Gender Dysphoria Alliance

The Gender Dysphoria Alliance is an international, non-partisan, not for profit, education and advocacy network for those with Gender Dysphoria.

Brief to the Standing Committee on Social Policy on Bill 17 Gender Affirming Health Care Advisory Committee Act

Summary of points:

1. Access to healthcare should be a priority
2. There are at least two known types of Gender Dysphoria
3. Different types of Gender Dysphoria need different interventions
4. Trans health services should be aligned with WPATH Standards
5. WPATH recommends psychotherapy and assessment
6. Psychotherapy and assessment are interventions not barriers
7. WPATH SOC 8 to be published in December 2021
8. Informed Consent Model is not in line with WPATH
9. Several countries who had been practicing ICM have pulled back
10. Stakeholders include those who regret medical interventions and parents

The Gender Dysphoria Alliance agrees with the government of Ontario that access to care, in general, should be a priority. Systemic barriers such as long waitlists and prohibitive costs are of concern across the healthcare system. We would add that the costs for psychotherapy is also prohibitive.

However, in the matter of caring for people exhibiting Gender Dysphoria, we urge you to take a careful look at what is meant by the “Affirmative Model” and the “Informed Consent Model (ICM)”, as well as alternatives such as “Watchful Waiting”. Care for people with Gender Dysphoria, as for any condition, must be evidence-based, with measured positive and negative outcomes.

Importantly, **Gender Dysphoria is not one thing**. Two primary types have been well studied and outlined in the medical literature and new types (or developmental pathways) have since been hypothesized. Early childhood-onset gender dysphoria with clear, persistent gender non-conformity is not the same as, for example, gender dysphoria that develops later in life in the context of sexual trauma, autism or homophobia. Since “trans” is not one thing with one cause, a one size-fits all approach to treatment is not adequate. It’s important that your committee understands these nuances of the clinical condition itself prior to determining the clinical pathways.

The current **World Professional Association for Transgender Health** (WPATH) Standards of Care (SOC) Version 7 is an Affirmative Model. You will note that those

standards *highly recommend psychotherapy* prior to medical interventions, and they specify that appropriate assessment should be done, especially for youth. These are important and fitting *interventions*, not barriers to care.

Pages 8-10 of the SOC 7 provides an overview of treatment approaches. Some points worth highlighting:

1. **Assessment and Outcomes**

> *"..the clinical approach largely focussed on identifying who was an appropriate candidate for sex reassignment…The approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MTF and 97% FTM patients, and regrets were extremely rare (1-1.5 % of MTF patients and <1% of FTM patients) (WPATH SOC 7, Page 8)*

This 1-1.5 % regret rate is still often quoted. What ICM activists fail to mention though is the first part of that paragraph: **the clinicians carefully screened patients**. We cannot be confident that regret rates have and will remain the same unless the implemented care model and patient population remain exactly the same as the studied care model.

As older transpeople who went through the system back when it was more careful, we wish to assure you that we were not harmed in any way by that assessment process

which guided our care and helped us to think everything through. Clinicians should consider, if anyone reports feeling traumatized by having an honest conversation about their symptoms, those individuals may require mental health services to stabilize their mental health prior to being considered eligible for medical interventions. Transition is a complex medical, social, and psychological process.

It should also be noted that this version of the SOC was written in 2012, before the sudden 4000% spike in adolescents presenting to gender clinics, and before the sex ratio reversal from mostly boys to mostly girls.

2. Psychotherapy and medical options

"Often, with the help pf psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their bodies." (WPATH SOC 7, Page 8)

We highly recommend that psychotherapy be the first line treatment of Gender Dysphoria. It is standard clinical practice to try the least invasive treatment first, before considering more invasive treatment. To what extent are people with Gender Dysphoria even taught that their condition is treatable with psychotherapy? We weren't.

We strongly advise against the design of a service model that is not in alignment with the WPATH standards. Especially since we don't yet know much about this new cohort of patients. Now is not the time to relax assessment and screening practices.

You are likely aware that the next version of the WPATH SOC is being written and is expected to be published in December 2021. Our contacts at WPATH have informed us that they are doing a careful systematic review of the evidence and this upcoming version of the SOC will be much more directive about how assessments should be done. We advise that your committee not make any firm decisions about service design until the SOC 8 is published and then follow their recommendations accordingly.

We are strongly advocating for more oversight and accountability in trans health, including ways to report clinicians who are not following the WPATH SOC. Clinical practice must have evidence-based standards and safety controls to ensure the best possible outcomes for patients. Surgeons have already pushed the limits of surgeries as far as possible, with poor to devastating outcomes. Phalloplasty and metoidioplasty, for example, have very high complication rates. The Province of British Columbia had been sending patients to Dr Crane in Texas, who had to move his practice out of California due to multiple malpractice suits. One of our members had several complications after surgery there, as did every other trans man we know of who went to Dr Crane's clinic for metoidioplasty or phalloplasty. Yet, Dr Crane is considered one of the best in the world.

This proposed legislation is seeking to implement the Informed-Consent approach just as clinicians, parents, politicians, and patients all around the world are raising an alarm about this same model. Several progressive countries like Finland, after conducting independent reviews of the evidence, are now favouring a more cautious, psychology-informed approach to care. Just this month, several WPATH board members have gone public with their concerns about “sloppy” trans care practices.

The integrity of our public health care system must be protected from political interference and remain firmly grounded in evidence and expert consensus. Why is Canada pushing forward this agenda just as the rest of the world is pulling back to a more careful approach? We will be holding our governments accountable for any harm done as a result of its decision to ignore evidence and the sounding of alarms by clinical experts and policy makers world-wide.

If your committee recommends this Bill to become law, we ask that it be amended such that the proposed committee be more balanced than what is presently in this proposed legislation, by including detransitioners, parents whose children have experienced sudden trans identification with no prior indication of gender non-conformity, and clinicians who understand the psychological and developmental aspects of the different kind of Gender Dysphoria – which should be a basic competency in trans healthcare.

We also urge you to consider what clinical supports are needed for those who wish to reverse their transition. Those interventions also need to be accessible to anyone who regrets their medical decisions, either partially or fully.

Thank-you for your care of those like us.

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