Canadian Gender Report

Brief to the Standing Committee on Legal and Constitutional Affairs on Bill C-6 An Act to Amend the Criminal Code (Conversion Therapy)

May 30, 2021

Canadian Gender Report is a non-sectarian organization of parents and professionals concerned about the medical treatment of gender distressed children and adolescents.

Your teenage daughter is depressed and struggling. She has a history of mental health problems and you suspect that she may be on the autism spectrum but have not been able to arrange a screening. Your daughter asks you to take her to another clinic she learned about on the internet. At the second appointment, the doctor wants to prescribe medication. The consent form reads in part, "The full medical effects and safety are not fully known, and some potential risks are serious and possibly fatal." The risks include increased risk of sleep apnea, heart attack, stroke, liver inflammation, diabetes, cardiovascular disease, and high blood pressure.[1]

The consent form does not say this, but you have found out that if after a few years of this treatment she will probably need a hysterectomy and will be dependent on medication for the rest of her life.

"That sounds too risky," you say. "Can't we just try a few months of psychotherapy and see if that helps?"

"No," the doctor says. "If I prescribed psychotherapy instead of this medication, I could be charged with a criminal offence and face five years in prison."

This scenario may sound far-fetched, but it describes the reality that parents are facing in gender clinics across Canada. The possibility of a five year prison term will become a reality if Bill C-6 is adopted in its present form.

Including "gender identity" in the definition of conversion therapy in Bill C-6 will have serious consequences for children and youth who feel an incongruence between their gender identity and their bodies.

The effect of the Bill will be to enforce, through criminal law, the "affirming model of care" which is currently being followed in Canadian gender clinics.

Affirmation is a new and poorly understood approach to children and adolescents experiencing gender related distress. The "affirming care" approach dictates that medical interventions such as puberty blockers, cross-sex hormones and irreversible surgeries be provided to youth based on their self-directed gender "goals".

The previously established clinical protocol of watchful waiting provided a supportive approach whereby children can be gently questioned about why they have started to identify as a different gender. It allowed parents, clinicians, and others to develop a complete picture of the child's needs and keep all options open to help the child resolve feelings of gender dysphoria without pushing them towards irreversible medical

[1] Trans Care BC, *Testosterone Consent* (BC Provincial Health Services Authority) , online: <http://www.phsa.ca/transcarebc/Documents/HealthProf/pctoolkit-testosterone-consent.pdf>.

interventions. This more cautious model of care has been phased out in favour of "affirmation" at Canadian gender clinics despite no evidence of improved health outcomes. [2]

The affirming model of care is risky because it does not allow a healthcare professional to explore how underlying factors may be contributing to a young person's newly adopted gender identity and feelings of gender dysphoria. Issues such as childhood trauma, psychiatric symptoms such as cutting or self-harm behaviours, autism or ADHD, feelings of shame due to same-sex attraction and many other issues a young person may be struggling with are often entangled with symptoms of gender dysphoria.

An "affirming" approach to care hides these other issues and does not allow for the possibility that other factors may be the cause of a young person's new-found gender identity and be driving the need to medically transition as a psychological coping mechanism.

Medical transition under the affirmation approach is experimental treatment. It uses drugs which have not been adequately studied for use in children and which can have serious long term side effects.

The distinction between the previous, cautious model of care and the new "affirmation" model is that children could be supported in their gender exploration without the need for all adults to agree and "affirm" that the child actually "is" the opposite sex or a gender of their choice and provide them with whatever medical means they desire to transform their bodies to match their gender identity.

