Supporting Gender Questioning Students in Canadian Schools

Towards an Evidence-Based, Mental Health Focused Policy

Who We Are

This document was created by a coalition of Canadians parents, health care professionals and others. Our goal is to develop policies which prioritize the present and long-term health and well being of all people who experience gender distress based on scientific evidence. We support the rights of lesbian, gay, bisexual and transgender people to live free from discrimination and harassment.

Canadian Gender Report - www.genderreport.ca

Canadian Gender Report raises awareness and seeks open discussion on how gender ideology is impacting children and families in Canada.

FAIR in Medicine - https://www.fairforall.org/fair-in-medicine/

FAIR in Medicine is a nonpartisan professional network dedicated to advancing the highest ethical standards in medical practice, and to promoting a common medical culture based on critical thinking and the pursuit of excellence in all medical endeavors.

Genspect - https://genspect.org

Genspect is an international, non-partisan, interdisciplinary professional and educational organisation devoted to advancing a healthy approach to sex and gender. Our team and members strive to promote high-quality, evidence-based care for gender-nonconforming individuals all around the world.

Gender Dysphoria Alliance - www.genderdysphoriaalliance.com

Gender Dysphoria Alliance is an advocacy group for people who experience gender dysphoria.

LGB Alliance Canada - https://www.lgballiance.ca/

LGB Alliance Canada is the only Canadian organization that advocates for the rights of same-sex attracted people. We are part of a growing international movement, with branches in over a dozen countries. Our organization campaigns for the rights of LGB people in Canada to live and be recognized as full members of society, *on the basis of our same-sex attraction*.

LGBT Courage Coalition - https://lgbtcouragecoalition.substack.com/

Lesbian, gay, bisexual, and transgender adults who are concerned with the current state of gender medicine for children and the silencing of diverse viewpoints.

Beyond Trans https://beyondtrans.org

Beyond Trans is the world's first and only organisation dedicated to supporting individuals who feel distressed or ambivalent about their transition. It offers subsidies for individual therapy and free professional facilitated support groups.

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Chapter 1. Introduction

Good intentions do not necessarily lead to good outcomes. The policies and curriculum around gender identity and sexual orientation in Canadian schools are intended to create a safe and welcoming space for LGBTQ2S+ children and families. However, the underlying assumptions and flaws in these policies and their implementation may prove harmful to the very people they claim to benefit as well as other vulnerable youth.

Over the last ten years, there has been a rapid increase in the number of children and adolescents experiencing distress over a perceived mismatch between their sex and sense of gender. This rise is consistent with the skyrocketing increase in mental health problems of all kinds among teens.

Current policies in Canada treat gender identity as a political and human rights issue based on the assumption that gender identity is innate and that anyone regardless of age knows what it means to be transgender. and eschews well-established research and theory on child and adolescent development. Further, it ignores the underlying mental health issues with which the majority of these youth are struggling. Children and teens with complex mental health problems are led to believe that transition is the key to solving their mental health problems. Parents are often excluded, especially if they question the affirmation model, and their consent is not required when schools change a child's name and pronouns. In schools across Canada, children are able to adopt a new name and pronouns without telling their parents and school board policies explicitly require teachers to keep this information from parents if requested by a student. Social transition can reinforce gender dysphoria and increase the likelihood that a child will seek medical transition, which has substantial risks and lifelong consequences.

Schools further contribute to the problem by teaching about gender identity and sexuality in a way that ignores science and the principles of child development. It is increasingly common for instruction to begin at an age where children are incapable of understanding the complex ideas within gender theory, especially when such theories are presented as fact.

One of the consequences of these policies is an increasing number of detransitioners who find themselves with their bodies permanently altered by puberty blockers, cross-sex hormones and surgeries - and still unresolved mental health problems.

The current policies on gender identity in schools need to be replaced with policies that are informed by well-established, long-standing biopsychosocial models of child and adolescent development which enable gender-questioning youth the opportunity to explore their identities without being told that they were "born in the wrong body.". Changes in the education system need to be complemented by changes in the health care system, both

substituting a holistic approach based on neutral psychotherapy for the current affirmative model, which fast tracks medical intervention with little to no psychological examination of the causes of gender distress.

Chapter 2 explains some of the terminology used in this paper. Many of the terms used in the discussion of gender issues are ambiguous or are used in a sense which embeds ideological assumptions. Clarifying the use of language is a necessary first step to a meaningful discussion.

Chapter 3 examines three faulty assumptions on which current policies on gender identity are based. The first is that children develop a stable gender identity from an early age, when in fact, gender identity is part of the larger process of identity development which takes place over decades. The second is that the transgender rights movement is simply an extension of the gay rights movement. In fact, gender identity and sexual orientation are different although interconnected. Cross-gender identification is often a stage in the development of awareness of sexual orientation, and many young gays and lesbians are now being harmed by being labelled as transgender and started on medical transition before their sexuality is fully realized and identity is full developed. While sexual orientation is innate, such is often not the case for those who experience gender-related distress or identify as transgender. The third error is the consideration of mental health problems experienced by gender-questioning youth primarily as a result of "minority stress"- a response to societal rejection, and therefore, a human rights issue rather than understanding the complex interactions between gender-related distress and other kinds of mental distress and neurodevelopmental conditions.

Chapter 4 reviews the current state of the debate on medical transition of children and adolescents. Medical transition has substantial health risks, and the evidence of benefit has not been substantiated. National health care systems in Finland, Sweden and England have conducted systematic reviews of gender-affirming hormone treatments in young people and all have rejected it in favour of neutral psychotherapy as the first line of treatment. Several other European countries have used these evidence reviews to inform their care of gender distressed youth, choosing to considerably limit medical pathways.

Chapter 5 explores the mental health crisis in youth. The last ten years have seen a rapid increase in gender-related distress and other mental health problems in adolescents, with the largest increases in girls. The chapter discusses the connection between gender distress and other mental health issues and the related issues of detransition and suicidality.

Chapter 6 discusses one of the most concerning aspects of current policies, which is the extent to which they permit or even require social transition of gender-questioning children without the knowledge of their parents. Social transition is a powerful psychosocial intervention which should only be undertaken with the involvement of a well-informed mental health professional and the support of the entire family.

This issue is sometimes inaccurately presented as a conflict between parental rights and children's rights. In fact, the overriding concern is always the best interests of the child. The point is that in almost all cases the best interests of the child are best protected by the parents.

Chapter 7 looks at the role of school curriculum in promoting transgender identification. Rather than counteracting the questionable information students are exposed to on social media, schools reinforce it with teaching materials that are scientifically inaccurate, biased, not age appropriate and sometimes even pornographic.

Chapter 8 has a human rights focus. Current policies make the unwarranted assumption that human rights legislation requires that students be given sports, washrooms, changing rooms and overnight accommodation on the basis of self-determined gender identity. The chapter explains why sex-separate spaces and sports are necessary to ensure safety and fairness.

Chapter 9, the final chapter, is a proposal for a new policy which incorporates these principles and will make schools a safe and welcoming place for everyone.

Chapter 2. Terminology and Definitions

The debate over gender identity is, to a large extent, a debate over language. Many key terms are technical or ambiguous. Clarifying the meanings and use of terminology is a necessary first step in a discussion.

Differences of Sexual Development (DSD) – An umbrella term for more than 40 conditions where sexual development deviates in some way from the typical male and female pathways. These conditions are extremely rare and seen in only 0.018% of births .[1] These conditions are also referred to as Disorders/Differences of Sexual Development or Congenital Conditions of Sexual Development. Persons with DSDs can still be classified as either male or female, not as third or other sex. The outdated term is "intersex" (see below).

Desistance – The process of stopping or reversing a social transition. It may also refer to resolution of gender dysphoria.

Detransition – Stopping or reversing (to the extent possible) the process of medical transition to resume a gender identity consistent with one's natal sex.

Gender – Sometimes used as a synonym for sex but now more commonly used to describe culturally influenced, societal expectations of behaviour, aptitudes and appearance based upon culturally influenced notions of masculinity and femininity.

Gender-Affirming Care – Psychological, social and medical interventions intended to unquestioningly support people who identify as transgender by aligning their bodies and social roles with their declared gender identity.

Gender dysphoria - The distress caused by the incongruence between one's experienced or expressed gender and one's primary or secondary sex characteristics. In its capitalized form ("Gender Dysphoria"), is a diagnostic category in the DSM-V, defined by age-group-specific sets of criteria referring to the clinical and significant psychological distress resulting from gender incongruence.

Gender Identity- An internal sense of one's own gender, which may or may not be at odds with one's biological sex. Not everyone accepts the concept of gender identity or believes that everyone has one. While it is often stated that gender identity is separate from sexuality, research on gender dysphoric youth indicates a close relationship. Previous research

[1] Leonard Sax, "How Common Is Intersex? A Response to Anne Fausto-Sterling," The Journal of Sex Research 39, no. 3 (August 1, 2002): 174–78, [Link].

indicates that those who experience gender dysphoria (and gender nonconformity) as children often grow up to be gay, lesbian or bisexual.

Gender Expression – The way a person represents or expresses gender to others, often through behaviour, clothing, hairstyles, activities, voice, or mannerisms. Gender expression may vary by culture.

Gender Questioning - Describes someone who is asking questions about or otherwise exploring a gender identity. This document will use this term in lieu of "trans" or "transgender" for young people whose identity is still in a formative stage.

Intersex - An outdated term used for conditions that are now described as Disorders/Differences of Sexual Development (see above).

LGB – An initialism used for lesbians, gays and bisexuals.

LGBTQI2S+ One of many initialisms currently used to describe people with diverse sexualities and gender identities. This document will avoid these initialisms because they are constantly shifting in content and meaning and do not describe a coherent community with similar needs and interests.

Medical Transition – Medical interventions intended to enable a person to take on the presentation of a different gender. These may include puberty blockers, cross-sex hormones and various surgeries.

Non-Binary -A gender identity where an individual's sense of self is neither male nor female. It is important to note that many, mostly biological females, are now identifying as non-binary. Non-binary individuals have access to the same gender-affirming medical treatments, including surgery.

Sex – The sex of an individual is determined by one of two developmental pathways (wolffian - male or mullerian - female). Sex is defined as the reproductive role an organism has developed to perform. The female sex develops to support the production of large gametes called eggs or ova, and the male sex develops to support the production of small gametes called sperm.[2] Sex in humans is determined at conception and does not change. The terms biological sex or natal sex are sometimes used for clarity.

Social Transition – The process in which a person takes on a new name, changes their appearance (hairstyle, clothing, makeup, and other non-medical changes) and uses preferred pronouns (such as opposite sex pronouns, non-binary pronouns such as "they" or neo-pronouns).

[2] Aditi Bhargava et al., "Considering Sex as a Biological Variable in Basic and Clinical Studies: An Endocrine Society Scientific Statement," Endocrine Reviews, no. bnaa034 (March 11, 2021), [Link].

Puberty Blockers- Drugs which inhibit the physical changes of puberty by acting on the pituitary gland to prevent the release of sex hormones. The scientific name is Gonadotropin Releasing Hormone (GnRH) agonists.

Queer – A term used to describe counter-normative sexualities and gender identities. In the past, the term was used as a slur against gay people, and many still find it offensive.

Transgender – An umbrella term which describes people who have a gender identity that does not match their biological sex. This document will avoid the use of transgender as applied to children and adolescents, as their identity is still in a formative stage, and instead use the term gender questioning.

Transsexual – People who have modified their bodies through hormones or surgery in order to present as a member of the opposite sex. It is incorrect to describe them as having undergone a sex change since it is impossible to change sex.

Two-Spirit – An umbrella term used to refer to gender non-conformity among indigenous communities. Different indigenous communities have different understandings of gender roles and therefore the usage of this term can vary in meaning. Some communities recognize two-spirit people as a special group with a particular cultural role. In other cases, the term may be used to describe a lesbian, gay, bisexual or transgender person who happens to be indigenous.[3]

[3] Michelle Filice, "Two-Spirit," in The Canadian Encyclopedia, 2015, [Link].

Chapter 3. Re-Thinking Some Assumptions

The current policies on gender identity are based on a series of faulty assumptions about the nature of gender identity and its relationship to identity development, sexual orientation and mental health. These assumptions need to be examined and corrected in order to develop a genuinely evidence-based policy.

The Nature of Gender Identity

A fundamental assumption behind the current policies, which also underlies the gender-affirming model, is that everyone has a gender identity which they realize at an early age. It is therefore assumed that the only appropriate response is to affirm their identity as a replacement for their sex and biological reality. This view disregards well-known principles of child and adolescent development. It also ignores the growing research on detransitioners.

