that in some cases androgynous youth (particularly females) are more at risk than their more masculine or feminine peers."[42]

While these children are less likely to access transition-related medical care,[74] they share many of the other needs of transgender children and youth, including needs for affirming environments, supportive and welcoming schools, gender-affirming programs and services, and gender-affirming policies and comprehensive training.[25] What's more, they may have even greater needs for access to all-gender universal facilities.[25]

## Indigenous children and youth

It is important that Indigenous people speak to the experience of Indigenous children and youth living under colonization. In the words of the *Joint Submission Regarding the Ministry of Children and Youth Services' Development of a Resource Guide for LGBTT2QQIA Youth*, the Native Youth Sexual Health Network and the Ontario Federation of Indigenous Friendship Centres jointly wrote the following:

> The colonization of North America has imposed European patriarchal values upon Indigenous societies, reconfiguring their gender roles to better assist their subjugation. In Western social and cultural constructions of gender, the male performance is valued as powerful and significant while female gender performance is viewed as submissive and marginal. It is both unbalanced and creates the supposition that there are two finite conceptualizations of gender: male and female. Within the Indigenous worldview, the construction of gender and sexual identities is much more fluid, preferring to have people embody certain roles and responsibilities within their clan, family, community, and nation based on the expression of their own personal gifts. Based on their gifts, they take up certain tasks and responsibilities within the community. At the centre of the conceptualization of traditional roles is the notion that individuals have dominion over the definition and implementation of their community position.[75]

Colonization has and continues to supress gender roles outside of the cis-normative binary, while imposing a dominant system of social and legal norms that denies legitimacy to gender fluidity.[76] Because of this, Two-Spirit, trans and non-binary Indigenous children face specific challenges. They and their families need to be able to access resources and supports in Indigenous-led, culturally appropriate settings that afford them a sense of pride and belonging, where children and youth are not forced to choose between an Indigenous identity and their gender identity.[75]

There has been very little research on this. More research, led and directed by Two-Spirit, trans and non-binary Indigenous people to address not just their needs, but also their strengths,[77] is vital.

## Newcomer children and youth

Newcomer children and youth in Canada of all gender identities frequently experience conflict between multiple cultural values, a lack of services in their first language, and racism and xenophobia.[78]

These intersections mean that trans and non-binary newcomer children and youth are more likely to experience discrimination at school and in other settings, less likely to feel they have a teacher at school they can turn to for help, and more likely to not be believed when they report the violence they experience.[27] Because of a lack of language and cultural knowledge, service providers from other communities may not understand either the needs of trans and non-binary newcomer children and youth, or the specific discrimination they are facing. In addition, discussions of sexuality may be deemed taboo among certain cultural groups, and therefore service providers within their home community may not represent a viable option to turn to.[79] In addition, newcomer youth have been found to have significantly lower rates of sexual health education than their peers,[80] which can increase internalized stigma as well as impact access to supports.

Newcomer services are often targeted to adults, and assume that children will passively benefit from services their parents and caregivers receive.[78] This means that there are often no specific services addressing the needs of newcomer children, let alone newcomer trans and non-binary or gender-independent children. More research into the needs, experiences and strengths of this population is necessary.

## Racialized children and youth

It is often not possible to disentangle racism, homophobia and transphobia in the experiences of racialized trans and non-binary children and youth.[81] What is clear is that they all significantly impact the experiences of youth of colour, and that in Canada and in the U.S., trans and non-binary people of colour feel less safe and experience more violence and discrimination than their white peers.[27,72] One study reported that:

> The transgender people of color whom we surveyed were significantly more afraid for their safety than were the transgender white people. Breaking down the data for people of color by specific racial groups, 73 percent of the African/African American/black respondents, 70 percent of the Asian/Asian American respondents, 82 percent of the Latino(a)/Hispanic/ Chicano(a) respondents, and 87 percent of the American Indian respondents reported that they feared for their physical safety. Given that almost all of the transgender participants of color had been physically assaulted, this fear was well founded.[72]

*Every Class in Every School* found that in Canadian schools, "Caucasians were far less likely to report having been physically harassed or assaulted because of their ethnicity (8.4% of Caucasian youth, compared to 13.3% of Aboriginal youth and 14.8% of youth of colour)."[43]

Harassment of racialized children and youth sometimes involves the use of culturally specific slurs (e.g., "battyman"), so school staff need to be familiar with these slurs in order to be able to recognize a breadth of forms of transphobic and homophobic bullying and protect racialized children and youth.

As with other underserved populations in this report, more research is needed into the needs, experiences, strengths and resiliency of racialized trans and non-binary children and youth.

## Francophone children and youth

Our literature review was unable to find any research into the needs of Franco-Ontarian trans and non-binary children and youth. While there is research into the needs of Francophone trans children and youth in Quebec, the differences in legal frameworks and in being a linguistic minority rather than majority mean that their findings are not transferable to Ontario. Research with this population is very much needed.

## Children and youth living in northern and rural areas

Because our understandings of gender are based in our communities, northern and rural youth have different experiences and significantly different access to resources than their more southern and urban peers. While we are not aware of Canadian research focusing on the experiences of trans and non-binary children living in northern or rural contexts, one U.S. study found LGBT youth had higher rates of victimization and harassment in rural settings than they did in urban or suburban environments.[82]

Working in rural schools, Karleen Pendleton Jiménez found that "Coercion and harassment of perceived alternative gender expression are common tactics performed by peers and adults alike. To support these young people to survive within their communities, we need to commit to understanding the nuances of regional expressions of gender." [83]

## Youth who are street involved, homeless and/or engaged in sex work

Because of family rejection, transphobia and a lack of resources in their home communities, trans and non-binary youth are "disproportionately represented in the homeless population. More generally, some reports indicate that one in five transgender individuals need or are at risk of needing homeless shelter assistance." [56] However, many shelters are sex segregated, and many trans youth report experiencing transphobia, including violence and a denial of services, in shelters.[53,54,56] Shelters need to have trans-inclusive policies and practices in addition to comprehensive training for all staff to increase the safety of trans youth needing their services.[53,54,56]

Because of transphobia, family rejection, and exclusion from many other areas of work, trans people, and in particular trans women, are disproportionally represented among sex workers. Results from the *Canadian Trans Youth Health Survey* found that 10% of youth surveyed reported trading sex for money, food, shelter, drugs or alcohol.[29] One U.S. study on transfeminine youth of colour found that 59% had used sex in exchange for resources.[84]

Trans sex workers are also more vulnerable than their cis peers to violence from both clients and police because of both transphobia

and stigma against sex workers.[55] Wilson et al. found that transgender female youth who had been engaged in sex work are at disproportionate risk for HIV, with results in this study showing an infection rate of 23%.[85]

## ACCESS TO AFFIRMING AND CLINICALLY COMPETENT HEALTH CARE

Access to competent and affirming primary care is critically important for gender-diverse children and youth.[74] The implementation of clear, comprehensive, evidence-based best practices and policies that address barriers to gender-affirming care are associated with positive mental and physical health outcomes for trans youth.[86] These take into account age, pubertal stage, desired future treatments and comorbidity. Paediatricians and family doctors play a key role in access:

> Transgender youth often first identify themselves to a general pediatrician. As the first medical provider that transgender youth and their families usually encounter, it is critical for pediatricians to understand available options for gender-affirming care and either provide those services themselves[87] or coordinate appropriate referrals and follow-up.[88]

The literature suggests that few trans youth who require interventions actually receive them.[89] Over the last five years, service providers have encountered an exponential increase in the number of children and youth seeking support around gender identity issues, resulting in long waiting lists now for for treatment and specialty services.[89,90]

Delaying gender-affirming treatment for those who need it can have significant consequences. Delays in the provision of hormone blockers and subsequent gender-affirming hormones is correlated with increased stress, anxiety and other signs of distress.[91] One Ontario study found that trans youth who were planning to transition but were unable to begin doing so experienced a range of adverse mental health outcomes, including suicidal ideation.[59]

The onset of a puberty that is not consistent with a young person's gender identity and the subsequent development of secondary sex characteristics that accompany this life stage can have grave consequences, leading to mental health challenges and emotional distress.[92]

Research has identified a range of barriers to gender-affirming care. One survey identified a mix of barriers unique to trans youth: a lack of gender-affirming treatment protocols for pre-adolescents, limited and delayed access to hormone blockers, and prohibitive minimum age requirements for initiating hormones to support a medical transition.[86] Other barriers identified in this survey were not age-specific, such as cost, limited access to trans-friendly and trans-knowledgeable providers, limited access to gender-affirming hormones, misgendering experiences, and uncoordinated care and gatekeeping.[86]

Similarly, Schumer & Spack reported that a lack of medical provider knowledge can make patients feel unwelcome and hinder appropriate referrals for mental health or hormonal interventions. The participants in this research study described major barriers to care as a lack of protocols for gender-affirming health care, especially for younger patients and those desiring hormone blockers, and a lack of awareness of professional guidelines and the

potential consequences of not following these.[89]

In a Canadian context, the *Canadian Trans Youth Health Survey* found that 61% of trans youth avoided seeking medical care in the previous year because they were afraid of what the doctor would do or say. Over half of trans youth (57%) in Canada felt uncomfortable or very uncomfortable discussing trans health issues with their family physician. An even larger segment of trans youth (77%) felt uncomfortable or very uncomfortable discussing trans health issues in walk-in clinics.[29]

Comfort in accessing care is linked with physician knowledge and behaviours: in one 2015 study, adjusted for other factors, greater perceived physician knowledge about trans issues was associated with reduced likelihood of discomfort for trans people, and previous trans-specific negative experiences with a family physician with increased discomfort.[93]

However, most health providers have not received training in gender-affirming health care, leaving them with an insufficient understanding of the unique health issues trans and non-binary youth face, and inadequate knowledge of how to prescribe treatments.[89] A survey of medical schools in 2009–2010 found that the median number of hours of lesbian, gay, bisexual and trans (LGBT) content was five hours, with one-third of schools reporting no LGBT curriculum during the clinical years.[94] A recent study of 319 residents in medical school found that only 12% felt that their training in medical school was adequate to care for trans populations.[95]

Access to trainings is linked with increased competence: recently, a study in a medical school class in Philadelphia found that the addition of even one medical school lecture improved provider competency in caring for trans patients.[96]

## De-pathologizing gender diversity

The World Professional Association for Transgender Health clearly states that "Being transgender, transsexual or gender non-conforming is a matter of diversity, not pathology."[97] However, until recently, the field of medicine enforced binary understandings of gender and pathologized children and youth who expressed identities outside of those expected based on their assigned sex.[98] Trans and non-binary children who are strongly pressured or threatened to conform are "prone to anxiety, sadness, social withdrawal, self-deprecation, and other signs of internalized distress."[99]

The evidence shows that pathologizing trans and non-binary identities is harmful and may increase stress, anxiety and pathology among this population.[100,101] Major medical associations including the Canadian Medical Association[102] and the Canadian Psychological Association,[103] as well as the Canadian Association of Social Workers,[104] now reject this approach, favouring instead respect for diverse gender expression. More recently, the Canadian Paediatric Society demonstrated support for an affirming approach to trans and gender-creative children with the publication of a resource to guide paediatricians in their work with parents, which encourages a supportive framework around gender identity.[105]

Additionally, in 2015 Ontario passed the *Affirming Sexual Orientation and Gender Identity Act*, which made it illegal for a health care professional to attempt to influence or change a child's gender identity or gender expression.[66]

## A gender-affirming model of care

Current research shows that affirming an individual's gender identity, at home,[29,33–35] at school,[17,27,42,106,107] and in medical settings,[13,14,93] offers the best care and outcomes.[70,101,108–110] Bonifacio and Rosenthal[13] describe the gender-affirmative model's fundamental tenets as understanding that:

1. gender variations are not disorders;
2. gender presentations are diverse and varied across cultures and, therefore, require our cultural sensitivity;
3. to the best of the authors' knowledge at present, gender involves an interweaving of biology, development and socialization, and culture and context, with all of these factors influencing an individual's gender self;
4. gender may be fluid and is often not binary, both at a particular time and [it may change] within an individual across time; and
5. if there are mental health or behavioural concerns, it more often stems from negative cultural reactions (e.g., transphobia) rather than from within the child[13]

Others describe it similarly,[62,64,70,108,111] and add that this model requires:

1. providers to be aware of their own understanding and biases, particularly in relation to gender, internalized transphobia and cissexism;[111]
2. creating an open safe space to explore the full range of gender identities and expressions without repercussions;
3. an informed consent model regarding medical transitioning;
4. acceptance and inclusion of people who do not identify as either or only masculine or feminine, and fostering acceptance for any and all gender identities, expressions and embodiments;
5. working with caregivers and families to help them accept and celebrate any and all gender identity and sexuality outcomes for the child;
6. working with caregivers to develop advocacy skills to ensure their child has support in all environments (at school, in the community, in the family);
7. clinicians taking on the role of advocates for the child at times when needed in other systems (school, healthcare, etc.);
8. understanding that anxiety and depression is a normal response to living in a transphobic world/community/system/family;[111]
9. working with caregivers and families in order to strengthen relationship bonds to better meet the needs of their child/youth;[108] and
10. working to build resilience by connecting clients to other gender-diverse children and youth.

