

**External Review
of the Gender Identity Clinic
of the Child, Youth and Family Services
in the Underserved Populations Program
at the Centre for Addiction and Mental Health**

November 26, 2015

Certain redactions were made to protect the privacy of individuals, and legal advice provided as part of the process (Appendix 10)

**EXTERNAL REVIEW OF THE GENDER IDENTITY CLINIC OF THE CHILD,
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I) OVERVIEW

The Gender Identity Clinic (GIC) of the Child Youth and Family Services (CYF) in the Underserved Population Program (UPP) at CAMH has been longstanding, for approximately 30 years. Engaging in clinical, academic and research activities, the GIC is recognized as one of the few clinics of its kind in Canada and internationally. Given its unique nature, it has not previously been reviewed.

In 2014, a well-established community based group, the Rainbow Health Alliance, presented to CAMH a review of the literature and practices in this field with a particular focus on children and youth. Concerns were raised that the GIC may not reflect emerging and accepted practices, particularly for younger children presenting with gender dysphoria and related issues. This community group also raised concerns that the model of the clinic may not conform to emerging human rights legislation, specifically with respect to children and youth who present with gender variance.

In the context of these concerns, and recognizing that reviews assist us in ensuring practice reflects the current evidence base, the leadership of UPP agreed that it was now prudent to:

- 1) Assemble an independent review of the clinical pathways associated with the clinic,
- 2) Review the literature on best practices and clinical guidelines with this population
- 3) Assess the extent to which the workings of the GIC were in accordance with those guidelines as well as national and international practice.

II) COMPOSITION OF THE REVIEW COMMITTEE

The committee was composed to two clinicians who are external to CAMH:

- 1) Dr. Suzanne (Sue) Zinck from IWK in Halifax, as lead reviewer. Dr. Zinck is a Child & Adolescent Psychiatrist with expertise in gender identity and gender variance, who has practiced for 10 years within a Canadian context.
- 2) Dr. Antonio (Tony) Pignatiello, a local Child & Adolescent Psychiatrist with 23 years of expertise in systems of care with children and youth presenting with complex needs.

Additionally, Dr. Peter Szatmari, Academic Chief of the Child Youth Mental Health Collaborative CAMH and The Hospital for Sick Children, and Dr. Sean Kidd, Discipline Chief, Psychology CAMH served as consultants to the committee and observers to the

majority of the interviews. Ms. Christina Bartha, Executive Director, UPP assisted in facilitating the review. Only Dr. Zinck and Dr. Pignatiello prepared this report.

The Review Committee will be accountable to the Executive of the UPP who will consider the recommendations.

III) SOURCES OF INFORMATION

1) Interviews

Date	Duration	Interviewee/s	Interviewer/s
July 7, 2015	75 minutes	Dr. Ken Zucker, Dr. Lori Wasserman, & Dr. Hayley Wood (on leave)	Dr. Zinck and Dr. Pignatiello
July 7, 2015	15 minutes	GIC Trainees	Dr. Zinck and Dr. Pignatiello
July 7, 2015	30 minutes	Ms. Kristen Sharpe (CAMH Legal)	Dr. Zinck and Dr. Pignatiello
July 7, 2015	30 minutes	Focus group	Dr. Zinck and Dr. Pignatiello
July 7, 2015	30 minutes	Focus group: (Oolagen) & (CTYS)	Dr. Zinck and Dr. Pignatiello
July 7, 2015	30 minutes	Opportunity for individual meetings	Dr. Zinck and Dr. Pignatiello
July 7, 2015	90 minutes	Meetings with former patients and/or parents (10 minutes each)	Dr. Zinck and Dr. Pignatiello
July 7, 2015	30 minutes	CAMH Empowerment Council	Dr. Zinck and Dr. Pignatiello
July 7, 2015	60 minutes	Dr. Zucker, Dr. Wasserman	Dr. Zinck and Dr. Pignatiello
July 8, 2015	75 minutes	Dr. Zucker.	Dr. Zinck and Dr. Pignatiello
August 4, 2015	30 minutes	and (Transgender Youth Clinic, The Hospital for Sick Children, Toronto)	Dr. Zinck (by telephone) and Dr. Pignatiello

- 2) Systemic literature Review of best practices, conducted by Stephanie Duda, MSc at the request of Dr. Peter Szatmari
- 3) Audit of a sample of client charts

- 4) Articles provided by Dr. Zucker (Appendix 11) and suggestions to the committee (Appendix 12)
- 5) Reports provided by stakeholders (Appendices 5-9, & 13, 14)
- 6) Verbal discussion of findings with Dr. Peter Szatmari, Dr. Sean Kidd, Dr. Kwame Mackenzie (Medical Director, UPP), Ms. Christina Bartha on August 10, 2015

Identification and invitation of external stakeholders was made by Ms. Janet Mawhinney in collaboration with Dr. Pignatiello and Dr. Zinck, to clinics and clinicians known to offer assessment and treatment and support to gender-questioning and gender variant children and teens. Invitations were sent by email, inviting these clinics to send representatives. Documentation was received during the review from participants.

Invitation of clients, former clients and families was made by Ms. Christina Bartha. As well, Dr. Kenneth Zucker approached several current and former clients who agreed to participate in the review. One former client's parent approached Dr. Zucker to volunteer to speak to the review committee.

_____ initiated to post an announcement that the review committee would accept written submissions from former clients and families until July 21, 2015. Three written submissions were received by the committee and one received after the deadline was acknowledged and redirected to Dr. Sean Kidd, Dr. Kwame McKenzie and, Dr. Peter Szatmari.

IV) HISTORY OF THE GIC

The CAMH GIC was founded by child and adolescent psychiatrist, Dr. Susan Bradley. Dr. Ken Zucker was initially a trainee working in the clinic and when hired as staff psychologist, further developed the clinical and research programs at the clinic. He has worked at the clinic for over 30 years and is the functional clinical and research team leader.

Team members 2014-15 Academic Year

Name	Title	Role	FTE
Dr. Ken Zucker	PhD, C. Psych	Clinician Scientist, CYP, and functional lead of GIC	1.0, with 50% dedicated time to research
Dr. Lori Wasserman	M.D.	Staff Psychiatrist, CAMH, with GIC. Provides psychiatric consultation, some follow up, including psychopharmacology	0.2
Resident in Psychiatry	M.D.	Assessments and treatment	Approx. 0.2 (for 5 months in fall of 2014)

Dr. Hayley Wood	PhD., C. Psych.	Psychological testing, therapy, supervision of trainees	0.8 (on leave at this time)
	PhD	CIHR funded post-doctoral research fellow	1.0 (September, 2012 – August, 2015)
	Ph.D., C.Psych	Provides therapy, as part of supervised practice	Approx. 0.1
	PhD	Provides therapy as part of retraining year via the College of Psychologists of Ontario	Approx 2 hours/week

Additionally, one pre-doctoral trainee and five M.A. Psychology trainee clinicians provide clinical service in the clinic, most for two hours per week, two for one day per week, and one for two days per week. Two researchers in the clinic include a Ph.D. student conducting his dissertation in the clinic and a Visiting Scholar from the University of Lausanne. Neither have clinical duties.

