

The Right to Thrive:

An Urgent Call to Recognize, Respect and Nurture Two Spirit, Trans, Non-Binary and other Gender Diverse Children and Youth

JUNE 2023



REPRESENTATIVE FOR
CHILDREN AND YOUTH

About the Artist

Chase Gray is a trans-Indigiqueer or 2-Spirit xʷməθkʷəḷəm (Musqueam) and Tsimshian artist. He was born in Nanaimo and moved to the Mainland in early childhood where he grew up. He is Musqueam and Tsimshian on his mother's side, and his father is a European settler of unknown descent. He is a father and lives in Musqueam. At 12-years-old, he was introduced to mask-dancing and has danced along with the Git Hayetsk Dancers: "The People of the Copper Shield", who have greatly influenced his art. In 2021, Chase revived his lifelong dream – drawing – formline drawing in particular. He took inspiration from the Indigenous characters and stories of his childhood and blended them with mainstream concepts. Chase believes people from every culture can understand and appreciate Indigenous artwork in some way, and hopes his work captivates a wide audience.

About the Cover Art

The cover art depicts a raven spindle whorl with two ravens to represent what many Indigenous people identify with – 2-Spirit. Ravens are tricksters, transformers and the catalysts for change. They hold significance and power for people all across the Northwest coast, and many people identify with their playful and wise natures. The spindle whorl itself is a form based on the traditional methods of spinning wool. Weavings made from this wool are a form of wealth to Coast Salish peoples, which solidifies the symbolism of the significance and importance of 2-Spirit teachings.

June 22, 2023

The Honourable Raj Chouhan
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C., V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting the report *The Right to Thrive: An Urgent Call to Recognize, Respect and Nurture Two Spirit, Trans, Non-Binary and other Gender Diverse Children and Youth* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act* which gives the Representative authority to make special reports to the Legislative Assembly if the Representative considers it necessary.

Sincerely,



Dr. Jennifer Charlesworth
Representative for Children and Youth

pc: Ms. Kate Ryan-Lloyd
Clerk of the Legislative Assembly
Ms. Karan Riarh
Committee Clerk, Legislative Assembly

Acknowledgements

Circle of Advisors

RCY acknowledges that the stories and systems of care for Two Spirit, trans, non-binary and other gender diverse (2STNBGD) children and youth are complex. There are no simple solutions and no one person or oversight body has all the answers, therefore RCY convened a diverse group of advisors with a range of lived and professional experience to assist in discerning the most significant opportunities for meaningful change.

In spring 2023, the Representative held three gatherings with 19 community practitioners, researchers, advocates and academics who offered their insights and knowledge on the experiences of 2STNBGD children and youth and their caregivers with provincial child- and youth-serving systems. Their feedback was considered at multiple points throughout the development of this report and is reflected within.

The Representative deeply appreciates the wisdom of this Circle of Advisors and the time they shared with RCY. She also notes that all the advisors provided their time and perspectives outside of their professional duties. Their voices represent their individual perspectives and not those of the organizations with which they are associated.

That said, it is with regret that, due to the rise of hate and violence directed towards 2STNBGD people including the most recent evidence from another Canadian jurisdiction, the Representative has made the difficult decision to exclude the names of the Circle of Advisors from this report. This decision has been taken solely with safety in mind, and does not reflect the immense value of their contributions, for which the Representative and staff of RCY are grateful.



Contributors

The Representative for Children and Youth (RCY) and her staff would like to acknowledge with deep gratitude all those who courageously shared their perspectives and made this report possible, especially given a recent increase in hate speech and harms directed towards Two Spirit, trans and other gender diverse children and youth in the world.

This includes, first and foremost, the youth who shared their voices and experiences for this report; UBC's Stigma and Resilience among Vulnerable Youth Centre; RCY's Circle of Advisors; and RCY staff from many teams including Reviews and Investigations; Systemic Advocacy, First Nations, Métis and Inuit Research; Individual Advocacy, First Nations, Métis and Inuit Engagement; Communications and Executive leadership.

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Territorial Acknowledgment

The Representative and staff, who do their work throughout the province, would like to acknowledge that we are living and working with gratitude and respect on the traditional territories of the First Nations peoples of British Columbia. We specifically acknowledge and express our gratitude to the keepers of the lands on the traditional territories of the Lheidli T'enneh peoples (Prince George) and the Songhees and Esquimalt Nations (Victoria), where our offices are located.

We would also like to acknowledge our Métis and Inuit partners and friends living in these beautiful territories.

Executive Summary

“Gender diversity is a natural attribute of human expression, not an illness that needs to be fixed.”¹

– Alok Vaid-Menon, author, speaker, poet, comedian

Everyone who works with British Columbia’s children and youth – from those in child welfare, to those in education, health care and justice – has a responsibility to ensure the proper care and safety of young people, just as those who oversee the systems that serve children and youth must ensure they are designed to provide attachments and connections that meet the needs and respect the rights of every child. This report makes it clear that Two Spirit, trans, non-binary and other gender diverse (2STNBGD) children and youth receiving services from B.C. child-serving systems face a number of serious challenges and obstacles, including that their rights are often overlooked and that, frequently, they do not feel they belong.

A Note on Language

RCY acknowledges that people who do not identify as cisgender may align with a specific gender identity (e.g., trans female) and not another (e.g., gender diverse). Further, some identities (e.g., Two Spirit, Third Gender) are culturally and spiritually specific and do not align with colonial notions of gender. Thus, to be as inclusive as possible of the many constellations and fluidities of gender identities that young people use and experience, in this report RCY has elected to use the acronym 2STNBGD which stands for Two Spirit, trans, non-binary, gender diverse. RCY recognizes that even this acronym is insufficient and will not capture every gender identity and expression. The language chosen by young people to describe their gender is constantly shifting and developing. As gender non-conforming poet, artist and writer, Alok Vaid-Menon, writes, “*This is actually the purpose of language – to give meaning to concepts as they evolve.*”²

It is also important to note that this is a report specially narrowed in scope to the gender identities and expressions – as distinct from sexual orientations – of children and youth in B.C. Thus, RCY does not use acronyms that also include sexual orientation (e.g., 2SLGBTQ+). When young people’s voices are included in this report, RCY uses the gender identity with which they self-identified during the interview unless there is a concern the youth might be identifiable. When referencing external research, RCY maintains the version of the acronym (e.g., LGBTQ, 2SLGBTQQA+) used by the authors and in the study methodology.

¹ Alok Vaid-Menon, *Beyond the Gender Binary* (New York: Penguin Workshop), 2020.

² Vaid-Menon, *Beyond the Gender Binary*.

Around the world, shaming, abuse and invalidation of 2STNBDG people has been documented and reported and is on the rise.^{3,4} This situation, coupled with a review of injuries and deaths of 2STNBDG children and youth reported to the Representative, provided the catalyst for this report.⁵

RCY receives reports of child injuries and deaths from across the province for children and youth in receipt of reviewable services.⁶ Reviewing and analyzing these reports allows the Representative to identify recurring themes and trends to better understand the systemic issues in B.C.'s child-serving systems. In December 2021, RCY analyzed the reports received for 2STNBDG children and youth from 2018 to 2021.

Common Terms

(see also Appendix 1 for a full glossary)

2STNBDG – Two Spirit, transgender, non-binary and other gender diverse people

Cisgender – people who feel their gender matches their assigned sex at birth

Gender-affirming care – The processes through which health care and other systems care for and support an individual, while recognizing and acknowledging their gender identity and expression. Also describes one's gender transition

Gender fluid – Someone who aligns with a gender that is changeable

Gender identity – one's internal sense of self as male, female, a blend of both or neither

2SLGBTQIA+ – An evolving acronym for lesbian, gay, bisexual, transgender, Two Spirit, queer and additional identities. There are many variations of this acronym (e.g., LGBTQ, LGBTQ+, 2SLGBTQ+)

Misgender – To refer to someone by using a word, such as a pronoun or form of address (e.g., sir, ma'am), that does not correctly reflect their gender identity

Non-binary – Refers to diverse people whose gender identity is neither female or male. Some people self-identify as non-binary while others may use terms such as gender non-conforming, gender queer or agender

Transgender – An umbrella term that describes a wide range of people whose gender identity differs from their assigned sex at birth. Transgender is often shortened to trans, as in this report.

Trans male – Describes someone who is a man, and identifies as trans. Most trans men were assigned female at birth and have since socially and/or medically transitioned to male

Trans female – Describes someone who is a woman, and identifies as trans. Most trans women were assigned male at birth and have since socially and/or medically transitioned to female

³ The European Region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-Europe) found that 2022 was the most violent year for LGBTQI+ people across 54 countries in Europe and Central Asia. Similar rises in violence and hate were also found in North America in 2022. See: ILGA-Europe's Annual Review Team. "Annual Review of the Human Rights Situation of Lesbian, Gay, Bisexual, Trans and Intersex People in Europe and Central Asia," ILGA-Europe, 2023. <https://www.ilga-europe.org/report/annual-review-2023/>

⁴ Killian Kinney, Taylor E. Pearson, Julie Ralston Aoki, "Improving 'Life Chances': Surveying the Anti-Transgender Backlash, and Offering a Transgender Equity Impact Assessment Tool for Policy Analysis," *Journal of Law, Medicine & Ethics*, (2022) 50, no. 3, (Fall 2022): 489-508. <https://doi.org/10.1017/jme.2022.89>

⁵ Under s. 20 of the Representative for Children and Youth Act (*RCY Act*), the Representative can release a special report with recommendations to relevant ministries.

⁶ The Representative receives critical injury and death reports for children and youth receiving a reviewable service at the time of or within the year prior to their injury or death. Reviewable services are defined in s.1 of the *RCY Act* as "services and programs under the *Child, Family and Community Service Act* or the *Youth Justice Act* and mental health and addiction services."

The findings from this analysis raised serious concerns about the experiences of, and outcomes for, these young people, who were doing consistently less well on many measures than their cisgender peers.⁷ This is especially troubling since recent research shows that 2STNBGD children and youth who are affirmed and well supported in family, school and community can have positive life outcomes that are similar to their peers.⁸

With a goal of upholding rights and improving outcomes, this report describes the experiences of 2STNBGD children and young people and their families engaging with child-serving systems in B.C. While there are some promising developments and first steps that have been taken in B.C. to better support these children and youth, the Representative is alarmed at the higher percentage of injury reports associated with suicidality and self-harm received for 2STNBGD children and youth compared to their cis-male and cis-female counterparts.⁹ A further concern is that nearly two-thirds of injuries reported for the 2STNBGD children and youth in this report were for those placed in staffed resources (often referred to as group homes) – settings that may cause further trauma and unbelonging.^{10,11} This report strives to understand and illuminate what is happening on the ground and identify areas for policy, service and practice improvements.

Data indicate that many 2STNBGD children and young people are not receiving the gender-affirming care and support they need, even though this care is a fundamental right as reflected in a number of provincial, national and international documents and is supported in the *Canadian Charter of Rights and Freedoms*. As a rights-based organization, RCY advocates for children and youth to have their rights respected and their voices heard and considered in key decisions that are being made about their lives.

⁷ Cisgender is the term used for people who feel their gender identity matches their assigned sex at birth.

⁸ Kristina R. Olson, Lily Durwood, Madeleine DeMeules, Katie A. McLaughlin, “Mental Health of Transgender Children Who Are Supported in Their Identities,” *Pediatrics*, 137, no. 3, (March 2016) e20153223. <https://doi.org/10.1542/peds.2015-3223>

⁹ It is important to note that it is not a young person’s gender identity or expression that leads to self-harm or suicidality but their individual experiences and the situation in which they are living and growing up that compounds the negative effects of stigma, contributing to a lack of gender-affirming care, support, and awareness among health care providers and society in general.

¹⁰ Staffed residential resources: a staffed residential facility or group home; may also include foster homes employing more than one full-time employee.

¹¹ Representative for Children and Youth, *Missing: Why are children disappearing from B.C.’s child welfare system?* (Victoria B.C.: Representative for Children and Youth), April 27, 2023. <https://rcybc.ca/hfaq/missing/>

What is gender-affirming care?

Gender-affirming care for 2STNBGD people includes the following broad categories:

- social (e.g., family, community and school acceptance for gender expression including appropriate use of names and pronouns, parent/caregiver education and intervention, connection to peer groups)
- emotional (e.g., access to reliable and affirming information to help a child or youth make sense of their experience and options, trauma-informed and culturally attuned counselling and mental health supports)
- legal (e.g., changes to gender marker or legal name on government documents)
- cultural (e.g., connection to knowledge about culturally specific gender roles and mentors)
- and/or health and medical (e.g., access to gender-knowledgeable physicians and appropriate health care, chest binders, puberty blockers or hormone treatments).

Gender affirming care supports, affirms and nurtures a child or youth's gender identity. Appropriate gender-affirming care is unique to each 2STNBGD child or youth and their family and/or caregivers.

Gender-affirming care ranges from fully reversible care such as social affirmation, puberty suppression, and suppression of cyclical bleeding, to partially reversible care such as hormone treatment, and finally to irreversible treatments such as surgeries, which requires a diagnosis of gender incongruence that is well-documented and persistent. Surgical treatments are almost never accessed by children under the age of majority in B.C.

Gender-affirming care for 2STNBGD children and youth is not an isolated or specialized form of medical care, but rather, a whole-system approach to care across all child-serving systems that is grounded in the principles of social inclusion, trauma awareness, cultural safety and relevance, and equitable, inclusive and intersectional access to services. Appropriate gender-affirming care needs to be integrated into other supports and services accessed by a 2STNBGD child or youth, rather than be contingent on resolving other concerns (e.g., problematic substance use) first.

With respect to medical decisions, B.C. is fortunate to have a renowned youth gender clinic and some of the foremost experts in this area working across the province. The Representative is confident that most physicians and health care professionals in B.C. are handling medical questions and concerns thoughtfully and creating specific and tailored plans for each child and youth based on their needs.

The *United Nations Convention on the Rights of the Child (UNCRC)* highlights the right of the child to preserve their identity, and the *United Nations Declaration on the Rights of Indigenous Peoples (the Declaration)* recognizes the right of Indigenous peoples to determine their own cultural or ethnic identity or membership in accordance with their customs and traditions and be free from discrimination on the basis of that identity. In B.C., it is recognized that 2STNBDG people have the right to live free from harassment, sexual assault and any type of violence, including intimate partner violence. This recognition appears in the most recent mandate letter for the B.C. Minister of Health (Dec. 7, 2022), which identifies addressing gaps in health care services for women, trans and non-binary people as a key priority.¹² The Parliamentary Secretary for Gender Equity has been tasked with supporting the Minister of Health in this work.¹³ B.C. also enacted the *Declaration on the Rights of Indigenous Peoples Act (DRIPA)* in 2019 as a framework for reconciliation. One of the goals of *DRIPA* is that “*Indigenous women, girls, and 2SLGBTQQA+ people enjoy full protection and guarantees against all forms of violence and discrimination.*”¹⁴

At the federal level, the Federal 2SLGBTQI+ Action Plan was launched in August 2022 and will be implemented over five years. The Action Plan is organized in six priority areas: prioritize and sustain 2SLGBTQI+ community action; continue to advance and strengthen 2SLGBTQI+ rights at home and abroad; support Indigenous 2SLGBTQI+ resilience and resurgence; engage everyone in Canada in fostering a 2SLGBTQI+ inclusive future; strengthen 2SLGBTQI+ data and evidence-based policy making; and embed 2SLGBTQI+ issues in the work of the Government of Canada.¹⁵ While this is federally led, provinces and territories are mandated to provide input particularly in the area of data and evidence reporting on key metrics. In B.C., this is primarily managed through the Gender Equity Office under the Ministry of Finance.

B.C.’s child-serving system is responsible for meeting the needs of all children and youth receiving services, no matter their gender identity or expression. Although many cultures have long recognized more than a simple gender binary, child and youth service providers across Canada and internationally have been playing catch-up in affirming the many different gender identities and expressions of children and youth and in ensuring the provision of services and professional training that supports that affirmation.¹⁶ This report shows that young people often feel they are forced to provide this education to service providers. It also establishes that a lack of knowledge in this area can delay or restrict access to crucial gender-affirming services.