Inherent in the definition of affirmation is the understanding that the individual is the expert on and determines their own identity, and that the parents' and clinicians' roles are to empathetically support the child's assertion of their identity.[112]

For pre-pubertal children, gender-affirming care often includes supporting a social transition.[112] This frequently includes a child changing their name, pronouns, clothing, hair style, which sex-segregated facilities they use, and other outward expressions of gender,[113,114] including through toys and games. All of these changes can be adjusted or reversed if appropriate to the child's identity[115]—what's important is that they feel valued, seen and believed.[116]

Numerous studies have examined transitioning in stages that are dependent on physiological development. As children begin puberty, they may seek medical interventions such as hormone blockers—medication that effectively stops them from experiencing puberty[92]—while the young person, their family and care providers together make decisions.[117] If a young person is consistent and persistent in their trans identity, gender-affirming hormone treatment (e.g., testosterone, estrogen) may be prescribed, [117] allowing a young person to have a puberty that matches their self-identity. Depending on their experience of puberty, older adolescents and young adults may require other transition-related surgeries or processes, such as electrolysis.

## Evidence in support of an affirming model of care

The affirming model of care, with children and youth living in their self-identified gender all of the time, high levels of parental and family support, and having supportive adults to turn to both inside and outside the family, has been associated with positive mental health and reduced risk of suicide among trans children and youth.[29,33] For example, the Ontario TransPULSE study found that strong parental support for trans youths' gender identities was associated with a 93% reduction in suicide attempts in comparison to those who had little or no parental support.[33] A recent Canadian study found that trans youth with supportive adults in their lives were four times more likely to report good or excellent mental health. [29]

Olson et al. compared a community-based national sample of trans children (3–12 years) who were supported in their identities during childhood to a set of 49 siblings as well as a group of 73 typically developing children, matched on age and gender identity (i.e., transgender girls with cisgender girls).[115] The group of children who were allowed to socially transition (e.g., change in pronouns used to describe the child, as well as his or her name, and, typically, hair length and clothing) experienced rates of depression that were similar to the sibling and control group, and only slightly elevated rates of anxiety.[115]

de Vries et al. conducted the first longitudinal study of a cohort of 55 trans adolescents undergoing gender-affirming therapy. Adolescents were treated according to a protocol that included a comprehensive psychological evaluation to diagnose gender dysphoria, followed by puberty suppression, gender-affirming hormones, and gender-affirming surgery at the ages of 12, 16 and 18 years, respectively. Participants were assessed at three times: pre-treatment (at intake), during treatment (at initiation of gender-affirming hormones) and post-treatment (one year after gender-affirming surgery). The findings showed that the psychological functioning of this cohort improved steadily over time, and behavioural and emotional problems significantly decreased from pre-treatment to post-treatment, resulting in rates of clinical problems that were, according to the authors, indistinguishable from general population samples. In terms of subjective well-being, none of the participants reported regret during puberty suppression, during cross-sex hormone treatment or after surgery.[118]

# SUMMARY OF LITERATURE REVIEW

In this literature review we summarized current research findings on trans and non-binary children and youth. The literature identifies that many children and youth experience transphobia, erasure and gender policing in many aspects of their lives, including in their homes, schools, while accessing physical and mental health services, and in other areas of service provision. The impacts of this climate include significant minority stress, leading to the need for physical health, mental health and socio-ecological issues to be addressed.

We have also identified many of the factors associated with positive outcomes, namely strong parental support, good social support, health care provider training in gender-affirming care, and access to competent primary and transition-related care. The benefits of transitioning and concomitant absence of regret support the need for affirming care models. Not only does a trans child's health and well-being improve when their gender identity is recognized and honoured, but their outcomes are found to match those of their cisgender peers.

In providing clinical care, an affirming care model that includes ensuring young people have pride in themselves and their identities has been shown to offer them the best opportunities to achieve positive outcomes. This is in line with the WPATH guidelines and many other health professions, as well as Ontario law.

In school settings, safer climates and better outcomes for trans and non-binary children and adolescents are supported through initiatives such as GSAs.

All-gender—rather than simply sex-segregated—washrooms, change rooms and other spaces are often seen as a key component to ensuring access for trans youth in a variety of settings.

We also observed multiple research gaps. Research often has not addressed the intersectional nature of trans and non-binary young people's lives and has failed to pay attention to the specific experiences of Indigenous children and youth, racialized children and youth, children and youth who have disabilities, and transfeminine and non-binary children and youth. Among racialized communities and Indigenous communities, experiences of colonization have created and continue to perpetuate heterosexism, cisgenderism, binarism and transmisogyny, which contributes to the multiple oppressions and stigma faced by trans children and youth in these groups.

Recent research highlights the importance of considering heterosexism, cissexism and discrimination experienced by young people with non-binary gender identities in relation to mental health problems, self-harm, suicidality and substance use in comparison to both their binary-identified trans youth and their cisgender peers.[119]

Less research has been conducted on the needs and outcomes of specific groups of gender-diverse youth, such as those at different stages of puberty, those with non-binary status, or across different geographical areas. Little of the research to date had been led by trans or non-binary people, and in particular trans and non-binary people of colour, meaning that trans and non-binary lives are often interpreted by others.

# findings: what we heard

## INTRODUCTION

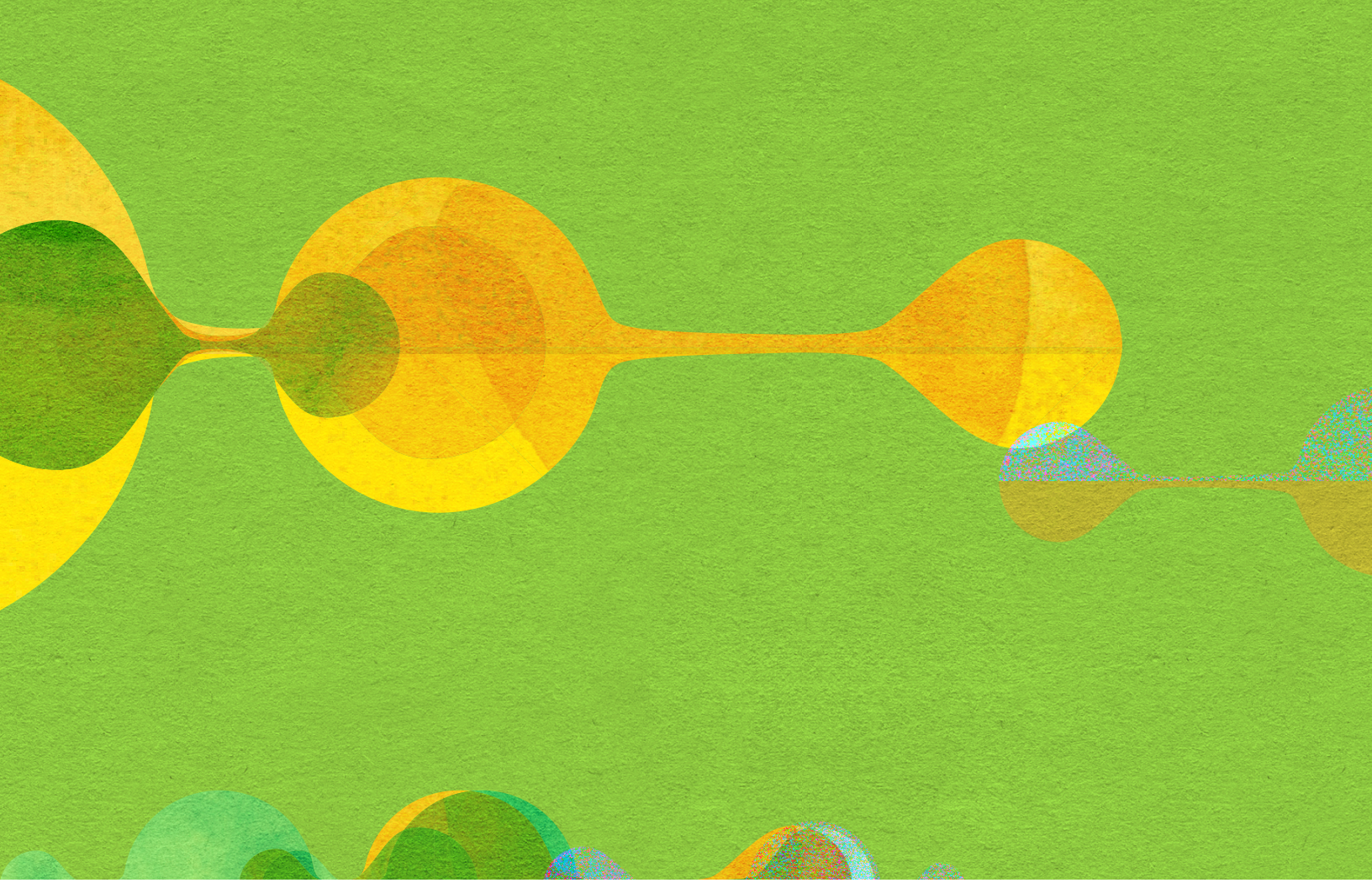
This section presents information from the data collected in the needs assessment. We have organized findings according to the data sources:

**The first section** presents findings from data collected in Phase 1 in the child and youth and parent and caregiver surveys.

**The second section** presents findings from data collected in Phase 1 from the service providers who support trans and non-binary children and youth.

**The third section** presents findings from data collected in Phase 2 from the Provider Capacity Survey.

**The fourth section** presents findings from our interviews and focus group addressing the needs of specific underserviced populations.



Each section begins by describing its survey respondents and goes on to identify key themes and needs.

In the final section, Underserviced Population Groups, we present findings for these groups of children and youth based on a triangulated analysis of data collected in Phase 1 (Child and Youth; Parent and Caregiver; and Service Provider Surveys), and Phase 2 (Provider Capacity Survey).

1

# CHILDREN AND YOUTH; PARENTS AND CAREGIVERS

## Introduction

This section details the children and youth and parent and caregiver respondents to the needs assessment survey.

It describes survey respondents, identifies key themes, and summarizes the evidence collected from these population groups.

## Description of survey respondents

### Children and youth

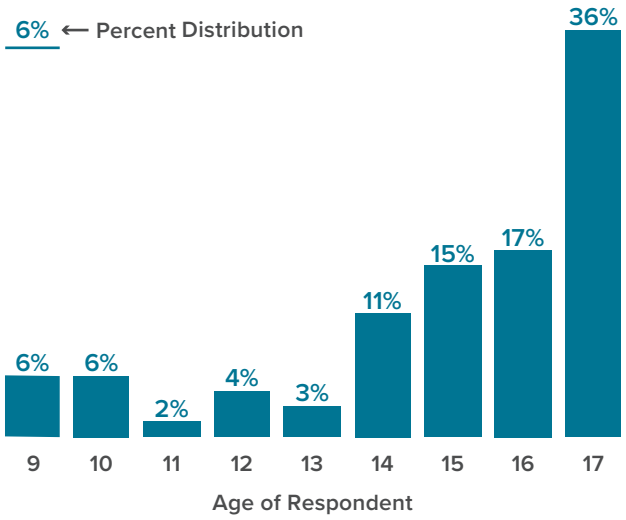
For children and youth who participated in the online survey we collected demographic information on gender identity, age, location, racial identity and whether or not they were Indigenous. Seventy-one youth responded to the online survey, and older teens aged 15–17 accounted for the majority of respondents, with the median age equalling 16.

The distribution of child and youth respondents by age is presented in Figure 1.

Four individuals (8%) of the sample identified as Indigenous. According to 2016 census data, Indigenous peoples make up approximately 2.8% of the Ontario population as a whole.[120] A larger portion of Indigenous populations are children and youth, with approximately 4.1% of Ontario's population aged 0–14 being Indigenous children and approximately 3.7% of 15–24-year-olds in Ontario being Indigenous.[121]

A low proportion of racialized children and youth responded to the survey (13%; 7 individuals). According to Statistics Canada, racialized people (a category that does not include Indigenous people) composed 28.9% of the Ontario population in 2016.[122] While we were not able to disaggregate this data by age, we know that "visible minority" populations in Canada are younger than other Canadians,[123] making this low participation rate even more significant.