Dr. Zucker is also with the Multidisciplinary Urogenital Clinic (MUG) at the Hospital for Sick Children one morning/month. The MUG sees infants, children, and adolescents with disorders of sex development. Patients seen at the MUG who require a more extensive psychological workup are seen at CAMH for a more extensive evaluation.

V) CURRENT CLINIC CASELOAD AND DEMOGRAPHICS

- 1) Number of Unique Clients (new registrations) from GIC by Age Group and by Gender, FY 2012-2013 to FY 2014-2015

- See table in Appendix 1

- 2) Gender Identity Clinic – LOS Summary Data (Sample of 68 cases closed in 2014)

Time from case registered/opened to date closed (rounded to the closest year – i.e. 20 months is 2 years; 32 months rounded to 3 years)

1 year	2 years	3 years	4 years	5 years +
13	38	9	3	5

3) Number of Adolescents as a Function of Sex and Year

- See graph in Appendix 2

Note: In the fall of 2014, the waitlist to the clinic was closed due to increasing growth of the waitlist and the need for a review.

VI) ASSESSMENT PROCESS

The team members report that they use a “developmental approach” to assessment which includes interview, play therapy assessment and observation, parent interview, and psychological testing. This is well-described in publications by Dr. Zucker and colleagues (Appendix 12). In summary, trainees participate in the assessment of new referrals in combination with or supervised by either Dr. Zucker or Dr. Wasserman. Children or teens and parents/guardians are seen independently and as a unit, over several sessions. Dr. Wasserman also provides consultations and monitoring of medications on a case-by-case basis. Almost every patient receives psychological testing. Trainees provide a fair amount of the psychotherapy. The team engages in weekly group supervision and case discussion.

VII) TREATMENTS/CARE PATHWAY

The team outlined their treatment approach in interviews with the Review Committee members, summarized below.

The treatment length varies and is not set or estimated at the outset. Play therapy is offered to young children and at times, a combination of CBT and play therapy. For older children and teens, play therapy is not used but rather, exploratory therapy designed to assist patients to explore or become comfortable with their biological gender and to facilitate adjustment, is provided. For older teens, the approach varies but can include exploratory therapy, treatment of co-morbidities, and preparation of youth and parents for referral for biomedical treatments.

VIII) LITERATURE REVIEW

1. Review of clinical practice guidelines

At the request of Dr. Peter Szatmari, Ms. Stephanie Duda, MSc, prepared a Systematic Review, *Psychological Treatments for Gender Dysphoria in Children and Adolescents* (Appendix 3), which summarizes the quality of clinical practice guidelines. Two clinical practice guidelines are recommended for use with modifications: Adelson for AACAP, 2012 & Coleman, 2011. These are considered to have a rating of 3 of 7 for quality of the guideline. (1= Lowest Quality; 7 = Highest Quality).

An excerpt from Coleman et al. 2011, the World Professional Association of Transgender Health (WPATH) guidelines states:

“The WPATH Board of Directors strongly urges the de-psychopathologisation of gender variance worldwide. The expression of gender characteristics, including identities that are not stereotypically associated with one’s assigned sex at birth is a common and culturally-diverse human phenomenon which should not be judged as inherently pathological or negative. The psychopathologisation of gender characteristics and identities reinforces or can prompt stigma, making prejudice and discrimination more likely, rendering transgender and transsexual people more vulnerable to social and legal marginalisation and exclusion, and increasing risks to mental and physical well-being. WPATH urges governmental and medical professional organizations to review their policies and practices to eliminate stigma toward gender-variant people.”

2. Additional clinical literature

Canadian Trans Youth Health Survey report (for the full report, see Appendix 4).

Key findings of the report include:

- While the majority of youth (83%) reported living in their felt gender at least part of the time, only about half lived in their felt gender full time. **Those who lived in their felt gender all the time were almost 50% more likely to report good or excellent mental health.**
- Safety, violence exposure, discrimination, harassment/bullying were major issues.
- Family relationships are important. **Trans youth who had supportive adults both inside and outside their family were four times more likely to report good or excellent mental health, and were far less likely to have considered suicide. When youth had high levels of parent support and family connectedness, they reported much better health.**
- Mental health issues were a key concern. **Nearly two-thirds reported self-harm in the past year; a similar number reported serious thoughts of suicide; and more than 1 in 3 had attempted suicide.**
- Trans youth generally reported low connectedness to school, but **those who reported higher school connectedness were twice as likely to report having good mental health.**
- Many youth reported missing needed physical health care during the past year (33% of younger and 49% of older youth) and even more missed needed mental health care (68% of younger youth).
- Over half of youth with a family doctor (53%) said their current family doctor knew about their trans identity. However, **only 15% of youth with a family doctor felt “very comfortable” discussing their trans status and trans-specific health care needs.** Even fewer felt comfortable at walk-in clinics.
- Poverty and hunger was also an issue for some transgender youth: **1 in 5 younger youth and more than 1 in 3 older trans youth reported going hungry in the past year because they could not afford food.**

- More than 1 in 4 younger trans youth reported they had run away from home in the past year
- Schools need to become safer and more welcoming for transgender youth, even before these youth make themselves known to school staff.
- Professionals from all health care disciplines need further training to improve their ability to offer high quality care, including discipline-specific training in protocols for addressing trans youth health issues.”

3. Guiding principles in the absence of RCT data

There are no RCTs of treatment for gender dysphoria. This is not inappropriate as the approach to it must be considered in the context of each individual. Especially in the absence of a definitive care pathway that can be applied to entire populations of children and youth, the underlying principles of safe, ethical, developmentally-appropriate psychological, medical and surgical assessment and treatment must always apply. These include but are not limited to:

a) Non-maleficence and beneficence

“*Non-maleficence* is the principle of doing, or permitting, no official misconduct. It is the principle of doing no harm in the widest sense. *Beneficence* is the requirement to serve the interests and well being of others, including respect for their rights. It is the principle of doing good in the widest sense” (from the University of Derby Research Ethics Committee). These can be summarised as ‘First do no harm’ and ‘relieve suffering where one can.’

b) Harm reduction

Harm reduction is a treatment and assessment approach and philosophy. Its principles include:

- No judgement
- Focus is on minimizing risks
- Change is not necessarily the clinician’s but the person’s goal
- Creates awareness that any change will create a space where health and choices can be examined
- Views change as a process that occurs in stages

There is much that is applicable in the harm reduction model. As research emerges on the negative health effects of discrimination, parental and family and peer rejection and the effects of delayed access to transition support treatment, the philosophy of harm reduction can guide a clinician as peer-reviewed outcomes research that will guide clinical practice continues to emerge.

c) Diagnostic reliability

Some research supports that 80% of gender-questioning and gender-variant young children may not persist in a gender identity that differs from the gender assigned at birth, with watchful waiting, education and supportive treatment where indicated. 20% of these children do persist in their gender identity. It is not possible to identify these children without prospective follow-up at this time. The basic principles then must be to allow the child and teen to safely express and explore their emerging gender identity without creating a condition that may make it difficult for them to fluidly express their gender identity. Nor should a treatment pathway prevent gender questioning youth from accessing necessary treatments to allow them to explore and express their gender identity. The mental health clinician's role is essential in the current clinical practice guideline. Access to assessment needs to be as efficient as possible. In order for this to occur, especially in the context of an increase in referral rates Canada-wide, the assessment and treatment course must be efficient as well as evidence-based and limited to what is required based on the individual's goals and treatment needs. This assessment and treatment is crucial as often is the first step to referral for those who are seeking gender-affirming medical or surgical treatment.