Exposure to negative trans-related media messages has been found to negatively impact the mental health of trans people and yet the United States Trans Legislation Tracker has noted more than 550 anti-trans bills introduced in 49 state legislatures in 2023 and more bills targeting gender-affirming health care than

¹² Premier David Eby, “Ministry of Health mandate letter,” (Victoria, B.C.: Premier and President of Executive Council), Dec. 7, 2022. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/hlth_-_dix.pdf

¹³ Premier David Eby, “Parliamentary Secretary for Gender Equity mandate letter,” (Victoria, B.C.: Premier and President of Executive Council), Dec. 7, 2022. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/fin_-_gender_equity_-_paddon.pdf

¹⁴ Reconciliation Transformation and Strategies Division, *The Declaration on the Rights of Indigenous Peoples Act action plan*, (Victoria B.C.: Ministry of Indigenous Relations and Reconciliation), March 30, 2022. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/indigenous-relations-reconciliation/declaration_act_action_plan.pdf

¹⁵ Government of Canada, “Federal 2SLGBTQI+ Action Plan,” *Women and Gender Equality Canada*, last accessed May 30, 2023. <https://women-gender-equality.canada.ca/en/free-to-be-me/federal-2slgbtqi-plus-action-plan.html>

¹⁶ Nastasja de Graaf and Polly Carmichael, “Reflections on emerging trends in clinical work with gender diverse children and adolescents,” *Clinical child psychology and psychiatry* 24, no. 2 (2019): 353-364. <https://doi.org/10.1177/1359104518812924>

in the last five years combined, with a particular focus on youth and their families.¹⁷ Canada has not been immune to this rise in intolerance: protests in this country against the 2SLGBTQ+ community reached their highest levels in January 2023.¹⁸ Anti-trans politicians and platforms have recently surfaced in cities, provinces and at the federal level.^{19,20,21}

In 2020, Statistics Canada released a survey that found trans people had more risk of experiencing physical or sexual violence than non-trans people and were more likely to experience acts that led to them feeling unsafe or uncomfortable, with a lasting impact on their physical and mental health.²² The United Nations High Commissioner on Human Rights has found that 2STNBGD people “*are particularly vulnerable to human rights violations when their name and sex details in official documents do not match their gender identity or expression.*”²³ In addition, 2STNBGD young people have been found to be more frequent targets of bullying at school. Such behaviours impact the sense of belonging, identity and well-being of these children and youth and can lead to poorer long-term outcomes.²⁴

In preparation for this report, RCY commissioned research by the University of British Columbia’s Stigma and Resilience Among Vulnerable Youth Centre (SARAVYC). The renowned research centre investigates how stigma, discrimination, violence and trauma affect the health of young people. SARAVYC conducted two literature reviews and a series of analyses using data from the 2019 Canadian Trans Youth Health Survey (CTYHS) and the 2018 BC Adolescent Health Survey (BCAHS). The full SARAVYC companion report can be found on page 79.

An additional problem is that the voices of 2STNBGD young people often go unheard, and, where they are heard, much of the research ignores their experiences of belonging and gender positivity. Ensuring effective systemic change in B.C. requires understanding the multifaceted experiences – both positive and negative – and the needs of this diverse group of children and youth. To gain crucial insights and to amplify their voices, RCY asked SARAVYC to conduct a series of interviews with 2STNBGD youth in which they were asked to share their stories and recommendations for improving services. Their voices were then integrated into this report.

¹⁷ “2023 anti-trans bills tracker,” Trans Legislation Tracker, n.d., Accessed June 6, 2023. <https://translegislation.com/>

¹⁸ Regional Overview United States & Canada January 2023, “United States: Anti-LGBT+ events continue to see high involvement of far-right militias and militant social movements,” *The Armed Conflict Location & Event Data Project*, Feb. 3, 2023. <https://acleddata.com/2023/02/03/regional-overview-united-states-canada-january-2023/>

¹⁹ Tegwyn Hughes, “How Victoria’s right-wing slate targets what kids learn,” *The Tyee*, Oct. 11, 2022. <https://thetyee.ca/News/2022/10/11/Victoria-Right-Wing-Slate/>

²⁰ Dean Bennett, “‘Embarrassed’: Alberta UCP candidate sorry for comparing transgender kids to feces,” *The Globe and Mail*, May 17, 2023, (updated) May 18, 2023. <https://www.theglobeandmail.com/canada/alberta/article-embarrassed-alberta-ucp-candidate-sorry-for-comparing-transgender-kids/>

²¹ Maxime Bernier “Policy announcement on radical gender ideology,” *People’s Party of Canada*, Press Conference, Winkler, ON: May 23, 2023 https://www.peoplespartyofcanada.ca/policy_announcement_on_radical_gender_ideology?utm_campaign=ppc230523_en&utm_medium=email&utm_source=maximebernier

²² Brianna Jaffray, *Experiences of violent victimization and unwanted sexual behaviours among gay, lesbian, bisexual and other sexual minority people, and the transgender population, in Canada, 2018*, (Ontario: Canadian Centre for Justice and Community Safety Statistics, Statistics Canada), Sept. 9, 2020. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2020001/article/00009-eng.htm>

²³ United Nations Office of the High Commissioner on Human Rights. “The struggle of trans and gender-diverse persons,” *United Nations*, n.d. Accessed May 30, 2023. <https://www.ohchr.org/en/special-procedures/ie-sexual-orientation-and-gender-identity/struggle-trans-and-gender-diverse-persons>

²⁴ Antonia Dangaltcheva, Chris Booth, and Marlene M. Moretti, “Transforming Connections: A Trauma-Informed and Attachment-Based Program to Promote Sensitive Parenting of Trans and Gender Non-conforming Youth,” *Frontiers in Psychology, Section: Psychology for Clinical Settings*, 12 (July 2021) <https://doi.org/10.3389/fpsyg.2021.643823>

As SARAVYC found in its literature review, few studies have focused on 2STNBGD youth with government care experience in Canada. The views and experiences of these children, youth and their families are critical in guiding our understanding of the strengths and weaknesses of current policies and services as well as hopes for innovation and improvement.

In examining the evidence, the Representative immediately found alignment between RCY's internal data and SARAVYC's research findings. Both data sets showed that, compared to their cisgender counterparts, Canadian 2STNBGD youth are experiencing more negative mental health outcomes, such as suicidal ideation, suicide attempts and self-harm. In addition, the data sets showed that being referred to by the wrong gender pronouns and/or by a dead name by caregivers and social workers can contribute to poor mental health.^{25,26} Both RCY's and SARAVYC's findings highlight accounts of housing instability and unbelonging. This report illuminates patterns in the experiences of 2STNBGD children and youth and their caregivers in navigating child-serving systems in B.C. and identifies impacts on young people as a result of service availability – or the lack thereof – and delivery.

The Representative does not wish to contribute to the further pathologizing of 2STNBGD children and youth. This report is a story not of the difficulties of being 2STNBGD, but of the difficulties of navigating a system that does not always uphold the rights or meet the needs of 2STNBGD children and youth. Kirkham et al. writes that it is important to “... *examine the contexts and conditions under which people are made vulnerable.*”²⁷ This perspective acknowledges that vulnerability is created through the social conditions of peoples' lives and is not an innate part of their identity.

The findings in this report clearly demonstrate the need for systemic shifts to better support 2STNBGD children and youth to thrive. By examining harmful or ineffective practices, in addition to protective factors and strengths, both this report and the companion SARAVYC report make recommendations to better support 2STNBGD children and youth and their families in B.C.

The Representative's recommendations begin on page 77. SARAVYC's recommendations begin on page 80.

²⁵ Dead name refers to the name that a person (often a trans person) was given at birth but is no longer actively using. The heavy connotation of the word dead is intended to stress the inappropriateness and offensiveness of a person's terminated name. Excerpted from QMUNITY, “Queer terminology from A to Q: 2022 edition,” *QMUNITY*, 2022. https://qmunity.ca/wp-content/uploads/2023/01/Queer-Glossary_2022_Digital.pdf

²⁶ Camille Brown, Hélène Frohard-Dourlent, Brittany A. Wood, Elizabeth Saewyc, Marla E. Eisenberg, Carolyn M. Porta, “It makes such a difference”: An examination of how LGBTQ youth talk about personal gender pronouns,” *Journal of the American Association of Nurse Practitioners*, 32 no. 1 (January 2020): 70-80. <http://doi.org/10.1097/JXX.0000000000000217>

²⁷ Sheryl Reimer Kirkham, Jennifer L. Baumbusch, Annette S. H. Schultz and Joan Anderson, “Knowledge development and evidence-based practice: Insights and opportunities from a postcolonial feminist perspective for transformative nursing practice,” *Advances in Nursing Science*, 30 no. 1 (January 2007): 26-40. <http://doi.org/10.1097/00012272-200701000-00004>

Linkages to Previous Reports and RCY Priorities

Many of this report's findings and themes have been reflected in previous RCY reports and are linked to long-standing concerns about opportunities and outcomes for children and youth who are involved with child-serving systems in B.C. These include: the availability of mental health services; the need to cultivate belonging; the importance of stable housing; and the call to ensure that young people understand their rights and that these rights are upheld.

Notably, the inadequacy of mental health services for children and youth, including for children in care, has been identified in several RCY reports with recommendations, including:

- *Toward Inclusion: The need to improve access to mental health services for children and youth with neurodevelopmental conditions* (2023), which provides evidence that mental health challenges are much higher for children with conditions such as autism, fetal alcohol spectrum disorder and intellectual disabilities and calls for government to fully fund and implement services for young people with support needs.
- *A Parent's Responsibility: Government's obligation to improve the mental health outcomes of children in care* (2022), which provided evidence that children in care have a one-in-two chance of having a mental health disorder.
- *Beyond Compliance: Ensuring quality in care planning* (2022), which highlighted a concern from service and care providers about a limited availability of community-based services for children and youth, particularly mental health and addiction services.
- *Missing Pieces: Joshua's Story* (2017), which called on the Ministry of Mental Health and Addictions to lead the planning and implementation of a full continuum of mental health services for children and youth.
- Two investigative reports (*Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl*, [2014]; *A Tragedy in Waiting: How B.C.'s mental health system failed one First Nations Youth*, [2016]), which detailed the inadequacies of mental health services for Indigenous children and called for appropriately resourcing mental health services for children.
- *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.* (2013), which called for the establishment of a minister responsible for youth mental health and adequate resources to develop and implement a full continuum of mental health services for youth ages 16 to 24.

The importance of belonging for children and youth is a major theme RCY has recently highlighted and is reflected in:

- *Missing: Why are children disappearing from B.C.'s child welfare system?* (2023), a research report that explores the role of the child welfare system in creating the conditions that lead to so many children and youth becoming lost, going missing or disappearing from care.
- *Skye's Legacy: A Focus on Belonging* (2021), which illustrates how critical it is for children to feel connected to family, culture, community and identity. The report also motivated the creation of a microsite, "*Skye's Legacy: The Importance of Belonging*," which offers a curated collection of resources on belonging for continued in-depth learning.

Children and youth in care often experience housing instability through multiple placements that can result in few meaningful connections in their lives and can lead to them becoming unhoused when they age out of care. These issues were a focal point in:

- *From Marginalized to Magnified: Youth Homelessness Solutions From Those With Lived Expertise* (2020), which called on government to incorporate the voices of youth in developing a plan to end youth homelessness in B.C.
- *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm* (2012), which identified housing instability as a significant factor for most of the youth in the report.

This report is guided by RCY's values and priorities, including the commitment not to pathologize or further traumatize groups, to situate the challenges facing children and youth in a rights-based context, and to commit to thoughtful engagement with external researchers, service providers and youth with lived experience to ensure their voices are heard. Additionally, this report is connected to the recent legislative review of the *RCY Act*. The Representative asked the Select Standing Committee on Children and Youth to consider broadening RCY's mandate to include services to gender diverse children and youth. This request has been considered and the legislative change has been recommended by the committee.²⁸

²⁸ Select Standing Committee on Children and Youth, "*Review of the Representative for Children and Youth Act*," (Victoria, B.C.: Legislative Assembly of British Columbia, 1st Report, 4th Session, 42nd Parliament), April 26, 2023, leg.bc.ca

Youth Voice: Strength, Pride and Gender Joy

To honour Two Spirit, trans, non-binary, and other gender diverse (2STNBGD) children and youth in B.C., this report begins with their voices. It is clear from their words that a 2STNBGD identity can be a protective and positive factor in a young person's life, despite the systemic risks they may encounter.²⁹

Embracing Two Spirit Identity as a Source of Freedom

On behalf of RCY, SARAVYC interviewed six Indigenous 2STGDNB youth from across B.C. about their experiences with mental health care, substance use services and government care. The interviews did not include questions about how youth felt about their Two Spirit or other gender diverse identity but, as the interviews progressed, questions about more positive aspects of young peoples' lives were included. The last two participants were asked, "What do you like about your identity?" Each identified a sense of freedom of expression:

"I found as I've gotten older, I've liked the freedom it gives me with things like fashion. And I found that as I've stopped trying to fit into any kind of role ... when I realized I didn't identify as either [male or female], I had a lot more, just, freedom to have fun with how I present myself. And that's always been a really great part of it for me, is I used to play all those dress up games online as a kid. And now I'm just, like, oh, I'm just a real-life version of that, and ... I'm allowed to have fun with my body, and it really helped consolidate ... other issues with my body growing up or things like dysphoria. When I realized that it's up to me ... it felt like it gave me a lot more freedom and confidence in that way."

– Non-binary, Two Spirit, 22, Okanagan

Another participant said, "It's being free. It's allowed me to be – have a sense of normalcy that I haven't had since I was a child." (Indigenous, trans female, 23, Fraser Valley)

Existing evidence documents, that prior to colonization, many Indigenous cultures held positive attitudes towards and honoured roles for gender diverse members of their communities.³⁰ Within the context of the ongoing legacy of colonialism, Two Spirit and other gender diverse Indigenous young people described experiences in care and in accessing services that included racism but also positive examples of cultural connection and support that offer guidance for improving services.

²⁹ For each youth interviewed for this report, the gender identity that they expressed to the interviewer is what is used here.

³⁰ Sarah Hunt (2016) *An Introduction to the Health of Two-Spirit People: Historical, contemporary, and emergent issues*. (Prince George, BC: National Collaborating Centre for Aboriginal Health) 2016. <https://www.ccsa-nccah.ca/docs/emerging/RPT-HealthTwoSpirit-Hunt-EN.pdf>

Trans and Non-binary Gender Identities are Sources of Joy and Liberation

In addition to the six Indigenous gender diverse youth interviewed, SARAVYC interviewed nine non-Indigenous gender diverse youth from across B.C. about their experiences with mental health care, substance use services and government care. At the start of the interviews, each participant was asked, “*What do you like about your gender identity?*” as a way not only to learn about their genders and perspectives about gender, but also to ensure the interview included positive aspects of 2STNBDG young peoples’ lives. For these 2STNBDG youth, their identities were a source of joy, self-acceptance and insight into – and freedom from – restrictive gender norms and expectations. Every participant had something positive to say.

Youth who were non-binary described how recognizing and embracing their gender identity gave them a sense of joy and allowed them to be liberated from the restrictions of traditional gender norms. “*I like the freedom of it,*” said one participant, adding “*I like the ability to express myself in the most authentic way I can without kind of a strict binary of what is expected of me based off of what’s on my birth certificate*” (non-binary, 25, Metro Vancouver). One gender-questioning youth echoed these feelings of freedom and gender expression as a positive and affirming way to explore their gender:

“I like that I am able to dress however I please. I’ve always dressed in male clothing and male ‘licensed clothing’ with baggy pockets and just everything. And I love being able to express that and have compliments from it, from people who are like me and understand that gender norms shouldn’t be the way they are.”

– Gender-questioning, 18, northern B.C.

Some youth credited their gender journeys with enabling them to gain a more complex understanding of gender norms and dynamics:

“Something I really enjoy is I’ve definitely seen the world from both perspectives for sure. I understand what it’s like to be, live a very feminine life and things like that and also what it’s like experiencing life as a man. It’s very eye-opening, actually.”

– Trans boy, 17, northern B.C.

“I remember one instance when I was pretty early on in my transition, I had a conversation with another trans guy about what male privilege looks like and what it would be like to start having it. Because I was yeah, like, kind of stepping into that. And that’s not to say that cis-men [don’t] recognize the privilege ‘cause there’s lots that do, but I definitely had to think about it a lot more and recognize that as I got it, what was happening.”