Figure 1 - Distribution of children/youth, by age (N = 71)




Among children and youth who disclosed their gender identities:

- slightly over half (57%) identified as trans;
- one-third identified as non-binary;
- 21% identified as gender fluid; and
- 17% identified as genderqueer.

More masculine-identified than feminine-identified children and youth responded: 42% of respondents identified as boys or men, while 13% identified as girls, women or femmes. 32% of respondents identified as non-binary.

Although we heard from youth from around Ontario, the majority of youth respondents reported living in the Greater Toronto, Southwest Ontario or Ottawa areas. The geographic distribution of respondents matched the geographic distribution of the population of Ontario.[124]

## Parents and caregivers

For parents and caregivers who participated in the online survey, we collected demographic information about the age of the child or youth cared for, and the caregiver's racial identity, location, income, and whether or not they were Indigenous.

Additionally:

- 98 parents and caregivers responded to the survey, and their children ranged in age from 4 to 17 years (median age = 14 years);
- approximately 6% of parents and caregivers identified as Indigenous, and 6% identified as racialized; and
- the majority of parents and caregivers who completed the survey reported living in the Greater Toronto Area, Southwest Ontario or Ottawa area.

Parent and caregiver respondents were somewhat more economically privileged than the population of Ontario as a whole. Among those who shared their annual household income, nearly half reported earning more than $90,000 in the previous year (48%), while 13% reported incomes between $70,000 and $90,000 in the previous year, and 38% reported incomes of less than $70,000 in the previous year. The median income of parents and caregivers was likely somewhat higher than the median income in Ontario ($76,510).[125]

## Key themes and needs identified:

### 1. Access to information and gender-affirming support

Many caregivers, and children and youth throughout the province, identified strong needs for information and support; however, many did not know *where* to turn. For example, 43% of children and youth and 33% of caregivers reported that it was difficult to find out about available services and supports. Additionally, 58% of children and youth and 47% of caregivers reported needing help finding out about these services and supports. As described by the parent of a 15-year-old in Thunder Bay:

> "Sometimes it feels like I'm driving in the dark without headlights. I know we need to move forward with the transition process but I don't always know which direction to go."

Figure 2 summarizes the main sources of information accessed by children and youth.

We found from our survey responses that a large proportion of children and youth rely on the internet for information and support; a proportion that may be even higher in rural and northern communities. However, these online groups and communities might not be the best source of information and support for children and youth.

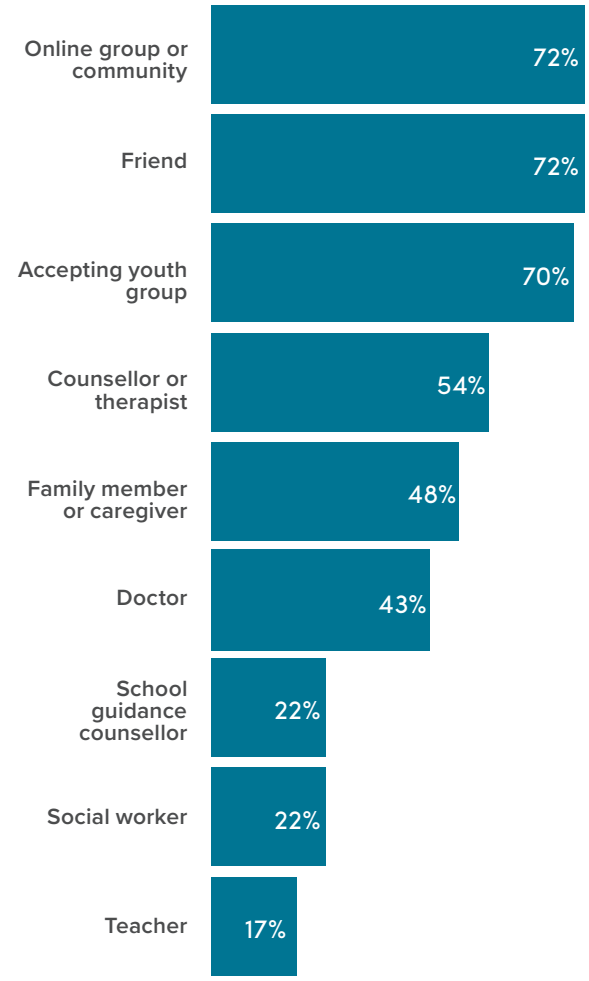
For example, some youth described online resources and support as impersonal and unreliable:

> "I did not like that these services and supports did not have all of the information that I may require having to do with my gender, forcing me to look for online resources that are not always dependable or accurate."
>
> – 15-year-old youth from Sudbury

> "Online [support is] impersonal because it's not face to face, [it includes] biased and potentially unreliable information, and it's easy for transphobes to bully or get in fights with you."
>
> – 15-year-old youth from Toronto

Figure 2 also demonstrates that approximately half of trans and non-binary children and youth are not turning to counsellors, family members, health providers, school guidance counsellors, social workers or teachers. The precise reasons for this were not determined in this study but can be speculated upon based on other data collected, including: lack of confidentiality; stigma; fear of rejection by families; lack of availability of help; perceptions of help not being gender-affirming; and cost or distance.

Figure 2 – Main sources of information and support used by children and youth (N = 54)




A high proportion of children and youth (33%) and caregivers (31%) reported negative experiences with service providers, ranging from lack of knowledge to outright erasure and transphobia. One respondent told us:

> "If we turn to professionals for help, like doctors, school staff or counsellors, it's as though they never expected us to exist. This makes us feel stigma, shame and guilt. They don't know what to do with us."

Approximately 41% of childen and youth and 30% of caregivers reported fearing that service providers would not understand their gender identity; 27% of youth reported fear of encountering discrimination from a provider.

Approximately 23% of caregivers also reported that the cost of services and supports created access challenges. For example, caregivers in lower-income households reported difficulties in:

- travelling long distances to access services or supports;
- taking time off work to accompany their children to appointments;
- paying for private services such as psychotherapy or speech pathology; and
- paying for transition-related treatments, in particular hormone blockers.

This survey was completed before OHIP+ (which ensures universal access to prescription medications for children and youth under 25, so long as they do not otherwise have private coverage for medication) came into effect; hormone blockers have been covered since January 1, 2018.

A number of caregivers suggested that they wanted and needed help to navigate the health care system to find information and supports for their trans children and youth. The parent of a 15-year-old in Thunder Bay described this need in terms of:

> "A service that can coordinate appropriate referrals, support the transition process and reassure what's expected."

## 2. Access to knowledgeable and gender-affirming health providers

Family health providers are the gateway to many health services in Ontario, and are often the first person parents or caregivers approach if they have questions or concerns about their children.

Study respondents reported experiencing significant barriers in finding primary health care providers who were both knowledgeable and competent in gender diversity, and who also provided respectful and affirming services.

Approximately 61% of children and youth reported being unable to access at least one needed support or service; more than half of whom cited needing a health care provider who knew about gender-affirming treatments. 33% reported needing a health care provider who would accept their gender identity and expression.

Several caregivers and children and youth told of encounters with health providers who were either unknowledgeable about the needs of trans and non-binary children and youth, or who expressed judgemental or transphobic attitudes:

> "My doctor constantly misgenders me and fails to correct himself."
>
> – 17-year-old, Toronto

> "Our family doctor did not think that [our] 16-year-old was really trans. He said 'Too young to decide, at 16!"
>
> – Caregiver of 17-year-old, Ottawa region

> "Unfortunately, lately we have encountered several 'old school' doctors who are judgmental and subtly transphobic. [They are] often totally uninformed about gender dysph[oria]. One wonders about the existence of [professional development] programs for new and existing physicians."
>
> – Caregiver of 14-year-old, Ottawa region

Although some parents and caregivers reported that they were able to find health care providers who were supportive of their child's gender identity, these providers were still at times perceived as lacking in the skills needed to provide transition-related support. As explained by the caregiver of a seven-year-old child in Toronto:

> "[My child's] doctor is ok, but I'd prefer someone more knowledgeable in this particular area, especially as they approach puberty."

## 3. Access to knowledgeable and gender-affirming mental health providers

More than one in five children and youth (21%), and a similar proportion of their caregivers, reported needing but being unable to access a counsellor or therapist who was accepting of the child or youth's gender identity or expression. Other respondents reported negative experiences with mental health providers. For instance, the caregiver of a 17-year-old in Toronto shared:

> "We encountered a psychiatrist who seemed unable to use the correct pronouns and was very defensive when this issue was raised."

Several respondents identified financial barriers in accessing mental health supports. For example, the parent of a 17-year-old in Ottawa recounted her family's acute needs:

> "We told her doctors and her social worker that we were concerned she might be suicidal. [They] didn't really pay attention... and they didn't seem to be monitoring her mental health. In the last couple of years she has attempted suicide several times. The cost of psychological services is very high, but how can we do without it, we want to keep our daughter alive! We have family helping us to pay for weekly psychology visits that cost $175.00 a visit. My health insurance only covers $400/year."

Respondents also reported challenges in accessing services for children and youth who had other mental health needs. As described by the caregiver of a 16-year-old in Ottawa:

> "It took some time to find services, and some providers did not have adequate knowledge of appropriate services. It has been difficult to find a child and adolescent psychiatrist who can assess or treat our child's illnesses (OCD and borderline) and who is also trans-positive."

## 4. Timely access to physical and mental health care

Parents and caregivers reported delays in accessing mental health services, and the need for timely access to these services. One caregiver was told that their child could wait up to 18 months for counselling.

When it came to clinical services for trans and non-binary children and youth, 43% of children and youth and one-quarter of caregivers identified long wait times as a factor that made it difficult to access the care they needed.

As described by the caregiver of a 17-year-old in Toronto:

> "It is hard to find [services and supports], and then when you do, you get told about their waiting lists—and then referred to another place that has waiting lists, too. When you are emotionally drained this is hard to take. You don't feel supported. This process made me feel stigmatized, too."

As described in the literature review, while waiting for clinical services, youth can undergo distressing changes to their bodies. Furthermore, youth who go through puberty without timely intervention may require future transition-related procedures, including electrolysis for trans women, or surgeries to reduce the body dysphoria they experience.

## 5. Supportive and welcoming school environments

Several children and youth described the importance of having supportive adults in the school system. As a 17-year-old in the Ottawa region described:

> "My guidance counsellors are all very supportive and able to [share] possible resources and make sure that I'm safe and supported at school."

However, a substantially higher proportion of caregivers (21%) reported negative experiences in the school systems. Many expressed a desire to make the system more supportive of trans and non-binary children and youth.

Caregivers, children and youth recounted examples where professionals in the school system failed to provide an affirming environment by not acknowledging chosen names or pronouns, or separating trans students from the general student population rather than promoting understanding and integration.

In these examples, school staff also exhibited condescension and indifference towards trans youths' concerns and experiences:

> "Speaking with my school's guidance counsellor was uncomfortable. Although my school is accepting of trans students, she didn't seem to understand why I wanted my name changed on the attendance, even though I explain[ed] my identity and discomfort with my birth name to her."
>
> – 14-year-old respondent from Toronto

> "Our son has attended three schools in three years. [We] left the first school, as we did not think they were supportive. The second school already had multiple transgender kids and took very good care of us. The third school was due to moving across the city. The principal had no experience with transgender students, but reached out to her colleagues and learned what we needed and what our rights were."
>
> – Caregiver of a six-year-old in Ottawa

## 6. Gender-affirming spaces for social participation

Approximately 47% of children and youth and 48% of caregivers identified the need for places to socialize where others accept their children's gender identities and expressions. As described by a 10-year-old respondent from Toronto:

> "... helping with connections to others with similar experience to make friends/ communities... having an opportunity to do fun things without too much HUGE [emphasis in original] spotlight on my diversity—being able to include my known family and friends, fun, fun, fun ..."

### 7. Increasing parental capacity and agency in gender-affirming actions

As reported in the literature review, affirmation and support from parents and caregivers is a primary determinant of the well-being of trans and non-binary children and youth. However, some youth reported having unsupportive parents, caregivers or family. As a 17-year-old respondent from the Peel region shared:

> "[My] family has done nothing; I am not out because it is unsafe for me to be. If you mean friends as caregivers, they have given everything I need."