d) Effects of early and late social, medical and surgical transition

There are effects of early social transition that are very important: for a child who is in the group of children whose gender identity is either non-binary or opposite to their gender assigned at birth, the opportunity to express their gender in dress and be called by their name and pronouns that match this identity is crucial. It is also very important for youth who may later identify as the gender assigned at birth. It is noted in the clinical literature that some children and teens may later wish that they had not socially transitioned. In these cases, an early social transition may make it more difficult to make the social transition to their gender assigned at birth. This fact should not deter clinicians from supporting a social transition, but rather, this information be included to children, teens and families who are seeking assessment, advice and education on how to support the gender expression and exploration.

e) Inclusive developmental approach

A developmental approach does not simply mean that one follows a child prospectively; it also implies that the education and interventions one provides are appropriate to the individual child's intellectual, social and psychological stage. Many complex diagnostic assessments are made and treatment plans initiated that do not require a full battery of psychological testing, particularly intelligence testing. There is literature on obtaining informed consent in children, pre-teens and teenagers that can guide clinicians about the education and assessment of their patient and the patient's family's capacity for clinical decision-making.

f) Parental support

There are now several published studies that demonstrate that trans, gender-variant and gender-questioning youth face misunderstanding and at times, rejection or dismissal by their families. The emerging literature, including the National TransHealth survey also shows how crucial family support is in the ongoing and future mental health of youth who seek social, medical and surgical transition. In adulthood, even after sexual reassignment surgery, internalized shame and poor mental health, and suicidal ideation and attempts are more common among those who faced familial rejection. Family education, support and treatment need to be cornerstones of assessment and treatment of gender-questioning and gender-variant children and teens. A patient-centred approach should include the parents and siblings, where appropriate. Delaying treatment referrals because the family is having trouble accepting a child or teen's gender expression needs is not recommended. Rather, this indicates a need for work with the family to ask about their fears, worries, and to provide education about how to best support their child. It is the responsibility of the clinician to provide truthful answers to the questions about outcomes. It is helpful to remind parents that a client or patient-centred approach stands on a foundation of what is known from the clinical literature, applied to an individual.

4. Literature received from review participants

- a) [redacted] a community stakeholder, researcher, transhealth activist and scholar, provided the following documents, found in the Appendices indicated:

Document	Appendix
'Is CAMH trying to turn trans kids straight?'	5
'Two Families Grapple with Sons' Gender Preferences: Psychologists take Radically Different Approaches in Therapy'	6
'Fix Society. Please.'	7
'Key Statements from Mental Health, Medical and Human Rights Experts.'	8
'Examples of Unethical Treatment in CAMH Children's Gender Identity Service'	9

- b) Kristen Sharpe, CAMH Legal Counsel, provided the document, 'Legal Context of Gender Identity Issues in Ontario' (Appendix 10).
- c) Dr. Ken Zucker provided copies of selected publications to the Review Committee, as well as the Ph.D thesis of a graduate student who recently completed his clinical and research placement at the CAMH GIC. (Appendix 11).

- d) The CAMH Empowerment Council provided an English and French copy of the Ontario Human Rights Commission 'Policy on preventing discrimination because of gender identity and gender expression.'

IX) SUMMARY OF PARTICIPANT RESPONSES

Please see Appendix 15 for the questions asked by the Review Committee to participants.

1. Dr. Ken Zucker, Dr. Lori Wasserman, and Dr. Hayley Wood

Dr. Ken Zucker and Dr. Lori Wasserman described that “as an academic health centre, our mission includes provision of clinical care and to conduct research,” which pervades every setting in the GIC. Employing what is described as a developmental biopsychosocial model, “the clinical work is to formulate and treat the presenting problems.”

Prior to the imposed wait list closure in June, 2014 the GIC had an approximate wait time of 9 months, with 80-90 patients waiting to be seen. A CAMH-wide centralized referral and screening process has replaced the former clinic-based intake process. Dr. Zucker indicated that “the strength of the clinic is that we do standardized assessments” and cited a 95% assessment completion rate. This standardized assessment includes play therapy to assess and treat any anxiety and/or depression symptoms, and “to determine to what extent the gender dysphoria is causing the anxiety and depression.” Play therapy is used to “gain access...to the child’s internal world”. DSM 5 criteria are used to diagnose Gender Dysphoria. The GIC attempts to be integrative, providing multiple levels of intervention within versus referring elsewhere for specific treatment modalities for mental health comorbidities.

The assessment includes a WISC IV, CBCL, parent and child gender identity scales, and a generic self-esteem measure. The GIC “standard approach” includes a 3 day assessment including family interviews, developmental history, and assessment for comorbidities, including trauma. Psychometric testing (3 hours) occurs with the child, while the parents are interviewed. Concordance between goals and history is assessed. Young children would be told “Mom and Dad would like to explore how to make you feel better about being a boy or a girl”, referring to natal biological sex. Dr. Zucker also indicated that “there are often loyalty conflicts [between parents and their children’s needs]. Some may not agree with the treatment approach. The response would depend on the problem.” He added, “in the client-centred way, one would ask the hypotheses of the parent and try to reduce fears by letting them know that gender identity development is multi-factorial.” Dr. Zucker explained that young children are interviewed individually for one hour and then feedback is given to the parents.

Recognizing the diversity of viewpoints held by parents, the team provides support to help parents “to manage their own reactions, especially anxiety around anything new. Helping them to manage their reactions to the child, to remain curious and not entrench a

behavior,” according to Dr. Zucker. Additionally, it was described that the team uses “a combination of play therapy and CBT in some cases 50-50, but most 15-20 minutes may be spent in a session teaching some CBT skills.” Typically the team psychiatrist would prescribe SSRI medication if needed for treatment of anxiety or depression.

Clinical collaboration tends to occur predominantly with “[redacted] of the M.U.G. clinic at the Sick Kids Hospital” as per Dr. Zucker. For the adolescents aged 17 years and above, the GIC works with endocrinologists [redacted] and [redacted] at Mt. Sinai Hospital. Younger teens are referred to a pediatric endocrinologist, [redacted] at the Sick Kids Hospital. There are also pediatric endocrinologists in Kitchener, London and Windsor. Other collaborators include other developmental clinicians in the community, who will see clients for treatment once they are assessed at the GIC. Dr. Zucker added that “the developmentally agnostic model is followed by the clinicians we send people to.” Dr. Zucker also stated that, “in late-onset gender dysphoria, puberty can be a driving force. Women are often objectified; another form of trauma may also be present. The cause of late-onset is often not relevant to treatment and we will try to explain this to the parent....In early-onset gender dysphoria, we would assess and explore.”