The previous model of care recognized that there are many factors that can lead to the development of distress over an individual's gender, and equally, that there are just as many routes out of such distress. The affirmation approach has been pushed forward along with the trans civil rights movement, and an "affirmation or conversion" binary is developing whereby any form of ethical psychotherapy that can ameliorate feelings of gender distress is being classified as conversion therapy. [3]

In fact, **a Canadian research team associated with TransYouthCan determined that 8.8% of Canadian youth being seen at gender clinics had participated in conversion therapy and a further 9.7% of parents had considered "having their youth participate".**[4] This means that hundreds of Canadian families are subjecting their children to conversion therapy – likely without understanding that any form of supportive therapy is now considered conversion therapy by the professional associations that are directing the approach to treating gender questioning youth in Canada. Canadian Gender Report contacted 2 members of this research team to request how they had defined "conversion therapy" for the purposes of this research but did not receive a response.

This is illustrative of a growing divide among healthcare professionals. Many clinicians have started to challenge the claims of "affirmation" advocates. They are pointing out that the availability of a broad range of non-coercive, ethical psychotherapies for individuals with gender-related distress is essential to meaningful informed consent, which requires consideration of the full range of treatment options, from highly invasive to non-invasive. Given the potential of agenda-free psychotherapy to ameliorate gender dysphoria non-invasively

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

[3] Roberto D'Angelo et al, "One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria" (2020) Arch Sex Behav , online: <https://doi.org/10.1007/s10508-020-01844-2>.

[4] Arati Mokashi, MD,FRCPC, Margaret L Lawson, MD, Sandra Gotovac, PhD, Greta R Bauer, PhD, SUN-LB14 Trans and Non-Binary Youth Accessing Gender Affirming Medical Care in Canada: New Research From the Trans Youth CAN!, *Journal of the Endocrine Society*, Volume 4, Issue Supplement_1, April-May 2020, SUN–LB14, https://doi.org/10.1210/jendso/bvaa046.2153

among young people with GD, withholding this type of intervention, while promoting "affirmation" approaches that pave the way to medical transition, is ethically questionable. [5]

What Does the Bill Mean?

To understand the possible impact of the Bill on therapy, it is helpful to consider some examples of cases which have occurred in Canada:

- A 13 year old girl is sexually assaulted and soon after, begins to identity as a boy.
- A 15 year old girl who is often the victim of bullying and harassment at school and feels shame and confusion because she is same sex attracted, begins to identify as a boy.
- A 12 year old pre-pubescent boy is a late-developer and experiences social isolation and anxiety. After a school presentation on being transgender he becomes convinced that he is a "demi-girl."
- A 14 year old girl with un-diagnosed autism decides that she is non-binary and demands a prescription for testosterone and a double-mastectomy.
- A 16 year old girl with an eating disorder and dependence on social media for validation finds that taking "T", the street name for testosterone, gives her a feeling of control over her body and helps the fat melt away.

How would the bill affect the way therapists would respond to each case?

There are two ways of looking at this question. The first is to ask what a criminal court would decide if a therapist who recommended against medical transition were charged with practicing conversion therapy on a minor.

The answer here is that we do not know and are unlikely to find out. The language of the bill, both in its definitions and exemptions, is vague and uses language and concepts that have not been examined by the courts. It is highly unlikely that any licensed therapist will be charged with conversion therapy for gender identity.

The second and more important question is how will therapists interpret the law in their day to day practice to avoid being charged in the first place? Even an unsuccessful criminal charge could ruin a professional through legal costs, lost income, and damage to reputation. Therapists will therefore try to avoid even the remote possibility of a charge by keeping well within the law.

Dr. Ken Zucker [6] and Dr. James Cantor [7] are clinical psychologists and researchers with extensive experience working with gender dysphoria. They both told the Justice Committee that while the bill allows therapists to conduct "exploration" of gender identity it does not provide any meaningful guidance as to what kinds of exploration would be permissible.

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[5] Anna Churcher Clarke & Anastassis Spiliadis, "'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties" (2019) 24:2 Clin Child Psychol Psychiatry 338–352.

[6] *Evidence of Kenneth Zucker* (2020) , online: <https://www.ourcommons.ca/DocumentViewer/en/43-2/JUST/meeting-13/evidence#T1235>.

