The Health and Well-Being of Trans and Nonbinary Youth in Canada

October 2026

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> *Revision and Editing:* ChatGPT-4o and Antidote 12 were used to assist with the rephrasing of certain passages in English (idiomatic word choice, improved language fluency, and summarization) and to proofread the English and French text (spelling, grammar, and punctuation). Each suggested rephrasing was reviewed by the authors.

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Land Acknowledgement

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Foreword

The authors of this report came together within the College of New Scholars, Artists and Scientists of the Royal Society of Canada to form the Interdisciplinary Research Group, *The State of Knowledge on Trans and Nonbinary Youth Well-Being*.

In this report, they present the current knowledge on the health and well-being of trans and nonbinary youth in Canada and the conditions that enable them to thrive.

Interdisciplinary Research Groups provide a vital means for members of the College to combine their expertise on important and complex subjects. Through this collaboration, they mobilize interdisciplinary knowledge in service of Canadian society.

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Executive Summary

Trans and nonbinary (TNB) youth in Canada face higher levels of psychological distress, discrimination, and minority stress. However, they also exhibit remarkable resilience when supported within affirming environments. This report synthesizes current research on TNB youth in various areas: law and policy, minority stress, mental health, gender-affirming medical care (GAMC), family and school environments. It aims to provide a comprehensive picture of the challenges faced by these youth and the conditions that enable them to thrive.

Research indicates that TNB youth are disproportionately affected by mental health issues, including high levels of anxiety, depression, and suicidal ideation. These disparities are not inherent to gender diversity, but are primarily driven by external factors, such as stigma, discrimination, and hostile social environments, such as school bullying. When TNB youth receive support from their families, healthcare providers, and schools, these disparities significantly decrease.

Studies on gender-affirming medical care (GAMC) suggest that individuals who require it can benefit from access to puberty blockers, hormone therapy, and related treatments. These interventions have been shown to improve mental health and overall well-being, with no reported adverse effects in the available data. Some people argue for limiting access pending further "gold standard" research. However, experts say that such standards are often impractical or unethical in this context. Instead, a broad range of research—from observational longitudinal studies to qualitative research—provides strong support for the benefits of gender-affirming care.

Families also play a critical role. Parental support, for example, emerged as one of the most powerful protective factors for TNB youth. Additionally, schools, notably supporting staff and peers, are crucial in shaping TNB students' well-being. Policies that foster gender inclusivity, supportive staff members, inclusive curricula, and safe school climates are all essential in reducing risk and promoting a sense of belonging.

Available data leave no doubt that TNB youth thrive in affirming, well-equipped, and welcoming settings. The report concludes with a series of tailored suggestions for families, professionals, researchers, and decision-makers. These recommendations aim to reduce disparities, enhance mental well-being, and ensure that TNB youth across Canada can experience safety, dignity, and opportunities in all areas of life.

1. Introduction: Socio-Political Context

Over the last decade, greater visibility for trans and nonbinary (TNB) people has contributed to increased public awareness of their experiences. More diverse and relatable representations have enabled some individuals to recognize and affirm their gender nonconforming identities (Mocarski et al., 2019), including among youth.

Defining Trans and Nonbinary Youth

Trans and nonbinary youth (TNBY) refers to adolescents under the age of 18 whose gender identity differs from their sex assigned at birth. For example, a trans girl identifies as a girl but was assigned male at birth (AMAB), whereas a trans boy identifies as a boy but was assigned female at birth (AFAB). A nonbinary youth does not identify exclusively as a girl or as a boy.

Some TNB youth may experience **gender dysphoria**—a distress associated with a feeling of incongruence between the gender identity and the sex assigned at birth, according to the Diagnostic and Statistical Manual 5 (Crocq et al., 2015). This concept is sometimes criticized for being pathologizing (Infantolino, 2025). In their 11th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-11), the World Health Organization (WHO) (2022) proposed the diagnostic of **gender incongruence**, which is also marked by a persistent discrepancy between gender identity and sex assigned at birth, with a desire to transition. The definition offered by ICD-11 is often considered less pathologizing because it does not require the person to experience distress and is placed as a 'condition related to sexual health' rather than a 'mental and behavioural disorder' as in the previous version of the ICD.

The feelings of incongruence experienced by a person can be **physical** (feeling of incongruence between gender identity and physical or secondary sexual characteristics), **social** (incongruence between gender identity and gender expectations) or both. However, not every TNB youth experiences gender dysphoria, and some youth prefer to label their experience as ***gender euphoria***, referring to positive feelings resulting from gender affirmation or transition (Austin et al., 2022). Gender euphoria and gender dysphoria can occur with varying degrees of intensity throughout one's life and may also alternate or occur simultaneously.

Positive media coverage of gender nonconforming identities has been shown to foster joy, hope, and a sense of belonging among TNB youth (Pham et al., 2020). This growing social acceptance is reflected not only in the increase in referrals to gender clinics (Pang et al., 2020), but also in legal changes at both the federal and provincial levels. Consider the Canadian Human Rights Act's 2017 inclusion of protection for gender identity and expression, or the 2022 federal ban on conversion therapies.

This growing visibility and recognition of TNB youth have also impacted health and social services provision, whereby increased efforts have been made to adapt services offered to those populations and to their families. Some professional associations, such as the Canadian Association of Social Workers (2017), the Canadian Paediatric Society (2023),

or the Canadian Public Health Association (2024) have also published guidelines or practice statements to accompany TNB and their families.

What is a transition?

TNB youth may want to transition, socially, legally, and/or medically.

A **social transition** involves changes in gender expression and social presentation such as clothing, behaviour, chosen name and pronouns.

A **medical transition** is usually achieved through **gender-affirming medical care (GAMC)** which are procedures that help align appearance with gender identity. GAMC includes a variety of treatment options, ranging from reversible to permanent, so individuals can select the approach that best meet their needs. Notably, GAMC includes puberty blockers prescribed at the onset of puberty (Tanner stage 2), and which pause the development of undesired physical changes It also includes hormone treatments (testosterone, estrogen) that prompt the development of physical characteristics in the affirmed gender, and surgeries (such as mastectomy, breast augmentation, phalloplasty, vaginoplasty, etc.). In Canada, surgeries are not accessible to minors except for mastectomies, which are sometimes offered from the age of 16. Other non-surgical interventions may also support gender affirmation, including permanent hair removal, voice therapy, and esthetic procedures such as facial fillers or injections to modify physical features.

A **legal transition** involves a change of the sex marker and/or the legal name on official papers (such as birth certificates and passports). The age at which one can legally transition depends on the province (see section on the Canadian legal framework).

Note that TNB youth may choose to pursue all, some or none of these forms of transition.

At the same time, growing awareness of TNB youth has coincided with rising concerns regarding minors' access to medical interventions and increased visibility of detransition (Slothouber, 2020), understood as the temporary or permanent interruption of a gender transition for diverse reasons (Expósito-Campos et al., 2023).

Defining Detransition

Detransition research is relatively new, and no consensus on terminology or definitions currently exists. However, some terms and usages are beginning to emerge. The most common term, detransition, can refer to the partial or complete, temporary or permanent cessation or reversal of certain medical, social, or legal aspects of a gender transition (Expósito-Campos et al., 2023). This may occur alongside a cessation of trans identification—but not always. The umbrella term detrans is sometimes used to refer to a range of experiences involving shifts or interruptions in transition (Hildebrand-Chupp, 2020).

People may detransition for a variety of reasons, both internal (e.g., identity shift, dissatisfaction) and external (e.g., discrimination, lack of support, health concerns). Detransition should not be conflated with regret, as some individuals experience regret without detransitioning, while others may detransition without regret (Expósito-Campos et al., 2023).

In 2018, a study published in the journal PLOS One suggested that the increasing number of TNB youth, especially those assigned female at birth could be explained by a form of online and social contagion. The author proposed the hypothesis of Rapid Onset Gender Dysphoria (ROGD) suggesting that some youth transition as a result of social

contamination through online peer interaction as well as a maladaptive coping response to underlying issues, such as mental health challenges, autism, internalized homophobia, or misogyny (Littman, 2018). This hypothesis has since been strongly criticized by both scholars (Ashley, 2020; Bauer et al., 2022; Restar, 2020; Vandendriessche & Cohen, 2024) and professional associations (Brierley et al., 2024; CAAPS, 2021; WPATH, 2018). One of the main criticisms is that the social contagion hypothesis relies solely on the testimonies of parents of TNB youth, most of whom have been recruited on websites that critic gender transitions (Ashley, 2020; Littman, 2019; Restar, 2020).

Since then, some studies have provided alternative explanations for the apparent rise of youth assigned female at birth who transition during puberty (Kahn et al., 2025; Vandendriessche & Cohen, 2024). No correlation was found between short-term gender identity awareness, one of the key characteristics of ROGD, and mental health challenges or peer contagion (Bauer et al., 2022).

Although the hypothesis of social contagion has not been proven, it has been widely cited in the written press (Slothouber, 2020) and referenced in several recently published reports—particularly in the UK, the US, and Sweden—which similarly question the sufficiency of the scientific evidence supporting gender-affirming care for minors (Cass, 2024; Department of Health and Human Services, 2025; The National Board of Health and Welfare, 2022). Those reports have themselves been subject to strong critics from scholars, notably for their selective interpretation of evidence and for omitting the demonstrated benefits of GAMC (Grijseels, 2024; McNamara et al., 2024; Noone et al., 2024).

Indeed, there is a vast body of scientific evidence related to factors and interventions, including GAMC, impacting TNB youth's functioning and well-being. Among key reference documents, the World Professional Association of Transgender Health (WPATH) published since 1979, their *Standards of Care (SOC) for the Health of Transgender and Gender Diverse People,* which are developed through a Delphi process and are based on the latest scientific evidence (Coleman et al., 2022).

That said, while these Standards are accepted by many professionals and organisation, including by the Canadian Paediatric Society, (Vandermorris & Metzger, 2023), its latest version, SOC 8, have also received increased public scrutiny, notably following the publication of the Cass Report (Cass, 2024) and the related independent systematic reviews produced in this context. At the core of the critics addressed toward SOC 8 is that it would be based on insufficient or weak evidence (Cass, 2024; Kulatunga et al., 2025). However, the Cass Report and the systematic reviews on which it is based have also faced substantial criticism, particularly regarding methodology. Critics have highlighted a high risk of bias across the reviews, citing unexplained protocol deviations, ambiguous eligibility criteria, inadequate study identification, and the failure to adequately account for these limitations in the resulting conclusions (McNamara et al., 2024; Moore et al., 2025; Noone et al., 2025). Importantly, while critics have used these limitations to question the benefits of GAMC, a substantial body of research continues to document positive outcomes.

Increasingly, scholars also argue that the most important question is not whether GAMC should be categorically allowed or prohibited, but rather how it should be delivered in the

safest, most patient-centred, trauma-informed, and evidence-based manner. This shift in focus is also reflected in evolving clinical practice over the past decade, which has highlighted the limitations of relying solely on practice guidelines, as such guidelines often adapt more slowly than emerging evidence and changing standards of care.

While important, those debates have contributed to the amplification of a discourse that fuelled a moral panic around gender-affirming care and the risk of regret (Bossé, 2025; Gelly et al., 2025; MacKinnon et al., 2022; Slothouber, 2020). Some authors have also pointed to a disinformation strategy that aims to normalize anti-trans legislation and is already producing tangible socio-political effects (Billard, 2024; McNamara et al., 2023).

More recently, some countries and jurisdictions have started to ban gender affirming medical care and pass what is considered anti-trans legislation (Cohen, 2023; Grossman, 2024; Movement Advancement Project, 2024). The latter has raised serious concerns about possible impacts on both the physical and mental health of TNB youth (Abreu et al., 2022; Barbee et al., 2022; Dhanani & Totton, 2023; Pham et al., 2020).

Some research has also begun to show these impacts. A US based study found that in states where anti-trans laws have been enacted, the number of TNB youth (particularly those aged 13–17) who had attempted suicide in the past year increased, as did the number of suicide attempts, after these laws were passed (Lee et al., 2024). Ongoing public debates and the passing of such policies targeting trans rights affect the well-being of TNB youth, beyond access restrictions themselves, because of the social climate it creates (Dhanani & Totton, 2023). Furthermore, research shows that negative media coverage of trans-health issues is associated with a decline in referrals to gender clinics, which may reflect growing resistance from professionals and/or parents to support a young person's transition (Indremo et al., 2022). These negative messages may also be internalized by youth, leading to a reluctance to discuss gender-related needs for fear of facing negative reactions (Dhanani & Totton, 2023). As a result, some youth may turn to alternative and riskier means—such as using online sources—to access the treatments they need (Dhanani & Totton, 2023; Pang et al., 2022). Moreover, studies have shown that TNB youth may experience stress, increased fear of discrimination and anxiety about disclosing their identity in response to a hostile socio-political environment (Abreu et al., 2022; Dhanani & Totton, 2023; Pham et al., 2020).

While Canada has not reached the same level of legislative challenges as other places, such as in the United States or the United Kingdom, a similar trend is beginning to emerge (Trianon, 2025). For example, some provinces have introduced measures that restrict trans rights: in Alberta, access to gender-affirming care for minors is now limited, while both Alberta and Saskatchewan require parental consent for students to change their names or pronouns at school (Dryden & Lee, 2024; Farrell, 2025). In Québec, an appointed Committee called the Comité des sages evaluated issues related to transgender people to inform future legislation, and ultimately published a report that reasserts the gender binary, which is male or female, as the foundation of legal recognition (Lavallée et al., 2025). Meanwhile, transphobic rhetoric and acts of trans violence have been on the rise in the past five years (Boynton, 2023; LeBel, 2023), to the point where the Canadian Security Intelligence Service (CSIS) issued a warning about anti-trans movements posing an

“extreme violence” threat and raising concerns about potential terrorist acts to TNB people or those who are seen as their allies (Tunney, 2024). The PRIDE surveys conducted by IPSOS in 2023 and 2024 reflect a deterioration in public opinion toward trans people (IPSOS, 2023, 2024). A similar trend was observed in schools, where discomfort related to a friend disclosing non-binarity rose from 34.5% in 2020–2021 to 59.5% in 2023–2024 (Charbonneau et al., 2025). Moreover, in a recent report, the Human Rights Committee has expressed concerns about Canada's lag in protecting LGBTQ+ rights (Human Rights Committee, 2026; La Presse canadienne, 2026).

Objectives

The current polarizing debate about TNB youth, their well-being, gender affirmation, their moral and bodily autonomy, and their possible impacts on accessing GAMC as minors call for a document provided by experts on different topics who examine the current state of research and practice. Indeed, in the pursuit of “greater objectivity”, many of the recently published reports have been authored by professionals who, despite being recognized for their significant professional achievements, were appointed to chair committees with very limited expertise on the subject itself or direct experience working with gender diverse youth (see, for example, Cass, 2024; Department of Health and Human Services, 2025; The National Board of Health and Welfare, 2022; Comité des sages, 2024). To respond to this polarization, an interdisciplinary research group composed of members of the College of the New Scholars, Artists and Scientists of the Royal Society of Canada was put in place in May 2024 to examine the research evidence and write this report. These experts draw on their involvement with and knowledge of the life paths of gender diverse youth, the challenges that shape their daily lives and the effect of stress on their well-being. Rarely does such a diverse group of experts convene to address urgent issues, and as this report explains, the challenges facing Canadian TNB youth represent one such pressing concern.