Regarding treatment in the hypothetical clinical situations presented, Dr. Zucker stated that he would explain to parents that he would advise puberty blockers for “older adolescents with persistent gender dysphoria... these are typically prescribed to inhibit erections and prevent menstrual periods which can cause significant emotional distress to youth whose gender identity is incongruent with these physiological processes.” He added that parents “would need to be willing”; however, “if parents refuse [to accept this recommendation], the child can’t pay for Lupron [puberty blocker].” To the parents of a 5 year old child with gender dysphoria who states, ‘We’d like our kid not to be gay’ Dr. Zucker described a common response to be “we have never had a therapeutic goal to alter sexual orientation. We would help them to unpack their fears and worries.” Dr. Zucker identified that advising the parents of very young child with gender dysphoria, who are contemplating a full social transition represents “one of the controversies.” Dr. Zucker also described that that the assessment considers ‘Why is the family presenting? What is the question?’ **70% of the children we see are sub-threshold for GD.** It’s a matter of degree rather than kind. **For example, we may see a boy [natal male] who may have feminine interests and want to be with girls who share these interests but if he would like to have male friends, we would encourage parents to expand on a repertoire of play dates for children, to include boys.**..To parents, I ask about the topics of their concern and ask what the kids are saying.” Additionally, Dr. Zucker included: “I have never been in a situation where we have seen a pre-pubertal child and the kid is still suffering and we do not facilitate a social transition. We would keep talking about how to understand what is happening and follow-up.”

Regarding school involvement, Dr. Zucker explained that “with schools, what the plan is depends on what the parents are hoping for. If the therapeutic plan is to expand the network of peers (eg. to play with boys) we may ask the teacher to facilitate this where possible. If the child has no interest, we would explore through play therapy why the

child has no interest.” Dr. Zucker also stated that “it is rare to hold school meetings regarding staff and peer education and school milieu adjustment, only because we do not have cases like this” where adjustment and social integration is the only concern.

On gender identity development Dr. Zucker identified that “at age 3, children begin to self-label and form their gender identity. Nascent signs of it emerge before age 18 months and perception of gender is present and forming.” Furthermore, “what does it mean to consolidate [gender] is at the heart of the debate. Kids lack gender constancy. In the developmental model, the narrowing of plasticity occurs at the age of 10-11 years.”

In their approach to assessment of gender identity, GIC members described that “25% of the referrals to the clinic are school-aged children. The assessment would provide further information: if the parents are not concerned [about their child’s gender variance], we would explore this”. There are no RCTs and three treatment approaches: ‘do nothing’ [also called “watchful waiting”]; engage in active exploration and assess if areas that can be helped; encourage social transition.”

Regarding the course of children with gender variance and gender dysphoria, the team described: “We explore [gender expression in young children] because we are starting to see that the degree of distress can predict whether gender dysphoria may persist and our data from follow-up is showing that the degree of cross-gender behaviours can also predict consolidation” [of that expressed gender identity]. They indicated to have found that for late teens who do or do not meet full GD criteria, “there is no difference in persistence but rather the severity [of distress] is the predictor of persistence.” At age 5, “according to the current literature, it will diminish in 80% of cases. There are three treatment approaches: 1. The therapeutic role is to assess and treat the co-morbidities causing the GD. 2. The watchful waiting is to support but not assume the outcome. 3. The accommodating approach is to suggest a full social transition at that age. At age 10, “For extremely gender dysphoric kids, the ballpark is higher for persistence but not guaranteed. One cannot predict persistence of GD with 100% certainty.” At age 15 “in adolescence, the most likely outcome is persistence of the GD. 75-80% would continue to have GD. The treatment would be social transition and biomedical treatment. The most common outcome has been for the youth to be gay. Family responses vary. We explain that this is the best possible adaptation in life and explore the parents’ feelings to identify any fears or homophobia. We tell them, ‘He’s your kid’ We aim to prevent rejection.”

In response to questions about referral for hormone therapies, Dr. Zucker identified “[Physiologically] at Tanner stage 2, which can occur at a variety of ages. The bottom number is age 11. The Dutch tell us it improves bone density to use masculinising hormones but not facilitate full transition. Persistent gender/body dysphoria at puberty” would determine this referral. Furthermore, “If a parent were not supporting it, who would pay?” “Some would say the ethical issue is to give the child a normal puberty” [as their identified gender]. If a parent of an older teen refused to allow their child access to a recommended hormone treatment, the team would “work with the parents.”

Referrals for hormone therapies are made to the above mentioned endocrinologists, who are typically have a wait time of 1-3 months. The typical age for referral for gender-affirming hormones was described as 16 years, “in rare cases, 15.” Approximately “two-thirds of older teens with persistent gender dysphoria are referred for hormone therapy. Dr. Zucker has provided a letter of support [for surgical therapies] “on a couple of occasions over the years. Generally, patients who turn 18 are referred to the Adult Gender Identity Clinic if they so desire.”

Dr. Zucker felt that the work of the GIC would not fall under Bill 77; however, indicated “it is possible that parents may misinterpret it to refer to our work.”

When asked about his view of the future of gender dysphoria assessment and treatment, Dr. Zucker replied: “That is an amazing question. I believe we will see more money invested in research. The clinic, (Dr. Zucker as PI and _____ received a large CIHR grant for an imaging study” [to examine the effects of hormone therapy on gender identity]. There will be more work in the area internationally, more research dollars put in. There will be more systematic studies of hormone blockers. There is also a non-binary picture emerging. Some youth are very confused and we need to understand the co-morbidities. In little kids, we need to look at long-term outcomes. How do these children do in psychiatric outcomes?”

When asked about Quality Improvement and Performance indicators, measures such as the CBCL (Child Behaviour Checklist) from potentially multiple informants were identified.

2. C&Y GIC senior trainees

_____, and two clinical psychology residents, _____ and _____, were interviewed by the committee. They felt that their training has been a very valuable experience” which exposed them to “an area most clinicians don’t have an opportunity to get to know and to understand the controversy in the field.” Trainees were aware of the divergent views in the field, and identified that not all views appear to be based on evidence. They described learning that differences in the developmental aspects are not taken into account and that many are “artificially applying adult concepts to teens and children, regarding biomedical decisions about transition.” Trainees also felt that the team is “not for or against transition.” They worried, however that Bill 77 will “have a chilling effect on this work.” _____ plans to engage in full-time research on of the effects of transition, particularly hormone treatment, on gender identity.

3. CAMH Legal (Kristen Sharpe)

Ms. Sharpe presented a confidential Brief on Bill 77 (Appendix 10). She indicated that Dr Zucker reaches out reactively rather than proactively, from a risk management or reputational risk perspective. Anecdotal complaints have been made; many which reflect balanced views. _____

4. Community Stakeholders

(a) _____ participated as a focus group and also accepted the opportunity to make individual submissions. The group emphasized that the 2011 WPATH guidelines stated that gender identity is not a matter of pathology. One participant stated that a mental health clinic is not needed at all, but if anything should be community based and with a focus on family and environmental supports. They expressed concern over the perception that the goal of the CAMH C&Y GIC is to reduce or eliminate cross-gender behaviours and that how understanding of causes of gender dysphoria is explored could have harmful effects if not done appropriately. One member indicated that “the guidelines of treatment of youth are often framed by this clinic as a debate. This is not the view of activists and other clinical professionals now, if it was ever true. There are many guidelines to guide treatment including WPATH; CA (SW); IFSW; the new gender consortium and CPATH position statements. In a German study (2014) which interviewed 13 international experts in the area of gender identity, 11 of these 13 stated that the approach and methods of the CAMH C&Y are unethical. The 2 who stated it was ethical were _____ and Dr. Ken Zucker.”