[7] *Evidence of James Cantor* (2020) , online: <https://www.ourcommons.ca/DocumentViewer/en/43-2/JUST/meeting-13/evidence#T1240>.

Dr. Cantor has also published a more detailed critique of the bill in his blog. He argues that there is no such thing as conversion therapy for gender identity in children and adolescents. The existing evidence all relates to sexual orientation in adults. [8]

He fears that the language which is intended to allow for exploration provides only ambiguous protection. The result will be a "chill effect" among licensed therapists who will fear that anything other than immediate affirmation of a patient's declared gender identity will be regarded as conversion therapy.

This "chill effect" already exists because of provincial legislation and professional and clinical policies. Canadian gender clinics are prepared to approve puberty blockers and cross sex hormones for young and younger patients after only one or two appointments. Meanwhile parents struggle to get autism assessments and other mental health support.[9]

The exemption in Section 320.101 for "exploration and development of an integrated personal identity without favouring any particular sexual orientation, gender identity or gender expression" only adds further uncertainty. Integrated personal identity is a recognized concept in psychology but it is a complex one with differing schools of thought. Professional therapists should not have to face uncertainty as to how judges who are not trained in psychology will interpret complex professional literature.

There is also a contradiction between the reference to not favouring a particular gender identity and the main part of the definition, which explicitly disfavours cis-gender identity. The only safe direction of exploration for therapists will be towards medical transition.

Changing International Consensus on Gender Re-assignment

The Bell v. Tavistock Decision

The same day that the Justice Committee began its hearing on Bill C-6, the High Court in the United Kingdom delivered a judgment which will have major implications for treatment of gender dysphoria in minors in that country. [10]

One of the applicants in the case was Keira Bell, a young woman who was a patient at the Tavistock Clinic, which is the main child and adolescent gender clinic in the U.K.. She received puberty blockers and cross sex hormones as a teen and a double mastectomy as a young adult. In her twenties, she resumed her female identity and brought the legal action in which she alleged that the doctors at Tavistock had not properly diagnosed and treated her mental health problems. [11]

The legal issue was whether minors had the capacity to give informed consent to the administration of puberty blockers. The court found that children under the age of 16 not capable of consenting to puberty blockers and court authorization was required for treatment. Even in the case of teens 16 and over, where there was a legal presumption of capacity to consent, there were cases where it would be prudent to seek court authorization.

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[8] James Cantor, "Bill C-6", (13 October 2020), online: *Sexology Today* <http://www.sexologytoday.org/2020/10/bill-c-6.html>.

[9] "Gender Dysphoria and Autism: A Parent Speaks Out", (3 September 2020), online: *Canadian Gender Report* <https://genderreport.ca/gender-dysphoria-and-autism/>.

[10] *R (on the application of) Quincy Bell and A -v- Tavistock and Portman NHS Trust and others*, [2020] EWHC 3274, online: <https://www.judiciary.uk/judgments/r-on-the-application-of-quincy-bell-and-a-v-tavistock-and-portman-nhs-trust-and-others/> (The applicant is named Quincy in the court documents because she had not changed her legal name back to Keira.).

[11] Keira Bell, "My Story", (7 April 2021), online: *Persuasion* <https://www.persuasion.community/p/keira-bell-my-story>.

The case is currently under appeal and the legal issues may not be directly applicable under Canadian law. However, the findings of fact, which were made after receiving extensive evidence from international experts, are highly relevant.

1. Puberty blockers are an experimental treatment.

There is very little scientific evidence to support the claims made by affirming clinicians that puberty blockers are safe and effective. The studies that do exist have small sample groups, short follow up periods and no control groups.

The claim that puberty suppression leads to improved psychological functioning is based on a single Dutch study of a sample group of only 70, a short follow up period. [12] A follow up study of 44 patients by the Tavistock Clinic in England, did not show that puberty blockers led to any improvement in psychological function.[13] Neither study had a control group so it is possible that there would have been a similar improvement with psychological support without medical transition.