– Trans man, 23, Metro Vancouver

Participants described the ability to explore gender identity and expression as not only liberating, but also a source of comfort. Similarly, discovering they/them pronouns “*triggered some sort of sense of belonging*” for one gender-questioning young person (18, northern B.C.). Another youth described how their identity provides them with a strong connection to their cultural heritage:

“I think that because my identity is also linked to my cultural background, for me, my gender identity also kind of brings fulfillment and purpose into my life. Like, third gender individuals in my culture, from what we know, what we’ve managed to learn after the impacts of colonization, is that we were basically social workers ... so to me, it gives me purpose, and it gives me a drive for what I want to do. It makes me want to create change and community care.”

– Immigrant, non-binary/gender fluid, third gender, 23, Vancouver Island³¹

This participant pushed back on some health professionals’ assumptions that their gender identity was to blame for their mental health problems and described their identity as a protective factor:

“You think that somehow being trans is the mental problem or is related to the mental problem ... when, in actuality, I think a lot of my identity is what rescued me and saved me throughout these processes.”

– Immigrant, Indigenous, non-binary/gender fluid, third gender, 23, Vancouver Island

Each of these young people whose voices are heard here gave generously of their time and thoughts to ensure this report reflected their reality. While they expressed the difficulties they encounter in their lives as gender diverse youth, there is no doubt that living their identity provides them with joy, freedom and strength.

³¹ Ingrid Sell writes, “In contrast to the binary thinking of Western society [...] many non-Western cultures have socially established roles that recognize a third entity, neither male nor female.” Ingrid Sell “Not man, not woman: Psychospiritual characteristics of a Western third gender,” *Journal of Transpersonal Psychology* 33 no.1 (2001): 18-19.

Methodology

This report seeks to understand the experiences of 2STNBDG children and youth in government care or who have received reviewable government-funded services and is informed by young people with lived expertise. Drawing on multiple sources of information, and with assistance from external researchers, it analyzes internal RCY data, explores current policies and practices of government ministries and community organizations serving 2STNBDG children and youth in B.C. and beyond, maintains a rights-based focus and highlights youth voice throughout.

RCY Data Collection

To ensure as full an understanding of the circumstances for 2STNBDG children and youth in B.C. as possible, a variety of data sources were used for this report.

Aggregate RCY data

RCY Reviews and Investigations Analysts reviewed data from all critical injury and death reports the Office received from April 1, 2018 to Dec. 31, 2022, gathering a dataset of 2STNBDG children and youth to illuminate patterns, trends and recurring concerns.^{32,33} In addition, RCY's Individual Advocacy, First Nations, Métis and Inuit Engagement team reviewed 171 calls from 2STNBDG children or adults in their lives that were assigned to Advocates from April 1, 2018 to Dec. 31, 2022 to determine themes in the concerns that were brought forward.³⁴

Stories of children and youth

To supplement data analyses with stories that illustrate the experiences of children and youth, the Representative reviewed 39 observations of 2STNBDG children and youth that were brought forward by RCY Investigations Analysts from April 1, 2021 to Feb. 28, 2023. These stories were developed through review of reportable circumstances reports, coroner reports, information in the Ministry of Children and Family Development's (MCFD) Integrated Case Management System (ICM), and occasionally media reports, and were limited in scope to the information shared and produced by care providers. The observations brought forward highlighted systemic gaps and failures as well as bright spots in practice. RCY also carefully reviewed the experiences and wrote long-form stories about two of these

³² The *RCY Act* defines the Office's key areas of responsibility and activities, including individual advocacy, reviews and investigations and monitoring – or systemic advocacy. The Reviews and Investigations team conducts reviews and undertakes investigations of critical injuries and deaths of children and youth who have received designated services to identify and make recommendations for improvements to services to prevent similar injuries or deaths in the future. These reports must be provided to RCY by child-serving public bodies as they inform comprehensive reviews and investigations which are mandated under the *RCY Act*.

³³ April 1, 2018 is the earliest date accurate data are available for this analysis.

³⁴ Individual Advocacy, First Nations, Métis and Inuit Engagement is an RCY team that, among other things, supports youth who are receiving government services, or who want to receive government services. In-mandate calls assigned to Advocates for follow-up involve concerns that are connected to designated government services. This includes services related to youth justice, Child and Youth Mental Health, Children and Youth with Support Needs, child protection, Community Living BC, Agreements with Young Adults, the Provincial Tuition Waiver program and Child Care Subsidy programs.

youth and their interactions with child-serving systems throughout their lives.^{35,36} The experiences of the 2STNBGD children and youth illuminated in this report illustrate gaps and opportunities in child-serving systems that exist for this population.

Policy, practice and jurisdictional scans

InsideOut Policy Research group was contracted to conduct a review of publicly available policy, practice standards, guidelines and programming at the provincial ministry and regional health authority levels to understand what is currently in place to support 2STNBGD youth in B.C. Areas in scope for the review included child welfare, health services, substance use services, mental health services, youth justice services and education. InsideOut also completed a jurisdictional scan to compare policies and programs in B.C. with those in Australia, New Zealand, the Netherlands and California. These jurisdictions were chosen with guidance from RCY's Circle of Advisors as comparable jurisdictions with potential findings that may be relevant to B.C.

To ensure a full understanding of internal MCFD policies related to gender diverse youth, RCY submitted a Section 10 request to the ministry to gather this information for review.³⁷

Data from these reviews were used to identify services and supports available in B.C. and other jurisdictions, identify strengths and barriers in services and supports available to 2STNBGD youth in B.C., and identify areas for development of services and supports for this cohort of youth in B.C.

Stigma and Resilience Among Vulnerable Youth Centre

SARAVYC conducted two literature reviews and a series of analyses using data from the 2019 Canadian Trans Youth Health Survey (CTYHS) and the 2018 BC Adolescent Health Survey (BCAHS). The Centre also completed interviews with 2STNBGD youth in B.C. SARAVYC's full companion report is included here on page 80.

Literature reviews

Two literature reviews were completed by SARAVYC to help provide context to the report. The literature reviews focused on the health care, mental health and substance use-related needs of 2STNBGD youth and on the experiences and needs of this population who have experienced housing instability and/or government care.

³⁵ The sources for these stories were: reported injury data received from MCFD and youth justice, case notes, care plans and other documents pertaining to the children collected by MCFD and stored online in its ICM system, and RCY Advocates' notes.

³⁶ The observations were used to help frame narratives; however, identifying information and specifics of these young people's lives have been removed to protect confidentiality.

³⁷ A s. 10 request refers to that section in the *RCY Act* that states that the Representative has the right to specific information from a public body. Representative for Children and Youth Act, SBC 2006, c. 29, s.10.

Population Level Analysis

SARAVYC's analyses were conducted using data from the CTYHS and the BCAHS. SARAVYC compared 2STNBGD and cisgender youth who have experienced government care on a variety of measures. It also compared 2STNBGD youth who have experienced care with 2STNBGD youth who have never experienced government care. Only youth under age 19 were included in the data analyses.

Youth engagement

RCY contracted SARAVYC to complete interviews with 2STNBGD youth in B.C. to better understand their lived experiences and to ensure that their voices would have direct impact on the recommendations. The study was limited to youth aged 16 to 25 who had received or were receiving reviewable services with an aim to better understand their experiences navigating these systems.^{38,39}

SARAVYC contacted more than 60 organizations and individuals who work with 2STNBGD youth to help recruit participants.⁴⁰ To recruit Indigenous gender diverse and Two Spirit young people, one of SARAVYC's Indigenous, Two Spirit research staff reached out to various First Nations and Indigenous organizations that support Indigenous youth in care and Indigenous youth in need or in receipt of mental health or substance use or other health services.

Interviews were conducted with nine gender diverse and six Indigenous gender diverse and/or Two Spirit young people who had experienced government care, mental health services, and/or substance use services in B.C.⁴¹ Participants were asked to share their history and personal experiences with child-serving services. Interviews with the Two Spirit and Indigenous gender diverse participants sought to explore their experiences and recommendations for improving government care and services. Similarly, non-Indigenous trans and non-binary participants were asked to share their experiences interacting with government care, mental health services and/or substance use services in B.C, along with their recommendations for improving these health and social services for other trans and non-binary youth. Finally, two Indigenous and Two Spirit participants and all non-Indigenous trans and non-binary participants were asked what they liked or appreciated about being 2STNBGD.

³⁸ SARAVYC's recruitment and interview procedures received ethics approval from the Behavioural Research Ethics Board at UBC.

³⁹ It has been suggested that retrospective interviews with young adults can potentially be flawed due to normative limitations in memory. Further concerns have been raised that anxiety and/or depression can hinder accurate recall or create biases in what is remembered. However, research has not supported the two latter concerns. Brewin et al. argue that "...provided that individuals are questioned about the occurrence of specific events or facts that they were sufficiently old and well placed to know about, the central features of their accounts are likely to be reasonably accurate." See: Chris Brewin, Bernice Andrews, and Ian H. Gotlib, "Psychopathology and early experience: a reappraisal of retrospective reports," *Psychological Bulletin* 113 no. 1 (January 1993): 82. <http://doi.org/10.1037/0033-2909.113.1.82>

⁴⁰ Despite reaching out to more than 60 organizations to help with recruitment, SARAVYC was unable to reach its goal of 25 participants. This may be in part due to the extremely small proportion of youth who are gender diverse and/or Two Spirit in the general population. As reported in the population-based 2018 BCAHS, only 2.5 per cent of respondents (ages 12 to 19) were trans, non-binary or gender questioning and just one per cent of Indigenous respondents were both Two Spirit and had been in government care. This may also explain the limited number of trans girls and women among participants, as the 2018 BCAHS also showed that trans girls only accounted for 0.1 per cent of gender diverse youth in B.C.

⁴¹ Participants could be interviewed either virtually or in-person and were given the option of either a written or verbal consent process. They could have a trusted person (e.g., friend, partner, support worker) sit in on the interview for additional support. The interviews ranged from 40 to 60 minutes.

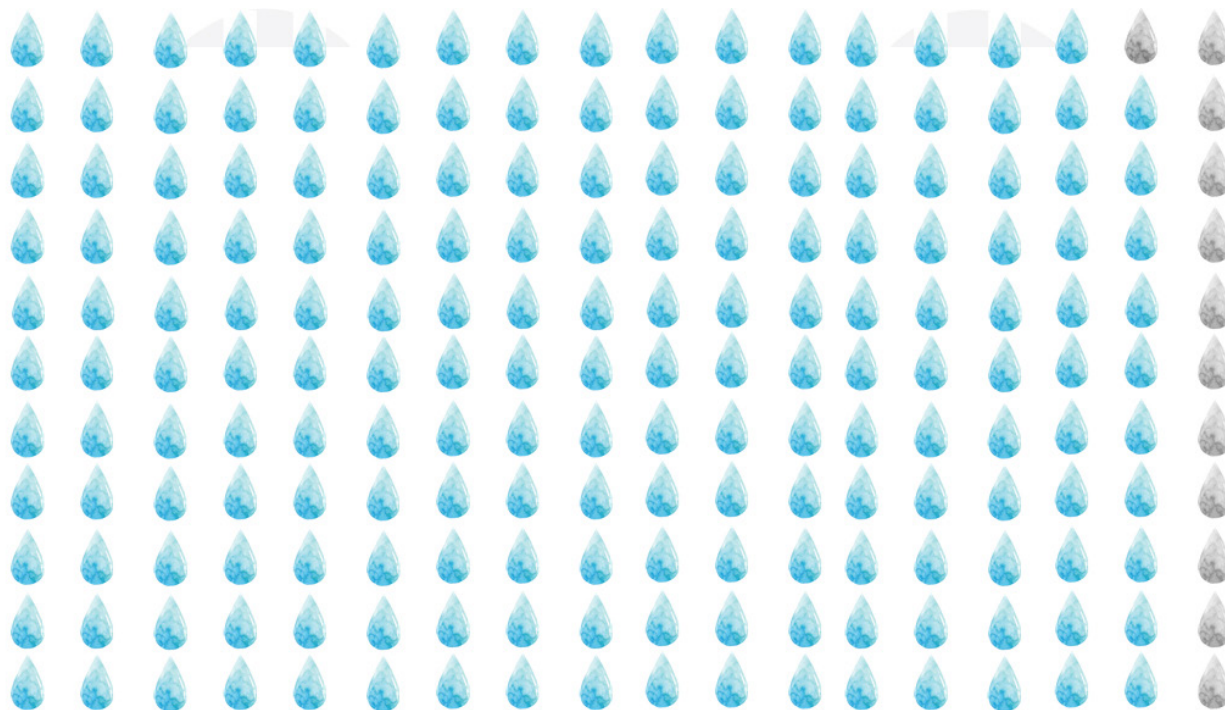
Methodology

Qualitative descriptive analysis was used to help identify and theme participants' experiences and their recommendations. Quotes were identified that provided evidence of these themes, offering insights into the experiences and needs of 2STNBGD youth. The Indigenous Two Spirit interviewer conducted the analyses of interviews with Two Spirit youth. The Two Spirit interviewer was supported by senior SARAVYC research staff, some of whom have decades of experience in research with Indigenous youth. Preliminary analyses were shared with several members of the SARAVYC Indigenous and Two Spirit advisory committee, which affirmed the approach and offered further insights and guidance for continuing the analyses.

It is important to note that youth participants were not sampled using a population-based approach and may not fully represent the entire population of 2STNBGD young people with these experiences. However, their stories are important examples of what is happening in B.C., and the range of their experiences, positive and negative, offers both hope and concern about the quality of care and support that 2STNBGD children and young people are receiving in B.C.

RCY Data and Analyses

RCY staff analyzed injury reports from April 1, 2018 to Dec. 31, 2022, and identified 198 2STNGBD children and youth with a total of 718 injury reports, including 11 deaths during this period. The results highlight the adversities faced by this group, including that some of these young people have frequent and reoccurring injuries.⁴² 2STNGBD children and youth with reoccurring injuries typically demonstrate multiple support needs (e.g., substance use treatment, mental health supports).



Each blue raindrop represents one of the 198 children who experienced at least one critical injury in RCY's data period and the 12 grey drops represent the deaths (includes one death from February 2023, outside the data period).

In 2018, more than 38,000 young people participated in the BC Adolescent Health Survey, a population-based survey administered to adolescents in Grades 7 to 12 (ages 12 to 19) in public schools across B.C. Of these young people, nearly 49 per cent identified as cis-male and another nearly 49 per cent as cis-female. Of the remaining students, 2.5 per cent of students indicated a gender diverse identity: 0.5 per cent identified as transgender (just over 0.1 per cent as trans girls, 0.3 per cent as trans boys),

⁴² One child accounted for 12 per cent of the total injuries reported for 2STNGBD children in this time frame while another accounted for nine per cent.

nearly 0.8 per cent identified as non-binary, and 1.3 per cent were unsure or questioning their gender identity.⁴³ In notable contrast, 4.5 per cent of all the children and youth for whom RCY received critical injury reports from April 1, 2018 to Dec. 31, 2022 identify as 2STNBDG (which includes gender questioning) – almost double that of the general adolescent population attending public schools in B.C., as reflected in the 2018 BCAHS. This 4.5 per cent is also likely an undercount due to the data limitations detailed below.

Data limitations

While MCFD has historically only provided a child’s assigned sex at birth through its information systems, the ministry is now working toward adopting the B.C. Gender, Sex and Sexual Orientation Health Information Standard throughout its information systems.⁴⁴

As of October 2022, MCFD workers have the option to identify gender diverse children and youth under the gender marker “non-binary.” However, this marker does not detail specific identities of Two Spirit, trans males and females and others that do not identify as non-binary. There is risk of trans and Two Spirit erasure when limiting gender markers to male, female and non-binary. The current guidance also requires that gender should reflect a young person’s gender as displayed on their primary ID.⁴⁵ If a child or youth’s gender does not align with the gender on their primary ID, a “preferred box” may be used to capture gender. This is, however, an optional inclusion and creates a risk of missing crucial identity information. It also discounts the importance of a child or youth’s gender identity by reducing it to an optional status.

In addition, any records prior to October 2022 must be changed manually by social workers. Unless they are provided time to review and correct gender markers for their caseloads, correct demographics of 2STNBDG youth receiving MCFD services will remain incomplete at best. An example of how this may impact the data in this report is the ability for proper comparison. From when MCFD started counting in October 2022 to April 2023, the ministry’s total 2STNBDG children and youth under a *CFCS Act* legal order or agreement total was found to be 39 based on the introduction of the “non-binary” gender identity variable. However, the limited detail (providing only female, male or non-binary) and the time frame of information (only allowing usage of the non-binary indicator since October 2022) makes cross-comparison challenging, as RCY has been tracking gender diversity since Sept. 1, 2017.