There is no reliable evidence that transgender identity has a biological basis. Contrary to popular belief, brain imaging studies have not been able to reliably identify any brain structures associated with transgender identity after controlling for hormone exposure and sexual orientation.[4] The theory of biological determination also does not explain why childhood gender dysphoria frequently resolves either on its own or after psychotherapy.[5]

Gender identity in children and adolescents should be viewed as part of the overall process of identity development. Adolescence is a critical period of development, but may be particularly significant for gay, lesbian and bisexual youth becoming aware of their sexuality. Many of these youth experience gender dysphoria at some time in childhood or adolescence. Research has consistently shown that the vast majority of those experiencing gender dysphoria in youth grow out of their dysphoria by early adulthood, align with their sexed bodies, many growing up to be gay, lesbian or bisexual.[6] Unfortunately, gender-

[4] Alberto Frigerio, Lucia Ballerini, and Maria Valdés Hernández, "Structural, Functional, and Metabolic Brain Differences as a Function of Gender Identity or Sexual Orientation: A Systematic Review of the Human Neuroimaging Literature," Archives of Sexual Behavior 50, no. 8 (November 1, 2021): 3329–52, [Link].

[5] J. Cohn, "Some Limitations of 'Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View,'" Journal of Sex & Marital Therapy, December 24, 2022, 1–17, [Link].

[6] Devita Singh, Susan J. Bradley, and Kenneth J. Zucker, "A Follow-Up Study of Boys With Gender Identity Disorder," Frontiers in Psychiatry 12 (2021), [Link].

affirming care, including social transition, can prevent the resolution of gender dysphoria [7] and disrupt the natural identity development process.[8]

Even labelling a child transgender can become a self-fulfilling prophecy.[9] This document will avoid the use of the term "transgender" or "trans" in connection with children and adolescents and instead use the word "gender-questioning" to emphasize that their identities are still in a formative stage and that schools should not use labels that prematurely judge the outcome of a child's development.

Transgender Rights and Gay Rights

The next assumption is that transgender rights are simply an extension of gay rights. This assumption arose because the political movements both supporting and opposing gay rights and transgender rights have been largely the same. However, it ignores important differences between the nature of sexual orientation and gender identity and the types of rights being claimed.

Sexual orientation is innate, has a biological basis, and cannot be changed. People usually realize their sexual orientation sometime during adolescence but may not disclose it until adulthood. A student's sexual orientation concerns private, intimate conduct. It does not affect other students or require any special response from the school. All students should receive age-appropriate sexual education including discussions of consent, contraception, sexually transmitted diseases, and safe-sex practices. All students should be protected from harassment and bullying.

Gender identity, on the other hand, is frequently changeable. There is no biological marker or test to determine when a transgender identity will be stable. There are grounds to believe that some transgender identification, particularly when it first emerges during adolescence, may be transient and the result of social influence.[10] The declaration of a transgender identity demands significant accommodations from other people. It can also lead to invasive and risky medical interventions.

There is one way in which sexual orientation and gender identity are connected. Research has found that there is a strong correlation between adult homosexuality and a

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[7] Kenneth J. Zucker, "The Myth of Persistence: Response to 'A Critical Commentary on Follow-up Studies and "Desistance" Theories about Transgender and Gender Non-Conforming Children' by Temple Newhook et al. (2018)," International Journal of Transgenderism 19, no. 2 (April 3, 2018): 231–45, [Link].

[8] Stephen B. Levine and E. Abbruzzese, "Current Concerns About Gender-Affirming Therapy in Adolescents," Current Sexual Health Reports, April 14, 2023, [Link].

[9] *Social Transition - Dr. David Bell in Conversation with Alison Jenner, 2023, [Link].*

[10] Cohn, "Some Limitations of 'Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View.'"

history of gender variance in childhood.[11] Gay, lesbian, and bisexual adults often experience a period of cross-gender identification or gender dysphoria while growing up. They may have a strong preference for the clothes and activities of the opposite sex (gender nonconformity) and even believe they are the opposite sex. These feelings tend to resolve by the end of puberty as they begin to realize their same-sex attraction.[12]

One of the dangers of the current approach to gender identity is that children who are affirmed in a transgender identity and started on social and medical transition at a young age will not have the developmental experiences that allow them to realize their same-sex attraction. Indeed, in one study of 100 detransitioners, "coming to understand my sexuality" was reported by 23% of the participants.[13]

Human Rights and Mental Health

Current school policies also make the error of regarding gender identity as primarily a human rights issue rather than also a mental health issue. To the extent that the mental health problems experienced by transgender people are acknowledged, they are assumed to be the result of minority stress which is best addressed through human rights initiatives. Any suggestion that mental health issues may be a contributing factor to gender questioning and gender dysphoria is rejected as stigmatizing to transgender people. This may seem appropriate in light of the now rejected view of homosexuality as a mental disorder, but it disregards the fact that the majority of those with gender distress also present with other mental health conditions. This is particularly so with the adolescents claiming a trans identity in the last 10 years.[14]

There should be no conflict. Removing the stigma around mental illness does not mean denying that it exists. It is possible to recognize that transgender-identified people have the right to be treated with dignity and respect and, at the same time, recognize that gender identity may fluctuate and be affected by various mental health conditions.[15]

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[11] Thomas D. Steensma et al., "Gender Variance in Childhood and Sexual Orientation in Adulthood: A Prospective Study," The Journal of Sexual Medicine 10, no. 11 (November 1, 2013): 2723–33, [Link].

[12] Singh, Bradley, and Zucker, "A Follow-Up Study of Boys With Gender Identity Disorder."

[13] Lisa Littman, "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners," Archives of Sexual Behavior, October 19, 2021, [Link].

[14] Riittakerttu Kaltiala-Heino et al., "Gender Dysphoria in Adolescence: Current Perspectives," Adolescent Health, Medicine and Therapeutics 9 (March 2, 2018): 31–41, [Link].

[15] Hilary Cass, "Independent Review of Gender Identity Services for Children and Young People: Interim Report" (The Cass Review, February 2022), [Link].

Detransitioners, for example, have reported that their trans-identification was a result of borderline personality disorder. Others have attributed their once trans-identity to being autistic.[16]

Looking at gender identity solely through the lens of social justice and human rights is ultimately harmful to people who identify as transgender. It can result in their real mental health problems being overlooked in favour of promoting transition as a cure-all (in effect, diagnostic overshadowing). This is one of the most common complaints of detransitioners and desisters.[17] The focus must shift from promoting group-rights based on identity to one that is centred around the long-term health and well-being of individuals as a whole person.

[16] Littman, "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned."

[17] Ibid.; Elie Vandenbussche, "Detransition-Related Needs and Support: A Cross-Sectional Online Survey," Journal of Homosexuality 69, no. 9 (April 30, 2021): 1–19, [Link].

Chapter 4. The Affirming Care Model

The final faulty assumption, which requires a chapter of its own, is that gender-affirming care has been proven to be safe and effective in children and adolescents. In fact, gender-affirming care has substantial risks, and the evidence that it is beneficial is of such low quality that any claim of benefit lacks certainty.

Low Quality Supporting Evidence

While many major medical groups including the American Academy of Pediatrics (AAP) and the Endocrine Society have endorsed gender-affirming care, these recommendations are less impressive than they seem. They reflect the views of a relatively small group of doctors with very little scientific support. The policy statement of the American Academy of Pediatrics, frequently cited in support of the gender-affirming model, for example, was not written by a team of experienced pediatricians who have consulted the literature, but by a medical trainee.[18] Psychologist Dr. James Cantor examined the supporting evidence for this policy and came to the following conclusion:

> The problems in Rafferty (2018), however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide extraordinary evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are despite the existing evidence.[19]

The authors of the AAP policy have not responded to Dr. Cantor's criticism. After turning down requests for evidence reviews by AAP members for 3 years, the AAP has finally announced that it will be commissioning an evidence review as part of the next revision of the policy.[20]

The current policy statements endorsing gender-affirming care are consensus-based rather than evidence based. They reflect the opinion of a committee of practitioners, based on their clinical experience. This process has a significant risk of bias as professionals will tend to favour studies that support their preferred model of care and ignore or downplay

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[18] Jason Rafferty et al., "Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents," Pediatrics 142, no. 4 (October 1, 2018): e20182162, [Link].

[19] James Cantor, "Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy," Journal of Sex & Marital Therapy, December 14, 2019, 1–7, [Link].

[20] Azeen Ghorayshi, "Medical Group Backs Youth Gender Treatments, but Calls for Research Review," The New York Times, August 3, 2023, [Link].

unfavourable studies. Their own practice is also at risk of confirmation bias. Evidence-based medicine is a set of practices that were developed to eliminate bias and develop more reliable standards of care.

An evidence-based standard of care begins with an independent, systematic review of scientific evidence. The methods of a systematic review are made public including the specific research question, inclusion and exclusion criteria, and the outcome variables of interest prior to review for transparency and replicability.[21] Thus, systematic reviews evaluate the scientific evidence in support of a treatment through a process that is designed to minimize bias and conflict of interest. A systematic review is conducted by researchers with expertise in research methodology who have no financial or intellectual conflict of interest in the treatments under review.[22] Systematic reviews rate the quality of supporting evidence ranging from high to very low according to specific standards that are agreed upon in advance. The strength of the recommendations in the standard of care should reflect the strength of the supporting evidence.

Neither the Endocrine Society guidelines nor the WPATH standards of care meet the standards for an evidence-based guideline. They have not conducted comprehensive systematic reviews, yet have made strong recommendations based on weak evidence.[23] The WPATH SOC7 guideline was rated as low quality in an appraisal by the Canadian Agency for Drugs and Technology in Health[24] and a review published in the *British Medical Journal.*[25]

There was little improvement in SOC8.[26] WPATH did commission a systematic review which found that the strength of the evidence that hormonal therapy led to improvements in quality of life and decreases in anxiety and depression was low and that it was "impossible to draw conclusions on the effect of hormonal therapy on death by suicide."[27] Nevertheless, SOC8 makes strong recommendations in favour of hormonal therapy and is not transparent

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[21] Matthew J. Page et al., "The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews," BMJ 372 (March 29, 2021): n71, [Link].

[22] Canadian Task Force on Preventive Health, "Policy on Disclosure of Interests and Management of Conflict of Interest," August 2020, [Link].

[23] Jennifer Block, "Gender Dysphoria in Young People Is Rising—and so Is Professional Disagreement," BMJ 380 (February 23, 2023): p382, [Link].

[24] Stella Chen and Hannah Loshak, Primary Care Initiated Gender-Affirming Therapy for Gender Dysphoria: A Review of Evidence Based Guidelines, CADTH Rapid Response Reports (Ottawa: Canadian Agency for Drugs and Technologies in Health, 2020), [Link].

[25] Sara Dahlen et al., "International Clinical Practice Guidelines for Gender Minority/Trans People: Systematic Review and Quality Assessment," BMJ Open 11, no. 4 (April 29, 2021): e048943, [Link].

[26] E. Coleman et al., "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8," International Journal of Transgender Health 23, no. sup1 (August 19, 2022): S1–259, [Link].

[27] Kellan E. Baker et al., "Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review," Journal of the Endocrine Society 5, no. 4 (April 1, 2021): bvab011, [Link].

as to the extent to which these recommendations are based on evidence, as opposed to consensus.[28]

Changing International Practice

The United Kingdom, Finland and Sweden, all countries with national health systems, have each conducted a systematic review of the affirming care model and in each case have found that the evidence for gender-affirming care is weak and that the potential risks of such treatments outweigh potential benefits.[29] These countries have moved to a model of psychotherapy as the first line of care, acknowledging the lack of understanding of the new cohort of adolescents presenting with gender dysphoria. Professional organizations in France, Norway, New Zealand and Australia have also openly called to limit medical gender transition for minors, advocating for a developmental approach and psychotherapy.

Finland was the first country to change course. It was one of the early adopters of gender-affirming care for youth, but by 2015 clinicians began to notice problems with the model.[30] They saw an overrepresentation of girls with significant mental health or neurodevelopmental conditions. This patient population of adolescents was very different from the patient population used in the foundational studies on gender-affirming care.[31] The Council for Choices in Health conducted a systematic review and issued a recommendation that psychotherapy be the first line of treatment for patients under 18, with puberty blockers and cross-sex hormones to be provided only in exceptional circumstances and as part of a research program.[32]

In Sweden, the government was preparing to pass legislation which would have reduced the minimum age for gender surgery from 18 to 15 and removed the requirement for parental consent. Opposition from concerned parents, professionals and the media caused the government to reverse course and commission three government agencies to review the treatment of gender dysphoria in children and adolescents.[33] As a result of these reviews, the

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[28] Block, "Gender Dysphoria in Young People Is Rising—and so Is Professional Disagreement."

[29] Ibid.

[30] Leor Sapir, "Finland Takes Another Look at Youth Gender Medicine," Tablet Magazine, February 21, 2023, [Link].

[31] Riittakerttu Kaltiala-Heino et al., "Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development," Child and Adolescent Psychiatry and Mental Health 9, no. 1 (April 9, 2015): 9, [Link].

[32] Council for Choices in Health Care in Finland (COHERE), "Medical Treatment Methods for Dysphoria Associated with Variations in Gender Identity in Minors – Recommendation," 2020, [Link].

[33] "The Swedish U-Turn on Gender Transitioning for Children," Canadian Gender Report (blog), November 12, 2020, [Link].