This report therefore aims to provide an overview of the Canadian context by synthesizing the most up-to-date Canadian research from the past decade on key issues affecting TNB youth, in order to de-polarize the debate to support a way forward that would improve trans rights and trans care. To this end, we conducted several thematic narrative reviews of research published over this period in Canada on various factors shaping the experiences of TNB youth. The World Health Organization defines adolescents as individuals aged 10–19, youth as those aged 15–24 and young people as those aged 10–24 (World Health Organization, n.d.). Our primary focus was on studies involving Canadian youth under 18—which is commonly used as a threshold between minors and adults. However, we sometimes had to include studies that encompassed broader age ranges, notably young people aged 18 to 25, when data were not disaggregated by age. This decision reflects both the variability of the age of majority across Canadian provinces and territories (ranging from 18 to 19) and the frequent inclusion of this age group in research on TNB youth, due to sample size constraints and the continuity of developmental trajectories across adolescence and emerging adulthood. Besides, some studies were conducted in transnational contexts, particularly between Canada and the United States, or in other international settings. When applicable, the geographical scope and age range of the studies are specified.

This white paper first provides an overview of the legal landscape regarding informed consent and access to gender-affirming care across Canadian provinces. Then, it offers a portrait of the mental health outcomes observed among TNB Canadian youth and analyzes the putative impacts of minority stress. This is followed by a more detailed examination of research investigating their lived experiences in three core contexts: the medical system (including access to gender-affirming care), family (especially parental support), and school environments. The report concludes with evidence-based recommendations for practitioners, policymakers, and researchers working with or on behalf of TNB youth.

2. Legal landscape in Canada: informed consent and protection against discrimination

Throughout Canada, healthcare, including psychiatric and gender-affirming care, is primarily a provincial and territorial jurisdiction, leading to a patchwork of legal frameworks. Some provinces and territories do not have any specific legislation regarding capacity for a minor to consent to treatment, whilst some provinces and territories have gone ahead to enact specific legislation. Specific policies on gender-affirming care (including puberty blockers, hormones, and psychiatric assessments) are under active revision in multiple provinces and territories, with psychiatric assessments being increasingly emphasized, sometimes being mandated as a precondition for medical interventions (for example, Prince Edward Island and Nova Scotia).

Recent political and judicial debates involve so-called parental rights. Organizations and parents have taken legal action to assert parental rights in education, attacking, for example, the "protections for LGBTQ+ students, including prohibitions on exposing children to their parents or peers, who participate in 'gay-straight alliances' and 'queer-straight alliances'" (*PT v Alberta* (2018), at parag. 1), or to remove their children from gender-related education (*Benkoula (Benkoula) c. Centre de services scolaire Marguerite-Bourgeoys* (2024)). These lawsuits were generally lost (*PT v Alberta* (2019); *Benkoula (Benkoula) c. Centre de services scolaire Marguerite-Bourgeoys* (2024)).

Litigations based on the Canadian Charter, or on provincial legislation, most often in matters of discrimination, have been filed over the past twenty years, with an increase of litigations in the last five years. This section of the report provides an overview of legal provisions and case law relating to discrimination related to gender, on consent to treatment, including affirmative care, and on other legal debates when relevant.

Federal

Protection against discrimination: The *Constitution Act* (1982) section 15(1): "Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on […] sex […]."

The Supreme Court of Canada in *R. v. Kap* (2008) determined a two-part test for assessing discrimination under section 15(1): (1) Does the law create a distinction based on an enumerated or analogous ground? (2) Does the distinction create a disadvantage by perpetuation prejudice or stereotyping? "Under s. 15(1), the focus is on *preventing* governments from making distinctions based on the enumerated or analogous grounds that: have the effect of perpetuating group disadvantage and prejudice; or impose disadvantage on the basis of stereotyping" (parag. 25). *Centre for Gender Advocacy c. Attorney General of Quebec* (2021) recognized gender identity as a ground of discrimination analogous to the grounds listed in section 15 of the Charter.

The *Canadian Human Rights Act* (1985), section 2 "extends the laws in Canada to give effect, within the purview of matters coming within the legislative authority of Parliament, to the principle that all individuals should have an opportunity equal with other individuals to make for themselves the lives that they are able and wish to have and to have their needs accommodated, consistent with their duties and obligations as members of society, without being hindered in or prevented from doing so by discriminatory practices based on […] gender identity or expression […]."

Based on section 15 of the Charter, courts have ruled against provinces and territories for discriminating against transgender people, for example concerning:

- sex designation on their birth certificates (in Alberta: *C.F. v. Alberta (Vital Statistics)* (2014); in Ontario: *XY v. Ontario (Government and Consumer Services)* (2012); in Quebec: *Centre for Gender Advocacy c. Attorney General of Quebec* (2021));
- the requirement to identify themselves as father and mother rather than as parent (in Quebec: *Centre for Gender Advocacy c. Attorney General of Quebec* (2021));
- the requirement for parental consent for a name change for a minor aged 14 or older (in Quebec: *Procureur général du Québec c. Centre de lutte contre l'oppression des genres*, 2024 QCCA 348);
- access to affirming care (*Hogan v. Ontario (Health and Long-Term Care)* (2006)).

In some cases, litigants invoke Section 7 of the Charter, namely the right to life, liberty and security of the person.

Update by Province and Territory

British Columbia

Protection against various grounds of discrimination: *Human Rights Code*: "gender identity, gender expression". British Columbia Human Rights Tribunal has punished discrimination based on gender identity and expression in matters of tenancy (*Wiebe v. Olsen*, 2025 BCHRT 14).

Consent to Treatment: B.C. uses a capacity-based consent model by virtue of the *Infants Act*. Under the Act, there is no minimum age to consent to medical treatment, including gender-affirming care. Youth under 19 may consent to their own healthcare if they understand the treatment and have the maturity to make their own medical decisions.

Access to affirmative care: Readiness assessment for puberty blockers, hormone therapy and surgery is conducted by primary care providers (Trans Care BC).

Debates: The current BC government strongly supports trans rights, with no plans to restrict access. The Court of Appeal and the Supreme Court of British Columbia have

repeatedly determined that young people under the age of 19 have the maturity to make their own decisions about hormone treatment or gender-affirming surgery, including without their parent's consent (*A.B. v. C.D.* (2020); *A.M. v Dr. F* (2021); *G.M.S. v Dr. Z*, (2021)).

Alberta

Equality as a fundamental principle: *Alberta Human Rights Act*, preamble: "gender identity, gender expression."

Protection against discrimination: section 3(1)(b): "gender identity, gender expression"

Consent to Treatment: Alberta, like most provinces, follows the "mature minor doctrine", which means that minors who demonstrated sufficient understanding could consent to their own medical care as it was held in the classic case of *A.C. v. Manitoba (Director of Child and Family Services)* (2009).

Access to affirmative care: Since December 2025, certain drugs, including puberty blockers and hormone replacement therapy, as well as gender-affirmative surgery are prohibited to persons under the age of 18 for the treatment of gender dysphoria or gender incongruence (*Health Statutes Amendment Act*, 2024 (N°2)).

New Developments: Several major legislative amendments were enacted in 2024 in Alberta. The *Education Act* (2012) was modified to include the following requirements in cases where a student wishes, for reasons related to gender identity, to have a "new preferred name or pronouns" used by teachers and school staff. In such cases, the board is required to notify the parents of the request. The teachers and school staff shall not use a new preferred name or pronouns "in the case of a student who is 16 or 17 years of age, until the student's parent is notified under subsection" or, in the case of a student who is under 16 years of age, unless the parent provides consent. If notifying the student's parent "is reasonably expected to cause emotional or psychological harm to the student," the student must be provided with counselling.

The *Fairness and Safety in Sport Act* (2024) establishes a board tasked with verifying the eligibility of sports participants and reporting to the Minister any complaints regarding eligibility determinations, as well as any requests for or establishment of mixed-gender or mixed-sex leagues, classes, or divisions.

With the aim of preventing litigation (*Egale Canada v Alberta* (2025)), the province has exempted the *Health Professions Act*, the *Education Act* and the *Fairness and Safety in Sport Act* from the application of certain provisions of the *Canadian Charter of Rights and Freedoms*, the *Alberta Bill of Rights* and the *Alberta Human Rights Act*.

Saskatchewan

Protection against discrimination: *The Saskatchewan Human Rights Code*, section 2(1): "gender identity".

Consent to Treatment: According to the Informed Consent to Care Policy, mature minors—that is, individuals under the age of 18 whose capacity to consent to treatment has been established in accordance with the procedure set out in the policy—are entitled to make decisions regarding their own care. Rule 3.4 provides that "the health-care provider most responsible for the care assesses, determines and validates that the patient has demonstrated capacity". Furthermore, rule 3.5 of the policy provides for an assessment by a professional who meets the specific needs of the patient where the healthcare provider does not have the expertise.

Access to affirmative care: Readiness assessment for puberty blockers, hormone therapy and surgery is conducted by primary care providers (Government of Saskatchewan).

Debates: However, *The Education (Parents' Bill of Rights) Amendment Act* (2023) which was passed in October 2023 using the notwithstanding clause to bypass the *Charter of Rights and Freedoms*, which has the effect of shielding the legislation from constitutional scrutiny by the courts (*Saskatchewan (Minister of Education) v UR Pride Centre for Sexuality and Gender Diversity*, 2025 SKCA 74). The law mandates: (a) parental notification and consent when a student under 16 requests to use a different name or pronoun at school (b) explicit protections for parental authority in directing children's education and upbringing. A case is presently in the court of appeal to decide on the constitutionality of the Act.

Manitoba

Protection against discrimination: *The Human Rights Code*, section 9(2)(g) "gender identity," 9(2)(g1) "gender expression". The Manitoba Human Rights Board of Adjudication has punished discrimination based on gender identity in matters of recognition of nonbinary sex designations on Manitoba birth certificates (*T.A. v Manitoba (Justice)*, 2019 MBHR 12).

Consent to Treatment: According to the *Health Care Directives Act* youth over 16 can consent independently. For youths within the ages of 12–15, capability is assessed case-by-case. Although the law primarily addresses advance care directives, it embeds the principle that a person must have the mental capacity to make their own health decisions.

Specifically: Section 4(1) of *The Health Care Directives Act* which states that "A person who has the capacity to make healthcare decisions for himself or herself may make a healthcare directive." By extension, capacity is always assessed individually, not by age alone.

According to the case of *A.C. v. Manitoba (Director of Child and Family Services*) (2009), it was held that children under 16 can consent to medical treatment if they demonstrate sufficient maturity to understand the treatment and its consequences. Thus, if a minor is mature enough, their treatment wishes must be respected. The Court acknowledged that the Child and Family Services Act of Manitoba allows intervention only if a minor is deemed incapable of making a decision and facing a serious health risk.

These legal principles for youth consent extend to gender affirming care, as there is no express law regarding gender affirming care in Manitoba.

Access to affirmative care: The Manitoba government eliminated the requirement for two specialist referrals to access affirmative care in 2024. Since then, assessment and referral by a primary health care professional is sufficient (Government of Manitoba, 2024). Some surgeries are available to people aged 16 and older, while others are only available after the age of 18 (Gender Diversity and Affirming Action for Youth).

Ontario

Protection against discrimination: *Human Rights Code,* section 1: "gender identity, gender expression." Human Rights Tribunal of Ontario has punished discrimination based on gender identity and expression in matters of employment (for example *S.R. v. DLPH Hambleton Group Inc. (aka Burger King Franchise 3566)* (2024); *Lewis v. Sugar Daddys Nightclub* (2016)).

Consent to Treatment: Ontario follows the *Health Care Consent Act* (1996), which bases consent on capacity, not age. The section prescribes a definition of capacity to consent to treatment: 4(1) *"A person is capable with respect to a treatment if the person is able to understand the information that is relevant to making a decision about the treatment and is able to appreciate the reasonably foreseeable consequences of a decision or lack of decision."* Youth of any age, including 12–13 years old, can consent if assessed capable.

For gender-affirming care, this means that any youth, regardless of age, can consent to puberty blockers, hormone therapy, or related care as long as they are assessed as capable. No parental consent is legally required if the healthcare provider determines that the youth understands the nature and effects of the treatment and appreciates the risks and benefits involved.

Access to affirmative care: Readiness assessment for puberty blockers, hormone therapy is conducted by primary care providers. For a chest surgery, one assessment by a qualified doctor or nurse practitioner is required. For a genital surgery, two assessments are required for genital surgery, one of which must be by a physician or nurse practitioner confirming, among other things, a diagnosis of gender dysphoria (Ontario Ministry of Health; Ontario Ministry of Health, Schedule for Benefits, February 14, 2025).

New Development: In the case *Ontario (Health Insurance Plan) v. K.S.*, decided in 2025 by the Ontario Court of Appeal, a dispute arose as to whether gender-affirming surgery qualifies as an insured service to be paid for by the Ontario Health Insurance Plan. In this case, K.S. had received a diagnosis of gender dysphoria, had undergone 12 continuous months of hormone therapy, and had lived for 12 continuous months in a gender role congruent with her gender identity. Two physicians recommended that a vaginoplasty be performed without a penectomy, a procedure that is not available in Canada but can be performed in Texas, which the Ontario Health Insurance Plan refused to fund. The dispute therefore did not concern the necessity or appropriateness of gender-affirming care, or the rights protected by the Canadian Charter associated with such processing, but rather public insurance coverage, with the Ontario Health Insurance Plan asserting that the requested

treatment did not appear on the list of covered treatments because it was considered experimental.

Relying on the Standards of Care of the World Professional Association for Transgender Health, which provide that healthcare professionals must conduct individualized assessment and treatment that allows for consideration of diverse nonbinary experiences of gender, the Court of Appeal held that the vaginoplasty recommended for K.S. is indeed covered by Ontario's public insurance.

Debates: There are minimal legislative debates on affirmative care restrictions. However, recent Parliamentary Activity on Bill 42, *Gender Affirming Healthcare Advisory Committee Act* (2024), which was first introduced by NDP MPP Kristyn Wong-Tam in 2022. This bill would have created a provincial advisory committee on gender-affirming healthcare access and equity, but it failed to pass second reading. The goal was to address systemic barriers, improve regional access, and standardize care (Hasard Transcripts).

Quebec

Protection against discrimination: *Charter of Human Rights and Freedoms*, section 10: "gender identity or expression". Quebec Human Rights Tribunal has punished discrimination based on gender identity in matters of employment (C*ommission des droits de la personne et des droits de la jeunesse (E.B.) c. 9302-6573 Québec inc. (Bar Lucky 7)*, (2024); *Cossette c. Entreprises B. Chouinard* (2021)). The court recognized the oppression resulting from misgendering and inappropriate questions in the context of police questioning (*R. c. Lévesque* (2022)).

Consent to Treatment: Quebec's law for medical decision-making is governed by the *Civil Code of Québec*. Quebec's Civil Code allows mature minors to consent to care. By virtue of section 14, "A minor 14 years of age or over may give his consent alone to care required by his state of health." This means that a 14-year-old or older minor in Quebec can consent independently to receive gender-affirming medical care (including puberty blockers, hormone therapy, etc.). However, for youths under the age of 14, parents or legal guardians must authorize medical care, including gender-affirming treatments.

Access to affirmative care: The standards of the World Professional Association for Transgender Health (2022) are applied in the province. They require a comprehensive biopsychosocial assessment of adolescents requesting care related to medical and surgical transition. It is unclear which professional can conduct the assessment, nor whether a diagnosis of gender dysphoria is required (as has been the case at least until recently).

Debate: Current law remains unchanged under Article 14 of the Civil Code of Québec, and minors aged 14 and older can consent independently to healthcare, including gender-affirming treatment. No bills have been introduced in the National Assembly to change this right or impose new restrictions on access to care for trans youth. Quebec's Ministry of Health continues to support access to gender-affirming care through the public system (RAMQ).