The group also referred to Bill 77 as a means to protect the rights to gender expression at any age and that, “a professional cannot seek to alter or change gender identity.” One participant stated that many clients who seek service at their organization are former clients of the GIC and many report traumatic experiences related to their assessment and have persistent, internalized shame about their gender identity and desires to express it that are related to their treatment. There were concerns about the excessively long and intrusive assessment process, referring to the use of one-way mirrors and questions about sexual behaviours, sexual orientation and sexual practices. They described that clients do not see the relevance of questions about sexual orientation. There was a description of younger clients reporting that photos were taken of them without their understanding of their purpose or their consent. For example, a client reported that pictures were taken of their painted nails. Furthermore, it was reported that these photos, taken with a cell phone, were reported to have been shown at the WPATH meeting in Bangkok.

One participant also described concern over the multiple publications emanating from the GIC which address the issues via pathologising language. Additionally, there is anger and concern that other clinicians are being trained in these practices and theories.

The focus group participants indicated that there is a great, unmet need for support for youth aged 3-13 in the province of Ontario and for their parents and families.

(b) Oologan clinicians _____ and _____, social worker clinicians and _____, from the Central Toronto Youth Service (CTYS) presented and were interviewed as a focus group.

One participant expressed concern that the review appeared to be unstructured and that a CAMH representative was present. They also were concerned that “CAMH has not

presented the review as a process. Dr. Kwame Mackenzie's interview about the review stated, 'We expect the clinic to be re-opened after the review.' This suggests a conclusion has already been reached." Dr. Szatmari offered to take that information forward to the CAMH leadership.

This group described that the community believes GIC practices "reparative therapy"; however, the newer trend is toward gender supportive therapy. As such, they felt that for many former clients, contact with the GIC has resulted in traumatized identity development.

Suggestions for improvement included liaising with the adult Gender Identity Clinic and thus increasing the age of service to 24, which would improve access to referrals for hormones and surgery. There is a perception that there is no longer a place for the current GIC but that a clinic like it is needed as youth services are in high demand. There were also concerns expressed that CAMH as a whole is not seen as a "safe space" for individuals with gender variance. Unfortunately, the group was not able to identify any perceived strengths of the GIC.

5. Clients, former clients and families

Seven parents of current and former clients and one former client, still a teen, and one former client who had been seen as a teenager, presented. Of the seven parents of former clients invited by Dr. Zucker and the one teen who volunteered, all had only positive feedback to give. Only one of these families' parents stated a concern: "the long assessment was exhausting."

One other former client, now an adult trans person, was quite distressed and stated it was difficult to decide to participate in this review in person. The former client had been seen starting in mid adolescence, for a period of 3-4 years and described the experience as largely negative. They recall being unclear and confused about the process, the use of questionnaires, IQ tests and being told by Dr. Zucker that 'I was too smart to be trans.' They felt that they were asked many invasive and unnecessary questions, yet felt intimidated to express their concerns. They also described that the staff often misgendered them and that they were not told about community and medical resources available.

6. CAMH Empowerment Council

The CAMH Empowerment Council stated that the clinic needs to undergo "modernization based on best practices." They identified inadequate client engagement and concerns around informed consent practices. The Council suggested that the GIC should connect youth to supportive adults in the community and help them change their legal ID, as well offer proactive education on gender diversity and how to avoid suicide risk. They also recommended that the GIC should focus on supporting young people employing a non-binary approach. Reviews of the clinic should occur more frequently. There was a call for greater collaboration and diversification of services referred to.

Examples of existing potential collaborators and partners would include PFLAG Toronto and Durham; LGBTQ police consultation service, and L'Egale.

Overall it was felt that there is “an oppressive history” with CAMH, with Dr Zucker and Dr. Blanchard as supporters of this. Waits lists are described as very long, practices are “unclear”, and not client driven or focused.

7. Consultation with Sick Kids Transgender Youth Clinic

This consultation took place in person with Dr. Pignatiello and with Dr. Zinck participating via conference call.

The SickKids Transgender Youth Clinic is not under the supervision of Dr. Peter Szatmari or Dr. Tony Pignatiello of the Department of Psychiatry, but is a clinic within the Division of Adolescent Medicine at the Hospital for Sick Children.

The SickKids clinic has received approximately 25 referrals from CAMH GIC to date. Both [redacted] and [redacted] described a collegial relationship with the GIC. Dr. Zucker and Dr. Wasserman both refer clients to the SickKids clinic. The clients of the CAMH GIC have told the SickKids clinicians that “they don’t see a need for the type of counseling they are receiving. They don’t understand their approach. They also report feeling left in the open if they do not have a trainee assigned to them, [in that] they may not be referred in a timely way or offered community referrals.” They also reported inconsistency in approaches in that, “some patients pay out of pocket to see a therapist in the community as they are not offered follow-up and there seems to be isolation as the clinic does not direct people elsewhere” if they do not wish to follow the treatment protocol of the GIC. The referral times for adolescents are too long for those of ages 14-16 years. They report that Dr. Zucker and the clinic referrals are “too conservative” and refer for GnRH [puberty-blocking] hormones later than most other clinicians who refer to them, and later than they themselves would see the youth as ready and eligible for gender-affirming hormones. Other patient feedback described patients feeling “poked and prodded” and that the two-way mirror is intrusive and not clear in purpose; introductions to multiple team members at one session were ‘overwhelming.’

X) WRITTEN SUBMISSIONS

Themes that emerged from the two submissions from former clients indicated some ethical problems. One former client, now an adult transmale, alleged that Dr. Zucker asked him to remove his shirt in front of other clinicians present, laughed when he complied, and then referred to him as “a hairy little vermin.” [See Note Below] He shared that Dr. Zucker then approved the request for a referral for surgery by saying, “Going once, going twice, and, you’ve got it!” The former client was understandably distressed but felt he could not comment or complain as it might affect his referral.

NOTE: It was determined that this “alleged” comment was misattributed to Dr. Zucker by the former client. Upon learning of this misattribution, CAMH released the following statement:

We have been advised that it includes an erroneous statement. CAMH was recently made aware that an individual who had participated in the review process had mistakenly attributed comments to Dr. Ken Zucker which were not made by him. We regret that this statement was included in the report and apologize for the error. A formal letter of apology has been sent to Dr. Zucker.

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A parent of another former client who wrote stated that she felt dismissed by Dr. Zucker when she asked about a more inclusive approach and that names of community support agencies were not given even when requested.

XI) CHART REVIEW

1. Description of chart review process

Twelve charts were reviewed by Dr. Zinck and one chart reviewed by Dr. Pignatiello to test the review method. The charts were reviewed and read in their entirety. The charts were chosen randomly by a Health records employee unaware of the criteria being examined, with the limitation that the charts reflect a range of ages and genders and age at intake be no earlier than 1999. Eighteen charts were pulled. Of these the first 12 were reviewed by Dr. Zinck in the order provided. The sixteenth chart was identified by Dr. Pignatiello. The others were not reviewed due to time considerations as the length of the 12 files was considerable.