Swedish National Board of Health and Welfare issued recommendations which emphasize the role of psychotherapy and restrict access to hormonal treatment.[34]

In the United Kingdom, therapists working at the Gender Identity Development Service (GIDS) for young people at the Tavistock Clinic, the youth gender clinic serving all of England and Wales, raised concerns about the quality of care being provided. The government appointed a commission headed by pediatrician Hilary Cass to review the service. The interim report found that there were serious gaps in the evidence base for the use of puberty blockers and cross-sex hormones in young people.[35] The National Health Service announced that it would be closing the youth gender service at the Tavistock Clinic and developing a new model of care.[36] The new interim service specification makes psychosocial support the primary intervention with puberty blockers and cross-sex hormones to be used only in the context of a research study.[37] It also reiterates that social transition is not a neutral act, that it may increase the risk of medical gender transition and that it requires the support of a mental health clinician.

Other countries are also questioning the affirmative care model. Norway recently announced that it will be reviewing its guidance on pediatric gender treatment.[38] The French National Academy of Medicine has issued a statement calling for medical transition of children to be used only with the greatest caution.[39] The Royal Australia and New Zealand College of Psychiatrists adopted a position paper which notes that the evidence supporting affirmative care is mixed and recommends a significant role for psychotherapy in treatment of gender dysphoria.[40] The National Association of Practicing Psychiatrists of Australia has also issued a guide to managing Gender Dysphoria / incongruence in young people which recommends that exploratory psychotherapy be the primary treatment and that medical transition be prescribed only with extreme caution.[41] Denmark has joined the other Scandinavian countries in adopting a more cautious approach. The percentage of children

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[34] "Summary of Key Recommendations from the Swedish National Board of Health and Welfare (Socialstyrelsen/NBHW)," February 27, 2022, [Link].

[35] Cass, "Independent Review of Gender Identity Services for Children and Young People: Interim Report."

[36] "Clinical Damage: The Tavistock Clinic's Closure Follows a Damning Report on Ideological Malpractice," The Times, July 29, 2022, [Link].

[37] NHS England, "Interim Service Specification for Specialist Gender Incongruence Services for Children and Young People," June 9, 2023, [Link].

[38] Jennifer Block, "Norway's Guidance on Paediatric Gender Treatment Is Unsafe, Says Review," BMJ 380 (March 23, 2023): p697, [Link].

[39] French National Academy of Medicine, "Medicine and Gender Transidentity in Children and Adolescents," February 25, 2022, [Link].

[40] The Royal Australian and New Zealand College of Psychiatrists, "Recognising and Addressing the Mental Health Needs of People Experiencing Gender Dysphoria / Gender," September 2021, [Link].

[41] Philip Morris, "Managing Gender Dysphoria/Incongruence in Young People," National Association of Practicing Psychiatrists (blog), March 17, 2022, [Link].

and adolescents approved for endocrine intervention at the national gender clinic has dropped from 65% in 2018 to only 6% in 2022.[42]

Weak Methodology in Studies Supporting Affirmative Care

The studies that are relied on to support the affirming-care model have major methodological problems.[43] The foundational studies for gender-affirming care for youth were published in 2011 and 2014, based on the same cohort, by a group of researchers in Amsterdam. These studies outlined a treatment process known as the Dutch Protocol, consisting of puberty suppression at age 12, cross-sex hormones at 16, and surgeries after the age of 18. The results of these foundational studies were inconclusive.[44] However, the protocol was enthusiastically adopted by other countries, including Canada. [45] Further, as these treatments became seen more and more through a human rights lens, clinicians began to ignore the cautious approach and thorough assessment used in the original study.

It is worth noting that the original Dutch Protocol was only applied to children who had experienced gender distress since childhood which worsened at puberty and had no other uncontrolled mental health problems. There was extensive psychological support, any mental health comorbidities were treated and the parents had to be fully supportive. Today, gender clinics routinely give hormones to teens who did not experience gender distress until puberty and make little or no attempt to screen for other mental health conditions. Assessment does not involve consideration of mental health comorbidities but the readiness for medicalization. Parental concerns are routinely dismissed by gender clinicians.[46]

A study of youth treated with puberty suppression at the Tavistock failed to replicate any of the positive findings reported in the foundational Dutch studies, finding no improvement in mental health status.[47] Recent reanalysis of this Tavistock cohort found that contrary to

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[42] SEGM, "Denmark Joins the List of Countries Who Have Sharply Restricted Youth Gender Transitions," August 17, 2023, [Link].

[43] E. Abbruzzese, Stephen B. Levine, and Julia W. Mason, "The Myth of 'Reliable Research' in Pediatric Gender Medicine: A Critical Evaluation of the Dutch Studies—and Research That Has Followed," Journal of Sex & Marital Therapy, January 2, 2023, 1–27, [Link].

[44] Polly Carmichael et al., "Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK," PLOS ONE 16, no. 2 (February 2, 2021): e0243894, [Link].

[45] Michael Biggs, "The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence," Journal of Sex & Marital Therapy 49, no. 4 (May 19, 2023): 348–68, [Link].

[46] G. Knudson, Daniel Metzger, and b findlay, "Gender-Affirming Care in British Columbia, Part 2," BCMJ 64, no. 2 (March 2022): 64, [Link].

[47] Carmichael et al., "Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK."

the conclusion of no mental health improvements, mental health actually deteriorated for 15-34% of patients.[48]

Medical Risks of Transition

While the psychological benefits of gender-affirming care are unclear, the physical risks are significant at every stage of the process.[49] There are very few studies on the physical effects of puberty blockers used to treat gender dysphoria. It is known that they may affect bone mineral density, which can lead to early onset of osteoporosis. [50] The combination of puberty blockers and cross-sex hormones can leave a child permanently sterile. [51]

Puberty is also a critical period of development of the brain, and there is some evidence that disrupting puberty may impair brain development.[52] Some risks of cross-sex hormones include loss of fertility, vaginal atrophy and other menopausal symptoms, loss of sexual response, further interference with bone mineral density, and increased risk of heart attacks, strokes, multiple sclerosis and early onset dementia. In addition, some of the intended effects of hormones, such as a deeper voice from testosterone, will be irreversible if the patient later decides to detransition. Not every trans-identified person has "bottom surgery" to remove their ovaries or testicles, but those who do will be dependent on artificial hormones for the rest of their lives.

The complication rate for phalloplasty (construction of an artificial penis) is extremely high. A multi-centre survey published in 2021 found that out of 129 patients there were 281 complications requiring 142 revisions.[53]

Medical transition of young patients is still very new. Most of the patients treated with a combination of puberty blockers and cross-sex hormones are still under 30 years old. There

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[48] Susan McPherson and David E. P. Freedman, "Psychological Outcomes of 12-15 Year Olds with Gender Dysphoria Receiving Pubertal Suppression: Assessing Reliable Change and Recovery" (medRxiv, June 1, 2023), [Link].

[49] Cohn, "Some Limitations of 'Challenges in the Care of Transgender and Gender-Diverse Youth: An Endocrinologist's View.'"

[50] Michael Biggs, "Revisiting the Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria," Journal of Pediatric Endocrinology and Metabolism, April 26, 2021, [Link].

[51] T. H. R. Stolk et al., "Desire for Children and Fertility Preservation in Transgender and Gender-Diverse People: A Systematic Review," Best Practice & Research Clinical Obstetrics & Gynaecology 87 (March 1, 2023): 102312, [Link].

[52] Diane Chen et al., "Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth," Transgender Health 5, no. 4 (December 1, 2020): 246–57, [Link].

[53] Isabel S. Robinson et al., "Surgical Outcomes Following Gender Affirming Penile Reconstruction: Patient-Reported Outcomes From a Multi-Center, International Survey of 129 Transmasculine Patients," The Journal of Sexual Medicine 18, no. 4 (April 2021): 800–811, [Link].

has not been time to study the long-term physical and mental health effects of these treatments.

Binding and Tucking

One aspect of gender-affirming care, often erroneously regarded as a relatively benign aspect of social transition, is the binding of breasts and tucking of male genitals. Some school GSA clubs support these practices by assisting students in obtaining supplies without their parents' knowledge.

Both these practices carry substantial health risks. A survey of transmen found that 68% were concerned about the health effects from binding. The most common symptoms associated with binding were back pain (65%), shortness of breath (48.6%), bad posture (32%), chest pain (30%), and light-headedness (30%). Another study found that 97% of participants reported at least one of 28 negative outcomes attributed to binding including poor posture, long-term skin damage and sores, reduced skin elasticity, rib damage, spinal misalignment, fluid buildup in lungs and circulation issues.[54]

Problems related to tucking included itching (28%), rash (21%), testicular pain (17%), penile pain (14%), and skin infections (12%).[55] Testicular torsion (twisting of the spermatic cord) is a rare but serious complication of tucking which can require removal of the testicles.[56] This is a particular danger for young teens who are tucking without their parents' knowledge and may therefore be reluctant to disclose their symptoms.

Binding and tucking should both not be encouraged by schools and should be done only under supervision of a medical professional. Schools that engage in promoting binding and tucking, especially to minors, should consider their role in the negative health impacts.

Informed Consent and Capacity

There is a reason why we have laws to prevent young people from drinking alcohol until the age of 18, 19 or 21; driving cars until age 16; getting tattoos until age 18; obtaining piercings until age 16; and consenting to sex with adults until age 16. The human brain

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[54] Sarah Peitzmeier et al., "Health Impact of Chest Binding among Transgender Adults: A Community-Engaged, Cross-Sectional Study," Culture, Health & Sexuality 19, no. 1 (2017): 64–75, [Link].

[55] Tonia Poteat, Mannat Malik, and Erin Cooney, "Understanding the Health Effects of Binding and Tucking for Gender Affirmation," Journal of Clinical and Translational Science 2, no. Suppl 1 (November 21, 2018): 76, [Link].

[56] Clarence Joy M. Debarbo, "Rare Cause of Testicular Torsion in a Transwoman: A Case Report," Urology Case Reports 33 (November 1, 2020): 101422, [Link].

continues to develop well into the 20s and the prefrontal cortex, which regulates risk assessment and long-term decision making, is one of the last parts to develop.[57]

Obtaining genuine informed consent for gender transition should be an extensive process that goes well beyond simply reviewing a form which lists potential side-effects of the treatment.[58] Gender transition is a complex process which raises considerations beyond the experience of a child or even a teenager. A child who has never been on a date, felt the slightest stirring of sexual desire, and may even have a shaky understanding of the difference between males and females is being asked to consent to a course of treatment, beginning with social transition, that may leave him or her sterile and incapable of sexual pleasure.

The sterilizing effects of the combination of puberty blockers and cross-sex hormones are a particular concern. Canada has a shameful history of coerced sterilization of women, especially indigenous women, suffering from mental health problems.[59] Today indigenous youth represent 18.8% of patients at Canadian gender clinics [60] while indigenous people make up only 5% of the Canadian population.[61] The informed consent process for any treatment which is likely to result in sterility needs to be very thorough.

Another concern is that the laws which allow mature minors to consent to medical treatment were developed in the context of physical illnesses where there are objective means to diagnosis and treatments are supported by strong evidence. A diagnosis of gender dysphoria, on the other hand, depends entirely on subjective, self-reported symptoms, and the treatment is supported only by weak evidence.

Moreover, many parents and even family physicians and pediatricians mistakenly believe that a gender clinic will do a differential diagnosis and assessment first, when evidence shows that this is no longer the case. The Dutch Protocol is no longer being followed as these treatments are being seen as a human right. Little consideration is given to known psychological developmental processes such as sex/gender constancy or adolescent identity development, as it is now believed that children know their gender identity regardless of age. Recently, the London Health Sciences Centre Children's Hospital Gender Pathways

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[57] Mariam Arain et al., "Maturation of the Adolescent Brain," Neuropsychiatric Disease and Treatment 9 (2013): 449–61, [Link].

[58] Stephen B. Levine, E. Abbruzzese, and Julia M. Mason, "Reconsidering Informed Consent for Trans-Identified Children, Adolescents, and Young Adults," Journal of Sex & Marital Therapy 48, no. 7 (March 17, 2022): 1–22, [Link].

[59] Jennifer Leason, "Forced and Coerced Sterilization of Indigenous Women," Canadian Family Physician 67, no. 7 (July 2021): 525–27, [Link].

[60] Greta R. Bauer et al., "Transgender Youth Referred to Clinics for Gender-Affirming Medical Care in Canada," Pediatrics 148, no. 5 (November 1, 2021): e2020047266, [Link].

[61] Statistics Canada, "Indigenous Population Continues to Grow and Is Much Younger than the Non-Indigenous Population, Although the Pace of Growth Has Slowed," September 21, 2022, [Link].