Child and youth respondents suggested a number of validating, accepting and affirming behaviours through which their parents, caregivers or family members could better support them, such as: learning and using their correct pronouns, facilitating their gender expression by giving them access to gender-affirming clothes and haircuts, transition-related items such as binders, packers and breastforms, and intervening on their behalf when others express transphobia.

Approximately 15% of children and youth identified the need for caregivers and other family members to educate themselves about gender identities, and trans and non-binary issues more generally. As decribed by a 17-year-old respondent from Toronto:

> "I want my dad to be more involved and learn more about trans people because he has good intentions; he just doesn't know how to talk about it."

Caregivers also reported that they require a lot of information and support to be able to act as advocates and navigate their child's needs in school, health, legal, community, social and other systems, especially for younger and more dependent trans children. Sources of support, such as other parents or trans and non-binary support networks, are important for learning how to be gender-affirming and supportive, and how to advocate for their children.

## Summary

Many needs were identified by child and youth and caregiver survey respondents, but access emerged as a major issue. The evidence collected highlighted the need for:

- access to information;
- access to gender-affirming support;
- access to knowledgeable and gender-affirming health and mental health providers; and
- reduction of waitlists for health and mental health support.

Additional access needs included: access to supportive and welcoming school environments, gender-affirming spaces for social participation, and programs and services that can support parents to build capacity and agency for supporting their children.

2

# SERVICE PROVIDERS/ ORGANIZATIONS

## Introduction

This section provides information on the service provider respondents to the Phase 1 needs assessment survey. It describes survey respondents, identifies key themes and summarizes the evidence collected from the group.

## Description of the study population

Service providers in the Phase 1 survey were eligible to respond to our survey if they had provided services to any trans and non-binary children or youth under the age of 18 in the last five years. The survey was completed by 33 different organizations in Ontario, and an additional 18 service providers from seven different organizations participated in interviews or focus groups.

Most of the organizations that responded were non-profit, publicly funded services. One organization was a peer-led initiative, and five individuals who responded offered services through private, fee-for-service practices. These respondents worked with trans youth in varying capacities and to varying degrees.

# Key themes and needs identified

Many of the key themes and needs identified by service providers were similar to those identified by child and youth and caregivers.

## 1. Access to information and support

Service providers reported that many caregivers experience tremendous challenges in finding information on gender diversity and in navigating the system.

For its part, RHO frequently receives calls from parents looking for services for their children, and from trans people of all ages seeking support. Many of the people calling are looking for more than a simple name and contact information: they're also seeking some basic emotional support, and more in-depth information about their options. Additionally, RHO receives calls from service providers looking for potential referrals, as well as detailed information about how to work with trans and non-binary children and youth.

Several respondents identified the need for a system navigator, someone who can assist children, youth, families and service providers to understand available resources and then get the support, services and training they need.

Access barriers are significantly more pronounced for low-income families. For example, several service providers observed that children and youth accessing specialist services were more likely to come from higher-income families.

## 2. Insufficient capacity in gender-affirming care and support in Ontario

Service providers identified many insufficiencies in existing supports and services to meet the needs of Ontario's trans and non-binary children and youth and their families. For example, service providers reported that current services and supports for this population have been "cobbled together" from existing resources, and that the few services that do exist rely on part-time staff who are "borrowed" from other programs—with "long waiting lists across the board." Trans youth are often assumed to be served in general health care programs or programming focused on LGBT2SQ youth, which can mean that there is little or no trans-specific content.

Another challenge identified by service providers was how little of an overlap there is between the systems that serve trans adults and those that serve trans children and youth. Service providers in settings focused on children and adolescents, who provide care such as access to hormone blockers, transition-related hormones and referals to surgery, noted that they struggle to ensure continuity of care for youth aging out of their services.

Furthermore, many service providers reported that they were "inexperienced" and had begun serving this population only recently: half of the service providers surveyed had less than five years of experience serving trans children and youth. Similarly, many of these service providers had worked with limited numbers of parents and caregivers: half of those surveyed had worked with fewer than 20 youth over the last five years (average = 34.7), and an equal proportion had worked with fewer than five parents and caregivers in the same time period. Approximately half of the service providers we heard from did not work with youth under the age of 12.

## 3. Dangerously long waitlists for transition-related care

Currently, a small number of experienced service providers are supporting a large proportion of the children and youth accessing transition-related care, and their caregivers. Waitlists for their services are unacceptably long; providers reported that they are stretched beyond capacity because of the exponential increase in the number of children, youth and families seeking support over the last five years.

When the Phase 1 survey was being conducted, one community health centre and two Ontario hospitals were operating clinics to support pubertal youth needing to either delay puberty or to medically transition: Sick Kids Transgender Health Clinic and the Children's Hospital of Eastern Ontario (CHEO). This is a concern, since these clinics are geographically inaccessible to many—especially to northern and rural children and youth, or youth who need to travel and don't have the support of their caregivers.

Both hospitals have comprehensive teams of healthcare providers—including social workers, nurses, nurse practitioners, psychologists, family physicians and endocrinologists—who are trained and experienced in adolescent medicine and transition-related care. However, none of the physicians, nurses or mental health providers at either institution work full-time with trans and non-binary children and youth, despite the overwhelming demand for their services.

In addition to both clinics having insufficient staff to meet the current needs, sustainability is a concern, given that neither clinic has dedicated funding. Both are funded through general streams of funding for adolescent medicine. As one provider at CHEO noted, the existence of the Gender Diversity Clinic at CHEO is precarious: should there be an unexpected absence of a staff member**,** this would significantly impact the clinic's ability to carry on with its work.

CHEO's internal target is that new referrals to their gender clinic see an adolescent medicine physician within 14 days. But, with over 200 patients on the waitlist as of early 2018, and no staff solely dedicated to the clinic, this is not possible. Currently, children and youth referred to CHEO will wait 300 days between initial referral and seeing an adolescent medicine physician, with a further 75-day wait to see an endocrinologist.

As of early 2019, Sick Kids' clinic currently receives 20-30 referrals per month and has the capacity to provide 14 new assessments (initial consultations) per month.

Service providers also noted that these are not the only wait times children and youth may face in accessing care. As youth age out of pediatric services, they will face additional wait times to access care as adults, such as the lengthy wait times for adults needing transition-related surgeries in Ontario.

Respondents from both Sick Kids and CHEO are concerned about the lengthy wait times, and noted that service providers' capacity to meet the demand for their services is challenged by the fact that they have a limited amount of time and resources to devote to the clinics serving trans youth.

Our literature review supports that they are right to be concerned: the Trans PULSE project identified that the period between deciding that transition was necessary and being able to

## Key themes and needs identified:

access transition was the period of highest risk for considering and attempting suicide, stating "social inclusion (social support, gender-specific support from parents, identity documents),[120] protection from transphobia (interpersonal, violence) and undergoing medical transition have the potential for sizeable effects on the high rates of suicide ideation and attempts in trans communities."[126] Moreover, researchers from Trans PULSE have repeatedly stated that long wait times for transition-related care are concerns and endanger lives, noting, "people's lives are actually at risk."[127]

Heightening the significance of these long wait times even more is what's known by many parents and youth: that puberty suppression can reduce the need for surgeries, electrolysis and other transition-related procedures.

### 4. Access to knowledgeable and gender-affirming health care providers and reduction in waitlists for transition-related care

Access to primary care was identified as another major challenge for trans and non-binary children and youth. While specialist clinics support children and youth in their transition processes, they do not provide comprehensive primary health care or assistance in navigating services and supports.

Only six primary health care centres indicated that they provide clinical care to trans and non-binary children and youth under the age of 18. The majority of these six primary health centres surveyed saw between one and 10 trans and non-binary children and youth over the last five years, with the exception of Quest Community Health Centre, the only primary health care centre that has considerable experience providing endocrine care, which has seen 300 clients.

Primary care providers regularly refer trans children and youth to CHEO, Sick Kids or Quest Community Health Centre rather than treat youth themselves, because they feel they lack the training and expertise to care for them. This increases the pressure on these three already over-extended clinics in the province.

Findings from the Provider Capacity Survey on the proportion of primary care professionals who feel they have the knowledge and comfort to provide care to trans youth and their referral patterns are presented in the next section.

## 5. Access to knowledgeable and gender-affirming mental health providers

Thirteen mental health providers responded to the survey. Nine of them worked in mental health services, and four worked in private practice. The former saw between three and 100 trans and non-binary children and youth over the five-year period, with two overall under the age of 12. The latter had each seen between three and 20 trans youth over the five-year period, and only one had seen a child under 12 years of age. This lack of services for children under 12 often leaves young children without professional support.

Mental health service providers reported that they are often uncomfortable engaging with gender issues, for fear that they are insufficiently knowledgeable and may do more harm than good. Consequently, they tend to focus on children and youths' mental health concerns—such as depression or anxiety—separate from their experience of gender.

Between the lack of knowledgeable and gender-affirming mental health providers and the high demand among trans children and youth, wait times for affirming mental health care are long: Central Toronto Youth Services (CTYS) staff reported that children and youth seeking individual therapy usually wait eight to ten months for an initial appointment.

Service providers at CHEO and CTYS raised further concerns that children's mental health services end at a young person's 18th birthday, and there is neither a transition process to ensure continuity of care, nor are adult services necessarily able to meet the needs of youth 18–25. Both felt that existing children's mental health services needed to be expanded to better support young people in this age bracket.

The next section presents findings from the Provider Capacity Survey on the proportion of mental health professionals who feel they have the knowledge and comfort to provide care to trans youth, and these professionals' referral patterns.

# Key themes and needs identified:

## 6. Supportive and gender-affirming school environments

Three school boards (out of Ontario's 78) responded to the survey, all indicating that they provided explicit supports and programming for trans and non-binary children and youth: Hamilton Wentworth District School Board, Ottawa-Carleton District School Board and the Toronto District School Board. All school boards in Ontario are required to have equity policies and strategies. It is unknown how many have specific supports or programing for trans or non-binary youth, although there are boards who did not respond and who do have explicit supports and programs, for example the Durham District School Board,[128] the Halton District School Board and the Thames Valley District School Board.[128]

Service providers who worked with school staff reported that the school can play an important role in the lives of children and youth, especially for students whose parents are not supportive of their gender identity or expression. For example, teachers and other school staff can connect these children and youth to resources, services and trans peers.

Service providers working at different organizations reported that there is currently a lack of system-wide mechanisms to ensure that schools provide supportive environments, and neither is there consistent support for trans children and youth in schools. Widely used student records management tools (such as Trillium) embed the erasure of non-binary students in registration, class lists, report cards, and things as simple as signing out a library book.

## 7. Gender-affirming spaces for social inclusion

Several service providers highlighted the benefits of social participation to trans and non-binary children and youth for community-building, friendship, mentorship and solidarity. In particular, they identified a need for inclusive recreational opportunities such as the dedicated inclusive swim nights for trans children offered by Regent Park Aquatic Centre in Toronto and Family Services Ottawa (FSO), as well as age-appropriate hang-out spaces. Currently Camp Ten Oaks is the only Ontario camp that specifically offers all-gender cabins, making it accessible to campers of all gender identities. Access to affirming day and overnight camps is a significant concern.

### 8. Parental supports

Several service providers reported that caregivers of trans and non-binary children and youth need mental and emotional support from someone outside the family in order to best support their children. As decribed by one service provider:

> "This type of support helps prevent gender-diverse children and youth from feeling responsible for helping family members to process mixed emotions they may have about the gender-diverse child or youth's gender expression."

There has been a marked increase over the previous six years in the number of parents looking to support their trans children and youth. However, there are only two organizations in the province that provide professional support services for parents and caregivers: CTYS in Toronto, and FSO in Ottawa. Parent peer networks such as PFLAG, Gender Creative Kids Canada and Canadian Parents of Trans and Gender Diverse Kids are attempting to address this need, but they're typically not funded, and operating these supports places additional demands on parents.

## Summary

Many of the needs identified by service providers were similar to those identified by children and youth and caregivers. Respondents identified access as a major issue across the board, with the evidence specifically highlighting access needs related to:

- information and gender-affirming support;
- knowledgable and gender-affirming health and mental health providers;
- supportive and gender-affirming school environments;
- gender-affirming spaces for social inclusion; and
- supports for parents and caregivers.

Additionally, service providers in the Phase 1 survey identified major issues related to reducing waitlists for transition-related care and building capacity in gender-affirming care and support throughout Ontario.

3

# PROVIDER CAPACITY SURVEY

## Introduction

**This section provides information from the health and mental health providers who participated in the Phase 2 Provider Capacity Survey, and summarizes the evidence collected from this group. It describes:**

- survey respondents;
- key findings related to their practice populations;
- referral patterns;
- capacity-building needs; and
- service gaps.