Other data programs, such as youth justice services’ CORNET and the Child and Youth Mental Health system CRIS, solely capture client genders in the binary – female or male.⁴⁶ Despite the changing

⁴³ McCreary Centre Society and Stigma and Resilience among Vulnerable Youth Centre, “*Gender-Diverse: A Spotlight on the Health of Trans and Non-Binary Young People in BC – Results of the 2019 BC Adolescent Health Survey*,” (Vancouver B.C.: University of British Columbia), May 31, 2021. <https://apsc-saravyc.sites.olt.ubc.ca/files/2021/06/Gender-Diverse-A-Spotlight-on-the-Health-of-Trans-and-Non-Binary-Young-People-in-BC-1-1.pdf>

⁴⁴ The Standard provides consistency and guidance for the collection of gender and sex data. See: BC Data Service, “Province of British Columbia: Guidelines to the Gender and Sex Data Standard” Version 1.0, (Victoria B.C.: Ministry of Citizens’ Services) Jan. 23, 2023. https://www2.gov.bc.ca/assets/gov/government/services-for-government-and-broader-public-sector/information-technology-services/standards-files/312_gender_and_sex_data_standard_guidelines.pdf

⁴⁵ This is a B.C. government standard that aligns with the federal government standard in which the systems are required to be integrated; however, this creates some limitations as there is a risk of missing crucial identity information.

⁴⁶ Note that the Vancouver/Richmond SDA uses Vancouver Coastal’s health management system rather than CRIS for its client base and provides gender options beyond male and female.

policies, practices and training that aim to uphold inclusive language, the information systems and resulting reports that RCY receives fail to reflect these necessary changes. Reportable circumstances, case summaries, notes and care plans may not include notes regarding a child's lived gender identity. A child must also feel comfortable expressing their gender identity to their social worker for it to be recorded accurately. As a result, the number of 2STNGBD youth who have interacted with MCFD is under-represented.

RCY's gender tracking system is also imprecise as it does not account for the constellation of gender identities a child may have or fluidity between and across gender identities. RCY data are also limited to those who are receiving designated services. As not all injuries are reported to RCY, it can be difficult to compare RCY data to the broader population of 2STNGBD youth in B.C. SARAVYC's use of data on a larger population scale has been drawn upon to widen the lens, where appropriate.

Critical Injuries reported by gender

A review of the 8,224 in-mandate injuries reported to RCY from April 2018 to December 2022, examined by gender, found that nine per cent of all reported injuries (718) were experienced by 2STNGBD children and youth. Thus, while only 4.5 per cent of all the children and youth for whom RCY received critical injury reports from April 1, 2018 to Dec. 31, 2022 identify as 2STNGBD, they comprise nine per cent of the total critical injury reports RCY received over the same time period (see Table 1).

Table 1 – Critical injuries reported to RCY by gender, April 2018 to December 2022

Gender	Injury n (%)
Cis-Female	4,476 (54%)
Cis-Male	3,030 (37%)
2STNGBD	718 (9%)
Total	8,224 (100%)

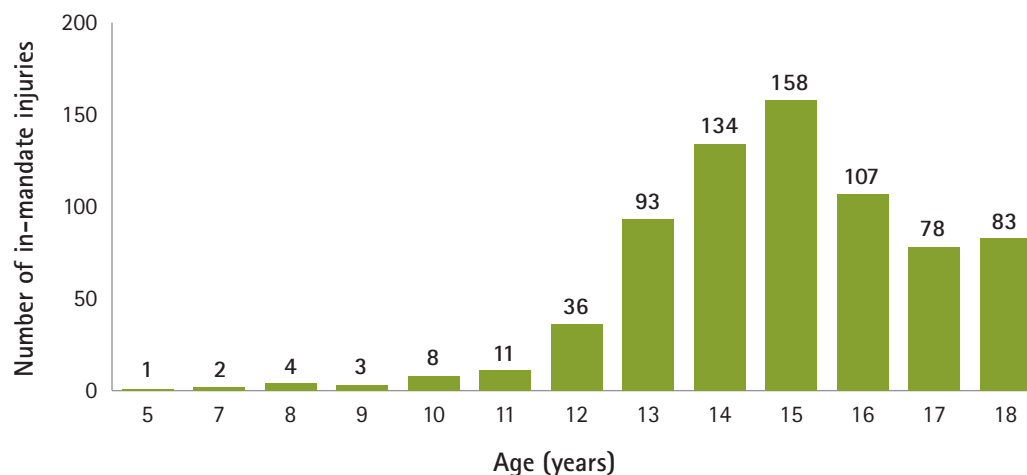
Critical Injuries of 2STNGBD children and youth by age

Most injuries reported for 2STNGBD youth were for youth ages 13 years and older (Figure 1). Of note is that the number of injuries reported for 2STNGBD children correspond with puberty.⁴⁷ More specifically, a heightened number of injuries is clustered around the typical ages for Tanner stages 3 and 4, when physical changes are becoming more obvious.⁴⁸ Middle adolescence also sees young people turn more to peer relationships and experience new and unfamiliar social experiences. Injury reports decline from ages 16 to 18.

⁴⁷ Of the 158 injury records associated to youth at age 15, 43 per cent were experienced by two individuals. For the in-mandate reported injuries at age 16, 43 per cent of the reported injuries were experienced by one youth. Thus, the age analysis could be skewed by these three youth. However, when reviewing injury reports by the age of the first injury experienced by a young person (i.e., all subsequent received injury records removed from analysis for each youth), the same age distribution was identified with the highest number of injuries occurring between ages 13 to 15.

⁴⁸ The Tanner scale is a scale of physical development as children transition into adolescence and then adulthood. The scale defines physical measurements of development based on external primary and secondary sex characteristics, such as the size of the breasts, genitals, testicular volume and growth of pubic hair.

Figure 1 – Critical injuries reported for 2STNGBD children and youth by age, April 2018 to December 2022



Critical injuries by Indigeneity and gender

The highest percentage of injuries reported to RCY for 2STNGBD children and youth were for non-Indigenous youth (54 per cent), in contrast to injury data for cis-male and cis-female children and youth where higher percentages of injuries are reported for First Nations youth.⁴⁹ The percentage of injuries reported to RCY for Métis 2STNGBD children and youth was comparable to their cis counterparts. While we do not know how many of the Indigenous youth RCY received critical injury reports for identify as Two Spirit, it is important to note that SARAVYC’s literature review found that Two Spirit youth who had been in government care experienced higher amounts of depression, stress and suicidality than their Indigenous counterparts who were not Two Spirit.

Table 2 – Critical injuries reported from April 2018 to December 2022, by Indigeneity and gender⁵⁰

Indigeneity	2STNGBD (n=718)	Cis-Female (n=4,476)	Cis-Male (n=3,030)
Indigenous: First Nations	35%	48%	48%
Indigenous: Métis	9%	10%	9%
Non-Indigenous	54%	41%	42%

⁴⁹ An analysis by child (that experienced at least one critical injury during this time period) found a similar distribution based on Indigeneity.

⁵⁰ Indigenous identities under one per cent have been omitted. This includes Inuit, Indigenous: Unknown, and Indigenous: Unspecified.

Critical injuries by injury classification and gender

Suicide attempts and suicidal ideation was the most reported critical injury classification for 2STNBGD youth (44 per cent) (see Appendix 2 for definitions of critical injury classifications). In contrast, emotional harm injuries were the most common injury type among cis-male (45 per cent) and cis-female (31 per cent) youth. Physical harm was also commonly reported for 2STNBGD youth (19 per cent). SARAVYC’s literature review found that, in a nationwide study, one-third of Canadian trans and non-binary youth had attempted suicide in the past year (see Table 3).

Table 3 – Per cent within gender of critical injuries reported from April 2018 to December 2022, by injury classification⁵¹

	2STNBGD (n=718)	Cis-female (n=4,476)	Cis-male (n=3,030)
Suicide attempt, suicidal ideation	44%	22%	14%
Physical harm	19%	12%	18%
Emotional harm	13%	31%	45%
Sexualized violence	13%	21%	5%
Substance-related harm	10%	10%	13%
Physical assault	2%	3%	5%

Looking further at these injuries, a strong variation in the kinds of physical harm injuries that occurred by gender is noted. Specifically, self-harm was the most common type of physical harm injury recorded for 2STNBGD children and youth (see Table 4). SARAVYC also found that self-harm is common among Canadian trans and non-binary youth.

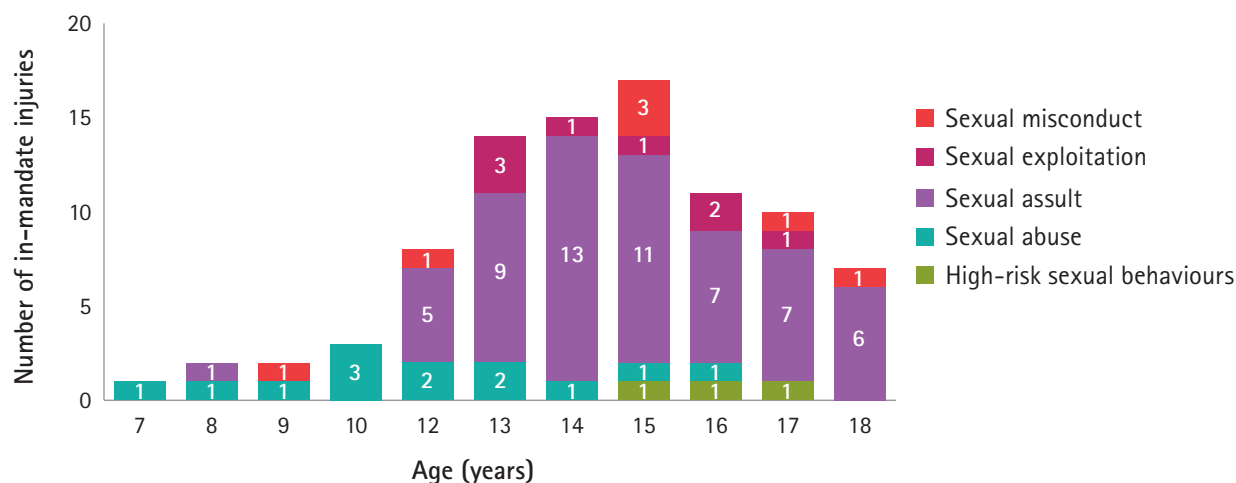
Table 4 – Number and per cent of critical self-harm injuries reported from April 2018 to December 2022 by gender

	Number (and % within injury type) of Self-Harm injuries	Total Physical Harm injuries
2STNBGD (n=718)	98 (73%)	135
Cis-Female (n=4,476)	192 (36%)	532
Cis-Male (n=3,030)	70 (13%)	544

An analysis of types of sexualized violence experienced by 2STNBGD children and youth by age showed that sexual assault is the highest type of sexualized violence injury reported, and the injury is reported most often at age 14. Sexual abuse is the most common type of sexualized violence reported for 2STNBGD children and youth under the age of 12 (see Figure 2). SARAVYC’S review of the BCAHS found that “a greater number of trans and nonbinary adolescents who had experienced government care reported physical and/or sexual abuse compared to trans and nonbinary youth who had never been in care (p. 27).” In analyzing the CTYHS, SARAVYC found that “14% of trans and nonbinary adolescents who had been in government care had [experienced sexual exploitation to gain access to] food, shelter, drugs, or alcohol compared to 4% of trans and nonbinary youth who had never experienced government care (p. 30).”

⁵¹ Percentage totals may not add up to 100 per cent due to rounding in per cent formulas.

Figure 2 – Number of critical sexualized violence injuries by incident type for 2STNBGD children/youth from April 2018 to December 2022



Definitions: sexualized violence injuries

A critical sexualized violence injury is an act committed on a child/youth without their consent. This may be a physical act, but it may include non-contact unwanted sexual experiences (such as invitation to touch, luring, or threats). Sexualized violence is non-consensual in that the child/youth did not or could not consent, and it is also non-consensual when the child/youth is not able to consent due to age, mental capacity, or other factors.

Sexual exploitation – sexual abuse of a child/youth through the exchange of sexual acts for drugs, food, shelter, protection, life necessities, and/or money

Sexual abuse – sexualized violence committed on a child/youth by a person in a position of trust, authority, or dependency

Sexual assault – non-consensual sexual act perpetrated on a child/youth – must involve touch

Sexual misconduct – non-touching and non-consensual acts (e.g., collection and distribution of images, exposure, harassment)

High-risk sexual behaviours – sexual activity with multiple partners without using barrier protections, sexual activity with partners that use intravenous substances.

Non-mandate injuries by gender

RCY also collects data on injuries that do not meet the threshold of a critical injury, but the injury happened when the child or youth was under age 19 and had received reviewable services within the previous 12 months. These injuries are considered “non-mandate injuries.” Some notable differences across gender are seen with respect to these non-mandate injuries, as seen in Table 5. When compared to non-mandate injuries of cis-females and cis-males, 2STNBD children and youth were more likely to be classified as a danger to others, danger to self, self-harm and/or having suicidal ideation without attempt or injury than their cisgender counterparts. Injuries coded as lost or missing from placements was more prevalent for cis-females and cis-males than for 2STNBD young people. Although RCY codes for 42 types of injuries, these five injury types comprised 72 per cent of the total injuries experienced by 2STNBD children and youth, which may suggest key areas for intervention and support. Hartley et al. have found that there is an “*association between reactive aggression and suicide-related behaviors, including suicide, nonfatal suicide attempt, and suicide ideation*”.⁵²

Table 5 – Selected non-mandate injuries by gender and injury type, April 2018 to December 2022⁵³

	2STNBD (total n = 689)	2STNBD % of total count	Cis-female (total n = 4,393)	Cis-female % of total of count	Cis-male (total n = 5,176)	Cis-male % of total count
Danger to others (any threats to safety of others including homicidal ideation)	133	19%	318	7%	905	17%
Suicidal ideation, no attempt and no injury	109	16%	402	9%	294	6%
Danger to self (psychosis, aggression, including non-physically harming self-harming behaviours [e.g., non-suicidal self-strangulation, destruction of environment with risk of injury])	93	13%	289	7%	573	11%
Lost or missing or not living in placement/with family	86	12%	961	22%	717	14%
Self-harm	73	11%	269	6%	133	3%
Total number (and %) of injuries accounted for by these 5 injury types	494	72%	2,239	51%	2,622	51%

⁵² The authors define reactive aggression as a “*defensive or retaliatory aggressive act that is performed in response to real or perceived provocation. Reactive aggression includes anger outbursts, temper tantrums, or vengeful hostility. ... Children who display high levels of reactive aggression are at elevated risk for depressive symptoms, substance use, and impaired social relationships.*” Chelsey M Hartley, Jeremy W Pettit, Daniel Castellanos, “Reactive aggression and suicide-related behaviors in children and adolescents: A review and preliminary meta-analysis,” *Suicide and Life-Threatening Behavior* 48 no. 1 (February 2018): 38-51. <http://doi.org/10.1111/sltb.12325>

⁵³ Injury types with fewer than 75 injury reports were not included in this table.

Critical injuries by care status

Children and youth who are unable to remain in their home and come into the care of MCFD do so through voluntary or involuntary options. Voluntary options include Special Needs Agreements (SNA), Voluntary Care Agreements (VCA) and other out-of-care options.⁵⁴ Involuntary options after an apprehension require a legal order and include Interim Orders (IO), Temporary Custody Orders (TCO) and Continuing Custody Orders (CCO).⁵⁵ Care statuses can change to meet the “best interests” of a child or youth (for example, a child might be with a relative under a voluntary extended family placement and then change to a court-ordered, in-care status). Living arrangements and legal status are not always stable over time, potentially resulting in multiple care arrangements over a child’s lifespan.

The majority (42 per cent) of injuries for 2STNBGD youth were reported for those in care via a VCA or SNA.^{56,57} In contrast, most injuries for cis-female (36 per cent) and cis-male (34 per cent) youth were reported for those in care under a CCO and only 14 per cent of injuries were for cis-female and cis-male young people on SNA/VCA agreements (see Table 6). This is of note because, when compared to other orders, VCA and SNA are agreements that parents or legal caregivers make with MCFD to place their child voluntarily and temporarily in the care of the ministry for a specific time frame. In both agreements, the parent or other caregiver remains the legal guardian.