New Brunswick

Equality as a fundamental principle: *Human Rights Act*, preamble: "gender identity or expression"

Protection against discrimination: section 2.1(n): "gender identity or expression"

Consent to Treatment: Under section 3 (1) of the Medical Consent of Minors Act M-6.1 of New Brunswick, consent to medical treatment of a minor below the age of sixteen years is allowed provided that, in the opinion of a legally qualified medical practitioner, dentist, nurse practitioner or nurse attending the minor, (a) the minor is capable of understanding the nature and consequences of a medical treatment, and (b) the medical treatment and the procedure to be used are in the best interests of the minor and his continuing health and well-being. This extends to treatment regarding gender affirmative surgery.

Access to affirmative care: Readiness assessment for puberty blockers, hormone therapy and surgery is conducted by primary care providers. Chest surgeries are accessible from the age of 16 (Government of New Brunswick).

New Development: The province amended its policy on sexual orientation and gender identity in 2023 to require parental consent for students under the age of 16 who request changes to their pronouns or names at school. In response to public outcry and legal proceedings, the incoming government revised the policy in December 2024, resulting in the discontinuation of the litigation.

Prince Edward Island (PEI)

Equality as a fundamental principle: *Human Rights Act*, preamble: "gender expression, gender identity"

Protection against discrimination: section 1: "gender expression, gender identity"

Consent to Treatment: Under the *Consent To Treatment And Health Care Directives Act* (1988), which governs healthcare treatments generally in PEI stipulates in section 7 of the Act that: "a patient is capable with respect to treatment if the patient is, in the health practitioner's opinion, able (a) to understand the information that is relevant to making a decision concerning the treatment; (b) to understand that the information applies to his or her particular situation; (c) to understand that the patient has the right to make a decision; (d) and to appreciate the reasonably foreseeable consequences of a decision or lack of a decision. " This means that there is no age limit set for a person to receive gender affirming care if they meet the criteria stipulated in section 7 of the Act; thus, youth aged 12–16 can consent if they meet the criteria. There is no specific legislation concerning consent to gender affirmative care.

Psychiatric Evaluation: Under section 9 of the *Consent To Treatment And Health Care Directives Act,* "where a health practitioner is of the opinion that (a) pursuant to section 7, a patient is not capable; or (b) pursuant to section 8, a patient has not become capable, with

respect to treatment, the patient may request that a reassessment of his or her capacity be conducted by a psychiatrist or such other practitioner as may be prescribed, and the health practitioner shall inform the patient of the right to make such request.". This means that psychiatric assessment is required if a patient does not meet the capacity test under section 7 of the Act, but is not unique to gender affirmation care.

Access to affirmative care: Readiness assessment for puberty blockers, hormone therapy and surgery is conducted by primary care providers, including for people under 16 (Governement of Prince Edward Island).

Nova Scotia

Protection against discrimination: *Human Rights Act,* section 5 (na)(nb): "gender identity, gender expression"

Consent to Treatment: The *Hospital Act* (1989) and the Consent to treatment Policy provide that no individual may be subjected to treatment without their free and informed consent. Mature minors—that is, individuals under the age of 19 whose capacity to consent to treatment has been established in accordance with the procedure set out in the Treatment Consent Policy—are entitled to make decisions regarding their own care. Where a person under the age of 19 is deemed incapable of consenting to treatment, decisions are made by the substitute decision-maker.

Access to affirmative care: On the 28th of July 2023, a new policy came into effect titled "The Gender Affirming Care Policy". Under the policy, the term adolescent means someone who reaches puberty as assessed by a clinician. It went further to state that the age at which someone reaches adolescence can range between 8 and 14 years. The policy provides criteria for adolescents to be assessed before progressing further to get gender affirming treatment, and it goes as follows:

Assessment process:

- A comprehensive biopsychosocial assessment, including relevant mental health and medical professionals.
- Involvement of parent(s)/guardian(s) in the assessment process unless their involvement is determined to be harmful to the adolescent or not feasible.
- If written documentation or a letter is required to recommend gender affirming medical and surgical treatment (GAMST), only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion of the team that involves both medical and mental health professionals (MHPs).

Criteria for puberty blocking agents, hormonal treatments and surgery:

- Gender diversity/incongruence is marked and sustained over time.
- Meets the diagnostic criteria for gender incongruence in situations where a diagnosis is necessary to access healthcare.

- Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender affirming medical treatments have been addressed; sufficiently so that gender affirming medical treatment can be provided optimally.
- Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility.
- Reached Tanner stage 2.

In addition, for surgery: at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures.

Newfoundland and Labrador

Equality as a fundamental principle: *Human Rights Act*, preamble: "gender identity, gender expression". The Newfoundland and Labrador Human Rights Commission has recognized discrimination based on the requirement of surgery to obtain a change in sex designation on registration of birth and ordered the revision of the criteria (*S.B. v Newfoundland and Labrador (Service Newfoundland and Labrador)*, 2015 NL HRC 153,582).

Protection against discrimination: Section 9(1): "gender identity, gender expression"

Consent to Treatment: The mature minor rule applies in Newfoundland and Labrador, meaning that the capacity to consent is not determined based on age. Minor individuals are considered capable of consenting to treatment provided they can appreciate the nature of the proposed treatment, its anticipated effect, and the consequences of refusing treatment (Consent to Treatment, Standard of Practice). As such, a minor may have the capacity to consent to certain treatments, but not others. Where a physician determines that a minor has the capacity to consent, they must obtain consent from the minor. If a minor does not have capacity, consent must be obtained from the minor's substitute decision-maker. There is no specific legislation or formal parliamentary debate in Newfoundland and Labrador targeting or regulating gender-affirming care for minors.

Access to affirmative care: Readiness assessment for puberty blockers, hormone therapy is conducted by primary care providers. The standards of the World Professional Association for Transgender Health (2022) are applied concerning surgery, which require a comprehensive biopsychosocial assessment of adolescents requesting transition.

Yukon

Protection against discrimination: *Human Rights Act,* section 7 (f.01): "gender identity, gender expression"

The *Sexual Orientation and Gender Identity Protection Act* aims to "protect minor or adults for whom there is a substitute decision-maker or for whom a guardian is appointed, from the harm caused by practices, treatments and other services provided with the objective of

changing their sexual orientation or gender identity," (section 1) i.e., conversion therapy (section 2).

Consent to Treatment: Under the *Care Consent Act* sections 5 and 6, every person, including minors, who is capable (i.e., able to understand relevant information, reasons, nature, risks and benefits) may give or refuse consent to care. Capacity is therefore presumed unless demonstrated otherwise (i.e., a presumption can be rebutted by evidence of a minor's immaturity).

Access to affirmative care: The standards of the World Professional Association for Transgender Health (2022) are applied in the province. They require a comprehensive biopsychosocial assessment of adolescents requesting care related to medical and surgical transition. Two assessments are required for surgery: one from a "qualified assessor", who must confirm among others the "gender incongruence" diagnosis, and one from a "health care practitioner". Several additional elements must be assessed for individuals aged 18 and under, including emotional and cognitive maturity, any mental health issues that may interfere with the assessment of gender congruence, and whether at least 12 months of hormone therapy has been completed (Government of Yukon, Policy B 14: Gender affirming surgery Policy, 2025).

Northwest Territories

Equality as a fundamental principle: *Human Rights Act*, preamble: "gender identity or expression."

Protection against discrimination: Section 5(1): "gender identity or expression"

Consent to Treatment: There is no law governing consent to treatment nor for gender-affirming care in Northwest Territories. However, the mature minor doctrine as held in the case of *A.C. v. Manitoba (Director of Child and Family Services)* (2009) will apply to minors under 19, since the common law applies to the Northwest Territory.

Under the doctrine, a minor may consent to their own medical treatment if a healthcare provider determines that the youth: (a) understands the nature and purpose of the proposed treatment, (b) appreciates the risks and consequences of the decision, (c) is making a voluntary, informed choice. This means that minors within the ages 12–16 can consent to gender affirming care.

Access to affirmative care: Readiness assessment for puberty blockers, hormone therapy is conducted by primary care providers. It is recommended by the *Health Care for Transgender, Non-binary, and Gender Non-conforming People Guidelines* to refer children and youths to a pediatric service. Surgeries are not available for individuals under the age of 19 except for chest surgery that may be possible if a "clinical expert" and a surgeon consider it appropriate. A list of several requirements must be met to access surgeries, including a "persistent and well documented gender dysphoria" (Government of Northwest Territories, 2020:10), confirmation that social, medical, and mental health needs have been assessed and addressed, and completion of 12 months of hormone therapy (recommended, not always required).

Nunavut

Protection against discrimination: *Human Rights Act,* CSNu 2002, c H-70, section 7 (1): "gender identity, gender expression" **Consent to Treatment:** There is no specific law or stipulated age of consent for treatment in Nunavut. However, the common law principles of the mature minor doctrine, as defined by Supreme Court of Canada in the case of *A.C. v. Manitoba (Director of Child and Family Services)* (2009) will apply to minors under 19 to the Nunavut, as it relies on common law principles.

Under the doctrine, a minor may consent to their own medical treatment if a healthcare provider determines that the youth: (a) understands the nature and purpose of the proposed treatment, (b) appreciates the risks and consequences of the decision, (c) is making a voluntary, informed choice. This means that minors within the ages 12–16 can consent to gender affirming care.

Access to affirmative care: Readiness assessment for puberty blockers, hormone therapy and surgery is conducted by primary care providers, but the criteria are not clear.

This section overviewed federal and provincial legal provisions and the case law that highlight key protections and their recurring gaps. It does not claim to be exhaustive but offers a foundation for understanding the broader legal context in which Canadian trans and nonbinary young people navigate daily life. Protections against gender identity and gender expression discrimination exist throughout Canadian provinces and territories yet have faced notable erosion in several provinces in recent years, spanning both educational and health contexts. Although legal recourse through the courts remains available, the tendency to exempt legislation from the *Canadian Charter*'s protections—and from provincial human rights laws—is a worrying development.

3. Mental Health and Well-being of Trans and Nonbinary Youth in Canada

The Mental Health of Trans and Nonbinary Adolescents in Canada

Mental health is a fundamental component of overall health and a basic human right. According to the World Health Organization, it enables individuals to manage life's challenges, realize their potential, and contribute to society (World Mental Health Report, 2022). Mental health is not merely the absence of mental disorders; it exists along a continuum, uniquely experienced by each person, ranging from well-being to disorder (Iasiello & van, 2020).

Adolescence is a critical developmental period, as approximately 50% of mental disorders emerge before the age of 18 (Solmi et al., 2022). In the context of gender diversity, trans, nonbinary, and other gender-diverse adolescents may face additional mental health challenges. Alongside the typical developmental transitions of adolescence, they often navigate experiences related to their gender identity—such as self-discovery, disclosure, and stigma—which can increase their vulnerability to mental health difficulties (O'Shea et al., 2025).

To better understand these issues in Canada, we reviewed large-scale studies (with sample sizes over 100) examining the mental health of gender-diverse adolescents. Our search identified only four relevant data sources: **COMPASS**, the **Canadian Health Survey on Children and Youth (CHSCY)**, the **Canadian Trans Youth Health Survey (CTYHS)**, and **Trans Youth CAN!**.

COMPASS Study

The COMPASS Study (Cannabis use, Obesity, Mental health, Physical activity, Alcohol use, Smoking, and Sedentary Behaviour) is a prospective cohort study that follows Canadian secondary school students from British Columbia, Alberta, Ontario, and Quebec. Gender identity was assessed in 2021/2022 by asking, "What sex were you assigned at birth?" with response options "Male" "Female" and "I prefer not to say" and "What gender do you identify most with?" with response options "Girl/Woman", "Boy/Man", "Non-binary", "Two-spirit", "I describe my gender differently", and "I prefer not to say". Adolescents whose sex was congruent with their gender identity were identified as cisgender; those whose sex and gender identity differed were identified as transgender and those who selected the options "Two-Spirit" or "I describe my gender differently" as others. In the sample of over 26,000 adolescents, 117 (0.4%) identified as transgender boys/men, 111 (0.4%) as transgender girls/women, 327 (1.2%) as nonbinary, and 398 (1.5%) reported other gender identities.

Mental health outcomes assessed in 2022/23 included depression (assessed with the Center for Epidemiologic Studies Depression Scale –10 [CESD-R-10]; cut-off ≥10), anxiety

(assessed with the Generalized Anxiety Disorder 7-Item Scale [GAD-7]; cut-off ≥10), and positive mental health (assessed with the 8-item Diener Flourishing Scale).

Compared to cisgender boys/men, transgender boys/men (but not transgender girls/women), nonbinary adolescents, and adolescents with other gender identities were significantly more likely to experience depression and anxiety, with odds ratios ranging from 1.5 to2.0 for depression and 2.0 to 2.2 for anxiety. They also reported lower levels of flourishing (Eccles et al., n.d.). While these findings do not reflect clinical diagnoses, they highlight the elevated mental health burden experienced by gender-diverse adolescents—particularly transgender boys/men, nonbinary youth, and those with other gender identities.

The 2019 Canadian Health Survey on Children and Youth

The 2019 Canadian Health Survey on Children and Youth (CHSCY) covers the population aged 1 to 17 years old living in the 10 provinces and 3 territories. Excluded from the survey's coverage are children and youth living on First Nations reserves and other Indigenous settlements in the provinces, children and youth living in foster homes and not eligible for the Canada child benefit (CCB), and the institutionalized population.

Gender identity and sex-assigned at birth were self-reported for participants aged 12–17. Those whose gender identity did not match their sex assigned at birth, or who reported a gender identity other than male or female, were classified as gender diverse or transgender youth (Hajo et al., 2024; Kingsbury et al., 2022), encompassing 0.5% of the 11,603 participants aged 12 to 17 (Hajo et al., 2024).

The mental health outcomes encompassed both negative and positive indicators. Negative indicators included suicidal ideation and suicide attempts, which were assessed through self-reported past-year suicidal ideation (i.e., "In the past 12 months, did you ever seriously consider attempting suicide or taking your own life?") and lifetime suicide attempts (i.e., "Have you ever attempted suicide or tried taking your own life?") (Kingsbury et al., 2022). Positive mental health was measured using indicators from the Positive Mental Health Surveillance Indicator Framework—self-rated mental health, life satisfaction, and happiness—and the Children's Intrinsic Needs Satisfaction Scale, which assessed eudaimonic well-being across autonomy (e.g., "I feel free to express myself with my friends"), competence (e.g., "I feel I do things well at home"), and relatedness (e.g., "I like to be with my teachers"), with response options ranging from "Really false for me" to "Really true for me" (Hajo et al., 2024).

Gender diverse adolescents had a fivefold higher risk of suicidal ideation (OR = 4.95) and a sevenfold higher risk of suicide attempts (OR = 7.60) compared to cisgender (and heterosexual) adolescents (Kingsbury et al., 2022). They were also less likely than cisgender adolescents to report positive mental health, including life satisfaction (6 vs. 8), self-rated mental health (34% vs. 66%), happiness (33% vs. 65%), autonomy (49% vs. 81%), competence (54% vs. 85%), and relatedness (70% vs. 90%) (Hajo et al., 2024).

These findings further highlight the substantial mental health burden among gender diverse youth in Canada across a wide range of self-reported indicators. Notably, sex assigned at birth and gender identity were not distinguished within the gender diverse group, preventing interpretations about disparities by sex or gender.

The Canadian Trans Youth Health Survey (CTYHS)

The Canadian Trans Youth Health Survey (CTYHS) is a bilingual online survey of trans and nonbinary (TNB) adolescents aged 14–25 across Canada, conducted in 2014[1]. Participants (N = 923 total; N = 137 from Quebec) were recruited through convenience sampling via investigators' networks, social media, community organizations, and pediatric endocrinology clinics. Of the total, 323 were aged 14–18 and completed health questions mostly adapted from the British Columbia Adolescent Health Survey (BCAHS; comparison cohort) (Veale, Watson, et al., 2017)[2].