## Description of the Survey Population

Survey respondents were 279 health and mental health care providers who responded to the survey, of which 218 were eligible to participate because they worked with children younger than 18 years. The distribution of providers by professional group is presented in Table 1. Approximately 11% were primary care providers (N=24), 43% were mental health workers (N=96) and 7% (N=16) were child/youth/family care workers. The “other” category included allied health professionals and health service managers, among others.

Health and mental health providers worked in a variety of practice settings. Approximately 25% worked in primary care, 20% worked in community mental health settings and 36% worked in other settings. The vast majority of providers reported that they worked with several vulnerable population groups: 51% worked with people of low-income; 34% with new immigrants, 30% with racialized people; 39% with Indigenous people; 31% with people living in rural communities; and 44% with LGBTQ communities. There was broad geographic representation of providers by LHIN (Table 2).

TABLE 1: Survey respondents, by professional role (N=218)

| | | |
|---|---|---|
| Health Promoter / CHW | 1.83% | 4 |
| Family/Primary Care Doctor | 5.05% | 11 |
| Nurse Practitioner | 5.96% | 13 |
| Psychotherapist | 6.88% | 15 |
| Psychologist | 1.83% | 4 |
| Counsellor/Mental Health Worker | 10.55% | 23 |
| Social worker | 24.77% | 54 |
| Psychiatrist | 1.38% | 3 |
| Nurse | 27.98% | 61 |
| Child / Youth / Family Worker | 7.34% | 16 |
| Other (please specify) | 6.42% | 14 |
| **Total** | | **218** |

TABLE 2: Survey respondents, by LHIN (N=218)

| | | |
|---|---|---|
| Erie St. Clair | 7.34% | 16 |
| South West | 9.17% | 20 |
| Waterloo Wellington | 10.09% | 22 |
| Hamilton Niagara Haldimand Brant | 4.13% | 9 |
| Central West | 3.67% | 8 |
| Mississauga Halton | 5.05% | 11 |
| Toronto Central | 14.22% | 31 |
| Central | 2.75% | 6 |
| Central East | 4.59% | 10 |
| South East | 11.01% | 24 |
| Champlain | 4.59% | 10 |
| North Simcoe Muskoka | 1.83% | 4 |
| North East | 4.13% | 9 |
| North West | 17.43% | 38 |
| **Total** | | **218** |

# Key findings

## 1. Practice populations

Health and mental health providers estimated that they saw an average of 11 trans and non-binary children and youth in the *past 12 months*; however, a sizable proportion, i.e., 55/218 (25.2%), did not see any openly identifying trans children and youth. During their practice history, service providers estimated that they had seen an average of 37 trans children and youth; however, 33/218 (15.1%) of respondents reported that, to the best of their knowledge, they had never worked with any trans children and youth.

Among primary care providers, an average of 11 trans children and youth had been seen in the past 12 months. However, a sizable proportion of these providers, i.e., 5/24 (20.8%), believed that they had not seen any. Primary care providers estimated that they had seen an average of 27 trans children and youth during their practice history. However, 3/24 (8.8%) reported having never seen any self-identified trans children and youth.

## 2. Provider capacity

Table 3 presents findings from all providers, including primary care and mental health providers, on how knowledgeable they were in various areas of service provision to trans and non-binary children and youth.

While respondents indicated high levels of knowledge in some areas of care, such as providing health counselling or assessing mental health needs, the findings demonstrate serious knowledge gaps among providers in several key areas. Notably, primary care providers do not feel somewhat or very knowledgeable in: assessing gender dysphoria (only 54.2%); assessing transition-related options (only 66.6%); prescribing hormones (only 50%); providing mental health counselling (only 58.3%); or providing individual or family guidance (only 62.4%).

Similarly, mental health providers do not feel somewhat or very knowledgeable in assessing gender dysphoria (54.0%). However, this group reported high levels of knowledge in assessing mental health needs (94%) and providing mental health counselling (92.5%).

When asked about levels of comfort in the same areas, similar variations in health and mental health provider responses were observed: primary care providers did not feel comfortable prescribing hormones (34.8%), assessing options for transition (30.4%),

providing mental health counselling (26%) or assessing or diagnosing gender dysphoria (21.7%). Approximately 32% of mental health professionals did not feel comfortable diagnosing gender dysphoria, and 26% did not feel comfortable assessing options for social as well as, or instead of, medical transitions.

It's important to note that providers who are more interested in providing care to trans children and youth are more likely to have answered the survey; it's possible that levels of knowledge and comfort across the province are even lower than this suggests.

TABLE 3: Percentage of providers reporting to be very or somewhat knowledgeable in different areas

| Knowledge area | All providers (N=218*) | Primary care providers (N=24*) | Mental health providers (N=105*) |
|---|---|---|---|
| Assessing/diagnosing gender dysphoria | 47.0 | 54.2 | 54.0 |
| Assessing physical health needs | 61.9 | 75.0 | 61.0 |
| Assessing mental health needs | 87.0 | 83.3 | 94.0 |
| Assessing options for social and/ or medical transition | 62.0 | 66.6 | 53.0 |
| Providing health counselling (e.g., safe sex, contraception, etc.) | 89.3 | 87.5 | 81.6 |
| Prescribing hormones | 24.7 | 50.0 | 5.7 |
| Monitoring growth and development | 53.5 | 70.8 | 37.3 |
| Providing mental health counselling | 79.2 | 58.3 | 92.5 |
| Providing individual/family guidance | 73.4 | 62.4 | 84.3 |

**Excludes providers who reported "not applicable"*

## Key findings

### 3. Referral patterns

Table 4 presents findings from all providers, primary health providers and mental health providers on how often they "always" refer trans and non-binary children and youth for different services.

Findings demonstrate that a substantial proportion of primary care providers "always" refer their trans children and youth patients for primary care, transition-related care and mental health counselling. When asked to explain why, primary health care providers cited "lack of expertise in mental health counselling," "access to mental health supports within their agencies/service settings" and "time constraints." As one primary care provider explained:

> "We have access to social workers, psychologists and psychiatrists in our clinic who are better trained than myself in counselling. I will certainly incorporate therapeutic techniques into my own care, but I am not well versed in formal counselling approaches."

Other primary care providers felt it was necessary to refer to specialized services if clients were under 16 and interested in hormones, or to enable their clients to access more continuous care. As a primary care provider explained:

> "I'm in a walk-in clinic type of environment. I want the youth I see to develop a relationship to a provider who can follow them long-term, so I refer them to at least a primary transition-related provider (not enough primary health care providers in the area)."

Almost one out of five mental health providers reported "always" referring children and youth for mental health counselling. When asked why they always refer, a couple of mental health providers responded:

> "My role is not to provide mental health counselling, but services that are specific to non-medical transition."

> "Most of what I do with gender-diverse children and youth is find the resources they need and make recommendations and/or refer them to the most relevant and appropriate supports, whether within or outside of my agency."

TABLE 4: Percentage of providers that always refer by service area

| Service area | All providers (N=184*) | Primary care providers (N=24*) | Mental health providers (N=96*) |
|---|---|---|---|
| Primary care | 31.5 | 9.0 | 77.5 |
| Transition-related care | 30.3 | 31.8 | 39.5 |
| Mental health counselling | 23.3 | 40.9 | 19.7 |

## 4. Capacity-building needs

The majority of all primary care and mental health providers (68%) were unaware or unsure of existing guidelines or protocols for trans and non-binary children and youth (< 18 years) in Ontario. Table 5 summarizes the proportion of all providers, primary care providers and mental health providers who received training on trans children and youth in specific training areas.

The findings indicate that a sizable proportion of primary care and mental health providers in Ontario (26.6%) have received no information or training in working with trans children and youth.

Among primary care providers, rates of training in key areas of care provision fall below what would enable optimal access to care. For example, only 68.2% have received any information on options for social or medical transition or assessing gender dysphoria, and less than 50% have received training in assessing mental health needs or monitoring growth and development. Most providers have received little information on referral options. Mental health was identified as a critical area for training, especially by mental health providers (87%) and child, youth and family care workers (85%).

TABLE 5: Percentage of providers receiving information or training in different areas

| Training area | All providers (N=184) | Primary care providers (N=22) | Mental health providers (N=96) |
|---|---|---|---|
| Assessment and diagnosis | 30.4 | 68.2 | 30.2 |
| Assessing options for social and/ or medical transition | 36.4 | 68.2 | 37.5 |
| Assessing mental health needs | 49.5 | 31.8 | 64.6 |
| Prescribing hormones | 13.6 | 54.6 | 4.2 |
| Monitoring growth and development | 11.4 | 18.2 | 6.3 |
| Referral options | 41.3 | 45.5 | 39.6 |
| No information or training received | 26.6 | 9.1 | 21.9 |

## Key findings

### 5. Service gaps

Table 6 summarizes the main service gaps identified by the service providers who responded to this question (N=115). The most frequently cited barrier was lack of access to services in rural and northern communities; this issue will be further discussed in a later section.

Other gaps that service providers identified are consistent with those identified in previous sections, such as:

- lack of access to information and support;
- insufficient capacity in transition-related care and primary care;
- insufficient access to mental health services; and
- lack of support for the needs of parents, caregivers, and children and youth.

Table 6 outlines details about these gaps. Among provider groups, several mental health workers highlighted gaps related to caregiver involvement and the ability to address the needs of the whole family. The majority of child, youth and family care workers who responded to this question identified training gaps as well as barriers related to accessing resources.

## Summary

The evidence collected from the Provider Capacity Survey indicated that a sizable proportion of the health and mental health providers who responded see trans and non-binary children and youth (i.e., 75% in past 12 months; 85% in lifetime), but that the majority do not feel knowledgeable or comfortable in providing care to this group.

As a result, a substantial proportion of providers "always" refer their trans children and youth patients to specialists for care. The vast majority of providers reported that they are unaware of existing guidelines or protocols for trans children and youth (< 18 years) in Ontario, and have received little training in working with this group. This is particularly concerning when coupled with our finding that a small number of experienced service providers are supporting a large proportion of the children and youth—and their caregivers—accessing transition-related care, resulting in very long waitlists, and these providers reporting being stretched beyond capacity. The cumulative impact is that many children, youth and their families are largely unable to access specific services and supports when and where they need them.

Additionally, the majority of service providers identified service gaps related to access and capacity, notably the lack of access to services and supports in rural and northern communities.

TABLE 6: Main service gaps identified by service providers

| Service gap | # times cited |
|---|---|
| Access to services in rural and northern communities | 27 |
| Lack of information on resources for support and referral<br>"I am unaware of other medical providers in Central Toronto who provide trans-related health care and access to medical transition outside of Sick Kids. More information would be great." | 18 |
| Lack of capacity in transition-related care/waitlists<br>"There are not enough practitioners doing this type of work!!!! Those of us who are doing this work are overwhelmed with referrals. We need more people doing this important work." | 13 |
| Lack of support for parents and youth, especially in smaller communities<br>"There are not enough organizations providing social support, programming for this group." | 10 |
| Lack of provider capacity in gender-affirming care – ongoing discomfort, negative attitudes/stigma<br>"Other providers who will not engage with this population due to lack of training, experience and/or knowledge. It comes off as [homophobia or transphobia], giving the respective professions, giving the respective professions the reputation of not caring or, worse, dismissing this often-vulnerable population." | 10 |
| Institutional/systemic barriers, no system of care<br>"There are not enough organizations providing social support, programming for this group." | 7 |
| Lack of parent education/parental attitudes<br>"There are not enough organizations providing anti-oppression-informed programming for the parents." | 6 |
| Insufficient access to mental health resources | 4 |
| Ongoing collaboration/mentorship | 3 |
| Lack of capacity in primary care providers, e.g., providers willing to provide hormones<br>"The physicians are reluctant to act before puberty is complete, which is devastating especially to trans female youth." | 2 |
| Definitional issues | 2 |

4

# UNDERSERVICED POPULATION GROUPS

## Introduction

There is no single trans experience. The literature is clear that racialized trans people experience greater rates of violence than white trans people, that youth are more vulnerable than middle-aged people, and that other factors such as (dis)ability, femininity, androgyny, transmisogyny, poverty, homelessness and sex work intersect with overlapping forms of oppression, meaning that some trans and non-binary youth are facing multiple forms of oppression or barriers.

Exploring the intersections and the needs of people living at these intersections is an important part of ensuring we are meeting the needs of all youth, and not just a privileged few.