2. Data extraction summary

Chart	Age at intake	Birth Gender & Course	GD dx.	GV	Other Dx.	# visits
1	9	M	N	Y	ADHD ODD LD?	2
2	12	M	Y	Y	None	4
3	4	M (c.e.)	N	Y	Borderline IQ; Cloacal extrophy	3
4	2?	M (c.e.)	?	?	Cloacal extrophy	1
5	5	M	Y	Y	ADHD LD ODD?	4 (2004); 11 (2011-12)
6	5	M	Y	Y	None	67
7	4	M	Y	Y	ODD ADHD	20+
8	5.5	M	N	Y	PDD NOS	104
9	8	M to F (p.a.)	N	Y	Penile agenesis	2
10	4	M (p.a.)	Y	Y	Penile agenesis	1
11	10	F to M	Y	Y	None	9
12	13	F to M	Y	Y	Major depression; Seasonal affective disorder	30; 26

Legend:

GD = Gender Dysphoria diagnosis (or Gender Identity Disorder, prior to 2011)

GV = Gender variant behaviours

Other Dx. = other diagnoses identified (psychiatric or medical)

c.e. = cloacal extrophy
 p.a. = penile agenesis

Chart	WPATH guidelines explained evident in charting	Name change	Pronouns used in chart	Supports Offered documented in chart	Advice about gender of friends	Removal of gender toys advised	Statements in chart that could be seen as reparative-type
1	"Gender confusion"	N	M only	N Confidentiality Concern/age-inappropriate	N	N	N
2	Gender variant	N	M only	Y	N	N	N
3	N:"case by case" treatment	Y	F	?	N	N	N
4	N/A	Y	F	N	-	-	N
5	N	N	N	N	N	N	N
6	N	N	N	Aggression ambiguous; interpreted as confusion re: gender	Y	Y	Y
7	N	N	N	Y for PDD	Y	Y	N
8	N/A	N/A	N/A	N	N	Y prior to assessment	Y
9	-	-	-	-	-	-	-
10	N	N/A	N/A	Y (book)	Y (2010)	Y (2007)	Y
11	N	Y	Y	Y	-	Y (clothing)	Y (clothing)
12	N	-	-	-	-	-	-

Chart	GnRH	GARx	GASx	Time to referrals (SOC)	Research participation noted in clinical chart
1	N/A	N/A	N/A	N/A	Y
2	N/A	N/A	N/A	N/A	Y
3	N/A	N/A	Y (birth & age 2)	N/A	Y
4	-	-	-	-	Y-invited
5	N/A	Not suggested	N/A	N/A	N
6	-	-	-	-	?
7	-	-	-	-	?
8	-	-	-	-	Y
9	Y	Y	Y (2013)	Timely	-
10	N/A	-	-	N/A	?
11	2011	Y (2012)	N (yet)	Long	?
12	Y (2009; session # 28)	-	2013(2015 sent to adult GIC)	Overlong	?

Legend:

GnRH = gonadotropin releasing hormone treatment referral

GARx = gender-affirming hormone treatment referral

GASx = gender-affirming surgery referral

SOC = within WPATH Standards of Care, where applicable and general SOC

XII) SUMMARY OF FINDINGS

Significant strengths were identified with the GIC. Dr. Ken Zucker is a Mecca of knowledge and information. Although not in scope for this review, it was clearly noted that the GIC has demonstrated exceptional research productivity and has led in raising global awareness of concepts of gender identity, variance and transgenderism. This continues to be the situation, even in its polarization of the subject. Dr. Zucker maintains good connection with international subject expert colleagues with awareness of diverse approaches. The GIC enjoys a mutually respectful and collegial relationship with the SickKids Transgender Youth Clinic. Dr. Zucker and his team members participate in continuous personal professional development on the subject matter. The team espouses a developmental approach, with attention to formulation. They are aware of and generally, though not consistently, follow treatment pathways for teens with gender dysphoria.

Those who believe in and respect Dr. Zucker and the GIC's work (ie, parents, trainees) are very loyal and committed. Families consistently report positive feedback about

working with GIC trainees. Dr. Zucker is reported by parents who presented to the committee to engage with greater facility with teenagers.

In gathering and reviewing data for this review, however, two predominant themes emerged as areas of concern: the GIC appears to operate as a fairly insular entity, and the GIC is out of step with current clinical and operational practices.

From a clinical perspective, the following areas of concern are highlighted:

- 1) The clinic was developed over 30 years ago, when play therapy was a dominant assessment and treatment modality in child and adolescent mental health clinics in North America and parts of Europe. The research knowledge and clinical guidelines have evolved and society's understanding and acceptance of the diversity of gender expression and identity have changed, but GIC's approach has not. Furthermore, play therapy is used as a treatment for anxiety and low mood, which is not currently considered to be evidence-based treatment for these problems.
- 2) CBT is often used in combination with play therapy which could affect its efficacy for low mood or anxiety. This combined approach could also increase dissonance and possibly distress in children by altering the frame of play therapy from exploratory to directive.
- 3) Some play therapy process notes indicate directive processes to the child with respect to toy choice and reporting of the week's activities related to gender expression in play or socially.
- 4) There appears to be a mismatch between literature research findings (including those from GIC itself), and clinical practice and approach. The wealth of factual knowledge tends to get lost in translation to practice. The approach to clinical practice appears to be filtered by a bias that assumes that most children presenting with gender variant behaviours require clinical intervention. This does not reflect the findings of the clinic's own research. While intensity of gender variant behaviours may correlate with persistence, this does not indicate a need to redirect this behaviour.
- 5) There appears to be a false dichotomy in the clinic's description between the 'developmental approach' and how it may fit with the approach of 'watchful waiting' and particularly with the approach of 'accommodation'. At any age, client-centred gender exploration, social expression and watchful waiting are needed to provide the most supportive and appropriate treatment for gender variant and gender dysphoric or questioning children and teens.

- 6) Dr Zucker states that he feels in many cases parents, schools, and community advocacy groups may advise too early a transition. There is a greater need than ever for the natural course of gender variance and dysphoria to be understood. The clinic focus is on intensive assessment and treatment and has not included participation in community education on this topic. This is a significant missed opportunity. While most advocacy groups clearly understand the natural course of very early gender variance and dysphoria, adding the voice of clinicians who advocate watchful waiting and where needed, an eclectic, child-centred approach would further improve the care of gender variant and gender dysphoric or questioning children and teens.
- 7) Family feedback has stated few resources are offered and they are not directed to community support agencies.
- 8) An exhaustive, “standard” approach to assessment, including psychometric evaluations without clear clinical rationale appears to represent the usual clinical practice. If these are part of research protocols, the necessity as well as risks and benefits to the patients should be considered and explained to the patient and guardian in each case, independent of the research protocol.
- 9) Assessments are described as intrusive and even traumatic by some, who described feeling “poked and prodded”. One way mirror and multiple observers create discomfort. Many questions were felt to be irrelevant, unnecessarily intrusive (particularly those regarding sexual fantasies), especially when asked without context, rationale, and what seems to be inadequate or even absent informed consent. Also, it is unclear whether any potential benefit of this line of questioning to the patient was explained. Parents of younger clients report their child appearing to be and later reporting feeling they were very uncomfortable with the way they were asked about their gender variance “as if my child was not okay as a person.” One parent described feeling “dismissed” when she spoke to clinicians about this.
 - a. The chart review revealed a 9 year old patient being asked about what made him sexually excited during his first meeting with a clinician in the initial assessment. This was a client with particular vulnerability from trauma and in foster care.
 - b. One former trans identified female to male client stated that they were asked by Dr. Zucker to take off their shirt in front of him and multiple team members. This client felt intimidated and unable to decline.