In the CTYHS, gender identity was assessed using the question: "Which one response best describes you?" with response options: (1) I am transgender and identify as a boy or man, (2) I am transgender and identify as a girl or woman, (3) I am transgender and identify in some other diverse way, (4) I am not transgender. Those who selected options 1 or 2 were identified as transgender boys/men or transgender girls/women, while those who chose options 3 or 4 were identified as nonbinary (Veale, Watson, et al., 2017)

The survey captured a range of mental health outcomes, including general mental health (i.e., "In general, how would you describe your mental health?"; 1 =poor to 4 =excellent); past-year self-harm and suicide attempts (ever and frequency); past-year suicidal ideation; and past-month stress/strain/pressure and discouragement/hopelessness (5-point scale from the General Well-being Schedule) (Veale, Watson, et al., 2017).

Mental health issues were highly prevalent across the sample. Compared with the BCAHS comparison cohort, trans and nonbinary adolescents were significantly more likely than their peers to have considered suicide (65% vs. 13%), to have made at least one suicide attempt (36% vs. 7%), and to have engaged in self-harm in the past year (75% vs. 17%). Further, they reported a greater number of self-harm episodes and suicide attempts, along with higher levels of stress, strain, and pressure, and greater feelings of discouragement and hopelessness, with Cohen's d values ranging from 0.97 to 1.42, indicating large effects. Finally, trans and nonbinary adolescents also had significantly lower general mental health scores than those in the control cohort (Cohen's d =–1.62) (Veale, Watson, et al., 2017).

Transgender boys/men and nonbinary adolescents reported higher rates of self-harm than transgender girls/women. Further, nonbinary adolescents reported higher levels of stress/strain/pressure and discouragement/hopelessness than transgender girls/women (Veale, Watson, et al., 2017).

Overall, findings from the CTYHS highlight a substantial mental health burden among Canadian gender diverse youth. However, interpretations are limited by the use of

[1]CTYHS 2019 was not included, as peer-reviewed studies based on this dataset did not present results separately for the 14–18 and 19–25 age groups.

[2] The CTYHS was also conducted in 2019; however, data from this iteration were not included because the results were not stratified by age. Instead, most findings were reported for a combined age group of 14–25 years.

convenience sampling, which may not generalize to all gender diverse adolescents in Canada.

Trans Youth CAN!

Trans Youth CAN! is a 2-year prospective cohort of adolescents aged 10–15 years (mean age: 14.3) with gender dysphoria, defined as significant distress that arises when one's gender identity does not align with their sex assigned at birth (Public Health Agency of Canada, 2024). Participants were recruited while seeking gender-affirming care (hormone suppression/therapy) in one of 10 medical clinics in Nova Scotia, Quebec, Ontario, Manitoba, Alberta, British Columbia between 2017 and 2019. A total of 174 adolescents, most assigned female at birth (N = 137), participated and completed mental health questionnaires from the baseline interviewer-administered youth survey.

Measures (taken from the Canadian Community Health Survey) included depression (5-Item Modified Depression Scale; cut-off ≥4 indicating probable depression disorder), anxiety (5- Item Overall Anxiety Severity and Impairment Scale; cut-off ≥8 indicating probable anxiety disorder), past-year self-harm, lifetime and past-year suicidal ideation and attempts, and substance use.

Mental health diagnoses, whether previous or current, as documented by the clinic or referring provider, were also extracted from their medical records. Mental health was then described and compared between transmasculine (assigned female at birth) and transfeminine (assigned male at birth) adolescents. Anxiety (40%) and depression (32%) were the most common diagnoses overall, followed by ADHD (23%) and autism spectrum disorder (ASD; 6%). Transmasculine adolescents reported higher rates of depression and anxiety symptoms than transfeminine adolescents, with 22% versus 8% meeting the cut-off for probable depression, and 71% versus 35% meeting the cut-off for probable anxiety. Further, ADHD and ASD were more prevalent among transfeminine than transmasculine adolescents (ADHD: 39% vs. 20%; autism spectrum disorder: 23% vs. 2%). Most transfeminine and transmasculine adolescents reported past-year self-harm (68%) and lifetime suicidal ideation (58%). Substance use was generally low, with no gender differences for common substances (e.g., alcohol, cannabis).

In sum, findings from Trans Youth CAN! highlighted a high mental health burden among gender-diverse adolescents, particularly regarding suicidality, with sex/gender differences varying across outcomes; however, interpretations are limited to youth who were pre- or early transition at enrollment and to the absence of a comparator group (Bauer et al., 2021).

It is important to note that gender diversity itself does not cause mental health problems. Rather, as described in more detailed in section 4 of this report, mental health disparities are best understood through the lens of *minority stress* (Meyer, 2003, 2015) which identifies multiple sources of stress which collectively contribute to poorer mental health outcomes. The limited but growing Canadian evidence highlights a substantial mental health burden among gender-diverse adolescents, marked by elevated rates of suicidal

ideation, self-harm, and suicide attempts. While existing studies indicate that transgender boys/men may be particularly affected, additional research is needed to further investigate this, examine a broader range of outcomes, elucidate contributing factors, and, critically, design and implement interventions and policies that address the minority stressors driving these disparities.

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4. Understanding Stress and Minority Stress: Implications for Trans and Gender Diverse Health

What is "stress" and how does it affect our health?

Since at least the time of Hippocrates, physicians and scholars have recognized a robust link between life stress and our physical and psychological well-being. When researchers talk about stress, they usually distinguish between a **stressor,** or a situation that challenges an organism's ability to maintain homeostasis, and a **stress response**, which is how the body and mind react to that challenge (Monroe, 2008). The stress response includes both psychological and physiological components and is thought to have evolved to allow organisms to cope with acute threats (e.g., a predator on the plains) and challenges (e.g., chasing prey to feed the family). Mounting this response to stressors involves the coordinated activity of multiple systems, including the hypothalamic-pituitary-adrenal (HPA) axis (for a review, see, e.g., Lupien et al., 2009). Activation of the HPA axis serves to mobilize the body's energy resources, allowing people to respond to these threats and challenges. It does this in part through the production of cortisol, a hormonal end point of the HPA axis. Having increased cortisol running through our bodies increases glucose availability, enhances cardiovascular output, and suppresses non-essential physiological processes like digestion and reproduction, allowing the individual experiencing a stressor to prioritize survival and restore balance once the stressor subsides. Thus, in the short term, the stress response can be very adaptive, allowing us to survive to face the next challenge. However, this stress response is not *only* activated in response to acute and immediate threats to our lives: It can also be activated in response to *perceived* threats (e.g., a challenging commute to work), and chronic stressors (e.g., social exclusion), resulting in prolonged activation of this physiological stress response. This ongoing physiological activation can turn what is meant to be a protective function into one with profound implications for physical and psychological well-being.

This is in part because of the effects of sustained cortisol release, which can disrupt the body's normal regulatory systems (Doom & Gunnar, 2013; Lupien et al., 2009). Persistent activation of the HPA axis can suppress immune function, making individuals more susceptible to infections and slowing wound healing. It also promotes visceral fat accumulation, insulin resistance, and dyslipidemia, increasing the risk of metabolic syndrome and cardiovascular disease. In the brain, excess cortisol can damage the prefrontal cortex and hippocampal neurons, impairing memory, decision-making and emotion regulation. Additionally, chronic cortisol exposure alters inflammatory pathways, contributing to systemic inflammation and accelerating aging processes. All of these effects have longer-term implications for physiological and psychological health.

Consistent with this, decades of research have shown that people who experience greater exposure to life stress are at elevated risk for a variety of major health conditions, including cardiovascular disease, gastrointestinal problems, metabolic disorders, chronic pain, stroke, rheumatoid arthritis, human immunodeficiency virus/AIDS, cancer, and asthma (Cohen et al., 2007). Psychologically, stress exposure is a major contributor to anxiety, depression, substance use, and burnout across the population (Cohen et al., 2007). These

well-documented effects of stress exposure also have implications for the health and well-being of TNB youth.

Can Stress Explain Mental Health Disparities in TNB youth?

As discussed in the previous section, TNB youth show elevated rates of many forms of psychopathology, including depression and anxiety, substance use and abuse, suicidal ideation and attempts, disordered eating, and even autism spectrum disorders (Connolly et al., 2016; Wittlin, et al., 2023). Physical health disparities also emerge, including higher rates of chronic pain, cardiovascular issues, and barriers to accessing affirming healthcare (Wittlin et al., 2023). Research suggests that these health disparities may be driven by the insidious effects of chronic stress exposure (Hendricks & Testa, 2012; Meyer, 2003). More specifically, minority stress theory (Brooks, 1982; Meyer, 2003), posits that, in addition to general life stressors, individuals from stigmatized social groups experience unique, chronic stressors that stem from prejudice and stigma. As an example of this, being unemployed could be considered a general stressor or a minority stressor, depending on its cause: if the difficulty finding a job is driven by bias against sexual or gender minorities, it would be considered a minority stress; if it resulted from an economic downturn affecting everyone regardless of identity, it is a general stressor (Frost & Meyer, 2023). For TNB youth, minority stressors can be **distal** (or external to the individual) or **proximal** (or internal to the individual). Distal stressors include things like discriminatory laws or policies, daily experiences of discrimination, lack of access to gender-affirming care, peer victimization, and family rejection. Proximal stressors are stressors related to an individual learning to reject their own identities. These can include things like internalized stigma, increased expectations of rejection from others, and, in some cases, identity concealment (Frost & Meyer, 2023). In what follows, we briefly discuss the evidence that TNB youth experience heightened levels of minority stress exposure. Because there is such limited work on this in Canadian TNB youth, the following section frequently draws on studies outside of Canada.

Distal Stressors

Discrimination and peer rejection: The past decade has witnessed a rise in the introduction of anti-trans legislation around the world. Although Canada affords federal legal protections to TNB people under the Canadian Human Rights Act, as discussed above, some provinces have introduced laws and policies in recent years that restrict trans rights (Khonina & Salway, 2025). These laws include motions to prevent TNB people from having their identities affirmed across multiple settings, and in some cases limit access to gender-affirming care (Khonina & Salway, 2025). In addition to the direct effect of these laws on the lives of TNB individuals, there is evidence that people living in places with these discriminatory policies toward TNB people also show evidence of stronger anti-trans attitudes (Roy et al., 2025), demonstrating the potential for these policies to be reflected in the everyday social interactions of TNB individuals. Consistent with this, TNB youth report more experiences of discrimination and threats and/or harm related to their identities than do cisgender youth (Kosciw, et al., 2019; Price-Feeney et al., 2021). These experiences include being directly teased or bullied for their gender identity and gender expression, hearing anti-trans comments, being excluded from extracurricular activities

because of their identities, being prevented from using public restrooms, and even being physically assaulted (Kosciw et al., 2019). These experiences of discrimination can have important downstream effects: In one study of transgender adults, 24% of those who were open about their identities in school experienced physical assaults, and 17% left school early because of bullying (James et al., 2016). TNB youth who report higher rates of bullying and isolation at school are also more likely to experience absenteeism (Pampati et al., 2020), which can contribute to academic problems. Further details regarding the experiences of TNB youth in school settings will be addressed in section 7 of this report.

Family rejection: Family members' responses to learning that a child is transgender or nonbinary can vary widely, ranging from acceptance and support to ambivalence, resistance, or outright rejection (Abreu et al., 2019). Many TNB adults report that, in their youth, they were punished for gender nonconforming behaviour, were rejected by family members, and in some cases were forced out of their homes (Gagné & Tewksbury, 1998). Studies of TNB youth show that they often report lower levels of family connectedness (Eisenberg et al., 2017) and higher rates of family rejection, hostility, and aggression (Grossman et al., 2006; Grossman et al., 2021) than cisgender peers. Many parents of TNB youth also fail to intervene or show support when their child is discriminated against and/or bullied by peers (Kosciw et al., 2019). Some research further suggests that gender nonconforming youth are at particularly high risk of verbal and physical abuse from their parents (Grossman et al., 2006; Thoma et al., 2021). In contrast, emerging research shows that TNB youth who experience caregiver support during social transition (e.g., are referred to by their chosen name and pronouns) show health outcomes comparable to those of their cisgender peers (Olson et al., 2016). Family impacts on trans youth well-being will be discussed in detail in section 6 of this report.

Proximal Stressors

Although more research on this topic in trans youth is needed, we know from research in other marginalized groups that stigma at the societal, cultural, community, and family levels can shape the way youth think about themselves and the world and people around them (Clark & Clark, 1950; Hatzenbuehler et al., 2013). Indeed, TNB youth report not only past experiences of rejection, victimization, and discrimination from others, but also potent ongoing fears of *future* mistreatment (Chodzen et al., 2019). Internalized transphobia, a process by which individuals begin to believe the negative and stigmatizing messages they hear regarding their identity, also emerges as a significant proximal stressor for TNB youth, and may be particularly strongly associated with mental health challenges (Chodzen et al., 2019). Finally, although research on identity nondisclosure in TNB youth is limited, studies suggest that some TNB youths conceal their identity to avoid verbal or physical victimization (Johns et al., 2021). These proximal stressors have been shown to contribute to a sense of personal isolation and loneliness for many TNB youth (Johns et al., 2021). Section 3 of this report examines TNB youth mental health in detail.

In summary, stress exposure, particularly minority stress, appears to play a critical role in shaping health outcomes for TNB youth. Addressing these disparities requires systemic change, including policy reform, inclusive healthcare practices, and societal efforts to

reduce stigma. Access to medical care and, more specifically, gender affirming medical care will be discussed more in detail in section 5 of this report.

Understanding the mechanisms of stress and its intersection with identity is essential for promoting equity and well-being for TNB youth. The following sections of the report delve into the main issues faced by TNB youth in greater depth. They examine their mental health, the impacts of gender-affirming medical care, the role of families in supporting their well-being, and the influence of schools and school climate.

5. Access to Gender-Affirming Medical Care

Some trans and nonbinary (TNB) youth may want to access gender affirming medical care (GAMC) to affirm their gender identity and/or to reduce gender dysphoria. Usually, puberty blockers, hormone therapy, and/or gender-affirming surgeries are offered as part of GAMC but other interventions, such as permanent hair removal, voice therapy, and other esthetic surgeries may also be provided. Of note, hormone blockers like spironolactone can be used by people assigned male at birth, even after puberty, in combination with hormone therapy. However, "puberty blockers" refer to hormone-suppressing treatments used during puberty to put it on hold. Depending on legislation, puberty blockers, hormone therapy, and some gender-affirming surgeries such as vaginoplasty and mastectomy may be covered by provincial health programs, private insurance, or both, while some esthetic procedures are usually charged to the patient. Transition pathways may vary in terms of prescribed dosages, types of interventions performed, and the order in which they are carried out.

Not all youth are prescribed GAMC. The WPATH's *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* recommend that a TNB youth meets seven criteria to be prescribed GAMC: a) meeting the diagnostic criteria of gender incongruence (or dysphoria wherever ICD11 is not used), b) has a marked and sustained experience of gender diversity or incongruence over time, c) has the emotional and cognitive maturity to consent or assent to care, d) the potential mental health issues that could interfere with transition outcomes have been addressed, e) has been informed about the reproductive effects and options for fertility preservation, f) has reached Tanner stage 2 of puberty, g) has been on gender-affirming hormone therapy for at least 12 months before having surgery (Coleman et al., 2022).