Gender identity and gender expression are one part of a person's identity. Their race, religion, socioeconomic status, sexual orientation, among other factors, form other parts of their identity. Different combinations of these identities can create multiple threats of discrimination at the same time.

The cumulative way that these forms of discrimination intersect in an individual's experience is known as intersectionality. Despite limited data and research, anecdotal evidence overwhelmingly indicates that Black, Indigenous, and racialized trans people, especially trans women, face high levels of discrimination, threats and physical and/or sexualized violence. Meaningful policy and service improvement efforts to fully include and serve trans people require decision-makers and service providers to understand the complexity and diversity of trans people and the multiple barriers that sub-populations of trans people face, especially at the intersection of their race and gender identity and gender expression.[129]

This section of the report identifies the needs of several underserviced population groups of children and youth, including: pre-pubertal, transfeminine, non-binary, newcomer, racialized, Indigenous, Francophone and/or residents of rural and northern communities. The information presented is based on data collected in Phases 1 and 2.

## 1. Pre-pubertal children and their care providers

Pre-pubertal children represent a sizable proportion of trans and non-binary children in Ontario. The response rate to the survey was low (i.e., only 13% were children aged 9 to 11; N=9), but this may reflect the parent or child's unwillingness to participate in a research survey, and does not reflect the prevalence of gender diversity in this group. It may also be a result of younger children having limited access to the internet, literacy skills in this group, the challenges in connecting with community as a young child, and how dependent young children are on their parents or caregivers. We also did not invite parents of children under nine to participate in the survey, although we know there are children as young as three asserting gender identities outside of what was expected for them.

An estimated 28% of caregiver respondents reported having a trans and/or non-binary child under the age of 12. According to the Provider Capacity Survey, providers estimated that 30% of the children they treated were pre-pubescent.

Overall findings suggested that there are very few services and supports in Ontario that specifically address the needs of younger (i.e., 12 and under) trans and non-binary children in Ontario. The vast majority of caregiver respondents reported that services and supports for children and younger youth were lacking or insufficient to meet the needs of pre-pubertal children. As the parent of one five-year-old child in Toronto stated, "There are still very few services for [very young] people."

Among the 33 organizations that responded to the survey, only 15 indicated that they were willing to provide services to pre-pubertal children. However, no data was available on whether children 12 and under were actually accessing these services. There was also little information on whether existing services and supports were appropriate for younger children: younger children may not feel comfortable sharing space with older youth, and the nature of the supports they need may be different.

Many service providers reported feeling unknowlegeable and uncomfortable working with this age group. For example, one mental health provider expressed some concern that therapists working with younger youth do not know enough about child and adolescent development.

The Provider Capacity Survey's findings indicated that only 37.3% of mental health providers knew about monitoring children's growth and development, compared to just over half of all service providers, and 71% of primary care providers.

## 2. Transfeminine children and youth

Among the respondents to the children and youth survey, the proportion of transmasculine respondents was higher than transfeminine respondents. Of the 52 respondents who provided information on their gender identity (aside from trans), 40% identified as a man or a boy (21 individuals), and only 12% (6 individuals) identified as a woman, girl or femme. 23 respondents (44%) identified as agender, non-binary, genderqueer or gender fluid. The larger 2013 survey by *The Human Rights Campaign* found similar results among their respondents: 7% indicated a transition from male to female (MTF) and 30% from female to male (43% indicated neither)[21]

Gender assymetry was also reflected in the documentation shared by service providers about the numbers of transmasculine and transfeminine people accessing their services. For example, in April 2019 the Gender Diversity Clinic at the Children's Hospital of Eastern Ontario was serving 386 patients, with a ratio of just over 2:1 people who had been assigned female at birth to people assigned male at birth. Similar proportions were also reported by both Quest Community Health Centre and the Transgender Youth Clinic at Sick Kids.

Our society's cissexist and sexist values valorize masculinity and masculine qualities, while devaluing femininity and feminine behaviours.

A number of studies have found that transfeminine children and youth are exposed to significantly more rigid gender policing, more negative responses, violence, harassment and outright denial of their identities than transmasculine children and youth.[43,72] It is possible that this difference in numbers can be explained in part by the hostility that trans feminine children and youth experience, forcing them to repress their identities longer and come out later.[72]

More research is necessary to better understand these trends and to be able to ensure that the needs of all trans and non-binary children and youth are met. For example, one community member suggested that transfeminine people may not feel comfortable accessing services or supports that are predominantly accessed by transmasculine people. As described by a 17-year-old respondent from Toronto:

> *"I've heard from my friends who are feminine-identifying that they feel under-represented in those groups and they end up not going. I notice there are so many transmasculine youth coming, because they feel safer there and are surrounded by people like them, but not transfeminine people."*

## 3. Non-binary children and youth

Almost one-third (32%) of children and youth respondents who disclosed their gender identities identified as non-binary. Several of the service providers interviewed reported an increase in the number of non-binary youth that they see. And yet, the experience of these children and youth is often erasure or denial of their identity. As one respondent described:

> "I went to [a doctor] in Ottawa once and she blatantly told me that non-binary identities weren't real, that I would eventually decide if I wanted to transition and that I needed to learn not to come out to people because they didn't care. She likened coming out as non-binary to telling people about my sexual habits."
>
> – 17-year-old, Ottawa region

Our literature review found that non-binary children and youth often experienced higher levels of discrimination and violence than their binary-identified peers [43] Certainly, living in a cis-sexist society means that systems are designed for binary identities; forms ask for male/female, and facilities often only offer two sex-segregated options for washrooms, showers, change rooms, overnight shelter accommodations, overnight camp accommodations, sports participation and more. All of this means that non-binary children and youth experience frequent moments of erasure when the built environment and existing program offerings indicate to them they don't exist or belong.

More research is clearly necessary to identify the knowledge and capacity gaps in responding to the needs of these groups.

## 4. Indigenous children and youth

Eight percent of the children and youth who responded to the survey identified as Indigenous, which is slightly higher than the percentage of Indigenous children 0–14 in Ontario (5%)[130] as reported by Statistics Canada.

Indigenous-led research found that the actual number of Indigenous peoples is two to four times larger than that reported by Statistics Canada[131]—in which case, Indigenous children and youth are under-represented in our survey.

Regardless of numbers, it is clear that Indigenous children and youth have distinct needs, and face distinct barriers that must be specifically addressed.

Two of the service providers surveyed (one in Toronto and one in Thunder Bay) reported seeing significant numbers of Indigenous children, youth and families. CHEO and Sick Kids, two of the largest clinical programs in the province, observed that Indigenous children and youth were under-represented in their practice populations.

In this section, we refer to Two-Spirit youth, rather than "trans and non-binary." We want to acknowledge the specific roles that Two-Spirit people have, and have had, in Indigenous nations across Turtle Island. We are using Two-Spirit in this section because it is a term that Indigenous people use for themselves. This term is understood to include both an Indigenous identity, and identities that are outside of Western cultural understandings of sex, gender and sexuality that have been imposed through colonization. We say "a term" above and not "the term," since Two-Spirit is an umbrella term; individual nations across Turtle Island have their own word(s) for Two-Spirit people in their own languages.

According to the Provider Capacity Survey, 38% of health and mental health providers in Ontario work with Indigenous children and youth. Among the gaps identified by these respondents, there were major gaps for children and youth residing in rural and northern communities (see next section), and many attitudinal and cultural barriers to health care. However, few identified specific gaps or needs related to Indigenous children and youth.

We collected supplementary information on this group's needs through interviews with Indigenous children and youth and key informants located in Toronto (TAASC) and Sudbury—specifically Sudbury Youth Action Centre, and Shkagamik-Kwe Health Centre (SKHC), which is an Aboriginal Health Access Centre. We gathered additional information from the Forgotten Voices, a research project for and informed completely by Toronto's homeless Two-Spirit and LGBT*QIA Indigenous youth).[132]

Among themes and needs identified by this group, discrimination and social exclusion emerged as a key finding, compounded by access barriers to information and support.

Colonialism has had, and continues to have, a significant negative impact on Indigenous peoples, their communities and their nations. Colonization has included specific violence directed towards Two-Spirit people, and the specific teaching of Western gender roles in residential schools.

Indigenous trans youth in Toronto described themselves as existing in the margins between Indigenous and Western cultures. As with mainstream organizations, Indigenous organizations—especially those that have been subjected to strict Christian doctrine, residential schooling and the effects of colonization—are not always welcoming to trans Indigenous youth.

There are Indigenous agencies that could have the potential to provide support to this group, but some, such as TASSC, do not work with this age group, and others, such as the Native Youth Sexual Health Network, have precarious funding .[132] Still, the Native Youth Sexual Health Network provides an example of best practices, where Two-Spirit youth are creating programs to meet their needs.

Additionally, Two-Spirit Indigenous youth frequently experience homophobia and transphobia from a heterosexist culture, as well as colonialism and appropriation from within predominantly white LGBTQ communities that do not always understand Two-Spirit identities and worldviews.

One Indigenous survey respondent in Toronto who had a five-year-old Two-Spirit child described the mainstream spaces where they had sought help as not respecting the Two-Spirit identities of her child.

Experiences of discrimination and social exclusion were also common among Indigenous trans children and youth outside of Toronto, and in these areas issues of marginalization were compounded by geography.

In rural and northern areas, Two Spirit Indigenous children also experienced barriers to information, services and supports. For example, an Indigenous youth who lived in Sudbury described not only a lack of awareness of Two-Spirit identities in their home community, but

also a dearth of information and support, as well as community stigma and discrimination (e.g., having garbage thrown at them at their home community's Pride event). As a result, they said:

> "I haven't met anyone like me [in my home community] except on Facebook. When I'm [in my home community] I have to be quiet about my identity and sexuality. I can't wear my binder. I need to present myself as a woman."

Several respondents and key informants identified the need to engage and support Indigenous communities in the development of Indigenous, culturally appropriate and welcoming care and support that could be available in both Indigenous and mainstream service agencies throughout the province.

## 5. Newcomer children and youth

The child and youth and caregiver surveys did not determine what proportion of respondents were newcomers, or their immigration status (e.g., refugee), nationality or countries of origin.

However, the Provider Capacity Survey indicated that a large proportion (34.6%) of the health and mental health providers surveyed worked with newcomer clients. Several provider respondents described attitudinal and cultural barriers to health care, but fewer identified specific needs related to newcomer trans children and youth. For example, only one provider identified that there were "no services for refugee populations in their mother tongue."

Interviews with service providers and key informants who work with this group gave us additional information on their needs. Interviewees included: Culture Link Settlement Services, Access Alliance CHC, Griffin Centre, and key informants at OCASI who provide training in gender diversity to settlement workers.

Some of the key themes and needs our findings identified for this group are common to other underserviced population groups, such as: non-Western identities not being recognized or respected, culturally specific access to information and gender-affirming support.

Others, however, are more specific to this newcomer group, like trauma and language, and can also involve intersectional identities (e.g., gender, language and racialized identities). Specific challenges for newcomers also exist, such as changing sex markers on identity documents (permanent resident cards, refugee documents, etc.).

## Need for culturally specific understandings of identity

According to one service provider, the ways in which newcomer and refugee clients express their gender identities may not align with how trans identities have been commonly understood in Canadian service-provision contexts. Gender is viewed through a non-Eurocentric lens in many newcomer communities. Several service providers indicated that North American trans and non-binary terminology is not universally understood across newcomer communities—a statement that both describes the problem and replicates it by locating the lack of understanding in newcomers and not service providers. This creates barriers to mutual understanding and communication.

As a result, immigrant children and youth do not always receive the services and supports they need. Additionally, gender-binary intake forms in various agencies (settlement, school, social and health) were perceived as judgemental and contributed to feelings of exclusion.

## Access to information and gender-affirming support

Several key informants identified informational access barriers to services for this group (e.g., hard to find resources in different languages), especially outside of the GTA. Even when resources are created in different languages, such as the Halton success *All Families Love Each Other*,[133] they may be hard to find, or exist only online, which may present access issues for some newcomers.

## Addressing mental health and trauma

Respondents identified several issues related to the mental health needs of newcomer trans and non-binary children and youth, especially those who have experienced trauma. For example, many of the children who are referred to the Griffin Centre present with social anxiety issues, not gender issues. Among trans newcomer youth referred for trauma, there is a danger of re-traumatization if providers cannot provide trauma-informed care as well as gender-affirming care.