Service in Ontario even recommended that family physicians begin hormone suppression while waiting to be seen at their gender clinic.[62]

A TransYouthCan study reported that 62% of children referred to one of the 10 major Canadian gender clinics they studied were prescribed hormonal treatment on the first visit.[63] Of the 10 major pediatric gender clinics, five do not require any psychological or psychiatric evaluation or psychotherapy before beginning hormonal treatment. One only requires it part of the time.[52]

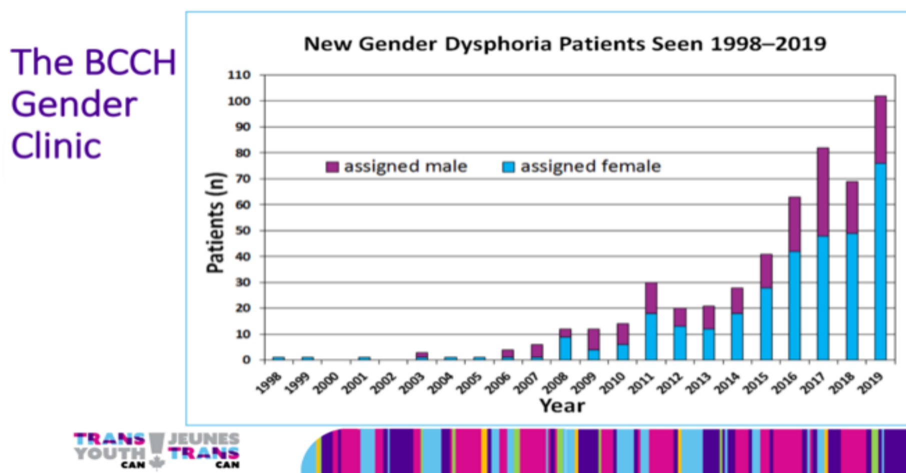
[62] Jonathan Bradley, "Ontario Hospital Allows Children to Take Puberty Blockers before First Assessment," Western Standard, August 3, 2022, [Link].

[63] Bauer et al., "Transgender Youth Referred to Clinics for Gender-Affirming Medical Care in Canada."

Chapter 5. Gender Identity and the Youth Mental Health Crisis

Over the last ten years, there has been a startling increase in young people experiencing gender dysphoria. Around the world, gender clinics for children which once saw only a few dozen patients a year now have caseloads of hundreds or thousands. Furthermore, there has been a change in the patient population. Historically, young boys were in the majority. Now, teenage girls dominate.[64] Recent data also indicate that the mean age of those seeking services for gender dysphoria has decreased between 2017 and 2022, with females seeking support for gender dysphoria at a younger age than males.[65]

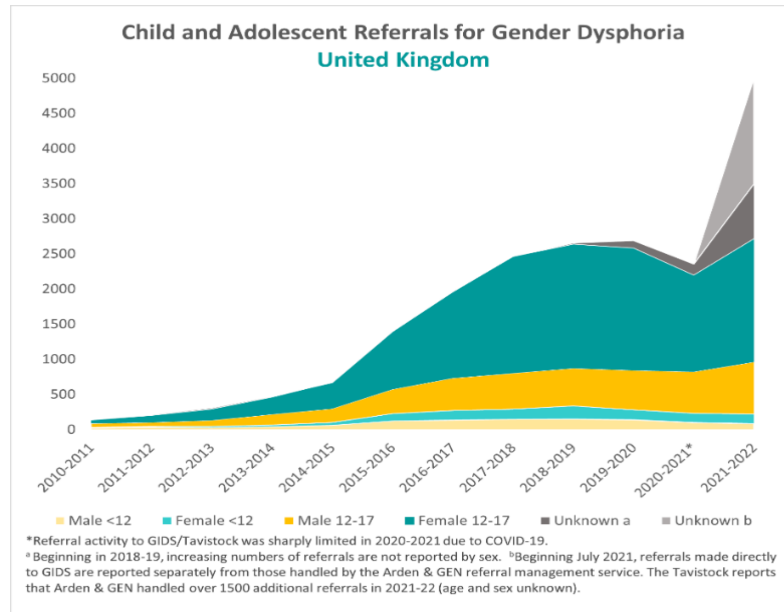
This chart from the BC Children's Hospital is typical of trends across Canada and around the world. In 2009, there were just over 10 new patients seen per year, evenly split between boys and girls. In 2019, the number had grown to over 100 new patients, with girls outnumbering boys by more than 3 to 1.



The most reliable data on gender dysphoria which comes from the United Kingdom is similar. This chart of referrals to the gender clinic for youth and children shows the same rapid growth between 2010 and 2022 with the largest increase among females between the ages of 12 and 17. Referrals for both sexes under the age of 12 grew only slightly.

[64] Kenneth J. Zucker et al., "Demographics, Behavior Problems, and Psychosexual Characteristics of Adolescents with Gender Identity Disorder or Transvestic Fetishism," Journal of Sex & Marital Therapy 38, no. 2 (March 1, 2012): 151–89, [Link].

[65] Ching-Fang Sun et al., "The Mean Age of Gender Dysphoria Diagnosis Is Decreasing," Journal of the American Academy of Child & Adolescent Psychiatry 61, no. 10 (October 1, 2022): S265, [Link].



While the growth in total patient referrals could be explained by greater social awareness and acceptance of gender identity, this does not explain why this growth is concentrated in teenage girls, or why the growth of gender dysphoria parallels the increase for other mental health conditions over the same period of time, also particularly affecting teenage girls.[66]

Social Influence

An alternate explanation clinicians and researchers have hypothesized to account for the exponential number of adolescents, particularly females, declaring a trans identity is social mediation, both through peer influence and through sociocultural means such as social media influencers. Data suggests that another surge of trans-identified youth appeared during the COVID-19 pandemic. Researchers hypothesize that the combination of heightened isolation and heavy internet exposure may be causal or contributing factors.[67]

The first published study to note the potential role of social factors was based on a survey of 256 parents of gender-distressed young people.[68] The findings from this study are consistent with clinical findings. For example, 63% of parents reported that their child had at least one other psychiatric disorder or a neurodevelopmental condition. Parents also reported that their adolescent child had recently been more engaged in social media and had at least one trans-identifying friend, often more. Parents reported that trans-identity tended

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[66] U.S. Surgeon General, "Social Media and Youth Mental Health," 2023; Jon Haidt, "After Babel," June 21, 2023, [Link].

[67] Laura Edwards-Leeper and Erica Anderson, "The Mental Health Establishment Is Failing Trans Kids," Washington Post, November 24, 2021, sec. Outlook, [Link].

[68] Lisa Littman, "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria," PLOS ONE 13, no. 8 (August 16, 2018): e0202330, [Link].

to occur in clusters, with more than one adolescent in a peer group coming out as transgender at approximately the same time. These findings led to the "social contagion" hypothesis known as Rapid Onset Gender Dysphoria (ROGD), which states that trans-identification may be due to maladaptive coping mechanisms to psychosocial stressors mediated by sociocultural factors such as social media and peer influences.

Dr. Lisa Littman, who conducted the original research, coined the term not as diagnosis but as a description, "rapid onset" because these adolescents did not exhibit gender dysphoria as children, and many were not even gender non-conforming. Their gender dysphoria, according to the parent report, developed over a very short period of time, often within just a few months.

The ROGD hypothesis is controversial[69] and has been contested by some clinicians and researchers.[70] Others, however, concur[71] that social contagion and maladaptive coping mechanisms are at play, for at least some portion of this adolescent-onset cohort. There is evidence that stressors such as family dysfunction, trauma and sexual assault may be implicating factors.[72] Although ROGD has met with criticism, no studies have tested and disproved the hypothesis.[73]

Testing the ROGD hypothesis has been difficult because of activist pressure to suppress any research which supports the hypothesis. A journal article based on a survey of 1655 parents found similar results to the original ROGD study.[74] However a pressure campaign by supporters of the affirming care model resulted in the journal retracting the article. (It will be republished in another journal.) The retraction was not based on any scientific errors in the article. The reason the publisher gave is that the survey respondents did not consent to having the data published in a peer reviewed journal. The authors responded that there was a consent to publication by the survey respondents which had similar wording to the consents used in most other published articles which use survey data, including many studies relied on to support the affirming care model.[75]

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[69] Becky McCall, "'Rapid Onset Gender Dysphoria' in Adolescents Stirs Debate," Medscape, September 13, 2018, [Link].

[70] Arjee Javellana Restar, "Methodological Critique of Littman's (2018) Parental-Respondents Accounts of 'Rapid-Onset Gender Dysphoria,'" Archives of Sexual Behavior 49, no. 1 (January 1, 2020): 61–66, [Link].

[71] Kenneth J. Zucker, "Debate: Different Strokes for Different Folks," Child and Adolescent Mental Health 25, no. 1 (February 2020): 36–37, [Link].

[72] Sarah C. J. Jorgensen, "Transition Regret and Detransition: Meanings and Uncertainties," Archives of Sexual Behavior, June 2, 2023, [Link].

[73] Lisa Littman, "Saying That Bauer et al Studied Rapid Onset Gender Dysphoria Is Inaccurate and Misleading," The Journal of Pediatrics 245 (June 1, 2022): 250, [Link].

[74] Suzanna Diaz and J. Michael Bailey, "Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases," Archives of Sexual Behavior (Pending Republication), March 29, 2023, [Link].

[75] Colin Wright, "Anatomy of a Scientific Scandal," City Journal (blog), July 22, 2023, [Link].

Subsequent research on detransitioners[76] validates the ROGD hypothesis with some supporting evidence. Many detransitioners reported that at least part of their reason for adopting a trans-identity and medical transitioning was due to social media and peer influence. The following is a summary of responses received by Lisa Littman to an online survey of 101 detransitioners:

> Sources of transition encouragement and friend group dynamics. Participants identified sources that encouraged them to believe transitioning would help them. Social media and online communities were the most frequently reported, including YouTube transition videos (48.0%), blogs (46.0%), Tumblr (45.0%), and online communities (43.0%). Also common were people who the respondents knew offline such as therapists (37.0%); someone (28.0%) or a group of friends (27.0%) that they knew in-person. A subset of participants experienced the friendship group dynamics identified in previous work, including belonging to a friendship group that mocked people who were not transgender (22.2%), having one or more friend from the pre-existing friend group transition before the participant decided to transition (36.4%), and experiencing an increase in popularity after announcing plans to transition (19.6%).[77]

There is also substantial anecdotal evidence from detransitioners of the link between social media use and transgender identification.[78]

It is important to point out that the use of the term "social contagion" is not meant to be derogatory and is used here in the same manner as in social psychology research. The APA defines social contagion as:

> the spread of behaviors, attitudes, and affect through crowds and other types of social aggregates from one member to another. Early analyses of social contagion suggested that it resulted from the heightened suggestibility of members and likened the process to the spread of contagious diseases. Subsequent studies suggest that social contagion is sustained by relatively mundane interpersonal processes.79

It is also important to point out that research suggests that we are not necessarily aware that we are affected by others in this way. Research suggests that our behavior and even our

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[76] Littman, "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned."

[77] Ibid.

[78] Eliza Mondegreen, "Trans Identity and Doubt: My Talk at Genspect's The Bigger Picture," Substack newsletter, Genderhacked (blog), May 15, 2023, [Link].

[79] American Psychological Association, "Health Advisory on Social Media Use in Adolescence,", May 2023,

emotions are prone to a contagion effect.[80] Social contagion has even been experimentally illustrated in the development of false memories.[81] At a societal level, social contagion is believed to play a role in suicide[82] and non-suicidal self-injury[83] and violence[84] to name a few. Using large complex data sets, researchers have illustrated the role of social contagion in obesity. It is not simply the case that similar individuals gravitate toward one another, but rather that there is a causal mediating mechanism that illustrates that the probability of obesity increases significantly beyond three degrees of separation.[85]

As such, it is important to be cognizant of how the role of social contagion may operate within schools and through larger sociocultural environments. The "spread" of eating disorders in adolescent girls in the past may be seen as similar to the spread of gender dysphoria and trans-identification. The parallel rise of other mental health conditions, such as depression, suicidality and anxiety, within the same timeframe, corresponding with widespread adoption of social media, especially among adolescent females, noticeable after 2012 when smartphones with front-facing "selfie" cameras were first available, [86] is worth considering, as is the sudden number of teens who are experiencing Tourette's-like tics and those claiming multiple personalities.[87]

The American Psychological Association has issued a health advisory on social media use in adolescence.[88] Social media was recently identified as the cause of an outbreak of tics resembling Tourette's' syndrome.[89] A link has also been found between use of Instagram

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[80] Brian Parkinson, "Interpersonal Emotion Transfer: Contagion and Social Appraisal," Social and Personality Psychology Compass 5, no. 7 (2011): 428–39, [Link].

[81] Michelle L. Meade and Henry L. Roediger III, "Explorations in the Social Contagion of Memory," Memory & Cognition 30 (2002): 995–1009, [Link].

[82] Vania Martínez, Álvaro Jiménez-Molina, and Mónica M. Gerber, "Social Contagion, Violence, and Suicide among Adolescents," Current Opinion in Psychiatry 36, no. 3 (May 2023): 237–42, [Link].

[83] Stephanie Jarvi et al., "The Impact of Social Contagion on Non-Suicidal Self-Injury: A Review of the Literature," Archives of Suicide Research 17, no. 1 (January 1, 2013): 1–19, [Link].

[84] Jeffrey Fagan, Deanna L. Wilkinson, and Garth Davies, "Social Contagion of Violence," in The Cambridge Handbook of Violent Behavior and Aggression, ed. Alexander T. Vazsonyi, Daniel J. Flannery, and Irwin D. Waldman, Cambridge Handbooks in Psychology (Cambridge: Cambridge University Press, 2007), 688–724, [Link].