- 10) Patients reported feeling intimidated to question Dr. Zucker regarding their concerns and were not offered the opportunity to decline. Multiple informants commented on this.
- 11) The GIC's therapeutic focus on 'understanding why' someone is the way they are, is described by former patients, current therapists of former clients and parents as "disturbing" and "harmful". One participant described that being told by a clinician that there is a need for ongoing treatment or assessment to 'understand why you are the way you are' is problematic in and of itself. Participants described that stating that there is a "cisgender goal" ("to make child comfortable in their biological sex") is "not right/shaming", nor is this in keeping with current guidelines. For those whose natural course is to identify as transgender or gender fluid, this leads to excessive shame and self-stigma even after successful access to gender-affirming hormones.
- 12) The GIC's described application of its 'developmental model' is divorced from important community resources and inconsistent with longitudinal follow-up data on outcomes of gender-variant children. Application of heterosexual cisgender as the most acceptable treatment outcome is inappropriate. Pathologisation of family and child is evident: correlational mental health problems are interpreted as causative and run counter to the prevailing clinical worldview on the direction of this correlation. Gender variance itself does not cause psychopathology but rather the distress associated with it does. An aim to treat normal human gender variation is unlikely to be successful and unethical.
- 13) Further issues of incomplete informed consent in the clinic were raised by reports of photos being taken without explanation of and approval by the client. A patient also report not being informed of how photos are being used. One person stated that the pictures were also taken with a cell-phone, which made them feel quite concerned about the possible dissemination of these photos.
- 14) We cannot state that the clinic does not practice reparative approaches (if not outright therapies) with respect to influencing gender identity development.
 - a. One patient's parent reported being "encouraged not to give into that" when their child insisted on wearing underwear of opposite-to-birth gender. Others related clearly seeing separate tables with 'girls' and 'boys' toys and asked to choose during assessment. In chart review, it was documented that one parent inquired about "being able to steer the outcome" and an exchange with parent documented by the clinician stated the parent is "not going to fight nature but more than willing to nurture to facilitate the development of becoming a boy. Gender Identity Disorder is

a diagnosable illness with treatment and thus, willing to facilitate the treatment.”

- b. Some parents report and chart review also documents cases in which parents were advised to avoid “boy” or “girl” toys for children, a child’s Christmas list was being requested and their potential purchases discussed as to what would be most helpful for the child. In one case, a parent was asked “to discuss” their choice to buy a child (natal male) an Easy-Bake oven; in another, to buy a Transformer doll of the natal sex.

- 15) Chart documentation revealed statements reflecting that the diversity of gender expression and variance are not accepted equally. One example is of a child for whom all gender and body dysphoria had resolved and multiple informants indicated sustained good mood and satisfaction with social and academic functioning. Despite this, the parents of the child were advised at discharge to encourage the child to spend more time with cisgendered boys because he had effeminate speech and mannerisms. These were not goals of the client or family.
- 16) Although the child is registered at CAMH as the client, the review of multiple informants, including clinic staff history and a review of the process notes in the chart review reveals that parent acceptance and desires for their child to identify as the gender matching their natal sex can guide the approach to the child’s treatment, particularly in school-aged children. One experience shared, describes a situation in which an older teen (>16) was not referred for gender-affirming hormones even though advised by the team that this would be the best course. The teen was not referred or offered a referral to an agency that could pay for them to access hormones as this would be viewed as unacceptable to the parent.
- 17) There appears to be less documented in the chart than one would expect on any therapeutic work with parents on either psychoeducation on the course of gender variant children or in helping parents work through any worry or grief with the clearly stated goal of accepting any potential outcome and supporting their child. While this may be a deficiency of charting, it is an important area to include in treatment and to document; its absence is a concern and one could conclude it is not a main focus of treatment.
- 18) Dr. Zucker has been described as “too conservative” by clinician and patient informants in terms of patient referral times and criteria of diagnosing readiness for referral for gender-affirming hormones.

- 19) The process for determining eligibility for treatment referral (internal or external) is not clear or consistent. **Some parents described that if they were seeking support and community agency referrals, none were offered and in some cases they were told that the clinic had nothing to offer as their goals were incompatible with treatment.** Another parent whose child had socially transitioned was offered over a year of frequent parent support sessions.
- 20) Clinical reports are very lengthy and most are mainly detailed process notes. Often the diagnosis, formulation, management plan are not clear or concise, with exceptions depending on which clinician was involved. **For clients in longer term treatment, there are few treatment summaries or re-evaluation of treatment goals.** Multiple pages of process notes are sent out to other professionals that the team refers to, with questionable utility. There may be a short letter suggesting the gender-affirming treatment recommended but no other summary of their assessment and current adjustments and needs.
- 21) **Chart review and colleague feedback suggested that there are delays to referral for gender-affirming hormones which could, for some clients, lead to irreversible physical consequences of natural puberty that either cannot be altered** (e.g., height in an FTM youth or voice pitch in a MTF youth) or only through surgery (e.g., breast development in an FTM youth).

From an ***operational*** perspective, the following areas for improvement were identified:

- 1) **Access to GIC is very limited due to long wait lists.** Long wait times are likely affected by not only increased referral rates but also by the lengthy and exhaustive assessments, protracted therapy courses, long lengths of stay which also hinder access to the clinic as well as result in delays in referring to other services
- 2) **The clinic tends to operate in relative isolation** (i.e. from CAMH and its various resources – legal, ethics, public relations, decision support, CAMH CYF; CAMH adult GIC; the larger University of Toronto Division of Child & Youth Mental Health; community agencies; schools, child/youth organizations, etc). This relative isolation inhibits timely and efficient transition of care to and/or from the community or to adult services. In one case, an 18 year old was referred to the adult GIC at CAMH, with no recommendation for a reduced assessment. As a result, the client was placed on what is currently a 2 year wait list, despite already meeting eligibility and readiness criteria for sex reassignment surgery at the time of referral.

- 3) No Quality Improvement (QI) plan or strategy was identified.
- 4) Dr. Zucker currently has no succession plan for the clinical services provision at his retirement.
- 5) The current intensive therapy oriented model cannot be sustained with limited staffing. We do not recommend that the current approach should be sustained, however.
- 6) There is no evidence of opportunities for client, family or stakeholder engagement and contribution to GIC direction and services
- 7) The GIC and CAMH in general, are not seen as a “safe space” for gender questioning & transgender populations.

XIII) RECOMMENDATIONS

This is an opportune and somewhat natural time for re-visioning and modernization of the GIC, for many reasons. Dr. Zucker may be approaching ‘end of career’. There is a tremendous need for specialty services such as this, clinically and academically. Knowledge of gender identity and expression has advanced significantly and society has also shifted in its understanding and acceptance of gender variance. Many of the children previously assessed and treated in the GIC and other similar services are now adults with their own voice, offering important insight to guide the development of services. At present, the political climate is palpable and this is an emotionally charged issue that would benefit from incorporating all evidence and voices.