TNB Youth Seeking GAMC

In Canada, research shows that less than 50% of TNB youth has accessed GAMC. For example, the *Canadian Trans and Non-binary Youth Health Survey, a* large study on trans and nonbinary youth health conducted among 1519 TNB youth aged 14–25, found out that only 12% of participants took puberty blockers and 44% had started a hormonal treatment. Among those who had not taken hormonal treatment, 20% did not plan to start, 36% were still unsure, and others reported challenges such as difficult access to a care provider who prescribes it or lack of parental support (Taylor et al., 2020[3]). Some provincial data provide a clearer picture of the use of puberty blockers and hormone therapy by age groups, allowing us to see that hormone therapy is more often accessed by older youth groups. For example, an analysis of a subsample of Quebec youth who participated in the *Canadian Trans and Non-binary Youth Health Survey* (n=220) shows that 60% of 19- to 25-year-olds had accessed hormone therapy and 9.2% hormone blockers, compared to 32.2% (hormones) and 30.5% (blockers) of youth aged 14 to 18 years old (Pullen Sansfaçon,

[3] This study was conducted with participants aged 14 to 25. Only certain articles or chapters of specific books analyzed 18-year-olds and younger separately.

Chadi, et al., 2024). According to another study conducted in Quebec with 239 TNB youth aged 14–17, only 12.4% had medically transitioned, 38.2% planned to do so, and 47.8% did not wish to pursue a medical transition (Cotton et al., 2025). Moreover, only 2.4% of youth assigned female at birth underwent a mastectomy (Cotton et al., 2025). It should be noted that 73.2% of this sample was composed of nonbinary individuals, which may explain the relatively low interest in medical interventions. Indeed, a previous a previous Canadian study has shown that non-binary youth tend to be less likely to seek or desire GAMC (Clark et al., 2018[4]). Notably, this research indicates they are less likely to access GAMC care for a diversity of reasons, including that they live more comfortably in their gender without medical care, indecision about their needs related to GAMC or financial barriers.

Age of Realization and Age of First Prescription of GAMC

Little data is available on pathways to care, including on age or realization of gender incongruence and age of first access to clinics or to prescriptions. The *Trans Youth Can! study*, conducted in 10 Canadian clinics offering GAMC and which includes 174 TNB youth, discovered that the mean age at which youth realized that their gender was different was 9.9 years old [9.4, 10.3]; that they started living in their gender at a mean age of 12.3 years old [12.0, 12.6], were referred at a mean age of 13.7 years old [13.5, 13.9] and were 14.3 years old [14.1, 14.6] at initial hormone appointment (Lawson et al. 2024). At the provincial level, a study conducted in an Ontario hospital observes that the age at first presentation to gender clinics tends to decrease (Sorbara et al., 2020).

Needs of TNB Youth Regarding GAMC

Research conducted in Quebec among 84 TNB youth aged 14–25 who had accessed or wanted to access GAMC showed that desires and priorities for the types of GAMC vary according to the gender identity of the person. For example, puberty blockers and hormone therapy appeared to be most desired among participants but seem less commonly desired by nonbinary youth (88%) than by transmasculine (100%) or transfeminine youth (100%) (Pullen Sansfaçon et al., 2025[5]). The same study shows that when it comes to surgical interventions, mastectomy was the most desired by transmasculine youth (100%), while only 47% of transfeminine youth wished to undergo a breast augmentation. Conversely, 94% of transfeminine participants desired facial procedures compared to 18% of transmasculine youth (Pullen Sansfaçon et al., 2025). Another study conducted in Quebec among 239 TNB youth aged 14 to 17 regardless of their need for GAMC and comparing sex assigned at birth revealed that mastectomy is the most desired (44.1%) or received (2.4%) intervention among youth assigned female at birth, while hormone therapy is the most commonly accessed or desired for youth assigned male at birth (15.8% started it and 5.3% desired it) (Cotton et al., 2025).

[4] This study involved participants aged 14 to 25. While minors and adults were sometimes analysed separately, they were grouped together in the comparison between binary and non-binary young people.
[5] This study involved participants aged 14 to 25. Minors and majors had to be grouped together to conduct gender-based analysis.

By accessing these medical interventions, TNB youth expect several benefits. The main goal is to prevent or reduce unwanted gendered bodily features (e.g., breasts, body hair, menstruation) and obtain physical changes that align with their gender identity (e.g., hair growth, a deeper voice, breast growth) (Pullen Sansfaçon et al., 2019, 2025). That way, youth hope to experience joy and gender euphoria, as well as to reduce physical discomfort caused by the use of gender-affirming tools and accessories such as chest binders (Thibeault et al., 2025). Youth also expect these changes to impact how they are perceived in society by improving their ability to "pass" (being perceived in the correct gender) (Pullen Sansfaçon et al., 2019, 2025; Thibeault et al., 2025). This, in turn, can prevent discrimination and enhance their sense of safety, especially for transfeminine youth (Pullen Sansfaçon et al., 2025; Thibeault et al., 2025).

However, TNB youth and their families also express some concerns. TNB youth notably expressed worries about unwanted physical changes as a result of hormone therapy (e.g., hair loss, body hair, etc.) and sometimes fear the pain associated with treatments or interventions (Pullen Sansfaçon et al., 2019; Thibeault et al., 2025). TNB youth may find it even more difficult to have a body that fits their expectations because they tend to only want some, but not all, the effects that come with hormone treatments (Thibeault et al., 2025). Parents, on the other hand, are more concerned about side effects on physical or mental health, such as mood swings, risks of further marginalization, loss of fertility and potential regrets (Pullen Sansfaçon et al., 2019; Thibeault et al., 2025). Indeed, parents, especially those who have children under 14, can feel a strong sense of responsibility as they get involved in a decision-making process that might have significant long-term impacts (Clark & Virani, 2021; Gelly & Pullen Sansfaçon, 2021; Thibeault et al., 2025).

GAMC and First Prescription

Canadian wide data obtained from 10 clinics among 174 TNB youth under 16 shows that many delays continue to be experienced to obtain a first prescription. On average, 269 days passed between the first visit to a gender-affirming clinic and the first prescription [244, 294] (Lawson et al. 2024). It should be noted that the informed consent process may require multiple visits for individuals under the age of 16. This period of time is also sometimes necessary to conduct assessments, provide multidisciplinary support before treatment begins or to wait for the youth to start puberty. Another study reports that 62.4% of TNB youth under 16 referred to clinics for GAMC received a prescription at first visits, mostly for puberty blockers (leuprolide acetate) alone (to 53.0% of transfeminine and 45.2% of transmasculine patients), or, more rarely, in combination with hormone therapy (testosterone: 1.7% of transmasculine; estrogen: 6.6% of transfeminine) (Bauer et al., 2021). A few participants were prescribed testosterone alone (11.7% of transmasculine), hormone blockers (spironolactone) (9.5% of transfeminine) or contraceptives.

Barriers and Facilitators in Accessing GAMC

The Trans PULSE study, conducted in Canada with 991 TNB youth aged 14 to 24 and 1874 older adults, reports that only 14% had all their gender-related needed care answered, which is far less than adults (32%), and that twice as many young people (22%) as adults

(11%) were planning to seek GAMC but had not begun (Navarro et al., 2021[6]). Another research among 174 TNB youth in 10 Canadian clinics has shown that some youth experienced barriers to obtaining their first prescription such as clinic protocols, age barrier, unconfirmed gender dysphoria, the need for additional health information, and waiting for parental consent (Bauer et al., 2021).

Youth's Decision-Making Capacity

Some studies have shown that GAMC providers sometimes fear that TNB youth experience future regrets and potentially detransition (MacKinnon et al., 2020), notably due to concerns about youth's maturity, insight, mental health or vulnerability to external influence or coercion (Clark & Virani, 2021; MacKinnon et al., 2020). As highlighted earlier, to access GAMC, youth must meet some specific criteria, including the presence of a diagnostic of gender dysphoria or gender incongruence.

Research has shown that to access GAMC care, some providers will require some proof of "authenticity" of gender, for example by requiring youth to undertake lengthy mental health assessments or by requiring parental consent even when youth are deemed capable of making a medical decision (Clark et al., 2020, 2021; Clark & Virani, 2021; MacKinnon et al., 2020). These experiences are said to be a barrier to accessing GAMC, especially by TNB youth who are not supported by their parents, who have mental health issues or who wish to follow a gender trajectory that does not fit what is seen as a "regular" transition pathway (Clark et al., 2020; Clark & Virani, 2021; MacKinnon et al., 2020[7]).

Yet, in a study conducted in British Columbia with 14- to 18-year-old TNB youth who accessed GAMC, participants demonstrated a strong capacity to consent (Clark & Virani, 2021). They showed maturity, a good understanding of the risks and benefits of interventions and awareness of the variability in outcomes. Youth also clearly articulated how their decisions aligned with their personal values of authenticity and gender expression. This capacity was also recognized by some care providers who use informed consent, focusing on youth capacity, medical screening, safety and support as well as by some parents (Clark & Virani, 2021).

Delays and Access to Knowledgeable Professionals

Many youth and their families have expressed frustration over the wait for GAMC access, feeling an urgent need to prevent unwanted physical changes during puberty (Clark et al., 2021; Maine et al., 2025[8]; Pullen Sansfaçon et al., 2019, 2022; Thibeault et al., 2025) or to alleviate the distress caused by gender dysphoria (Clark et al., 2021). A study conducted in 10 gender clinics in Canada with 174 youth under 18 seeking GAMC found that the average age at which youth first discuss gender identity with someone outside of their family is 12.6 years old (Lawson et al., 2024). However, the average age for receiving a referral is 13.7, typically after 13 to 14 months of research. Indigenous youth wait an additional 5

[6] This study involved participants aged 14 to 24 who were not analyzed separately.
[7] This study includes trans people who accessed GAMC in the past year. Their age was not specified.
[8] This study includes participants aged 14 to 25.

months on average (Lawson et al., 2024). Those delays may have impacts on TNB youth mental health. For example, while it is not possible to confirm whether delays in access or other reasons (i.e., late realization of gender identity) are at play here, a study conducted in one clinic found that youth who presented at a gender clinic at an older age were more likely to use psychoactive medication, and those who were further along in puberty reported higher levels of anxiety and depression (Sorbara et al., 2020).

On average, youth must also meet with 2.7 different types of professionals before accessing GAMC (Lawson et al., 2024) even though many youth feel uncomfortable discussing their gender-related needs with healthcare professionals. Indeed, the *Canadian Trans and Non-binary Youth Health Survey* study reveals that 36% of TNB youth were very uncomfortable talking about their gender-related needs in walk-in clinics, and only 19% felt very comfortable doing so with their family nurse practitioner or doctor (Taylor et al., 2020). In Manitoba, youth and their families also report difficulty access to gender-related services, especially mental healthcare (Bhatla et al., 2024). This lack of resources is particularly salient in rural areas (Bhatla et al., 2024). TNB youth in Alberta also complain about extensive wait times, which impact their mental health (Maine et al., 2025).

Additionally, TNB youth often report meeting professionals who lack knowledge about their needs (Bhatla et al., 2024; Maine et al., 2025; Navarro et al., 2021; Pullen Sansfaçon et al., 2022). The Trans PULSE study found that, among 687 youth with a family doctor, only 32% said their family doctor was knowledgeable about TNB-related health concerns, and 22% reported being told by their doctor that they lacked sufficient knowledge to provide such care (Navarro et al., 2021). Moreover, 27% of participants said they had to educate their family doctor about their needs as a TNB youth and 24% reported being repeatedly misgendered or deadnamed (Navarro et al., 2021). These negative experiences with healthcare providers are also reported specifically in Manitoba (Bhatla et al., 2024) and Alberta (Maine et al., 2025) and remote areas in Quebec (Pullen Sansfaçon et al., 2022), sometimes resulting in youth and parents seeking information online (Bhatla et al., 2024; Pullen Sansfaçon et al., 2022). Previous negative experiences with healthcare providers can stain the current relationship with professionals, for example, with a lack of trust (Clark et al., 2021; Maine et al., 2025). It can also result in youth not being properly informed about transition options and being denied care (Maine et al., 2025; Pullen Sansfaçon et al., 2022).

Yet, since a study reports that half of youth are referred to gender clinics by their family doctors (Lawson et al., 2024), it is crucial that these professionals have sufficient knowledge to support this population. Knowledgeable professionals can offer valuable support and education to youth and families. They can reassure parents, help them understand the situation, provide accurate and relevant information to support informed consent, and more broadly facilitate the decision-making process (Clark et al., 2020, 2021; Clark & Virani, 2021; Pullen Sansfaçon et al., 2023[9] ; Thibeault et al., 2025).

[9] This study includes participants aged 5 to 21.

The Impact of GAMC on TNB Youth

Assessing Treatment Efficacy and current controversy

At the heart of the current debates about GAMC, the question of treatment efficacy is often central. Most research that is produced will measure or discuss the efficacy of treatments in terms of impacts on dysphoria or well-being (improvement, deterioration, or no change). The same goes for research on intervention. For example, SOC 8 describes how youth is expected to exhibit sufficient *distress prior to transition* and move toward an *improved general state and a stable, regret-free gender identity* (Coleman et al., 2022). However, by attempting to isolate treatment efficacy and its impact on well-being, much research fails to account for other factors that cannot effectively be controlled in clinical research, such as the complex interactions between youth and their environmental context, or the many different ways in which care is provided, depending on the structure, training and expertise of the providing team. Indeed, TNB youth live in different contexts, such as different family configurations, and interact with different environments—some of which are more supportive than others. Research examining TNB youth well-being—beyond GAMC alone, shows that many other aspects and factors may lead to improvement or deterioration of well-being, including internal ones (such as dysphoria alleviation, gender euphoria, etc.) and external factors (parental or social support, discrimination, etc.) (DuBois & Juster, 2022[10]) (see the sections on schools and family support for extensive discussion). Many socio-political factors can also impact trans youths' life experiences and explain the persistence of negative effects despite GAMC's benefits (Oosthoek et al., 2024). Therefore, GAMC could simultaneously alleviate a feeling of incongruence, foster gender euphoria and expose youth to new social challenges, which overall may not lead to an immediate improvement in their mental health. For example, research on regret or detransition shows that youth can experience doubts or partial regrets about certain aspects of their transition, while still expressing overall satisfaction (Arnoldussen, 2024; Pullen Sansfaçon et al., 2023[11]) or a desire to continue their transition (Olson et al., 2024). Moreover, a research examining the prevalence and associated features of discontinued medical transitions reports a wide variety of environmental reasons why young people may stop seeking GAMC, such as costs, lack of accessibility, encouragement from professionals or loved ones to explore other ways of coping with dysphoria, lack of support, external pressure, etc. (MacKinnon et al., 2024).With that in mind, the next session aims to review the various studies that have examined the impact of GAMC (notably puberty blockers, gender affirming hormones or both) on the functioning and well-being of young transgender people.

[10] This study was conducted with adults.
[11] This study was conducted with international participants aged 15 to 25.

Current controversies regarding evidence to support the use of GAMC

Over the past five years or so, it has been possible to observe an increase in number of publications that have questioned the benefits and relevance of GAMC for TNB minors. Those publications include both systematic reviews and reports or public inquiries that themselves rely substantially on the systematic reviews, while also drawing on case studies, public consultation and various testimonies. The use of systematic reviews to examine the effectiveness of GAMC might seem appropriate at first sight since GAMC relies on medical treatments like hormone therapy (Pullen Sansfaçon et al., 2025).

That said, systematic reviews/meta-analyses need to be considered with caution in this particular field. While systematic reviews often prioritize methodological approaches that assess treatment effectiveness—particularly Randomized Controlled Trials (RCTs) that allows to control for exogenous factors (outside influence) associated with both receipts of treatment and health outcomes of the person, in the case of TNB youth and the use of GAMC, (Hariton & Locascio, 2018)— well-being and the alignment between a person's physical characteristics and identity are influenced by many factors that cannot be fully captured through GAMC alone.