[85] Nicholas A. Christakis and James H. Fowler, "The Spread of Obesity in a Large Social Network over 32 Years," New England Journal of Medicine 357, no. 4 (July 26, 2007): 370–79, [Link].

[86] Zach Rausch and Jon Haidt, "The Teen Mental Illness Epidemic Is International: The Anglosphere," Substack newsletter, After Babel (blog), March 29, 2023, [Link].

[87] John D. Haltigan, Tamara M. Pringsheim, and Gayathiri Rajkumar, "Social Media as an Incubator of Personality and Behavioral Psychopathology: Symptom and Disorder Authenticity or Psychosomatic Social Contagion?," Comprehensive Psychiatry 121 (February 2023): 152362, [Link].

[88] American Psychological Association, "Health Advisory on Social Media Use in Adolescence."

[89] Haltigan, Pringsheim, and Rajkumar, "Social Media as an Incubator of Personality and Behavioral Psychopathology"; Müller-Vahl et al., "Stop That! It's Not Tourette's but a New Type of Mass Sociogenic Illness"; Caroline Olvera et al., "TikTok Tics: A Pandemic Within a Pandemic," Movement Disorders Clinical Practice 8, no. 8 (August 9, 2021): 1200–1205, [Link].

and anxiety and depression in teenage girls.[90] Plastic surgeons have noted that social media sites like Snapchat and Instagram can influence patient desires for plastic surgery. This can be a sign of body dysmorphia, for which counselling, not surgery is the appropriate treatment.[91] There is also substantial anecdotal evidence from detransitioners of the link between social media use and transgender identification.[92]

In light of what we know about the influence of social media on the mental health of adolescents, it is not reasonable to dismiss, without examination, the hypothesis that at least some part of the current cases of gender dysphoria are socially mediated and as such an unchecked affirmation model may be inappropriate and even harmful.

Coexisting Mental Health Conditions

Children and teens who identify as transgender frequently have one or more other mental health issues such as depression, anxiety, borderline personality disorder, or obsessive-compulsive personality disorder or a history of trauma.[93] There has been a strong association between gender dysphoria and neurodevelopmental conditions such as autism spectrum disorders (ASD) and ADHD. Data from GIDS at the UK's Tavistock, for example, found that 35% of their referrals presented with moderate to severe autism traits.[94] School staff may not be aware of these associations, and they are very unlikely to be qualified to work with such complex conditions.

There are many studies which have found that children and teens referred to gender clinics have much higher rates of comorbid mental health issues than the general population. A study of patients at the gender clinic in Sick Children's Hospital in Toronto found that 78.8% reported more than one mental health problem. Depressive disorders were reported by 40% and anxiety disorders by 44.3%.[95]

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[90] Georgia Wells and Deepa Seetharaman, "Facebook Knows Instagram Is Toxic for Teen Girls, Company Documents Show," The Wall Street Journal, September 12, 2021, [Link].

[91] Kamleshun Ramphul and Stephanie G Mejias, "Is 'Snapchat Dysmorphia' a Real Issue?," Cureus 10, no. 3 (2018): e2263, [Link].

[92] Mondegreen, "Trans Identity and Doubt."

[93] Tracy A. Becerra-Culqui et al., "Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers," Pediatrics 141, no. 5 (May 1, 2018): e20173845, [Link].

[94] Gary Butler et al., "Assessment and Support of Children and Adolescents with Gender Dysphoria," Archives of Disease in Childhood 103, no. 7 (July 1, 2018): 631–36, [Link].

[95] Anna Churcher Clarke and Anastassis Spiliadis, "'Taking the Lid off the Box': The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties," Clinical Child Psychology and Psychiatry 24, no. 2 (April 1, 2019): 338–52, [Link].

Although there is evidence of a link between ASD and gender dysphoria, the nature of this link is not well understood.[96] ASD is particularly difficult to diagnose in biological girls, and milder cases may not be noticed.[97] Social challenges and bodily discomfort related to autism, which may be heightened during puberty, may be mistakenly assumed to be signs of a transgender identity, resulting in many girls undergoing irreversible hormonal and surgical treatment before they receive a proper diagnosis of their condition.[98.]

Teachers and school counselors are not qualified as mental health practitioners. Social transition interacts with complex mental health conditions of which they may not even be aware. They should not be making decisions regarding social transition at all and definitely not without the involvement of a child's parents.

Desistance, Detransition and Regret

Under the "watchful waiting" model, before social transition of children became common, twelve studies showed that the majority of children who experienced gender distress desisted sometime during puberty.[99] A study of 139 boys at a Canadian clinic, for example, found a desistance rate of 87.8%.[100] Another article reported that as of 2011, the desistance rate in 246 cases of gender identity disorder was 207 or 84.2 .[101] By contrast, a study of 317 youth who had been socially transitioned found that 97.5% retained a transgender identity after 5 years.[102] Only 2.5% desisted, reidentifying with their birth sex

For many years, advocates of the affirming care model claimed that the rate of detransition and regret among transgender people was very rare. However, the studies which found low regret rates have multiple shortcomings. Some of them used a very restrictive definition of regret, others had very short follow up periods or a high loss to follow up. Most significantly, these studies involved a patient population of adults who transitioned only after extensive psychological assessment and therefore are not likely

[96] Jonathan H. Leef et al., "Traits of Autism Spectrum Disorder in School-Aged Children with Gender Dysphoria: A Comparison to Clinical Controls.," Clinical Practice in Pediatric Psychology 7, no. 4 (December 2019): 383–95, [Link].

[97] Laura Hull, K. V. Petrides, and William Mandy, "The Female Autism Phenotype and Camouflaging: A Narrative Review," Review Journal of Autism and Developmental Disorders 7, no. 4 (December 1, 2020): 306–17, [Link].

[98] Christina Buttons, "How Autistic Traits Can Be Mistaken For Gender Dysphoria," Substack newsletter, Buttonslives (blog), March 24, 2023, [Link].

[99] James Cantor, "Do Trans- Kids Stay Trans- When They Grow Up?," Sexology Today (blog), November 1, 2016, [Link].

[100] Singh, Bradley, and Zucker, "A Follow-Up Study of Boys With Gender Identity Disorder."

[101] Thomas D. Steensma and Peggy T. Cohen-Kettenis, "Gender Transitioning before Puberty?," Archives of Sexual Behavior 40, no. 4 (August 1, 2011): 649–50, [Link].

[102] Kristina R. Olson et al., "Gender Identity 5 Years After Social Transition," Pediatrics 150, no. 2 (August 1, 2022): e2021056082, [Link].

relevant to the current population of child and adolescent transitioners who have received little to no assessment.[103]

Media coverage is finally beginning to acknowledge that detransition is a real and growing concern.[104] Regret and detransition are difficult to measure. Studies conducted by gender clinics typically underreport regret because patients who regret their transition are not likely to return to the clinic [105] There is evidence that regret rates are now much higher than once assumed. One study of youth in the UK indicates that it may be as high as 10.3% within 12 months of seeking treatment.[106] Another study of the United Kingdom NHS records documented the rate of detransition or regret as 12 percent, with 20 percent of patients stopping hormone therapy for various reasons.[107] Another recent study of the U.S. military health care system found that 30 percent of patients discontinued cross-sex hormone therapy after 4 years. [108]

While the rate of regret and detransition is unknown, when it does occur, the pain is real and substantial.[109] Detransitioners will have to deal with permanent changes to their bodies. Their natural endocrine system will likely have been damaged or destroyed so they will need to take artificial hormones for life. If they have had "bottom surgery," they will be infertile and may have diminished or absent sexual response. Women who are still able to bear a child will not be able to breastfeed if they have had a double mastectomy and will need emotional support. [110] These are only the unavoidable consequences of transition. Complications from surgery or health problems caused by cross-sex hormones can be a source of ongoing pain. Currently there are no official supports or medical treatment guidelines to help detransitioners' physical or psychological needs.

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[103] Sarah C. J. Jorgensen, "Transition Regret and Detransition: Meanings and Uncertainties," Archives of Sexual Behavior, June 2, 2023, [Link].

[104] Robin Respaut, Chad Terhune, and Michelle Conlin, "Why Detransitioners Are Crucial to the Science of Gender Care," Reuters, December 22, 2022, [Link].

[105] Littman, "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned."

[106] R. Hall, L. Mitchell, and J. Sachdeva, "Access to Care and Frequency of Detransition among a Cohort Discharged by a UK National Adult Gender Identity Clinic: Retrospective Case-Note Review," BJPsych Open 7, no. 6 (November 2021), [Link].

[107] Isabel Boyd, Thomas Hackett, and Susan Bewley, "Care of Transgender Patients: A General Practice Quality Improvement Approach," Healthcare 10, no. 1 (January 2022): 121, [Link].

[108] Christina M Roberts et al., "Continuation of Gender-Affirming Hormones Among Transgender Adolescents and Adults," The Journal of Clinical Endocrinology & Metabolism 107, no. 9 (September 1, 2022): e3937–43, [Link].

[109] Cohn, "The Detransition Rate Is Unknown."

[110] Karleen D. Gribble, Susan Bewley, and Hannah G. Dahlen, "Breastfeeding Grief after Chest Masculinisation Mastectomy and Detransition: A Case Report with Lessons about Unanticipated Harm," Frontiers in Global Women's Health 4 (2023), [Link].

Detransitioners are starting to sue. An Ontario woman who received testosterone, a double mastectomy, and a hysterectomy while suffering from mental health problems and autism has started a lawsuit which alleges that various health care providers were negligent in recommending irreversible medical procedures without properly assessing her mental health problems and offering her psychotherapy as an alternative treatment [111]. Cases have also been filed in the UK [112] and the US. [113]

The lawsuit in Ontario is still several years away from trial, but more claims are certainly coming, and there is a possibility that teachers and school administrators may be added as defendants. Schools owe a duty of care to protect pupils which is equal to that of a careful and prudent parent in similar circumstances. [114] These duties include an obligation to obtain medical assistance when required and not to undertake serious medical or psychological interventions without professional advice.

Suicidality

Any discussion of suicide is of the utmost importance both to families and to educational institutions. The belief that trans-identified youth are at exceedingly high risk of suicide are often based on online surveys which are unable to report accurate population estimates because they rely on samples of convenience. Further, many of these studies are self-reports of suicidal ideation, self-harm, and suicide attempts [115] and consider suicidal thoughts, self-harm, serious suicide attempts, and completed suicides as equally important measures of suicidality. Although thoughts of suicide should never be disregarded, it is important to keep in mind that thoughts and behaviors are quite different.[116] Further, such surveys are not able to discern whether the suicidality can be attributed to gender dysphoria or other mental health comorbidities common in this population. [117]

A recent study using a large data set of youth seeking treatment at the GIDS at the Tavistock and Portman Foundation found that the rate of completed suicide was 0.03% over a 10-year period. While this is very low, it is 5.5 times greater than the suicide rate of

[111] Adrian Humphries, "Ontario Detransitioner Who Had Breasts and Womb Removed Sues Doctors," National Post, February 23, 2023, [Link].

[112] Sian Griffiths, "'NHS Trans Surgery Damaged My Body for Ever — It's Not Safe,'" June 10, 2023, sec. news, [Link].

[113] Pete Suratos, "Kaiser Permanente Sued Over Hormone Therapy," NBC Bay Area (blog), February 24, 2023, [Link].

[114] Myers v. Peel County Board of Education, 2 SCR 21 (Supreme Court of Canada 1981).

[115] Roberto D'Angelo et al., "One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria," Archives of Sexual Behavior, October 21, 2020, [Link].

[116] E. David Klonsky, Alexis M. May, and Boaz Y. Saffer, "Suicide, Suicide Attempts, and Suicidal Ideation," Annual Review of Clinical Psychology 12 (2016): 307–30, [Link].

[117] Debra Soh, The End of Gender: Debunking the Myths about Sex and Identity in Our Society, First Threshold Editions hardcover edition (New York: Threshold Editions, 2020).

adolescents of similar age. This study also found that the rate of suicide was the similar, if not higher, for those who had and had not started medically transitioning ,[118] suggesting that it may be imprudent to assume that transition will decrease suicidality. Studies have also found an unacceptably high risk of suicide continues post-affirmation and post-medical transition. [119] It is critically important for school staff to know that social transition has not been shown to reduce suicidality.

Although increased risk of suicidality in those identifying as transgender has been documented, little is understood about the cause of suicidality in this population. It is well documented that those identifying as transgender are at risk of other mental health conditions [120]. In fact, adolescents with gender dysphoria are more likely than age-matched peers to experience mental health issues, with 40-45% presenting with clinically significant psychopathology, as compared to roughly 20% of the general population. [121] This increased risk is also true of the new cohort of gender dysphoric adolescents who present with significant mental health and neurodevelopmental conditions.[122] Since these conditions of themselves[123] are associated with suicidality and multiple comorbidities also significantly increases the risk of suicidality, [124] it would be prudent to not attribute the increased risk of suicidality simply to being transgender. In fact, the Center for Disease Control points out that the cause of suicide is multifaceted. [125] Students at risk for self-harm and suicidality should always be carefully assessed and directed to evidence-based suicide prevention protocols.