Another legal option is a Youth Agreement (YAG), which was connected to three per cent of the injury reports for 2STNBGD youth. A YAG is a ministry agreement with a youth (ages 16 to 19) who needs assistance to live independently, cannot be reunited with family and where there is a protection concern. While YAGs were a small percentage of legal statuses for the 2STNBGD children and youth in this report, RCY’s Advocates see a desire from 2STNBGD youth for these agreements. However, while youth may request being placed on a YAG, they may not qualify unless ministry criteria of a safety concern are met. A parent or caregiver not accepting and affirming a child’s gender identity (e.g., using correct pronouns or name) is typically not considered a safety issue unless there are other protection concerns present.

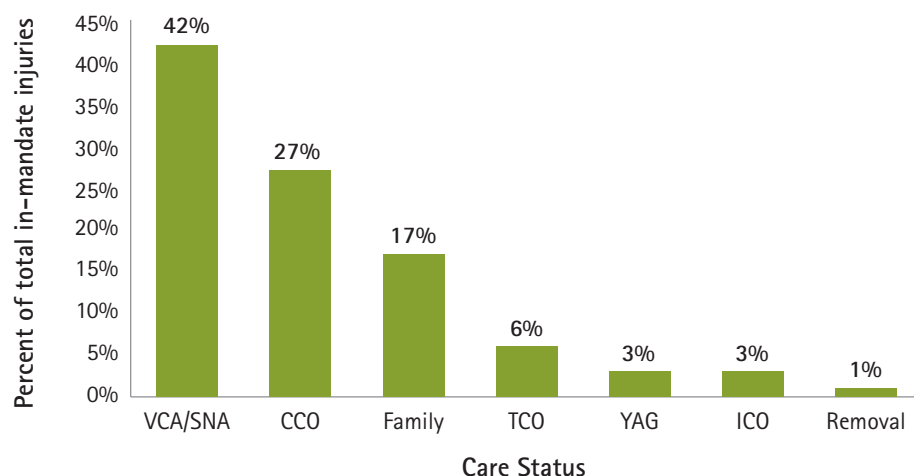
⁵⁴ Out-of-care arrangements include: an Extended Family Program (EFP) Agreement under s.8 of the *CFCS Act*; an interim custody order to a person other than a parent under s.35(2)(d); a TCO to a person other than a parent under s.41(1)(b), s.42.2(4)(a), s.42.2(4)(c), s.44(1)(b), or s.54.01(9)(b); A permanent transfer of custody to a person other than a parent (following an EFP Agreement or a TCO) under s.54.01; permanent transfer of custody to a person other than a parent (following a CCO) under s.54.1. https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96046_01

⁵⁵ CCO: An order in which the court has terminated all parental rights, assigning the permanent custody of the child to the Director of Child Welfare (*CFCS Act* s.41.1(d), s.49).

⁵⁶ VCA: A parent voluntarily and temporarily places the child in the care of the Director of Child Welfare for a specified period, age-dependent time frames (*CFCS Act* s.6).

⁵⁷ SNA: A parent of a child with support needs may voluntarily and temporarily agree to place the child in the care of the Director of Child Welfare (*CFCS Act* s.7).

Figure 3 – Critical injuries for 2STNGBD youth by care status, April 2018 to December 2022



Reasons for being brought into care under a VCA or SNA

Injury by care status was further investigated through a review of the files in the MCFD case management system of the 45 2STNGBD children placed in a VCA and/or SNA from April 1, 2018, to Dec. 31, 2022. RCY undertook this analysis to better understand why and when 2STNGBD children are placed in these agreements in the hopes of gaining insight into what family supports might be useful before a 2STNGBD child comes into care.

Several themes emerged as the reason the children and youth were placed in these legal arrangements. Often, several of these themes were co-occurring.

- A parent or other caregiver who was overwhelmed in providing care or supervision to a 2STNGBD child or youth was the most common theme identified (33 children or 73 per cent). MCFD staff and health care workers often heard that a child needed more supports than a parent or other caregiver could currently provide. In several instances, parents refused to pick up their child from a hospital following a mental health crisis, requiring MCFD to step in to provide care. At times, community members and formal supports identified that a family was struggling to provide adequate care for their child and raised concerns with MCFD.
- Parents and caregivers were often feeling overwhelmed due to a 2STNGBD child or youth's alarming behaviour (e.g., fire-starting, physical aggression or sexual intrusiveness with siblings, vandalism) (26 children or 58 per cent) and had concerns about a child's mental health (22 children or 49 per cent). These young people often exhibited suicidal thoughts and behaviours and may have experienced multiple hospitalizations before being brought into care.
- In some cases, a 2STNGBD young person initiated a desire to come into care. Some expressed feeling unsafe or uncomfortable in the home (14 or 31 per cent). These children or youth raised concerns about emotional and/or physical abuse by their caregiver, which could be difficult for MCFD to substantiate.

- Intolerance because of a 2STNBGD child's gender identity was also raised as a concern (11 children or 24 per cent). Children noted parents or caregivers not accepting their gender diversity due to their religious beliefs, being told it was “*just a phase*” or “*not real*,” and parents and caregivers not using their chosen names or correct pronouns. Social workers sometimes expressed difficulty in assessing risk to a child in these cases.
- Both 2STNBGD children and caregivers noted parent-teen conflict as a reason for desiring a VCA or SNA legal agreement (17 children or 38 per cent). In one case, the conflict was directly related to the caregiver not accepting the child's gender identity and included physical violence. Ultimately, the child left the home and began living with a friend's family.

There were other notable aspects of this group of young people brought into care voluntarily and temporarily:

- Twenty-three were Indigenous (51 per cent) and six were first- or second-generation immigrants (13 per cent), together representing 64 per cent of the 2STNBGD young people on a VCA or SNA in this report.⁵⁸ This is an over-representation of injuries connected to Indigenous youth on VCAs and SNAs when compared with the demographics of the larger 2STNBGD population with which RCY interacts. This highlights the potential to look at more culturally appropriate service provision to keep families safely together as well as to fully support the intersecting identities of 2STNBGD children or youth.
- A notable number of 2STNBGD children and youth in voluntary care in this report's time frame had been adopted (nine, or 20 per cent).⁵⁹ This is a larger number than seen in the full cohort of 2STNBGD children in this report (26 children or nine per cent) and double the number of cis-female and cis-male children who were identified by RCY as adopted (10 per cent) from April 1, 2018, to Dec. 31, 2022. In a meta-analysis, Palacios et al. found that children's behavioural and emotional problems are one of several factors systematically associated with adoption breakdown, often escalating during puberty.⁶⁰
- The majority of children placed on a VCA or SNA were placed in staffed residential resources (group homes) (38 children or 84 per cent).
- Six 2STNBGD children aged out of care (turned 19) while on a VCA or SNA (13 per cent). This is notable because MCFD does not provide post-majority services to children with caregivers as legal guardians, even if those children were being cared for by MCFD. If these six children did not reunite with their caregivers when they aged out of care, they may have been under-supported as they transitioned to adulthood. Lack of supports for 2STNBGD youth transitioning to adulthood – particularly for those with multiple support needs – has been noted as a concern by RCY Advocates.

⁵⁸ A ‘first-generation immigrant’ is born in a country other than the country of residence and a ‘second generation immigrant’ is someone born in their country of residence but has at least one foreign-born parent. MCFD does not currently track ethnic identity other than Indigeneity. However, ethnic identity is sometimes captured in other fields in the case management system.

⁵⁹ Analysts assign this code when a child/youth was or is currently adopted or has been involved in an adoption or permanency process at any point in their lifespan. This includes adoption breakdown, various forms of guardianship (generally family members or grandparents) or traditional permanency arrangements made outside of the *CFCS Act* by Indigenous communities.

⁶⁰ Jesús Palacios, Nancy Rolock, Julie Selwyn, and Maria Barbosa-Ducharme, “Adoption breakdown: Concept, research, and implications,” *Research on Social Work Practice*, 29 no. 2, (February 2019): 130-142.

Injuries by living arrangement and gender

Nearly two-thirds of injuries reported for the 2STNBGD children and youth in this report were for those placed in staffed resources (often referred to as group homes).⁶¹ This is in noticeable contrast to their cis counterparts, whose injuries were reported evenly across the three most common living arrangements (see Table 6).

Table 6 – Per cent within gender of in-mandate injuries reported from April 2018 to December 2022, by living arrangement and gender

	Per cent of 2STNBGD injuries (n= 718)	Per cent of cis-female injuries (n= 4,476)	Per cent of cis-male injuries (n= 3,030)
Staffed residential resource (group home)	63%	31%	27%
Family home	18%	31%	34%
Foster home	10%	26%	29%
On own	4%	7%	4%
With friend(s)	1%	2%	1%
Precarious living arrangement ⁶²	3%	3%	3%
Medical facility/hospital/treatment centre	1%	1%	1%
Custody centre	0%	0%	1%
Total	100%	100%	100%

Given the number of injuries for 2STNBGD young people associated with group homes, experiences of youth living in shelters and group homes is discussed further in the Findings section of this report, informed largely by:

- recent RCY research into the role belonging plays in young people’s lives, reflected in two public reports, *Skye’s Legacy: A Focus on Belonging* (2021) and *Missing: Why are children disappearing from B.C.’s child welfare system?* (2023)
- SARAVYC’s literature review, which found that 2STNBGD youth were often placed in spaces according to their sex assigned at birth that did not meet their needs for safety and belonging.

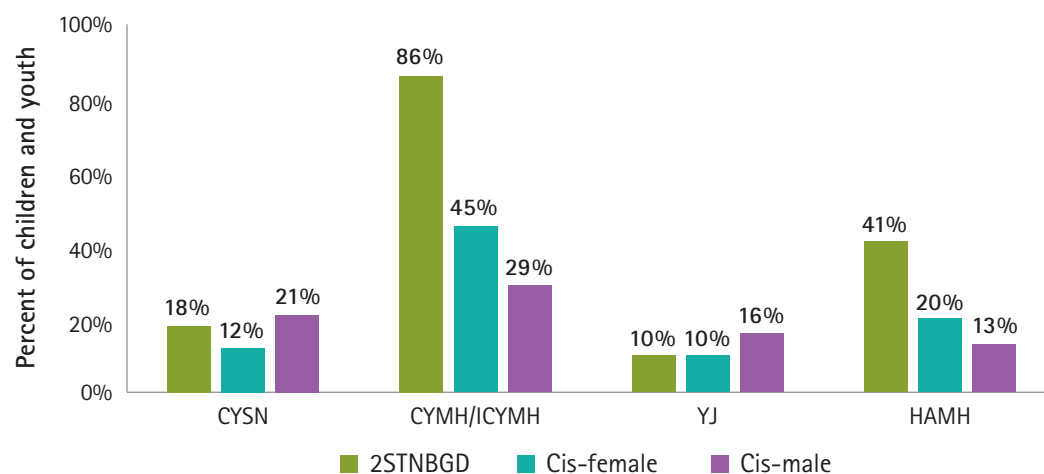
⁶¹ Staffed residential resources: a staffed residential facility or group home; may also include foster homes with more than one full-time employee.

⁶² Precarious living arrangement includes children and youth who are unhoused, in a hotel or motel, location unknown or living in a shelter or safe house.

Injuries by Reviewable Service Area and gender

Compared to cis-male and cis-female youth, the highest per cent of critical injuries for 2STNBGD youth were associated with CYMH, Indigenous Child and Youth Mental Health (ICYMH) and Health Authority Mental Health (HAMH) Services involvement (see Figure 4).⁶³ Similarly, a relatively high proportion of injuries associated with CYSN were reported for 2STNBGD youth.⁶⁴ Some young people may have received more than one of these services. Given the high percentage of suicidal, psychosis, and self-harm injuries of 2STNBGD children and youth, it is perhaps unsurprising that these injuries are also associated with a high percentage of CYMH, ICYMH and HAMH service involvement.⁶⁵

Figure 4 – Reviewable service area for children and youth with at least one critical injury, April 2018 to December 2022



⁶³ Health authorities are responsible for the provision of mental health hospital services such as are found at BC Children’s Hospital, Ledger House, the Carlisle Youth Concurrent Disorders Centre and regional in-patient adolescent psychiatric units.

⁶⁴ MCFD has recently re-described services to “children and youth with special needs” – which is commonly understood – as “children and youth with support needs. Both are otherwise known as “CYSN.” Other descriptors include children and youth with “diverse needs,” “children with disabilities,” “neurodiverse” children and youth, “neurocognitive developmental conditions” or “neurodevelopmental conditions.” Although there is no one agreed-upon term, this report uses the term “children and youth with support needs” to align with MCFD’s terminology. CYSN includes a broad spectrum of disabilities, including neurodevelopmental conditions, sensory impairments (e.g., deaf, blind) and physical disabilities (e.g., mobility). MCFD is responsible for most CYSN services.

⁶⁵ In Canada, anyone between the ages of 12 and 17 is considered a youth and may go through the youth justice system if they commit a crime or are accused of committing a crime.

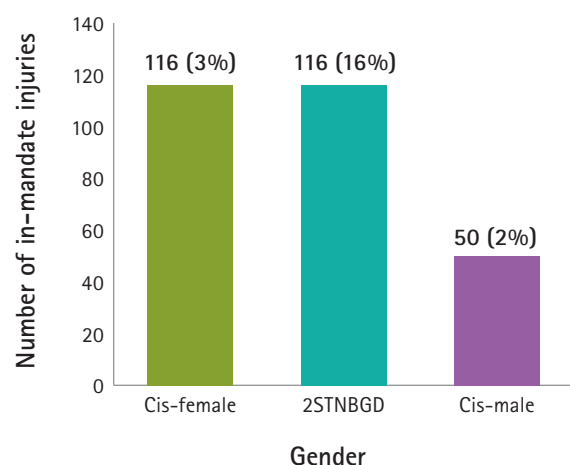
Critical injuries impacted by lack of services or waitlists

RCY began coding critical injury reports for concerns regarding lack of services and/or interaction with wait-lists in 2021/22. From April 2021 to December 2022, three per cent of all reported critical injuries across genders were coded with this concern. In contrast, looking at only the 2STNBGD children and youth in this cohort, 19 per cent had this code. Of the 116 injuries in the 2STNBGD group with this issue noted, 82 per cent of the injuries were related to youth with complex developmental behavioural challenges (CDBC), 98 per cent with a mental health challenge and 34 per cent with using substances.⁶⁶

RCY reviewed a random selection of 10 of these critical injury records, finding that the types of wait-lists or lack of services identified included: being placed on CYMH and ICYMH wait-lists; awaiting referral or intake to a gender clinic; wait-lists that extended beyond a youth's 19th birthday and, as a result, service was not pursued; a shortage of specialized staff for complex needs in group homes; psychiatrist care wait-lists; and autism assessment wait-lists.⁶⁷

The issue of wait-lists impacted two per cent of the critical injuries experienced by cis-males and three per cent of those experienced by cis-females, while it was associated with 16 per cent of the critical injuries experienced by 2STNBGD children and youth from April 2021 to December 2022 (Figure 5).

Figure 5 – Count and per cent of total critical injuries by gender from April 2021 to December 2022 coded as the incident issue of interest being "lack of services/wait-lists"



⁶⁶ The CDBC code is used if the child or youth has significant difficulties in multiple areas of functioning such as learning and development, mental health and behaviour or adaptive and social functioning. This can include a formal diagnosis or suspicion of neurodevelopmental differences and/or oppositional defiant disorder (ODD), conduct disorder, and/or the child or youth has a behaviour consultant or behaviour interventionist. This code includes personality disorders, trauma-related disorders and neurodiversity.

⁶⁷ MCFD's CYMH and ICYMH teams located across B.C. provide a range of mental health assessment and treatment options for children and youth (0 to 18-years-old) and their families at no cost. The clinics are staffed by mental health clinicians, psychologists and psychiatrists.

Avery's Story

Avery was a 16-year-old gender diverse child who enjoyed reading and hockey and was learning sign language. They were known to friends and family as kind and creative, and hoped to be a teacher one day.