The following recommendations are made to address *clinical* challenges identified:

- 1) The current assessment and treatment approaches need to be revised. Gender variance versus gender dysphoria should be distinguished and explained. The aim to reduce suffering can be achieved with a client-centred and family supportive approach. To move towards this goal, it is recommended that WPATH, CPATH & AACAP guideline-informed care paths be utilized, across the age spectrum. Some specific examples include, but are not limited to:
 - a) Explain these at the start of assessment (informed consent/harm reduction/client-centred)
 - b) Refrain from treatment of the child that targets reduction of gender-variant behaviors or use of language that pathologises these.
 - c) Refrain from allowing parent alone to choose the treatment path

- d) Educate parents and children about gender expression, gender identity, gender variance across the lifespan
 - e) Assist all families with communication and acceptance within and outside the family
 - f) Liaise with schools to provide advice on inclusion and obtain collateral about social adjustment and any protection needs
 - g) Refer teens taking hormone-blockers for gender-affirming hormone treatments when ready and eligible in collaboration with endocrinologists involved.
 - h) Staged sexual history interview using suggested approach:
 - i. Age-appropriate questions (pre-pubertal sexual history is not required)
 - ii. One may rule out paraphiliae with 2 screening questions: “How do you feel about yourself when you dress in your preferred clothing?” Follow-up, if unclear, “Does it affect your sexual confidence or your overall self-confidence?”
 - iii. Inquire about attraction and whether sexually active late in the assessment
 - iv. Inquire only about safe sex practice use at assessment
 - v. Inquire about details of sexual practices only when assessing for treatment that can affect sexual function and inform patient about the reason for these questions (informed consent).
- 2) More careful delineation of who is the client: focus on any clinical distress associated with gender dysphoria in the child. The family members should become the focus as needed for education and any work toward acceptance of their child. Do not treat family members individually for mental health concerns, but rather, collaborate with other providers, where needed.
- 3) When assessing for comorbidity and psychosocial outcomes, correlates and their relationships should be examined in the context of the effects of gender dysphoria. These would include, but not limited to:
- Anxiety
 - Depression
 - Disruptive mood dysregulation
 - Self-harm and suicide
 - Substance use disorders
 - Personality disturbances
 - Work in the sex trade
 - Underemployment
 - Underachievement of academic potential
- 4) A review of the use psychological testing, even in research context with attention to:
- a. Option to decline
 - b. Informed consent on use of IQ tests as not standard practice

- c. Separate consent for research and clinical use of all information
 - d. Employ Gender-specific scoring of any psychopathology measures
- 5) File consent forms on chart and renew periodically (i.e. every 30 days for consent to share of information or annually for consent to treatment, in keeping with other CAMH forms and procedures). Forms should state option to revoke consent at any time and specify that clinical care would not be affected by the change in consent. This should include separate consent for any photographs, which generally should be requested only after careful reflection on the client's needs and with full informed consent from child and teen and parent.

The following recommendations are made to address operational challenges identified:

- 1) Community engagement will be key in determining future directions (including physical location) of this specialty service. Whereas such a service need not necessarily to be housed at CAMH (in a hospital), it is imperative that it maintain an academic mandate.
- 2) Key organizations and institutions to consider for the engagement process could include Rainbow Health, Justice for Children and Youth, The Provincial Youth Advocate's Office, The Provincial Council for Maternal & Child Health, Children's Mental Health Ontario, LHINs, MCYS Lead agency/ies, as examples.
- 3) Collaborate with CAMH academic partners, resources, Chairs and Centres (i.e. The McCain Family Centre re Collaborative Care opportunities)
- 4) Develop a clear, implementable QI strategy, utilizing CAMH decision support as appropriate.
- 5) Update and create a governance model including an Executive and/or Advisory Committee (which should include as a minimum: clients (youth and/or family), CAMH Public Affairs, Legal, Ethics, community stakeholders, CAMH adult GIC, trainees)
- 6) Develop clearer, more streamlined processes for access to and flow through the clinic, and transfer to community resources and adult services, as appropriate. This should be consistent with Access CAMH, and CYF intake processes and procedures. Better collaborations/partnerships when dealing with crisis and concurrent mental health situations are advised—especially so the burden of treatment does not fall onto clinic trainees.

- 7) Consider adding Social Work or other professionals with expertise in family therapy to the GIC team.
- 8) Community supports should be included in recommendations and psychoeducation to families and youth. These would include choice of services for hormone therapies, and surgery assessment, where appropriate, for example.
- 9) GIC staff to take training courses in more streamlined and efficient record keeping, chart organization and report preparation.
- 10) GIC team members are highly encouraged to review CAMH policies re: informed consent, and email correspondence with families.
- 11) When dealing with GIC controversies in a public forum, GIC members are encouraged to work with CAMH Public Relations to effectively deliver messaging which also considers reputational risk to the institution, and employs client-centred language. GIC staff may benefit from media training.
- 12) GIC and CAMH as a whole are encouraged to develop a campaign towards collaborative creation of “safe spaces” for transgender children, youth, families, and community caregivers.

We hope this review and report are of assistance.



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Dr. Suzanne Zinck

Dr. Suzanne Zinck is an Assistant Professor of Psychiatry at Dalhousie University and a staff Psychiatrist at the IWK Health Centre. She received her M.D. from Dalhousie in 1998 and completed both her Psychiatry residency in 2004 and fellowship in Child and Adolescent Psychiatry in 2005, in the McGill University hospital network. Dr. Zinck became an inaugural fellow of the RCPSC in Child & Adolescent Psychiatry in 2013. She practices at the IWK Bipolar Disorders clinic and at the Halifax branch of the IWK Community Mental Health Clinic, where she serves as the psychiatrist with the IWK Transgender Health Team. Dr. Zinck teaches and supervises medical students, pediatric and psychiatry residents and fellows in child & adolescent psychiatry. Dr. Zinck also teaches and supervises psychiatry residents learning core CBT skills and is the head of the Human Sexuality component in the Faculty of Medicine Med I curriculum.

Dr. Antonio Pignatiello

Dr. Pignatiello is the Associate Psychiatrist-in-Chief at the Hospital for Sick Children and an Assistant Professor with the Department of Psychiatry, University of Toronto. In 1987, Dr. Pignatiello graduated from University of Toronto Medical School and then completed his psychiatry training in 1992, also in Toronto. Subsequently he completed a Fellowship in Adolescent Forensics with The Arson Prevention Project for Children (TAPP-C), at The Centre for Addiction and Mental Health (former Clarke Institute of Psychiatry).

Dr. Pignatiello is a general child and adolescent psychiatrist who has worked in private practice, and in various hospital and community based children's mental health services, providing consultation and direct clinical service, as well as in many administrative leadership roles. Since October, 2004, he has been the Medical Director of The Telepsychiatry/TeleLink Mental Health Program with The Hospital for Sick Children, where he also provides clinical and educational services. He has won Undergraduate and Post Graduate Teaching Awards in psychiatry from the Hospital for Sick Children and local, provincial, and national awards for his work through Telepsychiatry. In 2014 Dr. Pignatiello was also appointed as Director of Child, Youth, and Family Health for the Medical Psychiatry Alliance, Toronto.