Carl Heneghan, a professor of evidence-based medicine, reviewed the clinical evidence in support of "gender affirming" hormone treatment for children and concluded, "The current evidence base does not support informed decision making and safe practice in children." [14]

Evidence reviews by the National Institute for Health and Care Excellence in the United Kingdom also found that the evidence in support of the use of puberty blockers and cross-sex hormones in young people is very weak.[15]

James Cantor reviewed the evidence in support of the American Academy of Pediatrics policy statement on transgender children and concluded, "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." [16]

Most Canadian gender clinics still rely on the World Professional Association of Transgender Health Standards of Care.[17] This document does not meet international standards for a reliable clinical guideline and has not been accepted as reliable by any guideline review organization. [18]

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[12] Annelou L C de Vries et al, "Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study" (2011) 8:8 The Journal of Sexual Medicine 2276–2283.

[13] 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" (2021) 16:2 PLOS ONE e0243894; Michael Biggs, "Tavistock's Experimentation with Puberty Blockers: Scrutinizing the Evidence", online: <https://www.transgendertrend.com/tavistock-experiment-puberty-blockers/>.

[14] Carl Heneghan & Tom Jefferson, "Gender-affirming hormone in children and adolescents", (25 February 2019), online: *BMJ EBM Spotlight* <https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/>.

[15] *Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria* (National Institute for Health and Care Excellence, 2020) , online: <https://t.co/tLyPFblrMD?amp=1>; *Evidence review: Gender-affirming hormones for children and adolescents with gender dysphoria10?* (National Institute for Health and Care Excellence, 2020) , online: <https://t.co/E0rwGKkrwN?amp=1>.

[16] James Cantor, "American Academy of Pediatrics policy and trans- kids: Fact-checking", (2018), online: <http://www.sexologytoday.org/2018/10/american-academy-of-pediatrics-policy.html>; Cantor, *supra* note 2.

[17] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 7th ed (World Professional Association for Transgender Health (WPATH, 2012), online: <https://www.wpath.org/publications/soc>.

Media reports regularly overstate the strength of the science supporting the affirming model. In 2019 the American Journal of Psychiatry published a study based on Swedish data which found that hormonal and surgical treatment for gender dysphoria resulted in a statistically significant reduction in usage of mental health services.[19] These conclusions were widely quoted in the popular press. However, in response to several critical comments, the editors had the data re-analyzed and published a correction which withdrew the main conclusion.[20] This correction, which is virtually a retraction, has not received anything like the level of publicity of the original flawed findings. [21]

2. There is evidence that almost all children treated with puberty blockers will go on to take cross-sex hormones which in turn will lead to surgery.

Clinicians who follow the affirming approach argue that puberty blockers act as a "pause button" which will allow children time to reflect on their gender without being disturbed by the physical changes of puberty.

In the *Bell* case the evidence showed that they were more like a start switch for the process of medical transition. Prior studies of the "watchful waiting" approach have found that between 65 and 95 percent of children with gender dysphoria will desist and accept their biological sex once they reach puberty. [22]

At the Tavistock clinic, nearly 100 percent of the children who received puberty blockers went to on cross sex hormones followed, in most cases, by surgery after the age of majority. [23]

There are two possible explanations for this phenomenon. One is that the doctors at Tavistock were able to predict which children would desist and which would transition with almost 100 per accuracy. The other is that puberty blockers themselves act to prevent resolution of gender dysphoria. The growing teen remains in a

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[18] LisaMacRichards, "Bias, not evidence dominates WPATH transgender standard of care", (10 January 2019), online: *Canadian Gender Report* <https://genderreport.ca/bias-not-evidence-dominate-transgender-standard-of-care/>.

[19] Richard Bränström & John E Pachankis, "Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study" (2020) 177:8 AJP 727–734.