Lastly, in discussing suicidality, it is exceedingly important to not simplify the narrative to a causal one of being transgender or one based solely on minority stress as these overly simplistic messages may become internalized by these vulnerable youth, thereby increasing their risk.[126]

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[118] Michael Biggs, "Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom," Archives of Sexual Behavior, January 18, 2022, [Link].

[119] Ibid.; Cecilia Dhejne et al., "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," ed. James Scott, PLoS ONE 6, no. 2 (February 22, 2011): e16885, [Link].

[120] Becerra-Culqui et al., "Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers."

[121] Kaltiala-Heino et al., "Gender Dysphoria in Adolescence."

[122] Cass, "Independent Review of Gender Identity Services for Children and Young People: Interim Report."

[123] Maurizio Pompili et al., "Suicide in Anorexia Nervosa: A Meta-Analysis," The International Journal of Eating Disorders 36, no. 1 (July 2004): 99–103, [Link].

[124] C. Holmstrand et al., "Long-term Suicide Risk in No, One or More Mental Disorders: The Lundby Study 1947–1997," Acta Psychiatrica Scandinavica 132, no. 6 (December 2015): 459–69, [Link].

[125] CDC, "Risk and Protective Factors | Suicide | CDC," May 11, 2023, [Link].

[126] Silvia Sara Canetto et al., "Suicidal as Normal - A Lesbian, Gay, and Bisexual Youth Script?," Crisis 42, no. 4 (July 2021): 292–300, [Link].

This is especially the case given that suicide has been shown to be socially contagious. Organizations concerned with suicide prevention have developed guidelines for responsible media reporting on suicide which include avoiding sensational reporting of suicides, providing simplistic explanations for deaths by suicide and portraying suicide as a means to an end.[127]

[127] Mark Sinyor et al., "Media Guidelines for Reporting on Suicide: 2017 Update of the Canadian Psychiatric Association Policy Paper," The Canadian Journal of Psychiatry 63, no. 3 (March 2018): 182–96, [Link].

Chapter 6. Social Transition Without Parental Consent

The most concerning aspect of the Canadian policies is that they expressly permit and encourage schools to support the social transition of students, of any age, without notifying their parents. For example, the Toronto District School Board Policy says:

> There is no age limit on making an accommodation request, and young students have the same rights to privacy and to have accommodations made on their behalf with or without their guardians' knowledge.
>
> …
>
> A school should never disclose a student's gender non-conformity or transgender status to the student's parent(s)/guardian(s)/caregiver(s) without the student's explicit prior consent. This is true regardless of the age of the student.[128]

What this means is that a child of any age may be known by a different name and pronouns and at school, playing sports with the opposite sex or using the washroom and changing rooms of the opposite sex and the parents may not be told. This would also apply to sleeping arrangements on overnight field trips. The details of policies vary, but it is generally possible for a school to change a student's name and pronouns without notice to the parents. The student's legal name may remain on the students records and be used in communications with the parents, but the school will also keep a separate record of the student's preferred name.

Privacy or Active Intervention?

The policy of non-disclosure is justified on the basis that they are necessary to protect a student's privacy. However, the legal position is not clear. The details of privacy legislation vary from province to province, but there will always be some provision which allows parents or guardians to access information which affects their children's health and welfare.

Furthermore, current practices in schools go beyond simply protecting confidence. If a child simply discloses private thoughts about his or her gender identity, that conversation may be regarded as confidential. Gender-questioning children need to be able to decide when and to whom they will share their feelings. However, once the school begins to affirm a child's new identity with a new name and pronouns, it is no longer a matter of confidence.

[128] Toronto District School Board, "TDSB Guidelines for the Accommodation of Transgender and Gender Non-Conforming Students and Staff," September 9, 2019, [Link].

Instead, it becomes an open secret which is shared with all of the staff and students, but withheld from parents.

Further, changing a child's name and pronouns is a major psychosocial intervention. Social transition tends to reinforce a gender-distressed child's discomfort with his or her body and increase the probability that he or she will proceed with medical transition.[129]

According to the *Interim Report* of the Cass Review, social transition "is an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. [130] The interim service specification recently issued by the U.K. National Health Services calls for a multi-disciplinary team to "engage children and young people and their families in an in-depth process of discussion and thinking around the decision of social transition."[131]

Dr. Riittakerttu Kaltiala is a leading expert on pediatric gender medicine and chief psychiatrist at Finland's largest gender, which she was appointed to establish. She believes that social transition tends to solidify a gender identity which might otherwise be transitory:

> Evidence from a combined 12 studies to date demonstrates that when children with cross-gender or gender variant behavior are left to develop naturally, the vast majority—"four out of five," according to Kaltiala—come to terms with their bodies and learn to accept their sex. When they are socially transitioned, virtually none do. [132]

Dr. Erica Anderson is a clinical psychologist and transwoman who has been a board member of both the World Professional Association for Transgender Health and President of USPATH (the United States branch of WPATH). Although she is generally supportive of the affirming model of care for young people, she believes that social transition of children without a psychological assessment and parental involvement is irresponsible. She has submitted an affidavit in a Wisconsin lawsuit which challenges a school board policy permitting social transition without parental approval. The conclusion of this affidavit is:

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[129] Zucker, "The Myth of Persistence."

[130] Cass, "Independent Review of Gender Identity Services for Children and Young People: Interim Report."

[131] NHS England, "Interim Service Specification for Specialist Gender Incongruence Services for Children and Young People."

[132] Sapir, "Finland Takes Another Look at Youth Gender Medicine."

> 78. A school policy that involves school adult personnel in socially transitioning a child or adolescent without the consent of parents or over their objection violates widely accepted mental health principles and practice.[133]

The Endocrine Society guideline is frequently referred to by supporters of affirmative care. It recommends that social transition of children and adolescents be undertaken only with the involvement of a "mental health practitioner or similarly experienced professional." [134]

Teachers and school counselors are not trained as mental health professionals. In many provinces, facilitating the social transition of a child could amount to practicing psychotherapy without a license.

There is no clear research evidence that social transition has any real benefit for a child or adolescent's mental health.[135] A German study found that peer relations and family functioning, not social transition, were the most important predictors of psychological functioning in children with gender dysphoria.[136] Based on this study, if the welfare of the child is the primary goal, schools should, with the aid of appropriate personnel, support and facilitate communication with parents.

The previous chapters of this document showed that gender questioning children often experience other mental health and neurodevelopmental issues. Teachers and school counselors may not be aware of a student's entire mental health history and do not have the training necessary to deal with these complex conditions.

The right of a child to privacy in respect of medical information is linked to the capacity of the child to consent to medical treatment. In the case of mature minors, who have the capacity to consent to medical treatment, their medical information may not be disclosed without their consent even to their parents or guardians. However, where the child does not have capacity to consent, the necessary information must be disclosed to the parent or guardian who consents on their behalf.[137] The key point is that before agreeing not to disclose information to a child's parents, a health care provider must first determine whether the child has the necessary capacity to give informed consent to the treatment in question.

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[133] Erica Anderson, "Expert Affidavit of Erica-Anderson in B.F., T.F., P.W. and S.W. v. Kettle Moraine School District, State of Wisconsin Circuit Court," February 3, 2023, [Link].

[134] Wylie C. Hembree et al., "Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline," The Journal of Clinical Endocrinology & Metabolism 102, no. 11 (November 1, 2017): 3869–3903, [Link].

[135] James S. Morandini et al., "Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria?," Archives of Sexual Behavior, April 4, 2023, [Link].

[136] Elisabeth Dc Sievert et al., "Not Social Transition Status, but Peer Relations and Family Functioning Predict Psychological Functioning in a German Clinical Sample of Children with Gender Dysphoria," Clinical Child Psychology and Psychiatry 26, no. 1 (January 2021): 79–95, [Link].

[137] "Responding to Requests for Children," CMPA, 2023, [Link].

Schools will generally not have the background information or expertise to determine a child's capacity to consent to gender reassignment. A blanket policy of non-disclosure may create situations where the school is withholding information from parents in circumstances where a child's health care providers all agree that the child is not capable of giving informed consent. The school staff may not be aware that the child is being seen by a healthcare professional.

Teachers are restricted from giving a student so much as an over-the-counter painkiller without parental consent, but they are being allowed to undertake a far more potentially serious intervention without even notifying parents. Some teachers who have concerns about the gender-affirming model that requires them to lie to parents are also having their free expression denied and are being forced to use compelled speech. If the well-being of children is truly the aim, a balanced, open, honest, informed dialogue must happen, and each child's individual circumstances and needs must be considered.

Children's Rights and the Family

Canadian policies on gender identity in schools often reference the United Nations' *Convention on the Rights of the Child* but ignore two foundational principles of this document. The first is that children (which is defined to mean anyone under the age of 18) require adult guidance and supervision. The second is that the primary source of this guidance is to be the parents and not the state. This second principle is explicit in Article 5, which reads:

> **Article 5**
> States Parties shall *respect the responsibilities, rights and duties of parents* or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention. [138]

Article 9 provides that children are to be separated from their parents only by competent authorities in accordance with applicable law and subject to judicial review.

Article 14 recognizes the right and duty of parents to provide direction to the child in the exercise of freedom of thought, conscience, and religion.

The principle of the primary role of the family as the source of care and nurture of children is recognized in Canadian child welfare legislation. The preamble to *The Child and Family Services Act* of Manitoba is particularly emphatic on this point:

[138] "Convention on the Rights of the Child," OHCHR, November 20, 1989, [Link].

> The Legislative Assembly of Manitoba hereby declares that the fundamental principles guiding the provision of services to children and families are:
> The safety, security and well-being of children and their best interests are fundamental responsibilities of society.
> The family is the basic unit of society, and its well-being should be supported and preserved.
> The family is the basic source of care, nurture and acculturation of children and parents have the primary responsibility to ensure the well-being of their children.
> Families and children have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society.
> Children have a right to a continuous family environment in which they can flourish.
> Families and children are entitled to be informed of their rights and to participate in the decisions affecting those rights.
> Families are entitled to receive preventive and supportive services directed to preserving the family unit.
> Families are entitled to services which respect their cultural and linguistic heritage.
> It is inaccurate to frame this issue as a conflict between parents' rights and the best interests of the child. Parents do not have rights over their children but the responsibility to look after their best interests and the authority necessary to carry out that responsibility.

Social transition without the knowledge of a child's parents undermines the authority of parents by denying them vital information which they may need to supervise their child's medical and mental health care and protect their child. Parents who have known a child for his or her entire life are in a better position to make decisions about a child's best interests than school staff who see a child for a few hours each day.

There may be circumstances where the parents are not acting in the child's best interest in making decisions on medical treatment and it is justifiable to override their authority. However, that is a decision which would normally require a court hearing and the involvement of qualified health care professionals. These are not decisions that can be made without notice by a teacher or school counsellor.

It is true that homes are not always safe spaces. Research has found that gender dysphoria is often associated with problems at home, which may include physical or sexual abuse.[139] However, this simply emphasizes the importance of trying to work with and through the parents rather than cutting them out. Even if the home environment is not

[139] Michelle Anne Tollit et al., "What Are the Health Outcomes of Trans and Gender Diverse Young People in Australia? Study Protocol for the Trans20 Longitudinal Cohort Study," BMJ Open 9, no. 11 (November 1, 2019): e032151, [Link].

completely supportive, the alternatives an unsupported child will find on their own will almost certainly be worse. Where there is reason to suspect abuse at home, the school should and must by law report to the child welfare authorities so that a qualified professional can investigate. If a child is genuinely at risk, subterfuge on the part of the school will almost certainly worsen the situation. Schools should be mindful that there may be a risk of parental rejection when a child comes out as transgender, but this should not be the default assumption behind a policy as this default position has no basis in evidence. Schools should also recognize that parental support encompasses many things. A parent can be loving, nurturing and supportive, even if they have doubts or concerns about a child suddenly identifying as transgender.

Finally, schools should be aware of the concept of triangulation.[140] In family systems theory, triangulation refers to a situation in which one party in a dyad (two-person relationship, e.g., parent-child) who is in conflict seeks a third party to mediate the conflict. The less differentiated (mature) one is, the more likely they are to engage in seeking triangulation because less differentiated individuals, such as children and adolescents are unable to fully express themselves and discuss sensitive issues. The third party, through their actions, has the ability to help or harm the dyad. In the context of a trans-identified child or adolescent, school staff may become the third party who has the capacity to either bring the family together or fragment the family unit. When schools exclude parents by not disclosing a child's gender distress and engage in social transition without parental knowledge, they are engaging in acts that triangulate and fragment the family unit. Such disruption may cause stress, anxiety and other mental health difficulties for all parties involved and can result in the child avoiding important necessary communication. Triangulation is now occurring as a result of the erosion of parental authority in school and healthcare settings. School and medical systems have increasingly been adapting new policies regarding children and adolescents with gender struggles that are displacing the parents as the primary authority within a family regarding their own children. Such triangulation negatively impacts the long-term well being of the child and family unit.

[140] David Lee Jones, "The Difference between Triangles and Triangulation: Family Systems Theory for Church Leaders," The Presbyterian Outlook, February 4, 2020, [Link].