Avery was diagnosed with conversion disorder at age nine and connected to a therapist. At age 12, Avery was hospitalized due to suicidal ideation. They were referred to CYMH services and participated in eight sessions focused on anxiety and gender dysphoria. Ongoing suicide risk was determined.⁶⁸

In 2021, when Avery was 14, they completed an autism assessment in Alberta because there was an 18-month wait-list for private assessments in B.C. Public assessments were also estimated to take 18 months and up to 3 years in certain parts of the province. The autism diagnosis was critical for Avery to access supports through CYSN services. They were diagnosed with autism and approved for CYSN services through the Autism Funding Program.

In 2021, MCFD child protection services became involved after Avery was hospitalized for a serious suicide-related injury. Their parents said they could not take Avery home because they did not have the capacity to meet their needs and asked that they be admitted to hospital for treatment and assessment. Avery was placed on the wait-list for the Maples Adolescent Treatment Centre (a provincial MCFD facility that supports young people with mental health concerns). The family was also wait-listed for two intensive mental health programs and outreach support through community agencies. Avery was briefly transferred to an adolescent psychiatric unit to stabilize. MCFD was not able to provide a placement that could meet Avery's complex needs and they were released to their parents one month later with a family navigator referral and support plan.

Avery had now been diagnosed with conversion disorder, borderline personality disorder traits, anxiety, gender dysphoria and autism. In addition to the Maples' and community agency wait-lists, Avery was on a two- to three-year wait-list for a new autism assessment through the Interior Health Children's Assessment Network.

In 2022, Avery again attempted suicide. They said that their primary goal was for their mental health to stabilize so they would be eligible for testosterone treatment when they turned 16. Resources were provided to the family for transgender supports but they expressed they were insufficient, and some decisions felt "rushed." Avery was placed on a puberty blocker drug.

In spring 2022, Avery was coping more effectively and seeing a counsellor. After waiting nearly a full year, Avery was admitted to the Maples and completed the program three months later. Avery was extremely distressed about being discharged. They became aggressive and were self-harming and highly suicidal.

Upon discharge, the Maples submitted a service request to MCFD Child Protection Services with concerns that it was not safe to discharge Avery to their family. Although Avery was no longer receiving treatment, they were allowed to stay at the facility over the holidays in a different unit as an emergency measure. Avery continued to stay at the Maples without treatment. In January 2023, Avery's dad said he would like Avery transferred to an adolescent psychiatric unit closer to home, however no beds were available. Discussion across Child Protection, CYMH, and CYSN teams about possible supports for the family ensued. At a discharge meeting in early January, the family was told that the Maples no longer had capacity, and Avery would have to be discharged. Child Protection began work developing a resource for them in mid-January.

At a discharge planning meeting one month later, MCFD said it needed more time to prepare for a careful transition to the new resource. The ministry asked for a discharge date at the end of the month, but the Maples pushed for it to be earlier. Eight days before Avery's anticipated discharge and after three attempts, they completed suicide at the Maples.

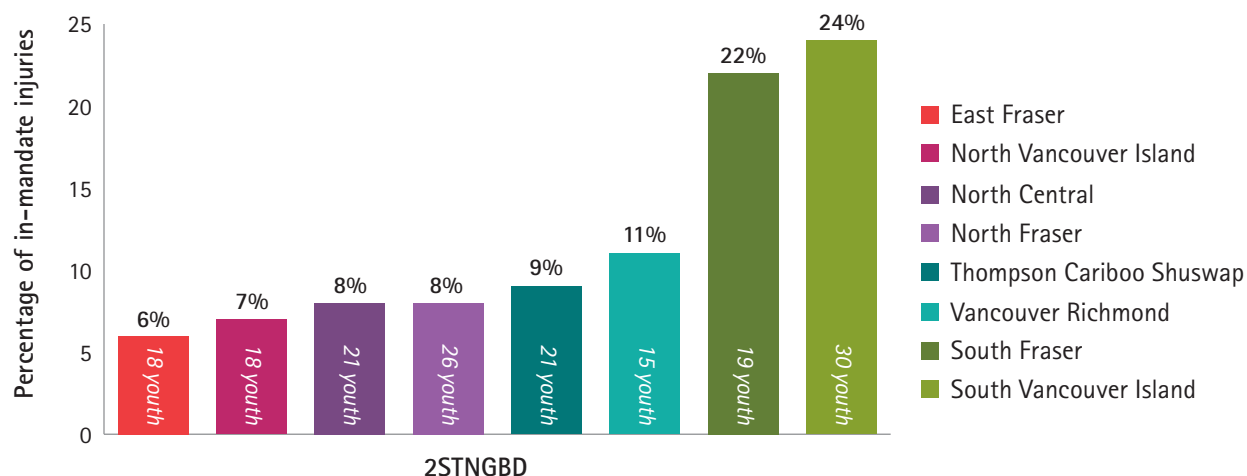
Avery and their family were deeply and tragically impacted by a lack of timely service provision and access to resources. Avery was never able to reach their goal of accessing hormone treatment.

⁶⁸ Conversion disorder – a condition in which a person experiences physical and sensory problems, such as paralysis, numbness, deafness or seizures, with no underlying neurologic pathology.

Critical injuries by geographic location

Geographic location in this analysis is based on MCFD's Service Delivery Areas (SDA). The ministry's services were primarily delivered across the province in 13 SDAs, however during the time period of this report, SDAs were condensed. By the time of the release of this report, the SDAs had been reduced to 8. Each reportable circumstance report RCY receives indicates an SDA associated to that individual young person and is used here for geographic analysis.

Figure 6 – Per cent of critical injuries attributed to 2STNGBD youth, April 2018 to December 2022 by SDA, and total number of individual youth with reported critical injuries in the SDA ⁶⁹



Although the overall population size of young people by SDA is highest in the Lower Mainland, in the 2STNGBD cohort, the highest percentage of injuries were connected to 2STNGBD children and youth in the South Vancouver Island SDA. Despite this SDA having a smaller overall population size, there are population trends that suggest this might be expected in the youth cohort. Among all census metropolitan areas in Canada, Victoria has the largest proportion of trans and non-binary people ages 15 and older.⁷⁰ Based on the by-child review, it appears a higher number of 2STNGBD children and youth, in addition to a higher percentage of injury reports in this cohort, are connected to this SDA.

⁶⁹ Any percentage below five per cent was removed to maintain confidentiality due to the small population size of those geographies.

⁷⁰ Statistics Canada "Canada is the first country to provide census data on transgender and non-binary people," Ontario, B.C.: Canada, April 27, 2022. <https://www150.statcan.gc.ca/n1/daily-quotidien/220427/dq220427b-eng.htm>

Lifetime issues of interest by child analysis

RCY defines a theme or characteristic that is likely to affect a child throughout their life as a lifetime issue of interest. These indicators are noted when critical injuries are assessed. They are identified in a child's story by reviewing their history as described in MCFD's centralized case management system (e.g., in a care plan, social worker's notes or incident reports).

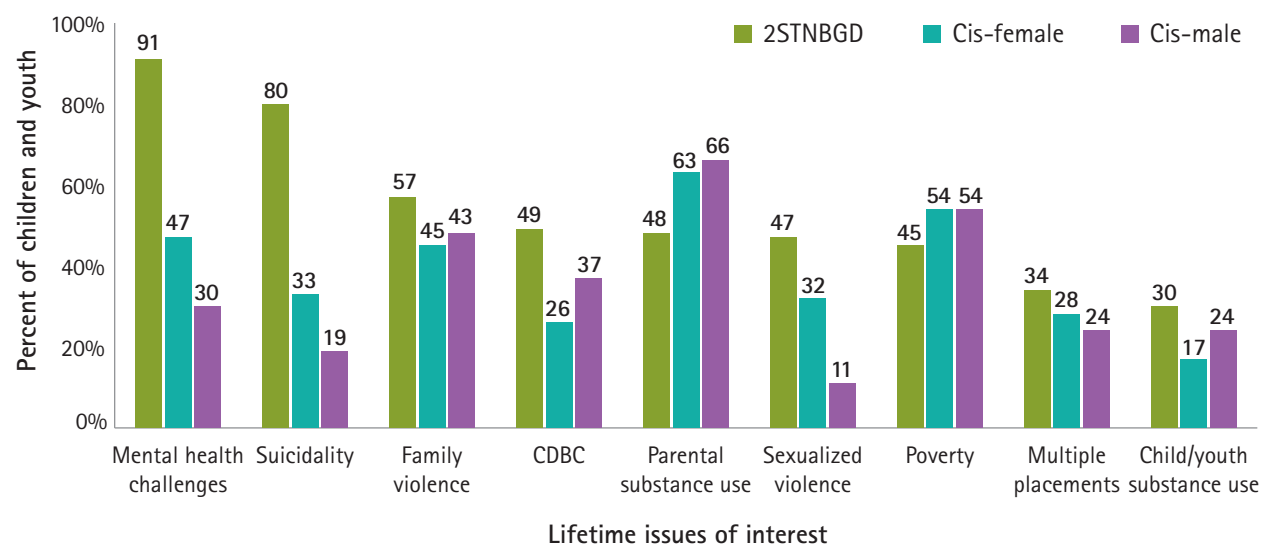
Several lifetime issues of interest affect a higher percentage of 2STNBGD children and youth than their cisgender counterparts (see Figure 7).⁷¹ For example, 91 per cent of the 198 2STNBGD young people who experienced critical injuries in this report's time frame have experienced mental health challenges. As well, suicidality, family violence, CDBC, sexualized violence and multiple placements were common lifetime issues of interest associated with this group. In contrast, cis-females and cis-males are more likely to experience parental substance use and poverty.

These issues can also intersect with and influence each other. For example, Grossman and D'Augelli found that transgender youth who experienced verbal and physical abuse from their parents were more likely to attempt suicide than those who did not.⁷² Further, eating disorders are not currently a tracked lifetime issue of interest. However, analysts observed a high number of reportable circumstances for 2STNBGD youth that made mention of eating disorders. Based on this understanding, a keyword search of "eating disorder" was conducted in the records. Nine per cent of the 2STNBGD children and youth in this analysis had either a diagnosed or possible eating disorder (17 youth). This is higher than the general population in Canada (two to three per cent). Of these 17 youth, all had been diagnosed with a CDBC. For these youth, substance use, self-harm and suicidality were common co-occurring themes.

⁷¹ The 2STNBGD cohort's lifetime issues of interest were reviewed for quality assurance and reliability. The cis-female and cis-male cohort did not receive the same review and, thus, may contain more variation in coding. However, because the populations of both cohorts (cis-female: 2,295; cis-male: 1,983) are large, the variation in coding becomes less significant (i.e., a regression to the mean).

⁷² Arnold H. Grossman and Anthony R. D'Augelli, "Transgender youth and life-threatening behaviors," *Suicide and Life-Threatening Behavior*, 37 no. 5 (October 2007): 527-37. <https://doi.org/10.1521/suli.2007.37.5.527>

Figure 7 – Per cent of selected lifetime issues of interest by child's gender, April 2018 to December 2022⁷³



Neurodivergence and 2STNBGD children and youth

2STNBGD children and youth were found to be more likely to be coded with CDBC than their cis counterparts (see Figure 7). Previous work has suggested a link between neurodiversity and gender diversity. Warrier and colleagues found that, “... compared to cisgender individuals, transgender and gender-diverse individuals have, on average, higher rates of autism, other neurodevelopmental and psychiatric diagnoses.”⁷⁴ It is important to raise this finding as it indicates other support needs that some 2STNBGD children and youth have.

⁷³ An assessment of what falls within the family violence lifetime issue of interest was conducted in the 2STNBGD cohort. Of the 57 per cent of 2STNBGD young people who were noted as having experienced family violence, a small sample of 20 randomly selected incident records were reviewed. Within the 20 records, young people were experiencing: domestic violence in the home between parents or other adults; verbal and emotional abuse including requests for silence around witnessing violence; physical abuse against the child or youth directly and in relation to their gender identity; ongoing parent-teen conflict and sibling conflict. Within this small sample, direct experience of physical abuse was noted most often.

⁷⁴ Varun Warrier, David M. Greenberg, Elizabeth Weir, Clara Buckingham, Paula Smith, Meng-Chuan Lai, Carrie Allison, and Simon Baron-Cohen, “Elevated rates of autism, other neurodevelopmental and psychiatric diagnoses, and autistic traits in transgender and gender-diverse individuals,” *Nature Communications* 11 (August 2020): 3959 <https://doi.org/10.1038/s41467-020-17794-1>

To understand this relationship further, a review was completed to identify suspected and diagnosed disorders written in the records RCY received for the 2STNBDG cohort. Ninety-five of the 198 2STNBDG children and youth were identified as having a suspected or confirmed diagnosis of a mental disorder as defined in the DSM-5 (48 per cent).^{75,76} In Table 7 the total count of all diagnoses (n=256) is identified and organized into disorder/disability groupings according to the DSM-5. The average number of diagnoses for the 95 2STNBDG children and youth coded with CDBC was three (range of diagnoses: zero to seven). The constellation of neurodevelopmental disorders and disabilities that are often captured as “neurodivergence” (defined in the DSM-5 as neurodevelopmental disorders) was identified as the most often diagnosed in the 95 youth with the CDBC code.

Table 7 – Count of CDBC diagnoses identified in 2STNBDG children and youth, April 2018 to December 2022

Disorder/Disability groupings based on DSM-5	Count
Neurodevelopmental disorders (ADD/ADHD, learning disability, FASD, autism)	145
Trauma and stressor-related disorders (PTSD, RAD)	51
Disruptive, impulse-control, and conduct disorders (ODD, conduct disorder)	29
Personality disorders (borderline personality disorder)	17
Bipolar and related disorders (Bipolar disorder)	8
TOTAL (95 youth):	256

*Note: Any diagnoses with a count under five have been removed from this table due to identifiability of unique conditions to specific young people; however, these counts remain in the overall total.

⁷⁵ The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association (APA). In many countries, including Canada, the DSM serves as the principal authority for psychiatric diagnoses. See: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th ed., Text Revision*, (Washington D.C.: American Psychiatric Publishing), 2022. <https://doi.org/10.1176/appi.books.9780890425787>

⁷⁶ RCY recognizes the history of medicalization of mental disorders (and the harm it has enacted on gender diverse communities); the diagnoses data are lifted only from what records RCY has access to in the MCFD case management system and injury reports received; therefore, any diagnoses cannot be validated, and the information could change over time and/or be incorrect/incomplete.

Robin's Story

Robin is described as outgoing and friendly, with a wonderful sense of humour. Robin enjoys watching horror movies and is a talented artist. They have an interest in fashion and makeup and would like to attend cosmetology school.

Robin was born in a small Indigenous community outside B.C. They moved to B.C. in 2013 with their Mom and two siblings. The family moved 20 times in the Metro Vancouver area between 2013 and 2017.

Robin first came to the attention of MCFD in 2017 after a report of maternal substance use, the children not attending school and lack of supervision. It was also reported that Robin regularly missed their medical appointments related to heart damage from an illness as a young child. Robin's mother experienced significant trauma as a child and intimate partner violence which has significantly impacted her ability to care for her children.

Shortly after the report to MCFD, 11-year-old Robin attempted suicide. While Robin was in hospital, their Mom contacted the Indigenous Child and Family Service Agency (ICFSA) in their city and requested a VCA for her children so she could focus on getting healthy and finding housing. Robin and their siblings were placed in a foster home together. Two-and-a-half years later, Robin's Mom consented to a CCO, relinquishing her parental rights.

In June 2019, Robin's relationship with their foster parents deteriorated, with the foster parents saying that Robin's behaviour was becoming aggressive, and they could no longer tolerate their substance use and frequent disappearances. Robin is diagnosed with ADHD, FASD and suspected PTSD. The ICFSA believed Robin would be best supported in a placement with staff available 24 hours. Over the next few years, Robin experienced six disruptions in placements.

Between 2018 and 2022, Robin experienced multiple life events that caused physical and emotional harm. RCY received 25 reportable incidents for Robin regarding injuries of sexualized violence and sexual exploitation, missingness and medical injuries due to substance use and substance-induced psychosis, which twice led to apprehension under the *Mental Health Act*. Robin has also been involved with youth justice.

Due to a lack of youth safe consumption sites, Robin goes to sites that adults also frequent. Robin has participated in inpatient treatment several times and additional substance use programs.