## Discrimination and social exclusion

According to one key informant, some newcomer communities do not have the resources to support a community member to be “out” safely. For example, settlement workers often do not have the knowledge or capacity to be able to support trans and non-binary youth. The Ontario Council of Agencies Servicing Immigrants (OCASI)’s Positive Spaces initiative is a model for developing knowledge and training within the settlement sector.[134]

Other key informants described families who fear being ostracized from the community at large following a child’s disclosure, or who feel that having a trans child should be hidden from their community. However, key informants also affirmed that many factors might contribute to the acceptance of gender-diversity within a community, such as geographic origin, religion, length of stay, and more. Newcomers face significant pressure to be “model citizens” and to conform to Canadian society expectations, both from within their communities and mainstream society. This includes pressure to suppress gender diversity.

Key informants stated that portraying newcomer communities as less supportive of trans people is not only inaccurate, but also stigmatizing, and must be avoided. Additionally, this fails to account for other forms of discrimination they also face.

Several respondents and key informants made recommendations on how to address information, support and service gaps within newcomer communities. Health providers and key informants alike recognized the need for anti-oppressive policies and training to ensure that mainstream agencies, service providers and LGBT2SQ groups are more inclusive of cultural diversity.

Additionally, respondents identified that newcomer communities could be better supported to continue to grow their understanding and recognition of gender diversity in their communities. This could be accomplished through promotional activities, positive space training, establishing youth groups in the community, or champion or peer sharing models that engage community leaders and peers as positive role models.

Several respondents and key informants also identified the need to include newcomer youth in the development of culturally appropriate and inclusive care and support. This would be available in both community-specific and mainstream service agencies throughput the province.

## 6. Racialized children and youth

Only 13% of the children and youth who responded to the survey identified as racialized, which is much lower than the proportion of Ontarians who are racialized (approximately 23.8%).

Racialized people are not a singular group: there are differences in needs and degrees of need within these populations, according to nuances of racism, cultures, identities and/or immigration patterns and government policies.

The Provider Capacity Survey indicated that 30% of the health and mental health providers surveyed worked with racialized populations. However, the service providers surveyed did not report seeing large numbers of racialized trans and non-binary children and youth. CHEO and Sick Kids especially observed few racialized children and youth in their practice populations. CTYS, and Supporting Our Youth programs in Toronto, on the other hand, reported that a large proportion of their clientele was racialized.

Supplementary information on the needs of this group was obtained from interviews with service providers and key informants who work with this group: Sherbourne Health's SOY, Salaam Canada and the Griffin Centre.

As with other underserviced groups, several common themes and needs were identified, but some needs were particularly prominent for this group. These included culturally appropriate access to information and gender-affirming support, support around experiences of discrimination and social exclusion, and the need for service providers of colour.

## Access to information and gender-affirming support

Several key informants identified a lack of resources for caregivers and community organizations serving racialized trans and non-binary children and youth. This is why, as one key informant described, racialized children and youth aren't accessing community organizations for information and support, but are turning to the internet and social media.

A key informant noted that many programs are located in downtown Toronto; however, youth often live outside of the downtown core and are unable to regularly travel to the city core. Other key informants described additional challenges to accessing youth programs for racialized children and youth questioning their gender, including fear that disclosure might lead to rejection, discrimination or being outed within their communities.

## Discrimination and social exclusion

Key informants and service providers alike described racialized youth as living in two worlds, neither of which is welcoming of their gender identities and expressions. Respondents identified perceptions that persist about people who are both queer and racialized, such as that "no racialized people are queer." We were also told that "LGBT2SQ community supports and queer spaces are predominantly white."

Respondents identified the need for anti-oppressive policies and training to ensure that mainstream agencies, service providers and LGBT2SQ groups are more inclusive of cultural diversity.

Key informants also identified institutional barriers such as staffing and training that need to be addressed when interacting with racialized and gender minority groups. According to one key informant, staff may not consider initiating a conversation about gender with racialized children, and youth who have questions might not know how to articulate them. Additionally, as one racialized youth explained, youth may "avoid services and supports in which racialized people are not well represented."

## 7. Francophone children and youth

There were no children or youth who responded to the survey in French. We obtained information from key informant interviews in Toronto, Ottawa and Sudbury.

According to key informants, the main barriers to information and support experienced by this group are similar to those already identified (e.g., access to information, trained and gender-affirming health and mental health providers, social participation, parental support, geographic) rather than linguistic. In Ottawa, Francophone trans and non-binary children and youth are able to access bilingual medical services and support groups at CHEO, but the waitlists are quite long and clients may have to travel long distances. For example, one key informant described a patient who came all the way from North Bay who would rather go to CHEO because their services were bilingual. Several providers identified the need for provider and support groups closer to home (e.g., in the Gatineau, Hull and Western Quebec areas). One key informant questioned the need for specific support groups in French throughout Ontario, but thought that some information should be available in French (e.g., consent forms, trans health booklets in primary care settings).

There are two strong Francophone organizations in Ontario whose mandates are relevant but do not include a focus specifically on trans children and youth. FrancoQueer, for instance, focuses on LGBT2SQ people. COPA is a strong anti-violence organization working with schools and communities across Ontario, including northern and a few Indigenous communities.

## 8. Children and youth living in northern/rural areas

The vast majority of children and youth who responded to the survey lived in the Greater Toronto Area, Southwest Ontario or the Ottawa area.

Analyzing survey respondents by postal code revealed that only 11.6% (5/43 respondents) resided in rural or northern communities. However, approximately 31% of health and mental health providers who participated in the Provider Capacity Survey reported that they worked with individuals from rural communities. Service providers or respondents identified many of the needs of children and youth living in rural or northern communities to the Provider Capacity Survey.

The service providers interviewed in Phase 1 confirmed that existing services and supports for trans youth and their parents or caregivers were concentrated in a few centres, and were hard to access for many Ontarians. It is especially difficult for youth who cannot drive, don't have access to a car, or those who are not out to their parents.

As discussed earlier, the most frequently reported gap among service providers was *access* to services in rural and northern communities. Table 7 provides several illustrations of how this gap was experienced in a practice setting. Table 7 also illustrates how other system gaps, such as the lack of awareness of resources for referral and care, lack of supports for parents and youth, and travel cost as well as distance to care, are more pronounced in rural and northern areas.

TABLE 7: Service gaps in rural and northern communities: what we were told

| | |
|---|---|
| Access to health and mental health services in rural and northern communities | • Many of the GPs in Kenora do not feel comfortable prescribing to trans youth and make referrals to specialty clinics, which geographically are difficult to access.<br>• Living in Northwestern Ontario leaves many youth with very limited access to specialized care. To see a family doctor/GP in our small town you may wait a month [for] your own doctor.<br>• Social barriers in remote conservative communities likely prevent youth from openly identifying and/or presenting to the (limited) health system to request support.<br>• Outside of Sudbury and Timmins it is virtually impossible to find practitioners in the northeast who will prescribe hormones, or who can make gender-affirming surgery referrals.<br>• Youth who live in the rural areas surrounding London have a very difficult time accessing our services due to challenges around transportation. This is even a challenge with youth who live locally who can't afford bus tickets, and caregivers are not supportive of their identities and won't bring them there. |
| Lack of awareness of resources/ resources for referral and care | • There is nowhere to refer children and youth living in northern or near-north communities.<br>• It is still relatively under the radar in most practices; knowing the people to contact and the supports available other than in Toronto is key. |
| Lack of support groups for parents and youth in communities | • Our community is small, isolated and limited in its experiences and abilities to help those with needs for providing care to trans children and youth. There are no local support groups either. |
| Travel costs/ distance to care | • Living in a rural northern community often translates to minimal services for youth and families, sometimes requiring travel to larger centres.<br>• Public transportation like Greyhound service is not available in all communities, so those who do not have their own transportation are stuck without any service to assist with medical transition. |

# SUMMARY

This section identified the needs of underserviced trans children and youth, including children and youth who are pre-pubertal, transfeminine or non-binary, newcomer, racialized, Indigenous, Francophone and/or living in rural and northern communities. It is clear that these groups share many similar needs in terms of accessing age-, community- and geographically accessible resources for gender-affirming information, care and support and initiatives to address the social exclusion and discrimination faced in their communities.

However, some of these groups also experience unique needs related to lack of research, linguistic barriers, trauma and lack of access to services and supports close to home. It is also evident based on these findings that community and health system collaboration and support for specific community-developed initiatives is essential to address the needs of underserviced groups.

# findings, recommendations and conclusions

It was evident from the literature review that children in Ontario exist within climates that are hostile and discriminatory towards trans and non-binary people, and that scrutinize gender non-conformity. This has a negative impact on all youth, and a particularly significant impact on trans and non-binary children and youth, as well as others that exist outside of expected gender roles. Exclusion, discrimination, stress, erasure and harassment puts trans children and youth at high risk for health, mental health and social problems, including suicide, health-risk behaviours, homelessness, social isolation and social exclusion.

However, there is ample evidence that the provision of gender-affirming care including parental education and support, access to competent primary and transition-related care, inclusive school and community environments, and access to universal all-gender facilities together create an affirming environment. This can reduce risk and can enable all children and youth—in particular those who are trans, non-binary and gender-diverse—to flourish and thrive.

The analysis of the surveys conducted with children and youth, and parents and caregivers, identified several key needs for this group, including:

- access to information and gender-affirming support;
- access to knowledgeable and gender-affirming health providers;
- access to knowledgeable and gender-affirming mental health providers;
- the reduction of waitlists for health and mental health support;
- supportive and welcoming school environments;
- increasing parental capacity and agency in gender-affirming actions;
- access to culturally specific programs across the province;
- access to social and recreational programs, both specific for trans and non-binary children and youth, and for youth in general.

Service providers from across Ontario identified an exponential increase in the number of children and youth seeking support around gender identity issues over the last five years. Waiting lists for specialty services and mental health support are unacceptably long. The key needs identified by the service providers surveyed were similar to those identified by the children and youth and parents and caregivers, but they also highlighted the need for an integrated system of care. This would mean that the bulk of care can occur in community and primary care settings, with referrals to specialized transition-related services only for children with complex physical or mental health needs.

The data collected in the Provider Capacity Survey made it apparent that health and mental health providers in Ontario are seeing many trans children and youth in their practices (i.e., an average of 11 reported in the *past 12 months)*. However, many providers in Ontario currently do not feel knowledgeable or comfortable in assessing gender dysphoria, assessing transition-related options, prescribing puberty blockers or hormones or providing individual or family guidance.

Furthermore, a substantial proportion of providers "always" refer their trans children and youth patients for primary care, transition-related care and mental health counselling to other providers, which contributes to the long waiting lists noted above. The data further indicated that providers in Ontario have received little training in working with trans children and youth. Additional training is needed, not only to meet the present demand for services and supports, but also to ensure that there are enough qualified providers to ensure their sustainability.

Finally, both the literature reviewed and the data collected identified significant research and service provision gaps in the equitable provision of services to children and youth who are pre-pubertal, transfeminine, non-binary, newcomer, racialized, Indigenous, Francophone and/or residents of rural and northern communities.

Our findings revealed strong recommendations to address the needs of trans children and youth in Ontario. These recommendations address the well-documented needs of trans children and youth in Ontario, including strategies and solutions aimed at improving access, as well as strengthening communities, individuals, families and research/evaluation.

# EXISTING POLICY FRAMEWORK

Ontario has a strong, clear, cross-sectoral legal and policy framework supporting trans and non-binary children and youth.

In 2012, the specific inclusion of "gender identity" and "gender expression" in *The Ontario Human Rights Code* prompted government, businesses and non-profits to take action to protect the rights and ensure the full social participation of trans and non-binary people.

Our recommendations build on this and other policy initiatives that aim to address access and equity in health, education, child protection, criminal justice and recreation sectors in Ontario, including:

- amendments to Ontario's *Education A*ct that specifically include protections for students of all gender identities and expressions, require schools to provide support to students of all gender identities, and that require education in Ontario to be free of discrimination, hate, prejudice or bias on the grounds of gender identity and gender expression via *Bill 157 Keeping Our Kids Safe At School*[136] and *Bill 13 The Accepting Schools Act*;[135]

- the Ministry of Education's *Achieving Excellence: A Renewed Vision for Education in Ontario* report's vision of ensuring equity in educational outcomes;[139]

- Bill 89: *Supporting Children, Youth and Families Act 2017*, which mandates that a child's gender identity and gender expression is respected and considered in the provision of services and decision making;[65]

- the Ministry of Children, Community and Social Services' *Gearing Up: A Strategic Framework to Help Ontario Middle Years Children Thrive*. This framework includes directions to respect and believe children when they express their gender identity, foster their exploration of their gender, and, as a measure of success, looks to reduce the number of children who "are treated badly or differently because of their gender identity";[68] and

- Bill 77, the *Affirming Sexual Orientation and Gender Identity Act, 2015*, which prohibits health care providers from seeking to change the gender identity of a person under 18.[140]

Decisions at the Ontario Human Rights Tribunal have similarly furthered full equity and access for trans and non-binary children and youth, for example with the Toronto District School Board's creation of *Guidelines for the Accommodation of Trans and Gender Non-Conforming Students and Staff* [141] and, more recently, Hockey Canada's *Transgender Inclusive Policies* and trans inclusion training for 30,000 Ontario coaches and trainers.[142]

# RECOMMENDATIONS TO IMPROVE ACCESS AND EQUITY FOR TRANS AND NON-BINARY CHILDREN AND YOUTH IN ONTARIO

Despite the many changes in policy and advancements in rights, trans and non-binary children and youth continue to face significant barriers to full social participation, access and inclusion.