[20] Richard Bränström & John E Pachankis, "Toward Rigorous Methodologies for Strengthening Causal Inference in the Association Between Gender-Affirming Care and Transgender Individuals' Mental Health: Response to Letters" (2020) 177:8 AJP 769–772.

[21] "Correction of a Key Study: No Evidence of 'Gender-Affirming' Surgeries Improving Mental Health", (30 August 2020), online: *Society for Evidence Based Gender Medicine* <https://segm.org/ajp_correction_2020>.

[22] James Cantor, "Do trans- kids stay trans- when they grow up?", (1 November 2016), online: *Sexology Today* <http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html>; Thomas D Steensma & Peggy T Cohen-Kettenis, "A critical commentary on 'A critical commentary on follow-up studies and "desistence" theories about transgender and gender non-conforming children'" (2018) 19:2 International Journal of Transgenderism 225–230; 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)" (2018) 19:2 International Journal of Transgenderism 231–245.

[23] Polly Carmichael et al, *Gender Dysphoria in Younger Children: Support and Care in an Evolving Context* (Amsterdam, 2016) , online: <http://wpath2016.conferencespot.org/62620-wpathv2-1.3138789/t001-1.3140111/f009a-1.3140266/0706-000523-1.3140268>; Michael Biggs, "The astonishing admission in the Health Research Authority report: The purpose of puberty blockers is to commit children to permanent physical transition", (17 October 2019), online: *Transgender Trend* <https://www.transgendertrend.com/health-research-authority-puberty-blockers-commit-children-permanent-physical-transition/>.

child's body while his or her peers become young adults. The changes to brain and body triggered by the normal flow of hormones which might otherwise help the child resolve his distress and accept his or her sex, do not take place.

4. There is no evidence to support the claim that puberty blockers are safe and reversible.

The claim that puberty blockers are safe and reversible is based mainly on their use to treat precocious puberty. In these cases, the drugs are stopped when the child reaches the normal age of puberty and puberty will proceed. However, this evidence is not necessarily applicable to interfering with the normal window for puberty. Puberty is a critical period for physical, mental, and social development. Very little is known about the effects of blocking the flow of hormones during this period.

Studies have found that puberty blockers slow or stop increase in bone density, which can lead to increased risk of fractures and osteoporosis, [24] and may lead to a decrease in cognitive development. [25]

When puberty blockers are used to treat precocious puberty, they do not result in sterility. However, it is not clear that this is also the case when puberty is blocked during the normal window for puberty. Almost all children treated with puberty blockers for gender dysphoria go on to take cross sex hormones and this combination almost always causes sterility.[26]

The court in *Bell* found that although the physical changes of puberty might resume after puberty blockers were stopped, "the child or young person will have missed a period, however long, of normal biological, psychological and social experience through adolescence; and that missed development and experience, during adolescence, can never truly be recovered or 'reversed'."

5. Children, and even adolescents, lack the capacity to consent to radical, experimental, and irreversible treatments.

Children do not have the capacity to consent to life altering treatments. The human brain continues to develop until around age 25, and the part that controls risk assessment and long-term decision making is the last to develop. [27]

The court in the *Bell* case found that a child or teen did not have the mental capacity or experience to consent to treatments of a life altering nature. Treatment with puberty blockers was experimental and there was little clarity as to the purpose of the treatment. Children under 16 could not be expected to understand how the loss

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[24] Michael Biggs, "Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria" (2021) Journal of Pediatric Endocrinology and Metabolism , online: <https://www.degruyter.com/document/doi/10.1515/jpem-2021-0180/html>; Sebastian E E Schagen et al, "Bone Development in Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones" (2020) 105:12 J Clin Endocrinol Metab; Mariska C Vlot et al, "Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents" (2017) 95 Bone 11–19.

[25] Maiko A Schneider et al, "Brain Maturation, Cognition and Voice Pattern in a Gender Dysphoria Case under Pubertal Suppression" (2017) 11 Front Hum Neurosci , online: <https://www.frontiersin.org/articles/10.3389/fnhum.2017.00528/full>.