Robin has been placed at the same staffed resource since March 2022. They are often reported missing from their placement and have told staff that they don't feel safe or accepted at their placement. At times, Robin will seek out their mother on the streets who then tries to find them places to stay. Robin mainly accesses shelters and supports in the Downtown Eastside of Vancouver that serve self-identified women. When missing, social workers and service providers who support Robin attempt daily connections with shelter staff who are often protective of their clients' privacy. Robin's gender identity is complex and fluid, and they have identified to service providers as trans, non-binary, gay and Two Spirit.

Robin currently has sporadic contact with their family. Robin's Mom continues to struggle with addiction and housing instability and has not had much contact with Robin over the past several years.

Robin is a 2STNBGD youth with multiple support needs and is living in an environment where they are at high risk of sexualized violence and substance use-related harm. Like many 2STNBGD youth experiencing multiple lifetime issues of interest, the services offered by child-serving systems have not yet met their complex needs.

RCY Advocacy and 2STNBGD children and youth

RCY's Individual Advocacy, First Nations, Métis and Inuit Engagement (Advocacy) team supports youth who are receiving government services or who want to receive government services. In-mandate calls that may be assigned to an Advocate for follow up involve concerns that are related to designated government services. These may include youth justice, CYMH, CYSN, child protection, CLBC, the Provincial Tuition Waiver program, AYAs and child care subsidy programs.

Advocacy received 173 calls from or about 2STNBGD children and youth from April 1, 2018 to Dec. 31, 2022. Of these, 108 (62 per cent) were assigned to an Advocate for further follow-up and assessment. Primary concerns of these calls were a child's housing or living arrangement and inadequate supports for mental health (see Figure 8).

For example, calls expressing concerns about housing included: the quality of care a child was receiving in their group or foster home; a child wishing to leave or stay in their current placement; a desire for respite services to give caregivers temporary relief from the emotional and physical demands of caring for a child; and placement instability, such as being unhoused. Calls regarding inadequate supports for mental health concerns included: being denied services due to wait-lists; no access to psychiatrist, psychologist or primary care provider; and needing more supports concerning self-harming.

Calls expressing concerns regarding gender transition included: name changes; supplies for gender affirmation (i.e., chest binders or packers); and moving forward with options for hormones or surgery. Transition to adulthood calls included: not ready to transition out of care; concern that supports and services will be lost; bridging to CLBC services; and concerns about becoming unhoused.

Lottie's Story

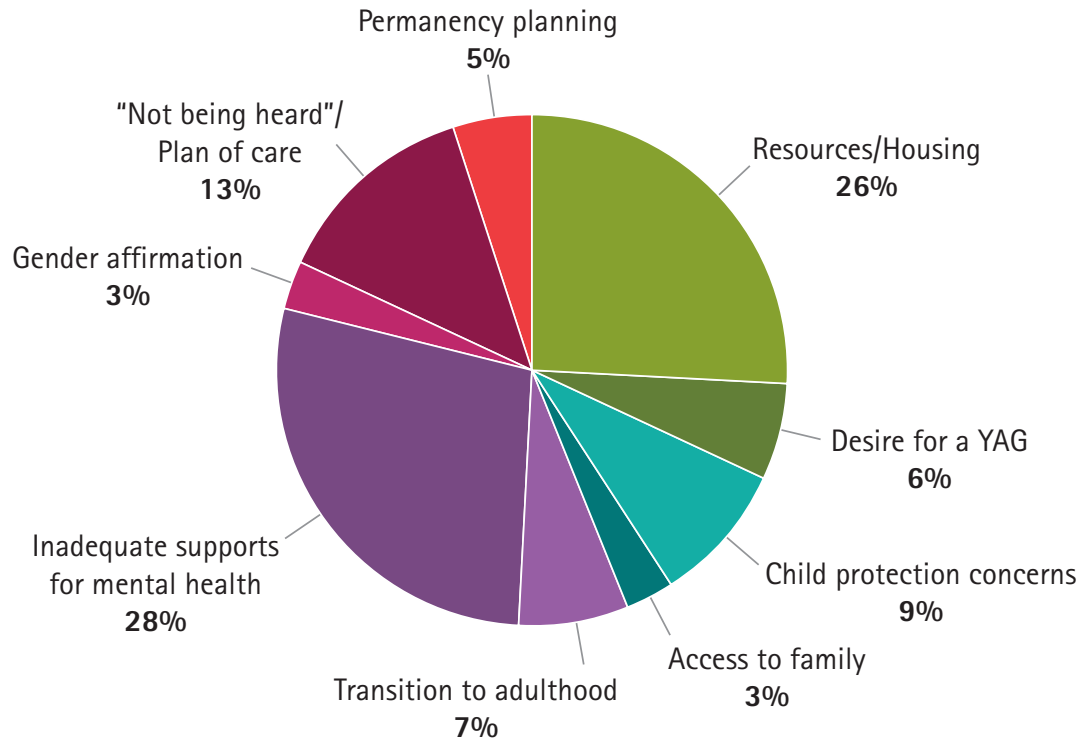
Lottie, a young Métis 2STNBGD person, had been in care since the age of five. They loved animals, creating art, writing and engaging in cultural activities with their mother. They were diagnosed with several neurodevelopmental-, trauma- and stressor-related disorders as well as mental health challenges. They had a large care team supporting them including CYSN, CYMH, and hospital and community partners. Lottie had been hospitalized many times for suicide and self-harm injuries and had been provided with harm reduction tools such as a "self-harm kit."

As Lottie approached the age of 19, they developed anxiety that their living arrangement in a staffed resource was going to end when they 'aged out' of care. They were not eligible for CLBC services and had significant complex behaviours.

RCY Advocates became involved when this young person was at risk of becoming unhoused if a resource was not identified. The youth's behaviours were becoming more challenging as their distress about transitioning out of care increased. An RCY Advocate brought MCFD and the hospital team together to collaborate with Adult Mental Health Services to find a solution. Adult Mental Health Services agreed to take over the housing contract for two years. This young person was able to remain in the same resource and is thriving. They have one-to-one support at all times and a strong sense of belonging. They expressed that they were happy to have more freedom after turning 19 and were developing some flexibility in the resource policies with their care team and the resource.

This story highlights what can happen when there is collaboration with different partners who have the same goal to ensure a young person is well-supported and has a sense of belonging.

Figure 8 – Assigned advocacy for 2STNBGD children and youth by priority theme, April 2018 to December 2022



SARAVYC Youth Interviews and Analysis

Ensuring that the views and experiences of young people are part of RCY reports is a value the Office strives to reflect in all its publications. In this report, as discussed in the Methodology section, the Representative asked SARAVYC to interview 2STBNGD youth to draw on their experiences in their own words. RCY is committed to engaging organizations that have already established relationships, methodologies and practices that the Representative is confident will respect and uplift young people in trauma-informed and culturally informed ways while supporting them to be heard. RCY worked with SARAVYC on the development of interview questions, but asked SARAVYC to take the lead in recruiting participants and completing the interviews given its connections and strengths in practice.

Interview participants from across B.C. were asked to share their personal histories and experiences with child and youth services. Themes were identified from these interviews, and quotes were extracted as evidence of those themes. The following is an analysis of the themes, offering insights into the young peoples' experiences and needs.⁷⁷

Gender binaries structure most services and fail to meet needs

Health services and government care are often structured along a gender binary, which youth told SARAVYC can fail to meet their needs. The young people SARAVYC interviewed reported facing restrictions based on the gender binary in all forms of care and expressed some level of discontent with the current state of services. As one youth said:

“I have a sense of hopelessness with the system ... it feels like depression through oppression. Like, there's not a time where I access a service, whether it be physical, mental or mental health or whether it be addiction, where I don't experience people who don't understand my identity and who make me feel like I'm abnormal in those rooms. The only time I don't experience that is when they are peer driven by queer people.”

— Immigrant, Indigenous, non-binary/gender fluid, third gender, 23, Vancouver Island

The majority of participants' negative experiences were related to their gender identity. These negative experiences occurred across all health care and child welfare services, suggesting that the barriers they face are widespread and reflect larger systemic issues. However, there were also bright spots within every service, with participants describing instances in which their identities were affirmed and respected while receiving quality care.

⁷⁷ Demographic information is omitted in many of these quotes to prevent patterning and possible identification of the youth by service providers and community members that have relationships with the youth.

Participants indicated that B.C. health and government care systems are not insulated from the stigmatization and discrimination within society toward 2STNBGD children and youth. In participants' accounts, transphobia manifested as misgendering, deadnaming and ignorance and erasure of trans and non-binary identities. It also manifested as active threats to the safety of 2STNBGD children and young people. For example, while in government care and living in a group home, one participant had a traumatic experience that required police interaction:

“I feel like I have no support. And I feel like government care failed me in terms of protecting me from people that hurt me and treating me like a youth instead of like an adult. I needed to figure out my own problems when I wasn't old enough yet. Like, I was the one that had to ask for the police to come interview me. They didn't do that for me ... And I feel very ... not supported.”

— Non-binary, 21, Fraser Valley

This traumatic experience did not involve any individuals related to the government care system or the youth's family; however, the role of government care workers is to ensure the safety of young people as the 'prudent parent.' This participant was openly non-binary and had faced explicit transphobia (including misgendering and deadnaming) in government care before. Another youth also reported that he had been ignored by government care workers and that this experience was explicitly related to his gender identity. This participant described how he had gone to government care workers for help because he was experiencing mistreatment and transphobia from his stepparent and had left home because he felt unsafe. However, government care workers told him to return home, as the situation was not considered “*bad enough*” to warrant intervention:

“... they were not great. [I] pretty much just felt like the people that were supposed to help me and were meant to be there to help people in situations like me, just completely ignored me because I was trans. And it really sucked 'cause it made me feel for a brief moment that I just wasn't worth it.”

— Trans man, 17, northern B.C.

Some participants believed that their gender identity had been pathologized and dismissed by mental health professionals. One youth described interactions with a previous psychiatrist:

“... because I have borderline personality, one of the traits is questioning your identity, they said. So I felt like me being a trans person ... was questioned as being a mental health symptom and not as something that was just who I was.”

— Non-binary, 21, Fraser Valley

According to some participants, having limited or no access to much-needed services, receiving sub-par care and experiencing systemic transphobia can be a matter of life and death. As one young person said:

“I know way too many people who have tried and have successfully ended their lives by accident or on purpose because of how limited care is and how it affects us.”

— Transmasculine, non-binary, 20, northern B.C.⁷⁸

⁷⁸ Transmasculine is an umbrella term to describe people who were assigned female at birth, who are trans, and whose gender expression leans towards the masculine.

Misgendering, deadnaming, and outdated intake forms are too common

While some participants described moments of affirmation, all participants had experienced misgendering and deadnaming at some point when accessing mental health and substance use services, government care and health care. In some cases, this lack of acknowledgement and respect began with the intake forms participants completed when accessing mental health services. “[These] really need to be updated ‘cause they only ever make you include your legal name. And it really sucks for those of us that don’t have their legal name updated.” (Trans man, 17, northern B.C.).

Misgendering and deadnaming extended to youths’ interactions with health care providers and foster families. One participant described how their foster parent only accepted female youth, continually misgendered them, and refused to use the more masculine name they had chosen, stating, “[she would] call me a more gender-neutral version of it and referred to me as a girl. And I found that very frustrating.” (Non-binary, 21)

In addition to exclusionary intake forms, some participants faced deadnaming and misgendering from mental health care staff. One participant described having been misgendered during the two gender-affirming surgeries they had received, which made them hesitant to attempt to access other gender-affirming surgeries in the future and had a profound emotional impact on them: “Those were supposed to be really special moments when I got to reclaim my body ... and they were ruined for me because of the way I was treated.” Non-binary youth reported unique barriers compared to binary trans youth with respect to having their names and pronouns used correctly. One participant described frustration with trying to change their electronic health record, while another said not having their affirmed name and gender in their records contributed to feeling disrespected while they were dealing with a mental health crisis, saying:

“It feels like a losing battle. It’s been about seven or eight months now of them trying to get my pronouns and preferred name into my information thingie. And the hospital is refusing to do it.”

— Transmasculine, non-binary, 20, northern B.C.

“I’m struggling with suicidal ideation. I’m struggling with intense mood swings and crippling anxiety ... and they don’t listen. They automatically assume because ... I went in saying, ‘Hi, my name is ‘blank.’ My pronouns are they/them. I know it says different on my file, but can you please refer to me as this?’ ... [that] I’m grasping for attention. And I’ve heard nurses say that outside my room.”

Navigating the health care system and accessing gender-affirming care is complicated

Services that are affirming, respectful and understanding are only useful if they can be found and accessed with minimal delay. Unfortunately, most participants reported facing barriers in some form or another, not only when attempting to find and connect to services but also when trying to receive the care offered by those services.

Some gender diverse participants reported facing challenges when trying to navigate the health care system on their own. When describing his experiences with navigating gender-affirming services, one participant mentioned that the “... *process isn't always super straightforward, and sometimes you have to jump through a couple of hoops.*” (Trans man, 17, northern B.C.).

Another participant said:

“... [as] people who suffer from mental health and addiction and are trying to navigate a broken medical system for [gender-]affirming care, sometimes we just give up. I lost my housing, and I gave up on HRT [hormone replacement therapy].”⁷⁹

— Non-binary/gender fluid, third gender, 23, Vancouver Island

Once participants had been connected to the services they needed, some faced additional obstacles to accessing those services. Youth who had been connected to gender-affirming services described varying experiences with wait-lists, depending on the support and/or knowledge of care providers.⁸⁰ For example, one youth received timely care due to their doctor being extremely diligent when it came to their gender-affirming surgery referrals, allowing them to get top surgery a year after referral and a hysterectomy the following year (Non-binary, third gender, 23, Vancouver Island).⁸¹

However, some participants continued to experience difficulties even after they had been connected to or wait-listed for gender-affirming services. One participant’s access to hormones was impeded because their family doctor was difficult to get hold of and appointments were booked far in advance (Non-binary, 25, Metro Vancouver). Another young person said, “*Communication with gender clinic staff was poor, making it difficult to navigate the system.*” (Non-binary, 21, Fraser Valley). This echoed a similar experience with miscommunication faced by a different participant:

“I was on the wait-list for one surgeon ... and [then] he just disappeared. I think he got sick or something, and they just never told me ... I was just waiting around. And then I realized through this Facebook group I'm in that he wasn't returning. And so I ... waited around in hopes that he would come back, but he didn't. So then I transferred to another ... surgeon who had a long wait-list.”

— Trans man, Metro Vancouver

⁷⁹ Hormone therapy or hormone replacement therapy (HRT) is the administration of sex hormones for the purpose of bringing one’s secondary sex characteristics more in line with one’s gender.

⁸⁰ Gender-affirming surgeries are a range of surgeries that create physical characteristics that are in line with one’s gender identity.

⁸¹ Top surgery is an umbrella term used for some gender-affirming, above-the-waist surgeries including masculinizing chest surgeries and feminizing breast augmentation surgeries.

Geography matters: gender diverse youth in rural areas face added challenges

Participants' experiences of the quality and availability of mental health, substance use and gender-affirming services seemed to depend heavily on where in the province they were located. While all participants reported barriers to accessing health care, those living in more rural parts of B.C. noted that such services were even less accessible and sometimes even nonexistent.

Experiences with services in rural communities were not entirely negative, although some participants described them as extremely limited and ill-equipped to address a diverse range of needs. Said one participant, *"I love my therapist. But there's only so much a cis woman can understand,"* before expressing a desire to find *"... someone who would better understand how to deal with dysphoria and things like that ... that's something that I would have really enjoyed, but where I am that is a very, very limited and hard thing to find."*

— Transmasculine, non-binary, 20, northern B.C.

Another young person was able to access hormones after being referred to a telehealth doctor but received no other forms of gender-affirming support or care: *"Her only purpose is to prescribe me medication because no one else in my area can."* (Non-binary, third gender, 23, Vancouver Island).

For many participants, safety played a large role in the accessibility of services. Some of those living in rural areas tied the lack of trans- and non-binary-friendly services in those areas to widespread negative attitudes toward, and/or ignorance about, gender diversity within these communities. Some participants said these attitudes made accessing gender-affirming support dangerous, a problem compounded by the scarcity of such supports:

"I am a part of a Trans Care group for people in my town. But we kind of have to remain under a certain level of privacy because of how dangerous it is in this town to be trans. And so the social worker who does run it – she is running it for this town and another town. And so she's always busy and resources are so heavily limited."

— Transmasculine, non-binary, 20, northern B.C.