These 26 recommendations are envisioned to strengthen communities, individuals and families. They are grouped into six domains:

1. supporting children, youth, their families and caregivers in all areas of life;
2. creating and supporting social inclusion in schools;
3. improving physical and mental health care;
4. bolstering community and social services settings;
5. fostering cross-sectoral work;
6. encouraging research and evaluation on the needs of trans and non-binary children and youth.

Our recommendations have similarities to those that emerged from the *Canadian Trans Youth Health Survey*, which were: a) to provide support for families of trans youth, in order to help them develop the knowledge and skills necessary to support their children; b) to cultivate safer school environments for trans youth; c) to ensure knowledgeable, timely and accessible health care services for trans youth, especially in primary care settings; and d) to involve trans youth and their families in creating change.

While our recommendations focus on the needs of trans children and youth, they will also strengthen the inclusion, safety and well-being of a broader population of children and youth across the province.

## Support children, youth, and their families and caregivers in all areas of life

1. Develop and expand caregiver support activities and peer support networks. Within this, ensure that Indigenous people, racialized and ethnocultural communities, newcomers, faith-based communities and Francophones have access to supports specific to their communities.
2. Ensure non-gender-specific facilities are universally available in spaces that have historically been sex-segregated, including but not limited to: washrooms, change rooms, shelter spaces, summer camps, university dorms and other overnight accommodations.
3. Create, maintain and promote accessible and local sources of information in various formats and multiple languages for children and youth, parents and caregivers, and others.
4. Provide system navigation supports to help children, youth, families and service providers across the province get the support, services and training they need.

## Create and support social inclusion in schools

5. Train and provide professional development for school staff.

6. Encourage school boards to adopt and implement gender-affirming policy and protocols that support students' gender identities and expressions and respect their other intersecting identities—including making facilities accessible to non-binary students.

7. Ensure dedicated staff resources to work with school boards, children and youth, families, educators, and administrators to address the needs of trans and non-binary students and their families.

## Improve physical and mental health care

8. Develop clinical practice guidelines to support primary care and mental health providers in providing competent, evidence-based care for trans and non-binary children and youth.

9. Develop capacity-building opportunities for primary care providers in gender-affirming approaches, as well as hormonal care. Similarly, build capacity in relevant elements of physical, social and emotional childhood development.

10. Ensure equitable and timely access to treatment and support in primary care contexts throughout the province, while also reducing financial, geographic and cultural barriers.

11. Boost the capacity of specialist services and hospital-based clinics to provide transition-related care—including for complex cases—and to provide consultation as needed to primary care providers.

12. Increase the number and proportion of mental health clinicians, such as social workers, counsellors, psychologists and psychiatrists, who are trained in and can provide gender-affirming care for children and their families and caregivers.

13. Ensure equitable access to general and targeted mental health care, including at children's mental health centres, by reducing barriers that are financial, geographic, cultural and otherwise.

14. Increase the availability of crisis supports for children, youth and their caregivers.

15. Monitor service use to ensure that staffing and service delivery models keep pace with need.

## Bolster community and social service settings

16. In municipalities, adopt and implement gender-affirming policy and protocols that support gender identity and gender expression along with other intersecting identities.

17. Ensure the availability of inclusive and targeted sport and other recreational and social activities for trans and non-binary children and youth and their family members, such as siblings, caregivers and parents.

18. Promote inclusion of, and targeted supports where necessary for, trans and non-binary children and youth in child welfare and shelters.

19. Create and provide educational opportunities for child protection services and family court officials and workers to ensure that trans and non-binary children are afforded respect and self-determination in all settings.

20. Explore needs in sectors such as substance use and addiction and criminal justice, where vulnerable youth are known to be over-represented.

## Foster cross-sectoral work

21. Develop mechanisms to improve inter-professional and community collaboration and referral, such as planning tables and communities of practice.

22. Develop culturally and linguistically appropriate information and supports.

23. Support the recruitment, training and employment of individuals from underserviced communities to improve representation and culturally competent service provision, for instance with more Indigenous and racialized service providers.

## Encourage research and evaluation on the needs of trans and non-binary children and youth

24. Implement gender-affirming data collection mechanisms in public and community data systems. Additionally, ensure trans and non-binary people have roles in data collection beyond being respondents.

25. Support research initiatives to address the knowledge gaps identified in this report—especially among underserved communities and for children ages zero to six.

26. Perform ongoing evaluations of implementation initiatives to ensure equitable access and outcomes.

# Conclusion

**Trans and non-binary children and youth in Ontario and their families are in urgent need of access to services and supports across many sectors.**

The framework for this exists: recent legislation and changes to government policies and commitments at many levels, combined with the tireless efforts of many community organizations and advocates, have created an environment full of opportunities for advancing the well-being of Ontario's trans children and youth.

This needs assessment looks at the gap between policy and practice—specifically, between the promise of legislation and the experiences of trans children and youth—and makes recommendations to enable sectors and agencies across the province to implement change in alignment with policies and regulations.

Our findings show that these solutions need to include parental education and support; timely access to competent primary and transition-related care; timely access to affirmative mental health services; inclusive school and community environments; and access to all-gender facilities, among others.

While there remains much work to be done, the evidence is clear that the provision of gender-affirming care combined with the creation of affirming environments can reduce risk and enable all children and youth—especially those who are trans, non-binary and gender-diverse—to flourish and thrive.

Moving forward, cross-sectoral collaboration will be key to developing and sustaining the solutions and strategies outlined in this report to support Ontario's trans children and youth.

# Glossary of terms

This glossary includes terms used throughout this document. For an extensive glossary of terms used in LGBTQ2S communities please see the 519's website at the519.org/education-training/glossary.

| | |
|---|---|
| Cis/Cisgender | A person whose gender identity corresponds with or "matches" the sex they were assigned at birth. Cis can also be used as a prefix to an assortment of words to refer to the alignment of gender identity and the sex assigned at birth including: cisnormativity, cissexual, cisgender, cis male, and cis female. |
| Gender-affirming care | A model of care that recognizes the individual as the authority on their own identity, including gender identity and gender expression. Those providing care acknowledge the individual as being the only person who knows what name they should be called by, what pronouns are appropriate and how a person should be expressing their gender. People around the individual then act in accordance to the wishes of the individual. |
| Gender-diverse | An umbrella term to describe people whose gender is not the same as that which they were assigned at birth. Gender-diverse is used to refer to people of all ages. |
| Gender dysphoria | A term used by the American Psychiatric Association (APA) to diagnose people of all ages who experience significant distress with the sex assigned to them at birth or with being treated as the sex assigned to them at birth. This replaces "Gender Identity Disorder" and is intended to be less pathologizing. Many trans people resist this diagnosis on the grounds that transphobia and not our gender identity is making us ill. |
| Gender fluid | Gender fluidity conveys a wide flexible range of gender expression, outside of the sex/gender binary, with interests and behaviours that may change, even from day to day. |

| | |
|---|---|
| Gender independent/ Gender creative | Positive words to describe children and youth whose gender identity or expression differ from what others may expect. These terms are an attempt to move away from pathologizing or judgemental language. |
| Genderqueer | A gender identity that queers the cisnormative gender categories. Genderqueer people may be outside of or beyond male and female, a mix of both, or may reject the binary all together. |
| Hormone blockers | A group of medications (primarily Lupron) that are used to inhibit puberty. |
| Lupron | The brand name of the most commonly used hormone blocker that is used to delay puberty in children. |
| Medical transition | Medical transition involves the use of hormones and/or surgeries to change a person's expression of sex/gender to align with their self-identified sex/gender. |
| Non-binary | A gender identity that is outside binary categories of "man" and "woman." |
| Puberty suppression | Physicians/nurse practitioners can prescribe hormone blockers to prevent/delay pubertal changes in gender-independent children, for whom bodily changes can be very distressing. |
| Social transition | A change in social gender role, often including a new name, appearance and pronoun. For many pre-pubertal gender-independent children, a social transition, including changing their name, clothing, hairstyle and pronouns, brings greater happiness and well-being. |
| Trans | Umbrella term sometimes used to include many gender-variant people. Trans identities include people whose gender identity is different from the gender associated with their birth-assigned sex. Trans people may or may not socially, legally or medically transition. |
| Transfeminine | A person on the feminine spectrum who was assigned male at birth. This includes people who identify as transfeminine, male-to-female (MTF), as a trans woman or as a woman of trans experience. |
| Transmasculine | A person on the masculine spectrum who was assigned female at birth. This includes people who identify as transmasculine, female-to-male (FTM), as a trans man or as a man of trans experience. |
| Transmisogyny | A unique form of discrimination experienced by transfeminine people, arising from the intersections of transphobia and misogyny. |
| Two-Spirit | An English term coined to reflect specific cultural words used by First Nations and other Indigenous peoples for individuals who have both a male and female spirit. Many Two-Spirit people are understood by settler society to be gay, lesbian, bisexual, transgendered or transsexual, or have multiple gender identities. [143] |

# Appendices

## ADVISORY COMMITTEE MEMBERS

### Rainbow Health Ontario Provincial Advisory Committee on Gender Independent Children and Gender-Diverse Youth

This is a partial list of advisory committee members. Some have requested to remain anonymous. The appearance of an individual or organization's name here does not imply an endorsement of this report.

Those who wished to have their name included in this report were asked to respond with their name and any other identifying information they wished to have included in this report.

#### Caregivers and youth

| Name | | Location |
|---|---|---|
| Julie Anne | Fox | Toronto |
| Katya | Schmied | Toronto |
| Sara | Gold | Toronto |

#### Service providers

| Name | Title | Program | Organization | Location |
|---|---|---|---|---|
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| Name | Title | Program | Organization | Location |
|---|---|---|---|---|
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| Barb Urman | Coordinator, LGBTTQ Services | York Rainbow Support Services | Family Services York Region | York Region |
| Dr. Carys Massarella | Lead Physician | Transgender Healthcare Program | Quest Community Health Centre | St. Catharines |
| Cathy Maser | Nurse Practitioner, Team Lead | Division of Adolescent Medicine | The Hospital for Sick Children | Toronto |
| Chris Veldhoven | Health Promotion & Systems Specialist Former Queer Parenting Programs Coordinator | Supporting Our Youth Queer & Trans Family Programs | Sherbourne Health The 519 | Toronto |
| Ernie Gibbs | Mental Health Counsellor for LGBTQ Youth | Mental Health Counselling Program for LGBTQ Youth | Centretown Community Health Centre | Ottawa |
| Gaela Mintz | Social Worker, Gender-Based Violence Prevention Office | Gender Independent Group (JK–Grade 5) | Toronto District School Board | Toronto |
| Hannah McGechie | Executive Director | Camp Ten Oaks; Project Acorn | Ten Oaks Project | Ottawa |
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| Name | Title | Program | Organization | Location |
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| Katie Stadelman | Social Worker | Transgender Youth Clinic | The Hospital for Sick Children | Toronto |
| Laurie Rector | Director of Community Programs | | Family Services Ottawa | Ottawa |
| LeeAndra Miller | Program Coordinator | Pride & Prejudice | Central Toronto Youth Services | Toronto |
| Lorraine Gale | Coordinator | Out and Proud Program | Children's Aid Society of Toronto | Toronto |
| Dr. Margaret Lawson | Pediatric Endocrinologist | CHEO Diversity Clinic | Children's Hospital of Eastern Ontario (CHEO) | Ottawa |
| Nicole Tanguay | Two-Spirit, Cree, Sturgeon clan | | | Toronto |
| Notisha Massaquoi | Executive Director | | Women's Health in Women's Hands Community Health Centre | Toronto |

## RHO Staff Support

| | |
|---|---|
| Loralee Gillis, | Committee Chair |
| Dominic Popowich, | Research Assistant |
| Jordan Zaitzow, | Trans Health Advisor |

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