[26] Brie Jontry, "Does prepubertal medical transition impact adult sexual function?", (7 September 2018), online: *4thWaveNow* <https://4thwavenow.com/2018/07/08/does-prepubertal-medical-transition-impact-adult-sexual-function/>.

[27] *The development of cognitive and emotional maturity in adolescents and its relevance in judicial contexts: Literature Review*, by Suzanne O'Rourke et al (2020), online: <https://www.scottishsentencingcouncil.org.uk/media/2044/20200219-ssc-cognitive-maturity-literature-review.pdf>.

of the ability to have biological children might affect their adult life or what it would mean to lose normal sexual response.

In Canada, the law of informed consent to medical treatment is a provincial responsibility but it is relevant to Bill C-6 because of the way in which the bill disrupts the process of obtaining consent. One of the key requirements of informed consent is that patients must be informed of any alternative treatments and their risks and benefits. The ambiguous wording of the definition of conversion therapy will discourage therapists from discussing alternatives to medical transition.

In Canada, a 14-year-old can consent to hormone therapy which will result in sterility and long term health risks. A 17-year-old can consent to surgery to remove her breasts. However, under Bill C-6 they would not be able to consent to talk therapy that that may help them gain a deeper understanding of their discomfort with themselves and the factors that have contributed to their distress and resolve these issues without the need for invasive medical interventions.

Other International Developments

The United Kingdom

The court decision reflects concern over practices at gender identity clinics for minors in the United Kingdom which has been growing over a period of years.

In September 2020, that National Health Service commissioned an independent review of gender identity services for children and young people, including issues relating to puberty blockers and cross-sex hormones.[28]

The NHS also revised its web page on gender dysphoria so that it no longer assures parents that puberty blockers (GnRH analogues) are "fully reversible" and advises instead that many risks are unknown.[29] By contrast, information promoted to the public in Canada such as the Trans Care BC website states that, "There are no known irreversible effects of puberty blockers...." [30]

Finland

Finland has recently issued new clinical guidelines for the treatment of gender dysphoria in minors. Hormone therapy is permitted only after a thorough psychological assessment determines that the gender dysphoria is severe and permanent in nature.[31]

Sweden

In Sweden, a major hospital recently announced that it would be discontinuing hormone therapy for gender dysphoria on minors under the age of 16 and offer it to those under 18 only on a restricted basis.[32] The

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[28] "NHS England » NHS announces independent review into gender identity services for children and young people", online: <https://www.england.nhs.uk/2020/09/nhs-announces-independent-review-into-gender-identity-services-for-children-and-young-people/>.

[29] James Kirkup, "The NHS has quietly changed its trans guidance to reflect reality" *The Spectator* (4 June 2020), online: <https://www.spectator.co.uk/article/the-nhs-has-quietly-changed-its-trans-guidance-to-reflect-reality>.

[30] Trans Care BC, "Puberty Blockers for Youth", online: *Trans Care BC* <http://www.phsa.ca/transcarebc/child-youth/affirmation-transition/medical-affirmation-transition/puberty-blockers-for-youth>.

[31] "Finland Issues Strict Guidelines for Treating Gender Dysphoria", (11 May 2020), online: *Canadian Gender Report* <https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/>.

[32] "Sweden's Karolinska Ends the Use of Puberty Blockers for < 16: New policy statement from the Karolinska Hospital", (5 May 2021), online: *Society for Evidence Based Gender Medicine* <https://segm.org/Sweden_ends_use_of_Dutch_protocol>.

government has dropped plans to reduce the minimum age for surgery from 18 to 15 and commissioned three government agencies to review the diagnosis and treatment of gender dysphoria. [33]

Changing Gender Identity – Desistance, Detransition and Regret

One of the premises of the affirming model of care is that gender identity is innate and cannot be changed through therapy.