As discussed in chapter 3 and 4, several key sources of minority stress, including gender-based discrimination and bullying (Eccles et al., n.d.), enacted stigma (Veale, Peter, et al., 2017), and long wait times for gender-affirming services (Lawson et al., 2024) can impact TNBY health mental health. The impact of minority stress on TNBY health and mental health therefore greatly limits greatly any studies attempting to control for exogenous factors (Flentje 2023).

Furthermore, several scholars argue that key methodological requirements for RCTs are difficult to meet in GAMC research. Challenges include obtaining representative samples, maintaining blinding given the visible effects of treatment, and ethically justifying the withholding of care from control groups, particularly when delays in access may increase distress (Ashley et al., 2024; Schall et al., 2024; Grant et al., 2025). Adapted RCT designs comparing immediate versus delayed access to GAMC have been proposed as an ethical alternative, with evidence suggesting that immediate treatment can improve outcomes such as gender dysphoria, depression, and suicidality (Nolan et al., 2023). Although adapted RCT designs, such as wait-list and open-label trials, may offer ethical alternatives for studying GAMC, they remain vulnerable to methodological limitations and potential biases (Trone et al., 2018; Higgins et al., 2025). More broadly, the value of RCTs lies in their contribution to a cumulative body of evidence that combines multiple methods and theoretical perspectives to explain not only whether interventions work, but also how and why they do so (Deaton & Cartwright, 2018).

The limited feasibility of RCTs in this field has contributed to ongoing debates about the strength of the evidence supporting GAMC. Although these debates have increasingly entered the public sphere, where GAMC is sometimes portrayed as experimental or harmful (Billard, 2024; McNamara et al., 2022; Schall et al., 2024), a substantial body of research has documented its benefits (Achille et al., 2020; Chelliah et al., 2024; Chen et al., 2023; Coleman et al., 2022; Olson et al., 2024; Tordoff et al., 2022; Wright et al., 2025). Importantly, there are currently no Canadian RCTs on this topic, reflecting the practical and ethical challenges discussed above. As with many areas of health research, conclusions therefore rely on the cumulative weight of evidence generated through multiple complementary methodologies rather than on a single study design. Given the prominence of these controversies, it is important to acknowledge them in a report that examine the efficiency of GAMC Care in Canadian Context.

Puberty Blockers

Puberty blockers are used to suppress endogenous hormone production and thereby prevent puberty. Most commonly, Gonadotropin-Releasing Hormone agonist (GnRHa) are prescribed to youth who have not yet completed puberty (Coleman et al., 2022). The term "blockers" is sometimes used more broadly to designate anti-androgens (like spironolactone), offered to TNB people with testes, during or after puberty, as a complement to hormone replacement therapy (Coleman et al., 2022). In the studies reviewed below, treatments are most commonly GnRHa, though some use the broader term 'puberty suppression' or 'puberty blockers' without specifying the agent used. Several studies have found beneficial impacts of access to puberty blockers on mental health, body satisfaction and gender dysphoria in TNB youth. In order to produce a more exhaustive examination of research on the impact of GAMC on TNB youth well-being, the following section also mentions recent studies conducted in Italy, the United States, the United Kingdom and the Netherlands with sample sizes varying between 36 and 201 TNB youth. The review draws on research employing different methodologies. It is important to also consider that while those studies attempt to examine the impact of medical interventions, other factors are at play, as described in section 4 on minority stress.

Recent clinical studies have systematically identified improvements in depressive symptoms (Achille et al., 2020[12]; de Vries et al., 2014[13] ; Fisher et al., 2024), anxiety symptoms (de Vries et al., 2014 ; Fisher et al., 2024), suicidality (Achille et al., 2020; Fisher et al., 2024; Lavender et al., 2023) and global functioning (Carmichael et al., 2021; Costa et al., 2015; de Vries et al., 2014) after initiating puberty blockers.

Most studies have also seen significant improvements in body image among TNB youth treated with puberty blockers (Carmichael et al., 2021; de Vries et al., 2014; Fisher et al., 2024). Some studies have also seen a reduction in self-harm behaviours (Lavender et al., 2023) and an increase in quality of life (Carmichael et al., 2021) after starting puberty blockers, although not all studies have seen such changes over time (Achille et al., 2020; Carmichael et al., 2021). Gender dysphoria appears to be only moderately improved in TNB youth treated with puberty blockers (Carmichael et al., 2021; de Vries et al., 2014; Lavender et al., 2023). However, these results are expected, as puberty blockers only prevent the development of unwanted secondary sex characteristics but do not lead to the development of characteristics promoting gender congruence. Of note, studies that use the UGDS scale (i.e de Vries et al., 2014) measure the persistence of the desire to live in the opposite gender rather than the distress caused by gender incongruence. Limited studies have observed any harms associated with puberty blockers on the mental health and well-being of TNB youth. One qualitative study reports the situation of a TNBY who had made a suicide attempt while on puberty blockers (Pullen Sansfaçon et al., 2019). However, in discussing the situation, the youth explained that many factors were at play and that he was already in a "dark place' at the beginning of the treatment and that accessing medical treatments was still very positive (Pullen Sansfaçon et al., 2019).

[12] This study was conducted in a clinic serving youth aged 9 to 25.
[13] This longitudinal study followed participants from adolescence into adulthood.

Current literature on puberty blocker mentions a risk of decreased bone density with a longer possible risk of bone density and development of osteoporosis in case where calcium and vitamin D would not be maintained appropriately (Ghosh and Gorgos, 2021). The authors note that use of hormone therapy and a close follow up with regular x-ray to follow bone density evolution is therefore recommended.

Hormone Therapy

Gender-affirming hormone therapy is proposed to TNB youth for them to develop desired sex characteristics. It should be noted that physical changes may take up to five years to become fully apparent, and that the first year of treatment may be marked by dissatisfaction and instability while waiting for the desired changes to occur, however, those expectations are often met after a certain period of time (Taillefer et al., 2023). Moreover, gender-affirming hormone therapy has been associated with improvements in mental health, quality of life, body satisfaction and gender dysphoria. A Finnish study conducted in 52 TNB youth showed that access to gender-affirming hormone therapy was associated with a decrease in the need for treatment for depression, anxiety, suicidality and self-harm (Kaltiala et al., 2020[14]). Several studies conducted in the United States and the United Kingdom with sample sizes ranging from 26 to 315 TNB youth showed significant improvements in suicidality (Achille et al., 2020; Allen et al., 2019[15]; Lavender et al., 2023) and quality of life (Chen et al., 2023[16]), although quality of life was not increased in all studies (Achille et al., 2020; Baines & Connelly, 2023). One study conducted in the United States found that improvements in depression, anxiety and quality of life following access to gender-affirming hormone therapy were only seen in transmasculine individuals, but not in transfeminine individuals (Chen et al., 2023). Overall, body satisfaction and gender dysphoria are also improved following access to gender-affirming hormone therapy (Chen et al., 2023; Lavender et al., 2023). However, these interventions typically do not improve relational well-being, as measured by romantic involvement and normative peer contacts (Kaltiala et al., 2020).

Puberty Blockers and Hormone Therapy

Very few studies have evaluated the relative impact of both puberty blockers and gender-affirming hormone therapy on the well-being of TNB youth. However, the available literature shows that both interventions can help alleviate depressive symptoms, suicidality and self-harm behaviours, although gender-affirming hormone therapy typically leads to greater improvements in gender dysphoria and body satisfaction (Achille et al., 2020[17]; Lavender et al., 2023).

Additionally, a recent study seems to point toward the benefits of GAMC. The Trans Youth Project is a large-scale longitudinal study conducted over five years or more in the U.S.

[14] This study examines the experience of youth who were referred under 18 but who might be older during follow-up.
[15] This study includes participants aged 13 to 20.
[16] This study includes participants aged 12 to 20.
[17] This study was conducted with children, adolescents and young adults aged 9 to 25.

(most of the sample) and Canada with 183 trans youth aged 3 to 12 at recruitment who had done a binary social transition and were planning to medically transition, and two control groups: 262 cisgender youth and 150 cisgender siblings of the trans participants. Mental health data were analyzed before puberty blockers, after puberty blockers and after hormones and show low and stable levels of depression and anxiety (Wittlin et al., 2025). As with other research reported in this document, it is often difficult to clearly distinguish the impact of GAMC on youth without taking into account other factors, such as the experience of minority stress, socio-cultural and socio-political contexts as well as attitudes from peers, family, or romantic partners, which can all significantly impact mental health (Cabral & Pinto, 2023; DuBois et al., 2024[18]; Holt et al., 2023[19]; Vance et al., 2021) and body image (Line et al., 2025; Romito et al., 2021[20]). These factors are often overlooked in clinical studies assessing the effectiveness of GAMC. Some projects attempt to take into account some of these factors. For example, The Trans Youth Project data shows that trans youth who were supported by their parents and accessed blockers and hormones had similar levels of anxiety and depression as their cisgender peers (Wittlin et al., 2025). This suggests that social and medical affirmation and support could protect youth from challenges (such as endogenous puberty) and mental health issues usually experienced by this population (Wittlin et al., 2025).

Qualitative studies examining the well-being of TNB youth who access GAMC have also shown generally positive outcomes. In the study Stories of Gender-Affirming Care, interviews were conducted individually with 36 youths aged 9 to 17 and their parents between 2017 and 2018, in three gender clinics in Canada (Winnipeg, Montreal, Ottawa). Participants reported mostly positive experiences. Notably, blockers allowed to pause puberty and avoid some of the undesired bodily changes associated with it (such as menstruation, erections, hair growth), reducing dysphoria and providing significant relief and a sense of optimism for youth (Gelly & Pullen Sansfaçon, 2021; Pullen Sansfaçon et al., 2019). Hormones enabled the development of desired physical characteristics and improved social recognition in the affirmed gender, especially for transmasculine youth (Gelly & Pullen Sansfaçon, 2021; Pullen Sansfaçon et al., 2019). Mastectomy has also brought significant relief for one participant who no longer had to wear a binder (Gelly & Pullen Sansfaçon, 2021; Pullen Sansfaçon et al., 2019).

Some unwanted short term side effects were also reported, such as hot flashes, acne, mood swings and in rarer cases, knee pain and stress fractures, although these studies are qualitive and cannot be used to established causal associations between use of blockers or hormone therapy and long-term side effects (Gelly & Pullen Sansfaçon, 2021; Pullen Sansfaçon et al., 2019). But despite those, all youth expressed satisfaction with their medical transition. Overall, GAMC had a positive impact on youths' mental health and helped reduce self-destructive behaviours, including self-harm and suicidal ideation (Gelly & Pullen Sansfaçon, 2021; Pullen Sansfaçon et al., 2019). Parents also noticed that their children were happier and more social and that family relationships had improved as well as school performances, which often comforted families in their decision to pursue a medical

[18] Cabral & Pinto, 2023 and Dubois et al., 2024 examine the experience of adults.
[19] This study was conducted with High School student, some of whom may be older than 18.
[20] This study was conducted with 9 participants aged 16 to 20. Only one of them was older than 18.

transition (Gelly & Pullen Sansfaçon, 2021). No youth had expressed regrets, other than wishing they had started earlier (Gelly & Pullen Sansfaçon, 2021; Pullen Sansfaçon et al., 2019).

More recently, the longitudinal research Growing-Up Trans, conducted with seven TNB youth in Quebec and who started or expressed a desire to start a medical transition and their families, examined the impacts of GAMC after year one (2022–2023) of a three-year ongoing project. At enrollment, participants were aged from 11 to 16. Early results show that participants report a decrease in stress caused by anticipated dysphoria thanks to blockers, a reduction in dysphoria and an increase in euphoria and well-being and flourishing with hormones (Ladry et al., 2026). Participants also report better social acceptance, improved family dynamics and the ability to resume some activities (like sports). However, some challenges remained, like some reticence to being out or losing some unsupportive friends (Ladry et al., 2026).

6. Trans and Non-binary Youth and Their Family

This section examines research on parental and family support and its associations on gender diverse youth. TNB youth are particularly affected by family dynamics and parental support because parents are often one of the first people to affirm or to reject them on the basis of their gender identity. They are also less likely to report living a happy home life (50.5%) compared to cisgender girls (72.6%) and boys (83.8%) (Varatharajan et al., 2024).

In Canada, TNB youth aged 14 to 18 years old are more likely to report a higher number of adverse childhood experiences than their sexual minority cisgender peers (Craig et al., 2020). Moreover, data from the *Canadian Trans and Non-binary Youth Health Survey* (CTYHS), conducted among 1415 TNB youth aged 14 to 25, reveal that 6% of them rarely or never feel safe at home and that 5% have spent time in foster care (Taylor et al., 2020[21]). Data from the province of Quebec show that they are at risk of family and sexual violence: 16.8% of 14- to 25-year-old TNB youth have witnessed family violence, 19.3% have been physically hurt in the last 12 months, 14.9% have been sexually touched by an older or stronger family member, and 44.1% have been sexually abused inside or outside their family, with a higher proportion of nonbinary youth (59.4%) compared to trans binary youth (34%) (Ladry et al., 2023). These adversities seem to also be amplified among youth who are indigenous or racialized. Indeed, racialized youth are less likely to be told by their parents that they respect and support them (36.5%) compared to non-racialized youth (61.4%) (Navarro et al., 2021[22]). Two-Spirit youth emphasize the importance of family connections for their well-being (Hardy et al., 2020[23]), yet these family bonds may be troubled by direct or indirect impacts of colonialism (Pullen Sansfaçon et al., 2024[24]). Two-Spirit youth notably evoke early separation from biological families as well as the non-recognition of chosen kin (Hardy et al., 2020).

Moreover, when it comes to parental support, some studies have shown that transfeminine and nonbinary youth tend to experience more parental rejection than transmasculine youth (Pullen Sansfaçon et al. 2020[25]). Similarly, one study observes that people who have had to interrupt their transition for social reasons, such as a lack of parental support, are more often youth who have been assigned male at birth (MacKinnon et al., 2023[26]).

Defining Family Support

Family support can be difficult to define, as it encompasses various dimensions, such as emotional (being a listening ear when youth face challenges, expressing love, facilitating community connections, ensuring their child's identity is respected, etc.), financial or material support (such as purchasing gender affirming accessories, facilitating access to GAMC) and even engagement in advocacy work (Pullen Sansfaçon et al., 2020). It is also

[21] This study was conducted with participants aged 14 to 25. Only certain articles or chapters of specific books analyzed 18-year-olds and younger separately.
[22] This study involved participants aged 14 to 24 who were not analyzed separately.
[23] This study defines youth as people under 30. The inclusion criteria is to be a youth aged 16 or older.
[24] This study includes participants aged 15 to 25.
[25] This study includes participants aged 14 to 25.
[26] This study was conducted with adults.

dynamic and evolves through time and circumstances (Pullen Sansfaçon et al., 2020). Therefore, family support is much more than the idea of having or not having support. Of note, the studies presented bellow often center parental support specifically because parents, as the legal guardians of their children, hold significant power over decisions made during the transition process, as well as over the child's material living conditions. However, other family members such as siblings or grandparents, may emerge as important sources of support, for example by acting as a bridge between the child and the parents or as a relay in the absence of parental support (Klepper et al., 2024[27]; McCandless-Chapman et al., 2024[28]; Pullen Sansfaçon et al., 2020; Pullen Sansfaçon, Aïtamon et al., 2025[29]).Some youth describe receiving only partial forms of support, without concrete actions to meet their gender-related needs or to validate their identity, a concept that was coined as "*neutral negativity*" (Pullen Sansfaçon et al., 2018[30]). Youth who experience *neutral negativity* explain that they are not necessarily invalidated or rejected in their gender identity but also do not receive the needed support to affirm it. Youth who experience negative neutrality could be supported in some aspects of their lives, such as in the form of material support or emotional support to go through difficult times at school, but receive no or little support to affirm their gender identity (Pullen Sansfaçon et al., 2018, 2020).