Chapter 7. Gender Identity in the Classroom

Schools are contributing to the problem of socially influenced transgender identity by the way in which they now teach about gender and sexuality. Provincial departments of education, assisted by experts in child and adolescent development, should review the materials used in sexuality education. Over the last ten years, curriculum materials on sexual health have been replaced with materials built around sexual orientation and gender identity (SOGI). The content of much of this material is misleading and harmful.

Children develop a sense of sex constancy, that is an understanding that being a boy or girl is determined by biology and does not change, at around the age of 6 or 7.[141] SOGI and other similar curricula being taught today often introduces children as young as 4 or 5 to the idea that a gender identity based on conformity to stereotypical gender roles is more foundational to identity than biological sex. This creates confusion in the minds of children who have not reached the stage of cognitive development where they can understand the interplay between socially determined gender roles and sex.

This may be particularly so for children on the autism spectrum who are often delayed in establishing sex constancy and tend to think in black and white terms [142] and for children who are developmentally delayed.[143] While schools once taught that gender stereotypes may be broken, that a girl or boy can have any interest, dress however they like and aspire to any profession regardless of their sex, schools are now furthering the message that if one does not conform to societal gender stereotypes, that it may mean they are transgender.

Questionable Science

The problems often begin with the teaching of the basic biology of sex. There are two sexes, male and female, which are defined by reproductive role. In humans, sex is determined at conception, observed at birth (or earlier by in utero scans) and cannot be changed. There are some variations within this binary system that are sometimes called Intersex but are more accurately known as Differences/Disorders of Sexual Development (DSD) or Congenital Conditions of Sexual Development (CCSD). These conditions are

[141] Lawrence Kohlberg, "A Cognitive-Developmental Analysis of Children's Sex-Role Concepts and Attitudes," in The Development of Sex Differences, ed. Eleanor E. Maccoby (Stanford, California: Stanford University Press, 1966).

[142] Yulia Furlong, "Autism and Gender Identity," in Autism Spectrum Disorder - Profile, Heterogeneity, Neurobiology and Intervention (IntechOpen, 2021), [Link].

[143] K. J. Zucker et al., "Gender Constancy Judgments in Children with Gender Identity Disorder: Evidence for a Developmental Lag," Archives of Sexual Behavior 28, no. 6 (December 1999): 475–502, [Link].

very rare (less than 0.018% of the population) and represent variations of the male or female development path, rather than a third sex.[144]

These facts are now being obscured by teaching tools like the "Genderbread Person" or "Gender Unicorn," which present sex as a spectrum of characteristics of "maleness" and "femaleness." Young children may have difficulty distinguishing between sex and socially determined sex roles.

Instead of helping to break down stereotypes and encourage acceptance of gender nonconformity, teaching materials focused on gender identity reinforce reductive stereotypes and the idea that gender non-conforming children may be born in the wrong body. [145] These lessons may be particularly confusing and detrimental to children who will grow up to be gay, lesbian or bisexual as research suggests that these children are more likely to be gender non-conforming. Children are learning that there is only one way to be male or female, rather than that our likes, interests and skills are not defined by our biological sex. No one suggests that school programs on gender identity will make a mentally healthy child trans, but many children today are not mentally healthy. The monumental increase in mental health conditions among youth, as well as the real potential of the link to social media, are well documented.[146]

Confusion over sex can lead to confusion over sexual orientation. Many young gays and lesbians go through a period of distress and uncertainty as they come to terms with their same-sex attraction. The introduction of gender identity into the mix can make this process harder. Gay writer Ben Appel describes the conflict and confusion that ideas of gender identity based on queer theory have brought into the lesbian and gay community. He describes his experiences growing up in a conservative community, where bullies often asked him if he was a girl. Young gay boys today, he fears, are being convinced they really are girls and started on the medical pathway.[147]

Another gay writer, Andrew Sullivan, explains that, "the difference between the gay and trans experience is vast, especially when it comes to biological sex." Young gays need to understand the sex differences in the body in order to come to terms with their homosexuality.[148]

Young lesbians face similar problems with the added burden that as they begin dating, they will face pressure to accept transwomen, who have not had "bottom surgery" as sexual

[144] Colin Wright, "Sex Is Not a Spectrum," Reality's Last Stand (blog), February 10, 2021, [Link].

[145] Colin Wright, "AMAZE Is Indoctrinating Children," Reality's Last Stand (blog), April 21, 2021, [Link].

[146] Haidt, "After Babel."

[147] Appel, Ben, "Homophobia in Drag," Spiked Online, May 20, 2023, [Link].

[148] Andrew Sullivan, "Who Is Looking Out For Gay Kids?," Substack newsletter, The Weekly Dish (blog), April 8, 2022, [Link].

partners as sexual orientation is becoming increasingly defined as same gender attraction, rather than same sex attraction.[149]

Biased Material on Gender Transition

If a child who is struggling with psychological and social problems is introduced to transgender identity in a simplistic manner, they may latch on to it as a solution to their problems. Detransitioners have reported that they interpreted their distress with their bodies, not fitting in, or confusion about their sexuality as being transgender.[150] The message the school may be trying to convey is that transgender people should be loved and accepted - which they undoubtedly should be - but the message the unhappy child receives is that if they identify as transgender, they will be loved and accepted and that the distress they have been feeling is simply due to being transgender. The trans-identified child is then enthusiastically affirmed and celebrated in their new identity. The message the school tries to send is "you deserve respect and support," but the message the child receives is "your gender identity makes you special and important." Experimenting with identity is a normal part of growing up, and schools should support such developmental exploration in age-appropriate ways. However, what schools are supporting with social transition, leads in many cases, to a pathway that ends in being a life-long medical patient.

Stories of gender transition are presented in a way that denies or minimizes the risks of transition. For example, *I am Jazz,* the story of Jazz Jennings, a "girl born in a boy's body" is an extremely popular book to introduce young children to gender identity. No one tells children that Jazz needed three corrective surgeries to the neo-vagina and is still struggling with depression and obesity from binge eating. Jazz's surgeon has warned that Jazz, like other children who have their puberty blocked, may never be able to experience an orgasm.[151]

Similarly, the book *The Other Boy,* intended for students in grades 6 through 8, presents the medical transition of a female middle schooler.[152] The book presents the process of informed consent to puberty blockers and cross sex hormones in a breezy, superficial way which ignores the very considerable risks involved such as loss of bone density and future infertility. By middle school, students will certainly be exposed to the possibility of medical transition and schools should not try to avoid the topic. However, the materials provided in

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[149] Kathleen Stock, "Why Should Lesbians Sleep with Men?," UnHerd (blog), May 4, 2023, [Link].

[150] Littman, "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned."

[151] Abigail Shrier, "Top Trans Doctors Blow the Whistle on 'Sloppy' Care," The Free Press, October 4, 2021, [Link].

[152] "Review of The Other Boy by M.G. Hennessey," accessed June 14, 2023, [Link].

classrooms and libraries should be balanced and include information on the risks of transition and the possibility of detransition and regret.[153]

Sexually Explicit Materials

Books for middle and high school students may contain extremely graphic descriptions or illustrations of sexual activity between minors that would have been considered child pornography not long ago. The book *Let's Talk About It,* which is often available in middle school libraries, is an egregious example. Among other things, it minimizes the risks of sexually transmitted diseases and recommends researching kinks by watching internet porn.[154] Early exposure to pornography may be another factor that drives transgender identity among teen girls. Sexual "kinks" often include dangerous practices such as choking which leave young teen girls terrified of the prospect of having sex as a female.[155]

This is not a call to remove all references to gender identity and sexual orientation or books discussing sexual activity from schools. Children need to learn about sex and LGBT people, but they need to be taught in a way that is grounded in biology and sound principles of child development and respectful of all religions and cultures. The New Zealand Group Resist Gender Education has collected some examples of books which present LGBT themes in ways which are age appropriate and should be a resource for Canadian educators.[156]

There is a difference between discussing the fact that a small percentage of the population (.03%- APA) is transgender and telling children, whose understanding of sex is not yet fully developed, that all of us have a gender identity and that they should actively consider if they may be transgender. Porn of any kind should never be available in schools. Parents and guardians should have access to library holdings and be able to communicate with school staff any concerns they may have without fear of censure

As many schools rely on external organizations to present on sex and gender identity, clear policies must be in place for how these organizations will be chosen and the criteria used to evaluate the content of their presentations. Provincial curriculum is carefully developed and involves in-depth consultations with a wide range of individuals and organizations, such as educators, students, parents, subject experts, education stakeholders and Indigenous partners. Curriculum is fact-checked by academics and other experts prior

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[153] Sarah C. J. Jorgensen, "Iatrogenic Harm in Gender Medicine," Journal of Sex & Marital Therapy 0, no. 0 (June 19, 2023): 1–6, [Link].

[154] Right Side of HistoryTM [@xxclusionary], "I Got the Book 'Let's Talk About It,' so You Don't Have to. A Thread," Tweet, Twitter, May 20, 2023, [Link].

[155] Abigail Shrier, Irreversible Damage: The Transgender Craze Seducing Our Daughters (Washington: Regnery Publishing, 2020), 153–55.

[156] "What Are Your Kids Reading?," Resist Gender Education, accessed July 17, 2023, [Link].

to release. Any content presented by external organizations should be held to the same standards as curriculum.

Chapter 8. The Need for Sex Segregated Spaces

Human Rights Law

School policies generally require that students who express a transgender identity must be affirmed by being allowed access to washrooms, change rooms and sports teams on the basis of their gender identity. No consideration is given to the impact of these policies on girls (who are at a vulnerable time of development), who may be required to undress in close proximity to a sexually mature boy. These policies are justified on the basis that they are required to comply with human rights law.[157] However, the law in this area is not at all settled.

The federal and provincial human rights codes all recognize gender identity and gender expression as prohibited grounds of discrimination. However, they also recognize other grounds including sex, sexual orientation, religion, belief and disability, which may give rise to claims which conflict with rights based on gender identity. When these conflicts arise, they need to be resolved on the basis of established principles of reasonable accommodation to the point of undue hardship. There are very few actual Canadian human rights decisions that have dealt with transgender rights, and none of them are necessarily applicable to school situations.

The cases on washroom use pre-date the addition of gender identity as a ground of discrimination and were decided on the basis of discrimination on the basis of sex. However, the context was very different from the present day. [158] These cases were decided at a time when a psychological assessment was necessary to access hormonal treatments, and they both heard evidence on a diagnosis of gender dysphoria. They also concerned washrooms used primarily by adults. In one case, the washroom was single use with a lock. Since those cases were decided, there has been a marked shift from a requirement of psychological assessment to unrestricted self-identification. There have been no Canadian cases which have held that an adolescent with a fully functioning male reproductive system has a human right to share changing, shower or sleeping accommodations with adolescent girls.

Provincial human rights commissions have given differing guidance on this issue. The Ontario Human Rights Commission guidelines explain that there are different options for

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[157] Catherine Kronas, "Audio and Transcript of Meeting with MPP Donna Skelly and HWDSB Trustees Regarding HWDSB Gender Identity Procedure 5.4, August 9, 2023," Substack newsletter, Catherine's Substack (blog), August 16, 2023, [Link].

[158] Ferris v. Office and Technical Employees Union, BCHRT 55 (BCHRT 1999); Sheridan v Sanctuary Investments Ltd (c.o.b BJ's Lounge)., 43 BCHRT (BCHRT 1999).

accommodation. It suggests that in the case of a fitness club member who is transitioning from male to female, an appropriate accommodation would be a privacy space in each change room or a single-user washroom with a shower.[159]

The Manitoba guidelines are more equivocal. They talk about the need for accommodation but suggest that providing a gender-neutral space is an acceptable alternative.[160]

The Saskatchewan human rights commission, on the other hand, says that refusing to allow a transgender woman access to the women's washroom would be discrimination.[161]

None of these guidance statements are legally binding and until the provincial human rights tribunal has actually conducted a hearing and issued a decision on an issue, the contents of school policies are only political choices made by provincial governments and school trustees to favour the interests of one group over another.

Washrooms, Change Rooms and Overnight Accommodation

School policies which allow students to access washrooms and changing areas on the basis of gender identity rather than sex represent a serious breach of the right of women and girls to privacy and bodily autonomy. Women and girls are vulnerable at every age, but puberty is a particularly difficult time. They need to cope with changing bodies, the onset of menstruation, the beginnings of sexual attraction and the realization that they could become pregnant. Meanwhile, the boys around them are becoming bigger and stronger and developing sexual interests of their own.

Women and girls need the privacy of single sex spaces when they are undressing, changing and sleeping. Sex-segregated bathrooms have existed throughout recorded history, and in the nineteenth century they began to be required by law as a social reform measure for the protection of women and girls. [162]

Single spaces provide women and girls with some security against male violence. A Canadian study from 2008 found that females are 10 times more likely to be the victim of a sexual assault than males and males are responsible for 79% of violent crime.[163] Transwomen do not pose a threat to women and girls because of their trans identity, but

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[159] Ontario Human Rights Commission, Policy on Preventing Discrimination Because of Gender Identity and Gender Expression, 2014, 26.

[160] Manitoba Human Rights Commission, "Discrimination Based on Gender Identity: Your Rights and Responsibilities," accessed June 15, 2023, [Link].