The myth of innate and unchangeable gender identity is exploded by the testimonies of detransitioners and desisters. People who experience gender dysphoria as children and grow out of it are the silent majority in the debate on gender identity. They simply get on with their lives and have no further reason to worry about gender issues. The minority who transition become the transgender activists. At least one desister did tell her story to the Justice Committee. She worries that this Bill will deny children the kind of supportive therapy that helped her.[34]

Transgender activists claim that regret and detransition are extremely rare. The truth is we do not know much about this. Studies which find very low rates of regret also have very high rates of loss to follow up. This may reflect the fact that people who regret their decision to transition will often resent and avoid the clinicians who supported that decision. [35]

The combination of large increases in referrals to gender clinics and the elimination of mental health assessments makes a large increase in detransition and regret almost inevitable. Detransitioners are now beginning to organize and speak out. The newly formed Detrans Canada submitted a brief to the Justice Committee which explains their concern that the Bill will prevent detransitioners from receiving the mental health support they need.[36]

Autism and Other Mental Health Issues

Individuals experiencing gender dysphoria are more likely to be on the autistic spectrum or have other psychiatric issues such as ADHD, bipolar disorder and depression compared with the general population. [37] Autism is a developmental disability which creates difficulties with communication and social interaction. Children on the autism spectrum think differently from other children of their sex. Autistic girls struggle socially during puberty. It is easy for them to fall into the trap of thinking that gender transition is the solution. [38]

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[33] "The Swedish U-Turn on Gender Transitioning for Children", (11 December 2020), online: *Canadian Gender Report* <https://genderreport.ca/the-swedish-u-turn-on-gender-transitioning/>.

[34] Erin Brewer, *Submission to the Standing Committee on Justice and Human Rights Respecting Bill C-6 An Act to Amend the Criminal Code (Conversion Therapy)* (2020) , online: <https://www.ourcommons.ca/Content/Committee/432/JUST/Brief/BR10961884/br-external/BrewerErin-e.pdf>.

[35] Robert Withers, "Transgender medicalization and the attempt to evade psychological distress" (2020) 65:5 Journal of Analytical Psychology 865–889.

[36] Detrans Canada, *Brief to the House of Commons Standing Committee on Justice and Human Rights Regarding Bill C-6* (2020) , online: <https://www.ourcommons.ca/Content/Committee/432/JUST/Brief/BR11002561/br-external/DetransCanada-e.pdf>.

[37] Varun Warrier et al, "Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals" (2020) 11:1 Nature Communications 1–12.

[38] Sian Griffiths, "Autistic girls seeking answers 'are seizing on sex change'", *The Sunday Times* (1 September 2021), online: <https://www.thetimes.co.uk/article/autistic-girls-seeking-answers-are-seizing-on-sex-change-3r82850gw>; Elizabeth Hawker, "Autism, Puberty, and Gender Dysphoria", (31 March 2020), online:

In Canada, it seems that a prescription for cross sex hormones can be obtained very quickly but there are long waiting lists for autism assessments. [39] Some clinicians are working on best practices for treating co-occurring gender dysphoria and autism. The current consensus appears to be that transition may be appropriate in some cases, but an extended assessment period is required. [40]

While Canadian research has proven a specificity link between autism and gender dysphoria along with a recommendation for autism screening, no Canadian gender clinics conduct autism screening as a pre-cautionary principle. [41]

Bill C-6 will shift the forum for resolving the issues of the complex interaction of gender dysphoria and autism from medical journals and clinics to the criminal courts. Many young women risk ending up sterile and missing their breasts because clinicians were under legal and professional pressure to approve gender transition without doing a proper mental health assessment.