On the other end of the spectrum, some TNB youth say they receive no support at all from their parents or family and experience diverse forms of rejection based on their gender. Families that are qualified as unsupportive are said to express disapproval of youth gender identity in several ways, such as invalidating youths' gender, not using the right name ("deadnaming") or pronoun ("misgendering"), pressuring youth to conform to their assigned gender, emotional or physical violence and sometimes by expulsion from family home (Pullen Sansfaçon et al., 2020; Pullen, Aithamon et al., 2025).

Research tends to show that strong parental support is only experienced by a minority of TNB youth. For example, 58% of TNB Canadian youth report their parents tell them they support and respect them; one in three says their parents inform themselves to better understand them, but only one in five received material support in their transition (Navarro et al., 2021).

That said, a non-negligible number experiences negative neutrality or lack of family support/rejection: 51% say their parents do not respect their pronouns, 25% of participants had lost a family relationship because of their gender, 7% were threatened by a family member, 6% have been the target of violence and 7% have been kicked out of their house (Navarro et al., 2021). Between 9.8% and 10% of TNB youth have also been sent to some sort of conversion program to change their gender identity (Navarro et al., 2021; Lawson et al., 2024).

[27] This scoping review included international articles with youth aged 6 to 29.
[28] This study was conducted with US Latinx LGBTQ+ participants aged 16 to 19.
[29] This study was conducted with international participants aged 14 to 25.
[30] This study was conducted with participants aged 15 to 25.

Impact of Parental Support on TNB Youth

Supported TNB youth report high levels of well-being (a self-assessed score of between 8/10 and 9/10) because they are emotionally supported when they face challenges, which helps reduce their stress and makes them feel happier (Pullen Sansfaçon et al., 2020). This finding reflects the CTYHS' data from Canada and from Quebec, both of which show that youth who feel safe at home and connected to their families are significantly less likely to report high levels of emotional distress, suicidal thoughts and suicidal behaviours (London-Nadeau et al., 2023[31] ; Taylor et al., 2020). Supported youth are 2.6 times more likely to report good or excellent mental health in Quebec (London-Nadeau et al., 2023).

For youth who specifically access GAMC and are supported by their parents, research shows that youth have lower odds of suicidal ideation or behaviours compared to national results (Bauer et al., 2021; Taylor et al., 2020; Veale et al., 2017). In supportive families, youth also report greater harmonious family relationships (Gelly & Pullen Sansfaçon, 2021; Pullen Sansfaçon et al., 2020). In addition to providing consent for younger TNB youth, parents play an important role in decision making, as parents can help youth access information, reflect on their needs and communicate it to care providers (Thibeault et al., 2025; Clark et al., 2021).

Conversely, a lack of parental support can discourage TNB youth from affirming their gender (Pullen Sansfaçon et al., 2018) and can instigate doubts about their decision to transition (Clark et al., 2020; Pullen, Aithamon et al., 2025), or even cause a detransition (MacKinnon et al., 2024; Pullen Sansfaçon, Planchat, et al., 2023[32]; Pullen Sansfaçon, Aithamon, et al., 2025; Savard et al., 2022[33]; Vandenbussche, 2022[34]).

Even the thought of a negative reaction from parents can affect youth who may choose to hide or to delay their coming out, to avoid discussing their gender-related needs (Clark et al., 2020). Data from the CTYHS show that 12% of TNB youth aged 14 to 25 plan to ask their parents to use their correct name and pronouns but have not done so yet, while 17% do not plan to ask (Taylor et al., 2020). In Quebec, a study conducted with TNB youth aged 14 to 17 reveals that only 28.3% have fully expressed their gender to their close family, 21.5% have done it partially, 10.3% plan to do it, whilst 39.1% have not and do not plan to do so (Cotton et al., 2025). In comparison, 81.7% have partially or fully revealed their gender to their close friends and 56% at school (Cotton et al., 2025). Hence, many youth feel they cannot express their gender at home or that they have to navigate multiple gender expressions.

Lack of parental support can also have direct impacts on youth capacity to affirm their gender with GAMC (Pullen Sansfaçon et al., 2023, 2025; Taylor et al., 2020; Thibeault et al., 2025). Indeed, gender-related care providers sometimes require parental consent to administer hormonal treatments to minors, which can be a barrier when parental support is

[31] This study was conducted with participants aged 15 to 25. Minors and majors were not separated in the bivariate analysis.
[32] This study was conducted with international professionals working with TNB youth.
[33] This study was conducted with international participants aged 14 to 25.
[34] This study was conducted with participants of any age and nationality.

lacking (Clark et al., 2020). This can be exacerbated in families where there are parental conflicts (Pullen Sansfaçon, Medico, et al., 2023[35]). Where parental support is lacking, youth may also have more difficulty navigating systemic barriers to access GAMC (Clark et al., 2020).

Therefore, some TNB youth who anticipate negative reactions or do not have parental support may also decide to transition without their parent's knowledge (Pullen, Aithamon et al., 2025). While it is not possible to correlate that all youth who access hormone therapy outside the medical system lack parental support, a small number of them do so. Results from the *Canadian Trans Youth Health Survey* have shown that 3% of TNB youth aged 14 to 25 reports having used hormones obtained from a friend, 2% from internet pharmacies, and 7% from other sources (Taylor et al. 2020). While these practices of "DIY HRT" can be viewed as riskier, they are sometimes considered as safer and empowering practices in contexts where access to care is hindered by a lack of parental support, gatekeeping, transphobia or other forms of intersecting oppressions (August-Rae et al., 2024[36]).

Additionally, TNB youth are overrepresented within Child Protection services, a phenomenon that may relate to family conflicts or difficulties surrounding gender identity (Pullen Sansfaçon, Blanchet, et al., 2023). Data obtained from Youth Protection Services in Quebec have highlighted that 4.1% of youth in child protection services are not cisgender; that is their gender is different from their sex assigned at birth (Pullen Sansfaçon, Blanchet, et al., 2023) while TNB youth only represent 0.79% of youth (14 to 25 years old) in Canada (Statistics Canada, 2022). The same study also shows that TNB youth are more likely to have *parental abandonment* (28.6%) written in their file than cisgender girls (13.8%) or cisgender boys (12.8%) (Pullen Sansfaçon, Blanchet, et al., 2023).

Parental rejection can also come with precarity, which is sometimes tied to substance use among TNB youth. Indeed, a study observes that youth sometimes use drugs as a coping mechanism to face challenges such as dysphoria, shame or discrimination as well as parental rejection or queerphobia (Goodyear et al., 2024[37]). Drug consumption can also increase family tensions and precipitate their expulsion from home (Goodyear et al., 2024). As such, some authors suggest that the relationship between gender identity, social health factors and substance use warrants further investigation (London-Nadeau & Rioux, 2026; Varatharajan et al., 2024).

A recent Canadian study highlights that, in the absence of parental support, school staff can be an important source of support for TNB youth (Yu et al., 2025). In the following section, we will discuss the experiences of TNB youth in school, as well as the school climate.

[35] This study includes participants aged 5 to 21.
[36] This study was conducted with adults in the US (53% were under 24 and 19% had experiences DIY HRT as a minor).
[37] This study was conducted with participants aged 14 to 29.

7. Schools and School Climates[38]

Schools are a significant site of socialization for youth, and yet are dominated by broader cultural and political struggles over gender diversity, causing exclusion and hostility toward trans and nonbinary (TNB) youth (Baum, 2022; McKibban et al., 2021; Meyer et al., 2016; skelton, 2022). This exclusion and hostility reflect deeper cultural and systemic forces, cementing educational institutions as not neutral and, instead, as active agents in sustaining heteronormativity and cisnormativity. Heteronormativity is the assumption that heterosexuality and binary gender roles are the only way of being. Cisnormativity is the assumption that everyone identifies with the gender they were assigned at birth, treating this as the standard way of being. This normativity then shapes social norms, practices, and expectations accordingly. Broader political discourses on gender, identity, and rights profoundly shape the conditions under which TNB youth experience education. In Canada, political debates surrounding "parental rights" are underpinned by myths and assumptions that fuel anti-trans sentiment and obstruct inclusive practices (Herriot et al., 2018). These developments and practices directly compromise the mental health of TNB students. As reflected elsewhere in this report, Miller et al. (2024) observe that recent waves of anti-transgender legislation restrict educators from providing a safe and caring school environment and worsen the mental health trajectories of TNB youth. Political rhetoric, legal reforms, and educational practices collectively shape the complex school environments in which TNB youth navigate daily life, making schools inhospitable to TNB students (Martino et al., 2022). In other words, schools are not merely failing to protect TNB youth but are actively reproducing conditions of exclusion. This failure can have harmful effects on TNB youth and their mental health.

What follows are two major themes that shape the literature on TNB youth, their mental health, and educational contexts. The first theme concerns the current state of TNB youth mental health and its relationship with schools. As explained below, contemporary research underscores TNB youths' mental health challenges that are directly influenced by their school environments, including heightened risk of anxiety, depression, and suicidality. The second theme focuses on recommendations for education staff, with a growing emphasis on systemic change that affirms gender diversity. Despite the hostilities and exclusion, schools *can* provide affirming spaces for learning, belonging, and identity development. Researchers argue that affirming policies, inclusive curricula, and supportive relationships with teachers and peers foster resilience and promote well-being among TNB students.

Current State of TNB Youth Mental Health in Schools

The literature consistently states that TNB youth face disproportionately higher risks of adverse mental health outcomes compared to their cisgender peers (Bastian & Rohlik,

[38] Given the limited body of Canadian education literature on this topic, the research presented here incorporates both Canadian and international sources and is not restricted to work focused exclusively on TNB youth under 18.

2022; Day & Bromdal, 2024). Among the most pressing concerns is the pervasive experience of school-based violence, which research has repeatedly shown to have long-term, negative consequences for the TNB youth's well-being and educational attainment (Gallardo-Nieto et al., 2021). This violence is ongoing and represents manifestations of structural, interpersonal, and intrapersonal barriers that inhibit TNB youth and their ability to maximize their learning potential and flourish in schools (Day & Bromdal, 2024; Gallardo-Nieto et al., 2021; Martino et al., 2022). Key factors include peer victimization, ongoing bullying, perceptions of safety, and the lack of a sense of belonging within the school environment (Bartholomaeus & Riggs, 2017; Gallardo-Nieto et al., 2021; Gorse, 2020; Mackie et al., 2021; skelton, 2022). Gorse (2020) explains that multiple interrelated risk factors shape the heightened rates of suicidal ideation, attempts, and deaths among TNB youth. These factors include minority stress, racism, homelessness, domestic violence, and the absence of supportive and gender affirming schools, among others.

School climate emerges as a salient determinant of TNB students' experiences (Meyer et al., 2016). Research consistently identifies unsafe or indifferent climates as a significant source of chronic stress (Bastian & Rohlik, 2024; Fraser, 2025; McKibban et al., 2021). In Canada, the *Still in Every Class in Every School* climate survey found that 90% of transgender students identified at least one unsafe space for 2SLGBTQ students in their school (Peter et al., 2021). In a deeper analysis of this survey data, Fraser (2025) found that washrooms, change rooms, and hallways, which are all heavily used, are particularly unsafe for TNB students. Furthermore, Chan et al. (2022) highlight how negative interactions with the learning environment, whether through bullying, assault, or the invisibility of LGBTQ+ identities in the curriculum, lead to poorer academic outcomes and diminished self-esteem. Safety and climate are central to understanding unmet mental health needs among TNB youth. Importantly, these conditions are not produced by passive or neutral systems; instead, schools often reproduce and reinforce social hierarchies and exclusions that actively harm TNB youth (Horton, 2020; McKibban et al., 2021).

These experiences also intersect with geographical and social contexts (Peter et al., 2021). TNB youth in rural and small-town environments, for example, are least likely to encounter affirming staff, LGBTQ+-inclusive curricula, or supportive peer networks (Bastian & Rohlik, 2024). Similarly, queer and trans youth of colour face compounded forms of oppression that magnify vulnerability. Experiences such as coming out, negotiating identity within families, and enduring discrimination in the K–12 system are intensified by racism, creating further barriers to well-being (Nadal et al., 2024). An intersectional lens reveals how queer and trans youth of colour experience victimization, retention challenges, and decreased academic performance, which are compounded by broader psychosocial determinants such as systemic racism and socio-economic precarity.

Protective factors such as whole-of-school approaches towards improving the wellbeing of all trans people in schools, affirming curricula, role models, and supportive staff remain relatively rare in schools (Bartholomaeus & Riggs, 2017; Chan et al., 2022; Xu & Roegman, 2025). Conversely, when such factors exist, research indicates that schools succeed in meeting students' safety needs. In such affirming contexts, TNB youth report lower rates of depression, suicidality, and other adverse health outcomes (Horton, 2020). Wilson and Cariola's (2020) qualitative synthesis identifies five recurring themes in

LGBTQ youth narratives: isolation and rejection; marginalization; depression, self-harm, and suicidality; policy and environmental factors; and the importance of connectedness. Each theme highlights the need for multi-level interventions that facilitate individual support and structural transformation. As explained below, educational cultures are collective products of students, educators, administrators, and policymakers; therefore, systemic change requires coordinated efforts across all professional roles. For TNB youth to thrive psychologically and academically, education systems must move beyond reactive measures and adopt proactive, holistic strategies that affirm identity, ensure safety, and foster a sense of belonging.

Practices to Support Trans and Nonbinary Youth in Schools

Horton (2020) emphasizes that there is now "strong evidence that socially transitioned children who are supported have good levels of well-being and mental health" (p. 1; see also Baum, 2022, for similar findings). Central to this support are affirming practices such as healthy family functioning, the use of chosen names and pronouns, and the provision of consistent emotional and practical support (Feijo et al., 2022). Similarly, there are a range of protective factors associated with reduced rates of suicidal ideation and behaviour among TNB youth, which are: the presence of gender and sexuality alliances (GSAs), LGBTQ+ inclusive curricula, supportive legislation and policy frameworks, familial and peer support, safe school environments, positive coming-out experiences, and accessible and affirmational mental health interventions (Gorse, 2020; Meyer et al., 2016; Wallace et al., 2024). Collectively, these studies underscore the need for a whole-of-school approach that can create inclusive cultures for all trans people in schools. This approach, as illustrated below, involves reshaping the policies, staff training, support services, school climate, and teaching practices (Bartholomaeus & Riggs, 2017) thus forming critical buffers against the mental health risks faced by TNB youth. Further discussion of each of these important factors is below, which cut across elementary, secondary, and post-secondary education.

Legislation, Policy, and Safety

When supported by appropriate legislation, schools can implement policies and curricula that affirm gender diversity and prevent bullying, thereby promoting TNB youth health and well-being (Feijo et al., 2022; Manley et al., 2024; McKibban et al., 2021; Martino et al., 2020). A notable example is the Government of Manitoba's (2017) *Supporting Transgender and Gender Diverse Students in Manitoba Schools*, which provides comprehensive guidance for K–12 schools. The document emphasizes affirming gender diversity, ensuring access to gender-inclusive washroom facilities, and implementing privacy and confidentiality procedures that support transitions. It further highlights the legal and ethical obligations of schools under Manitoba law and human rights codes, encouraging school divisions to develop written policies (e.g., regarding gender inclusive washrooms, bullying and discrimination, school trips, record-keeping), articulate a school ethos that supports gender diversity, train staff, and engage with students and families to uphold these obligations. Notably, while not legally binding, the guidelines stress that inclusivity extends beyond formal rules, requiring consistent practices and interactions that affirm gender diversity and actively protect students from harassment, discrimination, and exclusion. Such documents work in tandem with provincial legislation, directives, and

partner organizations to ensure that gender diversity flourishes in schools. Guidelines help facilitate these interactions and position staff training as a crucial protective factor.