[161] Saskatchewan Human Rights Commission, "Human Rights of Transgender People," Saskatchewan Human Rights Commission, accessed June 15, 2023, [Link].

[162] W. Burlette Carter, "Sexism in the 'Bathroom Debates': How Bathrooms Really Became Separated by Sex," Yale Law & Policy Review 37, no. 1 (2018): 227, [Link].

[163] Roxan Vaillancourt, Gender Differences in Police-Reported Violent Crime in Canada, 2008 (Statistics Canada, 2010), [Link].

because of their male anatomy and physiology. Research on transwomen has found that they continue to show a male pattern of criminality. For example, data from the United Kingdom found that while sex offenders made up 16.8% of men in prison and 3.3% of women, they represented 58.9% of transwomen.[164]

This is not to suggest that all or even most transwomen are potential sexual predators. Society recognizes that only a very small percentage of males are a threat to women, yet women have won the rights to their own spaces. The current policies of unrestricted self-identification do not provide any means of separating people who genuinely experience gender dysphoria from sexual predators who assume a female identity to gain easier access to victims.

The balancing of interests around washroom access raises multiple issues and may have to be worked out on a school-by-school basis. The physical layout of the toilets will determine the degree of risk. Some new schools have toilets which are enclosed from ceiling to floor and lockable for complete privacy. The risk to privacy and safety by designating this type of facility as mixed sex is minimal. However, most schools still have toilets where it is possible to see both under and over the partitions and the lock on the door is non-existent or flimsy. Many girls may not feel safe using this type of facility when males are present. Showers and change rooms where students have to undress completely in front of one another are another case. Girls should not ever be compelled to undress in the presence of boys.

Adult transwomen often claim that washroom use is not an issue and they seldom if ever encounter problems. (Many women would differ on this point.) However, it is important to remember that we are dealing with adults. Many will have undergone some stages of medical transition (although most have not had bottom surgery), and most will have developed the social skills to navigate female spaces without causing offence. Teenage males, on the other hand, are not noted for their social skills in dealing with females, and many gender-questioning teens are on the autism spectrum or have other neurodevelopmental or psychological problems.

Meanwhile, girls will have their own problems. Every school will have some students from religious backgrounds with strict rules about separation of the sexes. There will be others with a history of sexual abuse which would make undressing in close proximity to a male traumatizing.

The best solution, which is likely to result in the least overall hardship, is to retain sex-separated washrooms, showers and change rooms and provide designated all-gender facilities for use by students who express a transgender or non-binary identity. The

[164] Rosa Freedman, Kathleen Stock, and Alice Sullivan, "Evidence and Data on Trans Women's Offending Rates," November 2020, [Link].

alternative solution of providing a separate space for students (mostly girls) who object to changing or using the toilet in the presence of the opposite sex is less equitable. This will draw unwanted attention to the girls who use these facilities.

A girl who absolutely requires a sex-segregated space because of her history of sexual trauma should not be put in a position where she has to defend herself against allegations of transphobia.

Sports

Sex-segregated sports were created to account for the physiological differences between males and females. Prior to puberty, the difference between males and females is small and, since girls generally go through puberty earlier than boys, there may be a short time around age 11 when they have an advantage. Once puberty starts, the release of testosterone in the male body gives males more muscle mass, more lean body mass and more efficient respiratory and cardiovascular function. The male bone structure is also designed to make males more effective at running than females. These advantages persist across categories based on height, weight and age and are only partly mitigated by hormone therapy in transwomen. The result is that males have a performance advantage of from 10% to over 50% in most sports. [165] The results of these differences are obvious from an earlier age. By age 15, top male high school athletes outperform female Olympians in most events. [166]

In individual sports, a mediocre male athlete can, competing as a female, move into the championship category. Girls who have trained for years will lose the opportunity for advancement, recognition and athletic scholarships.

In team sports, the risk of injury increases when males and females play on the same team. The World Rugby Federation conducted a scientific review of male and female performance and concluded that the risk of injury to females was unacceptably high when males and females played together at any level.[167] This risk is not just theoretical, Serious injuries are occurring on a regular basis, such as this case of a female volleyball player who suffered a concussion and severe head and neck injuries when a male player spiked a ball in her face.[168]

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[165] Emma N. Hilton and Tommy R. Lundberg, "Transgender Women in the Female Category of Sport: Perspectives on Testosterone Suppression and Performance Advantage," Sports Medicine 51, no. 2 (February 2021): 199–214, [Link].

[166] "Boys vs Women: Male High School Athletes vs Female Olympians," accessed June 3, 2023, [Link].

[167] World Rugby, "Transgender Guidelines," 2021, [Link].

[168] Alex Schemmel, "Injured Volleyball Player Speaks out after Alleged Transgender Opponent Spiked Ball at Her," ABC 13 News, April 20, 2023, [Link].

Different considerations apply to transmen. Hormone therapy can increase muscle mass to the point where it gives them an unfair advantage in the female category but not to the point where they can compete successfully in the male category.

Some international sports governing bodies are adopting eligibility policies for the men's and women's categories which are in line with the scientific evidence. World Aquatics and World Athletics have both adopted regulations which prevent athletes who have experienced any part of male puberty from competing in the women's category. [169]

Policies in other sports vary. Some simply allow competitors to choose the class that reflects their gender identity. Others require transwomen to maintain their circulating testosterone below a certain level. Neither of these solutions is practical at the school level. Another possibility is to replace the boy's category with an open category and retain a girl's category for females who are not taking artificial hormones.

[169] World Aquatics, "Policy on Eligibility for the Men's and Women's Competition Categories," 2022, [Link].

Chapter 9. A Model Policy for Canadian Schools

1. Guiding Principles.
    a. Childhood and adolescence are a time of growth, exploration and development. Every school will have some students who experience extreme discomfort with their sexed bodies and socially mandated gender roles. Schools need to provide all students with a safe and welcoming space where they can explore their identity without being subject to bullying, discrimination and harassment, and also without being exposed to the idea that they need social or medical transition to be their true selves.
    b. Gender identity in children and adolescents is still in the process of development and is highly unstable. Unlike sexuality, gender identity is not innate. Cross-sex identification in children usually desists before adulthood. This policy will therefore use the term gender-questioning rather than transgender for children and adolescents.
    c. Gender-questioning children and teens frequently have one or more other mental health issues such as depression, anxiety, borderline personality disorder, or obsessive-compulsive personality disorder or neurodevelopmental conditions such as autism spectrum disorders or attention deficit hyperactivity disorder. Based on detransitioner accounts, any of these conditions may result in distress that a child may interpret as gender dysphoria.
    d. Schools must embrace all types of diversity including female students with traditionally masculine interests and male students with traditionally feminine interests.
    e. School staff must recognize and respect the primary role of parents in the healthcare and moral and religious upbringing of their children.
    f. Gender identity and gender expression are recognized as prohibited grounds of discrimination under the *Human Rights Code* which gives all students and

staff the right to a school environment free from discrimination and harassment and reasonable accommodation of their needs.

g. The right to accommodation based on gender identity and expression is not absolute and may be limited when it would result in undue hardship to some other protected class.

2. Privacy and Confidentiality.
    a. Students have a right to confidentiality regarding their sexual orientation and gender identity. These are private matters and everyone has a right to choose when and to whom they disclose them. Not all students will feel comfortable having their first discussion of these issues with their parents, and teachers need to respect this. However, a child's discomfort with speaking to their parents cannot be interpreted as prima facie evidence that parents are unsafe. Consideration must be given to the implications of not involving loving, supportive parents.
    b. In conversations with students concerning sexual orientation and gender identity, teachers must refrain from disparaging a parent's religious or cultural beliefs or undermining a parent's authority.
    c. Confidentiality no longer applies when the student seeks active assistance in affirming the student's gender identity. The request must be dealt with in accordance with the policy on social transition.
    d. The practice of "open secrets" in which students are directed not to share information about another students' public gender transition while at school with their parents is unacceptable. It has the potential to fracture families and break down parent-child relationships, which is not in the long-term interest of the student.
3. Social Transition (names and pronouns).
    a. Social transition is a powerful psychosocial intervention which can solidify an identity that would otherwise be transient, leading to unnecessary medical transition. Schools must consider the long-term consequences of social transitioning and must not promote social transition of a student under the age of 18 without the consent of the parents. The involvement of a mental

health professional is highly advisable, but arranging for this is the responsibility of the parents.

b. Gender-questioning students under the age of 18 will require parental consent in order for their preferred first name to be officially used for record-keeping purposes and daily management. [If provincial law permits changes of name without parental consent at a younger age than 18, that age will apply instead.]
c. If it is not possible to obtain consent to talk to the parent, the student will be directed to the appropriate professional (i.e., school social worker, school psychologist) to work with the student to develop a plan to speak with their parents if and when they are ready to do so. If it is not in the best interest of the child or could cause harm to the student (physical or mental threat), the student will be directed to the appropriate school professional for support.
d. When a student is engaging in social gender transition, all students and staff should be required to use the student's preferred name in day to day interactions and all documents except where there is a legal requirement to use the current legal name. Use of the student's preferred pronouns should be encouraged but not mandatory. Students and staff who object to using preferred pronouns should be allowed the option of using names rather than pronouns when speaking of a gender transitioning student. Staff and students should not be required to declare their preferred pronouns when introducing themselves or on name tags, e-mail signatures and the like.
e. The school must keep a record of each students' biological sex so that this information can be passed on to medical care providers in emergencies.
f. Schools must be aware that some students who transition will desist or detransition and that this process can be as difficult as transition. Schools must be prepared to provide a safe and non-judgmental space for such

students, including support from a school psychologist or social worker as needed.

4. Sports Participation.
    a. All students are entitled to participate in sports and to enjoy fair and safe competition.
    b. After the onset of puberty, the physical differences between males and females require sex-separated teams in order to allow fair and safe competition for girls. Schools may establish open categories or teams which are open to all students, but they must also provide a female team or category which is reserved for biological girls who are not receiving male hormones.
5. **Dress Codes.** Dress codes should be gender neutral. Students should be able to express themselves through their clothing given that the attire is appropriate for a learning environment.
6. **Binding and Tucking.** For students who have socially transitioned, the school shall make materials available to parents about the health consequences of binding and tucking, especially during sports activities, to enable families to discuss whether their child's concerns about appearance should override serious health concerns. Under no circumstances shall the school provide students with binders or other clothing or devices to allow students to change their physical appearance. Schools should also refrain from directing students where to purchase such items. Schools should ensure the GSA's or other clubs operating with the consent of the administration do not promote or offer binding or tucking materials.
7. **Washrooms and Change Rooms**. The school has a responsibility to provide all students with washrooms and change rooms in which they feel safe and secure. Single-sex spaces shall be maintained, and a third space shall be provided where single-occupancy toilets and changing rooms are available, allowing anyone who wishes to use a gender-neutral space to do so. Gender-neutral stalls should contain floor to ceiling walls to allow for privacy.

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Appendix – Canadian School Policies on Gender Identity

This is a list of some of the current policies on gender identity in Canadian schools.

British Columbia

Ministry Policy Guide: https://bc.sogieducation.org/sogi1

Education Resource Guide: SOGI-INCLUSIVE EDUCATION RESOURCE GUIDE

Alberta

Ministry Policy Guide: 1.Policies / SOGI 1 2 3 / Alberta

Education Resource Guide: 3.Teaching / SOGI 1 2 3 / Alberta

Saskatchewan

Teacher's Federation Policy: https://www.stf.sk.ca/resource/gender-and-sexual-diversity

Education Resource Guide: Deepening the Discussion: Gender and Sexual Diversity

Manitoba

Ministry Policy Guide:
https://www.edu.gov.mb.ca/k12/docs/support/transgender/full_doc.pdf

Ontario

Legislation: Accepting Schools Act, 2012, S.O. 2012, c. 5 - Bill 13

Policies are set at the school board level. The Toronto District School Board policy is a typical example:
https://www.tdsb.on.ca/Portals/0/docs/tdsb%20transgender%20accommodation%20FINAL_1_.pdf

Quebec

Ministry Policy Guide: Improved understanding and practices for sexual and gender diversity in schools

New Brunswick

Ministry Policy Guide: Improved understanding and practices for sexual and gender diversity in schools (August 17, 2020)

New Version Effective July 1, 2023: https://www2.gnb.ca/content/dam/gnb/Departments/ed/pdf/K12/policies-politiques/e/713-2023-07-01.pdf

Nova Scotia

Ministry Policy Guide: Guidelines for Supporting Transgender and Gender-nonconforming Students

Prince Edward Island

Ministry Policy Guide: MD 2021 06 Guidelines for Respecting, Accommodating and Supporting Gender Identity, Gender Expression and Sexual Orientation in our schools

Newfoundland and Labrador

Ministry Policy Guide: Guidelines for LGBTQ Inclusive Practices

Nunavut

Ministry Policy Guide: Department Of Education Inclusive Education Policy

Northwest Territories

Ministry Policy Guide: Guidelines for Ensuring Equity, Safety and Inclusion in Northwest Territories Schools - LGBTQ2S+

Yukon

Ministry Policy Guide: Sexual Orientation and Gender Identity Policy | Government of Yukon