It is also unlikely, given the highly politicized nature of the "affirmation" approach itself, that any mental health assessments will be re-introduced. Canadian gender clinics have been phasing out mental health assessments as they are deemed "stigmatizing" and "pathologizing" according to the Canadian arm of WPATH (CPATH) which leads the world in advocating for a consent based approach to care, regardless of age, and has actively advocated for the elimination of "gender conversion practices" through legislation: the wording of the definition of conversion therapy found in Bill C-6 can be found on page 4 of this CPATH briefing to the Standing Committee on Health. [42]

Conversion Therapy and Suicide Risk

"Would you rather have a live daughter or a dead son?" is a line from a British mini-series on childhood transition. The fear that a child or teen will commit suicide is often used to frighten parents and clinicians into approving medical transition.

These claims are not backed by any good evidence. The two most recent studies on the issue, which received wide publicity, are both seriously flawed. The first purports to show that recalled exposure to "conversion therapy" results in increased suicide attempts among transgender adults.[43] The second claims that availability of puberty suppression reduces suicidal ideation among transgender adults. [44]

4W - A Feminist Publication <https://4w.pub/autism-puberty-gender-dysphoria-view-from-an-autistic-desisted-woman/>.

[39] note 8.

[40] John F Strang et al, "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents" (2018) 47:1 Journal of Clinical Child & Adolescent Psychology 105–115.

[41] Jonathan H Leef et al, "Traits of autism spectrum disorder in school-aged children with gender dysphoria: A comparison to clinical controls." (2019) 7:4 Clinical Practice in Pediatric Psychology 383–395.

[42] Canadian Professional Association for Transgender Health, *Brief to the Standing Committee on Health: A Canada without barriers to the health and well-being of trans and gender diverse people* (2019) , online: <https://www.ourcommons.ca/Content/Committee/421/HESA/Brief/BR10482210/br-external/CanadianProfessionalAssociationForTransgenderHealth-1-e.pdf>.

[43] Jack L Turban et al, "Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults" (2020) 77:1 JAMA Psychiatry 68–76.

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Both studies contain serious flaws. They both relied on the same survey conducted by a transgender advocacy organization which is considered to be low quality data for research purposes.[45] Neither study included controls for mental illness, which is the largest contributor to suicidal thoughts. A critique of the study on conversion therapy found numerous errors in the data analysis and concluded, "Presenting a highly confounded association as causation is a serious error, given its potential to dangerously misinform and mislead clinicians, policymakers, and the public at large about this important issue." [46]

Conclusion

Bill C-6 will disrupt the process of obtaining informed consent and enforce a one-way path to medical transition for gender questioning youth. It is already extremely difficult for parents, gender questioning youth and detransitioners to access non-invasive and agenda-free healthcare options to allow them to receive a differential diagnosis prior to medical transitioning or to receive support to manage symptoms of gender dysphoria without hormones and surgery.

We are asking for the following exemption to be added to Bill C-6 to ensure healthcare professionals can support youth effectively:

> For greater certainty, this definition does not apply to any advice or therapy provided by a social worker, psychologist, psychiatrist, therapist, medical practitioner, nurse practitioner or other health care professional as to the timing or appropriateness of social or medical transition to another gender, including discussion of the risks and benefits and offering alternative or additional diagnoses or courses of treatment.

Without this exemption, Bill C6 will further entrench the doctrine of "affirmation" in the Canadian healthcare system. While all individuals should be treated with dignity and respect, the poorly understood approach of gender-affirming care is being challenged around the world for leading children down a narrow treatment pathway of invasive and often irreversible medical interventions with no evidence of improved long-term health outcomes. Our government should be protecting the interests of all youth by conducting an independent review of gender transition services including a review and evaluation of whether children possess the ability to consent to the life-altering treatments that are being offered to them under the mantra of "affirming care".

[45] Michael Biggs, "Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria" (2020) Arch Sex Behav , online: <http://users.ox.ac.uk/~sfos0060/PubertyBlockers&Suicidality.pdf>.

[46] D'Angelo et al, "One Size Does Not Fit All", *supra* note 3.

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