Staff Training

Research indicates significant gaps in staff preparedness: Peter et al. (2021) found that 79% of transgender students who experienced physical harassment reported that their teachers and school staff were ineffective in addressing transphobia in schools. A majority of school staff report needing additional training and resources to adequately support these students (Bastian & Rohlik, 2024; Fraser, 2025; Simons et al., 2018).

In addition to teachers, school administrators, school nurses and other frontline staff play a crucial role in advocating for positive mental health interventions for TNB youth (Ancheta et al., 2020; Bastian & Rohlik, 2024; Mangin, 2019). As Gallardo-Nieto et al. (2021) note, "Education on LGBTQI+ issues and gender perspective can help in the long-term prevention of a sociocultural problem that affects the life of transgender and nonbinary subjects in many spheres of their life" (p. 10). They further emphasize that "the implementation of consistent and critical and evidence-based training from a gender perspective and in the LGBTIQ+ reality for the school staff can prevent failures in the treatment of gender transitions, the reception of experiences of bullying, or the management of conflict" (p. 10). Put differently, training becomes a valuable tool for preparing school staff in identifying and addressing transphobia and cisnormativity in schools (Feijo et al., 2022). Enhanced training for school staff not only improves understanding of TNB student experiences but also strengthens capacities in leadership, operations, faculty development, coalition building, and community advocacy (Baum, 2022; Peter et al., 2021; Simons et al., 2018).

Support Services and Multi-Level Approaches

Providing adequate and affirming support is essential for promoting the health and well-being of trans youth (Day & Bromdal, 2024; Fraser, 2025; Mackie et al., 2021; Scrofani et al., 2025). School-based mental health professionals, including school psychologists, and counsellors, play a pivotal role in delivering high-quality, affirming services that address the needs of TNB students (Mackie et al., 2021). Scrofani et al. (2025) found that "supportive faculty allies, peer support, and parent support emerge as strong protective factors at the micro-level. At the exo-level, school programming efforts that are proactive by prioritizing a discourse that nurtures agency for trans students [are] shown to be the most protective" (p. 1; see also Fraser, 2025, for similar findings). These findings support the adoption of a multi-level approach to TNB-affirming school climate, one that integrates a gender support team and involves changes at the individual, relational, and organizational levels (Bartholomaeus & Riggs, 2017; Baum, 2022; Scrofani et al., 2025). Digital therapy is starting to show some promise in supporting alleviating mental health issues among post-secondary students, which may be helpful to trans students (Austin et al., 2025). Such approaches not only provide targeted interventions about gender diversity but also fosters a broader culture of affirmation and safety within the school (Bartholomaeus & Riggs, 2017).

School Climate and Belonging

Feeling a sense of belonging is a protective factor that supports positive mental health among students (Moffa et al., 2020). However, Canadian transgender students are significantly less likely than their cisgender peers to experience a sense of belonging within their schools (Fraser, 2025). In this context, interpersonal support from friends, peers, and teachers is crucial in shaping the school experiences of TNB students and fostering resilience when facing hostile or unsupportive environments (Xu & Roegman, 2025). TNB students can also contribute to promoting more inclusive school climates, demonstrating resilience while helping to cultivate environments that affirm diverse gender identities.

Positive school climates are associated with a reduced risk of suicidality and depressive symptoms among TNB youth. Thus, embedding mental health literacy and health literacy programs within schools further strengthens TNB students' capacity to navigate challenges and access support (Kutcher et al., 2015). Gallardo-Nieto et al. (2021) emphasize that creating "healthy and supportive spaces for students to share and live gender and sexual orientation freely" can positively influence the school climate, resulting in lower psychological distress and increased help-seeking behaviours among victims (p. 10; see also Lytle & Sprott [2021] for relevant practical strategies). Complementing these findings, Miller et al. (2024) note that "interventions that strengthen interpersonal relationships and local environments will reduce suicidality among TNB youth" (p. 118), highlighting the central role of relational and environmental factors in promoting TNB students' mental health. GSAs may be one opportunity to strengthen interpersonal relationships.

There is a growing body of evidence that GSAs hold promise as a protective factor for TNB youth. The presence of a GSA in a school decreases suicidality among LGBTQ+ youth, improves comfort with various gender expressions, improves family relationships, and lowers bullying instances (Di Stasio et al., 2023; Feijo et al., 2022; Walls et al., 2013). In addition to their presence in schools, GSAs can facilitate discussions around substance abuse, mental health, and sexual health, thus improving mental health outcomes for LGBTQ+ youth (Proteat et al., 2017).

Teaching for Inclusion

Mangin (2022) suggests that elementary school teachers can decrease their gendered practices, strengthen conversations about gender, and affirm gender identity and expression in the classroom. Critical pedagogy, or teaching for critical awareness of various life situations, serves as a foundation for advancing human rights and fostering inclusive educational environments (Chan et al., 2022; Woolley & Airton, 2020). Trans pedagogies also help reconsider teaching and learning practices to examine their cisnormative values, such as the need to reify the gender binary and essentialize gender identity (Keenan et al., 2023). Integrating discussions of gender diversity into curricula, with distinctions clarifying gender identity and sexual orientation, has been shown to enhance students' understanding and promote affirming school climates (Jones, 2017; Fraser, 2025; McKibban et al., 2021). Student input plays a central role in how social transitions are managed within schools, allowing students to exercise agency over their identities while navigating necessary accommodations (Meyer et al., 2016; skelton, 2022). Concomitantly, research highlights potential tensions arising from external influences or sociocultural

norms, particularly as they relate to TNB students' age and the perception of their body autonomy (Frohard Dourlent, 2017; Peter et al., 2021).

Furthermore, including topics such as gender diversity education, sexuality education, and puberty education has demonstrated positive effects on individual well-being and social outcomes, supporting both personal development and broader inclusivity goals (Jones et al., 2015; Woolley & Airton, 2020). Creating space for educators to articulate and enact their own vision of student success helps prioritize the well-being of all students (Baum, 2022; Meyer et al., 2016; Woolley & Airton, 2020). Together, these approaches underscore the importance of curriculum, pedagogy, and teacher responsibility in creating affirming learning environments for TNB students.

In conclusion, both Canadian and international research highlights the urgent need for further investigation into the mental health and well-being of TNB youth. Expanding research will not only deepen understanding of the unique challenges these students face but also support the development of innovative, evidence-based strategies to reduce disparities and promote affirming, safe, and inclusive school environments (Gorse, 2020; Mackie et al., 2021). The research contexts and recommendations discussed provide a foundational starting point for education staff and stakeholders, emphasizing the importance of legislation, policy, staff training, supportive services, inclusive curricula, and positive school climates in promoting the well-being of TNB youth. Continued collaboration and applied research are essential to ensure that these strategies are both meaningful and sustainable across diverse educational contexts and are resilient to harmful external sociopolitical influences.

8. Conclusion and recommendations

The different sections of the report have examined the current state of research on transgender and nonbinary (TNB) youth, with attention to minority stress, mental health, gender-affirming medical care (GAMC), family support, and school environments. Collectively, the evidence underscores that while TNB youth face significant systemic, social, and health-related challenges, these challenges are not inevitable. Rather, they result from modifiable conditions, such as the level of social stigma, restrictive policies, limited access to affirming care, and inconsistent support across families, healthcare systems, and educational institutions.

Research demonstrates that affirming environments, accessible and evidence-informed healthcare, supportive families, and inclusive schools significantly improve mental health outcomes and reduce suicidality among TNB youth. Importantly, the evidence base extends beyond traditional clinical trials to include longitudinal studies, clinical records, qualitative research, and life-course analyses, all of which provide robust insight into the experiences and needs of TNB young people and allow for capturing the impact of the social environment.

The following recommendations synthesize the key findings of each section of the report into targeted actions for four primary stakeholder groups: the families of TNB youth, providers working with TNB youth, researchers, and policy-makers. By implementing these strategies, stakeholders can help reduce disparities, foster resilience, and create environments where TNB youth are affirmed, supported, and able to thrive.

Families of TNB Youth

Affirmation, Support, and Communication

- Provide open, empathetic, and validating support to TNB youth, fostering dialogue, exploration, and collaborative decision-making about identity and care.
- Use your child's chosen name, pronouns, respect their gender expression and encourage school and community spaces to do the same, as these practices are linked to improved well-being and reduced suicidality.

Addressing Stress and Mental Health Needs

- Recognize the impacts of minority stress on TNB youth and help reduce stigma at home by cultivating an environment of acceptance and understanding.
- Stay attentive to signs of mental health distress—suicidal ideation, self-harm, anxiety, and depression are elevated among TNB youth—and ensure access to affirming mental healthcare.

Seeking Support for Family

- Pursue professional support, parent peer-support groups, and reliable information resources to help navigate the challenges of supporting a TNB child.

Supporting Access to Gender-Affirming Medical Care (GAMC)

- Understand that the evidence supports the benefits
- Support your child in making informed decisions about care.
- Advocate for your child's access to appropriate services and avoid reinforcing "conditional acceptance" or requiring them to meet rigid or narrow expectations before supporting their care journey.

Practitioners (Healthcare, Mental Health, School-Based, Social Services)

Affirming and Evidence-Informed Practice

- Provide care informed by a **broad spectrum of evidence**: clinical trials, longitudinal studies, qualitative work, life-course data—recognizing that strict "gold standard" designs are not feasible for many TNB youth populations but that strong evidence nonetheless exists.
- Recognize young people's autonomy and ability to express their preferences, even in cases where they cannot legally consent to their own care.

- Deliver **gender-affirming, youth-centred care** that avoids unnecessary gatekeeping, rigid pathways, or narrative requirements that can damage trust.
- Practitioners should maintain current knowledge of relevant provincial and federal legislation, policies, and youth rights to ensure that services are delivered equitably and in compliance with legal requirements. This can help prevent the inadvertent imposition of barriers, discrimination, or inappropriate denial of services to young people.

Addressing Minority Stress and Mental Health

- Incorporate minority stress frameworks into assessment and care planning, recognizing that stigma, discrimination, and social exclusion are core determinants of TNB youth mental health.
- Prioritize social changes, as well as suicide prevention and mental health interventions tailored to TNB youth, focusing on resilience, coping strategies, and protective factors such as school belonging, peer support, and affirming family relationships.

Reducing Barriers to GAMC

- Increase practitioner knowledge and confidence by participating in **specialized training**, especially in underserved regions (rural and remote communities), to ensure accurate information and timely referral pathways.
- Support youth by providing **clear, developmentally appropriate information,** encouraging exploration, and partnering collaboratively with families when safe and appropriate.

School-Based Practitioner Responsibilities

- Engage in **consistent and evidence-based training** on 2SLGBTQ+ inclusion, anti-transphobia, and gender diversity to identify and address discriminatory practices.
- Support the creation and maintenance of GSAs and individualized gender support plans at schools to enhance belonging and reduce psychological distress.

Researchers

Expanding the Evidence Base

- Conduct research according to different methodologies and approaches, including mixed methods, chart reviews, qualitative research, and longitudinal studies, to fully capture TNB youth experiences.
- Prioritize research that examines:

- Long-term outcomes of GAMC (puberty blockers, hormones, surgical interventions).
- Broader mental health trajectories and associated protective or risk factors.
- The unique experiences of subgroups (e.g., trans boys, nonbinary youth, racialized youth, rural youth).
- The impacts of online support and victimization on the mental health and well-being of TNB youth specifically in Canadian context.

Ethical and Feasible Research Approaches

- Recognize the **limitations of randomized controlled trials** in this context and develop ethical, youth-centred methodologies that avoid harm (e.g., withholding care).
- Use participatory and co-design research with TNB youth, families, community partners or youth serving organizations to ensure relevance, accuracy, and community trust.

- Investigate the mechanisms of **minority stress** and how stress pathways intersect with identity and development

Knowledge Mobilization

- Translate research into **practical guidance**, accessible educational materials, and tools for practitioners, families, and policymakers to counter disinformation that is currently circulating on TNBY and GAMC, for example.

Legal Practitioners and Policy Makers

Legal practitioners and policymakers should receive comprehensive trans-inclusive education, including training on the relevant legal frameworks and protections affecting transgender individuals. Such education should equip them with the knowledge necessary to apply the law fairly and responsibly. It should also strengthen their ability to critically evaluate information, enabling them to distinguish credible evidence from misinformation and disinformation that may influence legal interpretation and policy decisions.

Legislation and Policy Frameworks

- Support the development of **inclusive, rights-based policies** that affirm gender diversity and protect TNB youth against discrimination, bullying, and exclusion.
- Include gender identity and gender expression as a fundamental principle of equality in human rights laws.

- Support young's autonomy in their care, by reiterating the importance of considering their wishes even in cases where they are unable to consent to their care.
- Avoid restrictive policies or over-burdensome assessment requirements that are not supported by evidence and can harm youth.
- Avoid laws and policies that create age discrimination in obtaining GAMC.
- Avoid using the exemption from the application of the *Canadian Charter of Rights and Freedoms* to protect discriminatory laws.
- Ensure schools adopt policies that promote:
    - Gender-affirming practices
    - Privacy and confidentiality
    - Access to gender-inclusive washrooms
    - Staff training and community engagement

Support for Access to Care

- Challenge laws and policies that restrict access to evidence-based GAMC.
- Advocate for expanded services, equitable funding, provider training, and reduced wait times.
- Remove systemic barriers to GAMC by:

    - Expanding services across regions
    - Ensuring equitable funding models
    - Supporting training for healthcare providers
    - Reducing wait times

Funding for Research and Services

- Invest in:
    - Long-term, mixed-method research on TNB youth outcomes
    - Community-based and peer support programs
    - School-based mental health services and staff training initiatives
    - GSA programs and safe school climate initiatives

Addressing Minority Stress at Structural Levels

- Additionally, expand anti-discrimination laws and anti-harassment protections, and develop public education campaigns targeting transphobia and fostering positive societal attitudes.
- Strengthen protections against online discrimination, harassment, hate speech, and violence targeting TNB youth, while promoting access to affirming and inclusive online spaces.
- Support public health and education initiatives that embed gender diversity into curricula, mental health literacy programs, and teacher preparation.
- Develop campaign to fight against disinformation

Rights advocacy organizations

- Advance and defend rights-based policies protecting TNB youth from discrimination, bullying, and exclusion.
- Support and pursue strategic litigation and legal interventions when governments or institutions violate youth rights.
- Hold governments accountable for compliance with human rights and constitutional protections.

Affirming School Environments

- Require schools to implement a whole-of-school approach that includes, but not limited to, gender-affirming practices, privacy protections, efforts that advance inclusive cultures, policies, pedagogies, curricula, and facilities, and mandatory staff training.
- Policymakers and educational authorities should avoid implementing policies that require the disclosure of a student's transgender or non-binary identity to parents or guardians without the student's consent. Current evidence indicates that involuntary disclosure may expose TNB students to harm and undermine their safety, well-being, and access to supportive educational environments.

Research, Services, and Public Education

- Invest in long-term research, community-based supports, school mental health services, and GSAs.
- Lead public education and anti-disinformation campaigns to reduce transphobia and structural stigma.

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