This participant seemed to feel a sense of pressure to keep their gender identity hidden for their own safety, further describing how accessing what little gender-affirming care was available in their small rural community could potentially pose a risk to their confidentiality and put them in greater danger:

"... as soon as that question of gender comes up, it is just fear 'cause you don't know how they're going to react, especially in the town that I'm in. It is a very conservative town. And I am always scared, but I don't want to have to hide who I am. I don't feel like that's something that I should do just to get help, just to get basic human kindness. I shouldn't have to pretend to be someone I'm not."

Some participants noted that gender-affirming care was even less available and typically nonexistent in rural areas, making it necessary to travel long distances for care that may not be available once they arrived:

"I was the first person in my community to access gender-affirming care when I did .. it was a lot of me driving two hours to bigger cities to try to access gender-affirming care with the only person within a three-hour radius to my town. And a lot of being denied left and right, even after going long distances."

“I have emailed a clinic in a city, like two hours away to get a consultant about going on testosterone. They have not emailed me back. And that is as far as I’ve been able to go because everywhere I look in this town, it’s just a closed door.”

— Transmasculine, non-binary, northern B.C.

However, even for those located in Metro Vancouver, some services were not accessible to them because they resided in the wrong health authority. One youth who lived just outside of Vancouver Coastal Health reported being unable to access the comparatively large number of gender-affirming and trans/non-binary-friendly health services offered within that health authority:

“I can’t access the Three Bridges clinic or any other sort of trans resources through Vancouver Coastal Health because I’m [a few blocks away]. And [my health authority] doesn’t have anything ... their website literally just says, talk to your doctor ... And that’s a whole other issue with the shortage of family doctors that we encounter ... and no one can afford to live in downtown Vancouver anymore. So, you’re then limiting these resources only to people who can afford a house or can afford Vancouver rent, which is very restrictive. And that in and of itself becomes a class issue.”

— Non-binary, Metro Vancouver

One participant’s description of accessing physical health care may reflect barriers shared by many 2STNBGD youth in these rural communities:

“In general, it absolutely sucks for trans people in the north. Nine out of 10 times we are discriminated against for absolutely no reason other than we are trans ... Especially in emergency care ... they’ll make a comment about how it’s not a good decision for me to be transitioning.”

— Trans man, northern B.C.

General knowledge of gender diversity missing among health care providers

All participants reported having interacted with at least one knowledgeable staff member or health care professional. However, some also reported mixed-to-negative experiences when interacting with health care providers and government care workers, who seemed to lack the knowledge necessary for addressing the needs of 2STNBGD youth. Across support services, some participants drew a distinction between providers’ competency in their work and their competency about and respect for gender diversity, noting that some providers had one but not the other. One participant said:

“I don’t think he was very knowledgeable about trans people in a social way. Like, he knew [about trans people] and was actually helping people get their blood drawn for HRT and all that ... medically he understood, but socially he wasn’t sure what to say and how to refer to me.”

— Trans man, 17, northern B.C.

Those who were competent in their field but lacked knowledge and respect for gender diversity were seen by some participants as distinct from those who lacked both competency and respect, such as the health care staff one participant described: *“On top of being misgendered, they couldn’t refer me to medical supports that I needed.”* (Non-binary/gender fluid, third gender, 23, Vancouver Island).

Some participants described experiences in which mental health and substance use professionals seemed to be willing to learn about trans and non-binary identities so that they could provide appropriate care; however, in such cases, participants reported having to educate staff about the needs of 2STNBGD people. One participant summarized their interactions with emergency mental health care staff this way:

“The first thing they ask is, ‘I saw you filled out they/them pronouns on your sheet. Can you explain that to me? Can you explain your gender identity to me? Oh, cool, how does that work? Why are you like this?’ And it’s, like, ‘I came here to get some professional help, and now I am teaching you about pronouns.’”

— Non-binary/gender fluid, third gender, 23, Vancouver Island

Another participant described similar experiences with having to constantly explain they/them pronouns to mental health professionals while in the middle of a mental health crisis:

“I don’t really want to get into a conversation about my identity. I just want help. I definitely wish that it was something ... they had more knowledge on. And that [they] didn’t rely on the trans and non-binary clients to inform them.”

— Transmasculine, non-binary, 20, northern B.C.

However, even when recounting such experiences, some participants expressed a level of understanding about health care providers’ lack of knowledge about gender diverse identities. As one youth said:

“I don’t think they were super necessarily knowledgeable. But ... they were nice enough that they could see, like, ‘Oh, I should use the correct name. I should use the correct pronouns’ ... those are pretty basic, but I mean, some people don’t get it.”

— Trans man, 23, Metro Vancouver

Feeling unseen and having to hide: Two Spirit youths' challenges navigating services

While Two Spirit participants described their identity as a source of freedom, they also shared feeling unseen by service providers, or facing additional challenges in being Two Spirit that resulted in the need to hide their identity. Participants agreed that being Two Spirit youth in care brings additional challenges,

“... because when we add that Two Spirit identity, even as the Two Spirit community, there’s only ... we’re still learning so much about what that really means and how we can feel a sense of what it is and belong.”

— Two Spirit, 24, Vancouver

This youth further explained that since Two Spirit does not fit into the binary system, it can make anyone feel lonely and push them towards substance use:

“Thinking of someone who identifies as Two Spirit, then they’re also overly not really going to fit in the binary of how we’ve built society. So, you have that additional desire to escape from reality because you don’t see yourself as an active participant in the society within which you exist. So yeah, I would definitely say that ... it would disproportionately impact those youth.”

Some participants felt a need to hide their identity, as this participant said:

“Being Two Spirit, I tried to deny and hide my identity and how I felt inside so much as a teenager, so much as a young person. I tried to make friends with people who weren’t really my friends, really, and used [substances] to try and make myself feel better or stop feeling ... So, I think there were multiple things going on, like there is the identity thing with being Two Spirit. And then there’s the identity thing with being Indigenous, too, and how we’re treated or how people observe us.”

— Two Spirit, trans man, 22, Lower Mainland

One participant expressed concern about service providers not acknowledging their experience, leading to this young person dropping out of counselling:

“... accessing counsellors, quite often when I started talking about queer stuff, they were, like, ‘No, that’s not a thing.’ And then I would completely shut down about everything and just tell them what they needed to hear to tell my Mom that I was okay and didn’t need to be in counselling anymore ... But it’s always been really rough as both a mixed Indigenous person and a queer person to feel safe with service providers.”

— Non-binary, Two Spirit, 22, Fraser Valley

Professionals lack knowledge about Two Spirit Identity

Most participants spoke about professionals’ lack of knowledge of Two Spirit identity, similar to the lack of knowledge identified by most of the non-Indigenous, gender-diverse participants. One participant described the burden of education that this places on them:

“It makes it hard because then sometimes my first two sessions end up being me educating them on my identity because they haven’t had any – they don’t have another resource to get this information. So then basically sometimes my appointments end up half being I’m educating them. And then we finally get to talk about my stuff. And I’ve found that happens quite a lot.”

— Non-binary, Two Spirit

Lack of knowledge by service providers can lead to youth disengaging from the services completely, as this participant shared:

“... and that really sucked, and I actually stopped ... accessing any kind of care for a year after that. I had completely given up and really snowballed that year. And then that was when that all kind of came to an end, when I ended up in the hospital again.”

Further, they felt that the foster and residential care system did not have sufficient resources or education to support Two Spirit youth specifically. One youth said:

“I think a lot of group homes and stuff, like hey kids, you get pizza or chicken wings and that’s it. But what about education around, like what does my body need to function well? If you are a Two Spirit person who’s transitioning, right, what does a trans body need differently?”

— Two Spirit, 24, Vancouver

Another participant said, “*More knowledge around Two Spirit folks for, like, my foster family [is needed].*” (Two Spirit, 22, Okanagan).

However, Two Spirit youth also noted that even small efforts by professionals can be meaningful:

“My counsellor is definitely someone you can tell is very new, but he is trying very hard. Which you still appreciate when you ... even if you can tell someone’s ... you can tell someone’s trying, that means a lot.”

— Non-binary, Two Spirit

Another Two Spirit youth spoke about the important connections she made with Indigenous care providers through school that they felt understood them and their culture and how this helped them thrive:

“I personally never had the urge to use drugs, really, or anything. And I think a big part of that was how I had people in my life who actually took an interest in me and my well-being. Especially [in the] teenage, adolescent years and the early years. And, like, even me going to university now, there were Indigenous caretakers and care workers and social workers at my high school who did their best and connecting us with culture, you know, sweat, smudging, potlatch, beading. They even took us to some cultural festivals that happened during the summer ... So you could actually see that I was improving in school after doing more with, like, native clubs and stuff.”

— Two Spirit, 22, Okanagan

Two Spirit youth in rural areas face additional challenges in accessing services

The participants talked about how living in a rural area could hamper access to services. One described walking their family doctor through every step of the way because he was in rural B.C. and knew very little (Non-binary, Two Spirit, 22). Another participant mentioned that none of the medical staff in the rural area where they lived before they moved to an urban area knew what Two Spirit was (Two Spirit, trans man, 22, Lower Mainland).

One participant pointed out that it wasn’t just health professionals’ lack of knowledge, but their beliefs and attitudes, too:

“So, to access something like gender-affirming care in a rural area, you’re going to be really limited by the beliefs of that primary care provider. And so, I think that is the disservice sometimes that happens when you are in a rural area, and then community and connection to better connect identity is next to impossible.”

— Two Spirit, 24

One participant who had lived in both rural and urban areas compared their experiences:

“I have lived in both really small towns and also cities. I would say that I had much better access to things like doctors or other folks who knew about my situation in cities rather than in the country. There was literally no gender-affirming care in my small town.”

— Two Spirit, non-binary, 21, Vancouver

Two Spirit youth also navigate additional challenges of intergenerational trauma and difficult family experiences with services

The young people all spoke of family members' experiences and their struggles in a variety of ways. Some participants noted the experiences of family members accessing health services and the racism Indigenous people can face. For example, one participant shared that their parents' bad experiences with the health care system discouraged them from accessing services they needed themselves:

“And where I lived, it wasn't super common in my family ... to go to the doctor. And I don't blame my parents or eventually my caretakers or my foster family. Because they also have had bad experiences with doctors or just the health care system in general. So, I've seen a lot of talk about racism towards Indigenous people in hospitals and emergency rooms and things like that. And I can definitely see that personally for me, 'cause the times that I have gone to a doctor I definitely come from a small community, and I feel like people may look at me a bit differently.”

— Two Spirit, 22, Okanagan

Other participants shared their experiences of racism and bias when accessing services, including transphobia and colonial views.

The intersection of racism and transphobia can make it even more challenging for Indigenous 2STNBGD youth to access gender-affirming services. A few participants shared the racism and bias that they experienced when accessing services. One participant said, *“It was hard to feel safe in a live-in program where they just ... they were quite transphobic. Which does happen with Indigenous communities with the history of residential schools and stuff.”* The participant further expressed the implicit bias that is in the system: *“You can tell it's not intentional, but these people grow up with these views that Indigenous people are all alcoholics and things like that”* (Non-binary, Two Spirit, 22, Okanagan)

Another participant shared their traumatic family experiences, including the legacy of residential school in their family:

“[S]omething I still struggle with and my Mom also uses and had throughout my childhood. So that's why I went into foster care in the first place and my Mom was a residential school survivor and passed on a lot of trauma to me. And although we have a frustrating relationship she does – will accept me for who I am.”

— Two Spirit, non-binary, 21, Vancouver

When talking about substance use among youth, one of the participants shared that, *“I feel like a lot of the root causes of these health issues is the colonization and also the self-esteem thing and how we see ourselves in society.”* (Two Spirit, trans man, 22, Lower Mainland)

Finding: 2STNBGD young people are too often faced with support workers in child- and youth-serving systems who lack knowledge about gender diversity and can be disrespectful

A key issue faced by 2STNBGD youth is interacting with uninformed staff while accessing services. All interview participants for this report discussed this point, as did members of this report's Circle of Advisors. When young people are required to educate staff, it takes valuable time away from the support or treatment they need. Unfortunately, this is not unique to B.C. Pullen Sansfaçon et al. found that trans and non-binary youth in Canada, Switzerland, England and Australia “described staff working with them as lacking training to varying degrees, noting that they and their families had to educate professionals from whom they sought care ...”⁸³ Participants in interviews with SARAVYC emphasized the importance of ensuring providers have training regarding the needs and experiences of gender diverse people. In fact, some participants said this education should be youth- and peer-led so that staff receive information directly from gender diverse people.

“I would like to see more health care professionals being more knowledgeable and in a perfect world, respectful. I am getting very tired of the toleration of it. I feel like we should be past tolerating trans and non-binary people and respecting people like me just as people. ‘Cause there’s nothing different. We are still people, and we still deserve the same respect ... [and] I don’t want to go into a place and have to be a teacher and then get help. It’s exhausting.”

— Transmasculine, non-binary, 20, northern B.C.

Members of the Circle of Advisors supported the idea of building an education component on gender diversity into the training programs that now exist for all child- and youth-serving professionals, including social workers, child and youth care workers, teachers, nurses, physicians and registered clinical counselors, as a way to lift everyone up. The Circle of Advisors also suggested that all new staff in these fields should complete a training module on gender diversity designed for their profession.

Similarly, some interview participants felt that extensive education should be a required part of the training and education that foster parents and group home workers receive, and it should emphasize the harms of transphobia within the home so that it can be recognized and taken seriously. As stated by one trans male youth who had experienced transphobia at home that made him feel unsafe but was refused help when he tried to access government care, “... just making sure that they are well educated on how transphobia can affect youth ... and why they need to leave situations like those.” (Trans male, 17, northern B.C.)

⁸³ Annie Pullen Sansfaçon, Denice Medico, Damien Riggs, Anna Carlile, and Frank Suerich-Gulick, “Growing up trans in Canada, Switzerland, England, and Australia: Access to and impacts of gender-affirming medical care,” *Journal of LGBT Youth* 20 no. 1 (May 2021): 55-73. <https://doi.org/10.1080/19361653.2021.1924918>

One crucial issue described by all interview participants was having their name and pronouns respected by support workers, regardless of their legal name and gender marker.⁸⁴ Respect for name and pronouns played a key role in participants' interactions with government care and mental health, substance use and gender-affirming services. A few interview participants reported positive experiences with government care workers who supported their identity and addressed them with the correct name and pronouns, but most did not. RCY sees this same issue in reportable circumstance reports, with 2STNBDG children and youth misgendered in the reports and case management system. These reports also note 2STNBDG children and youth expressing concern to their social workers that they have shared their dead name with foster parents or used incorrect pronouns when speaking with the child or youth. Research has shown that correct pronoun usage can lead to a child feeling validated and less emotionally stressed.⁸⁵

Bright Spot – California

In March 2023, California introduced a bill aimed at further improving conditions for gender diverse young people in foster care. The bill includes a provision that will make the needs of LGBTQ youth mandatory considerations for all home and environmental assessments. The bill also states that approved foster families will need to review these criteria to ensure that they have the appropriate "skills, knowledge, and abilities" to support LGBTQ youth.

B.C.'s Ministry of Education has made some constructive progress in this area. In September 2016, the minister announced that all B.C. public boards of education were required to reference sexual orientation and gender identity (SOGI) in district and school codes of conduct by Dec. 31, 2016. Independent schools are required to have anti-bullying policies in place to protect the safety and well-being of students, but are not required to reference protected grounds of identity. The Ministry of Education's SOGI Policy Guide – a voluntary resource provided to the K-12 sector to support policy and procedure development – makes clear that all students have the right to self-identification, which includes the name by which they wish to be addressed and their pronouns that correspond to their gender identity. Further, they have the right to confidentiality of their assigned and/or self-identified sex, gender and name. Staff are expected to protect this right and not expose the sexual orientation, gender identity and/or gender expression of students. The Ministry of Education is responsible for the creation of SOGI BC curriculum. *SOGI 1 2 3* provides ready-to-use, grade-appropriate SOGI-inclusive lesson plans that align with that curriculum. Teachers can adapt or adopt *SOGI 1 2 3* lesson plans to meet the needs of their classrooms.^{86,87}

⁸⁴ Gender marker is a term used in reference to the sex/gender marker on identification/documents.

⁸⁵ Brown et al., "It makes such a difference."

⁸⁶ SOGI 123 "SOGI Policy Guide," Victoria, B.C.: B.C. Ministry of Education, n.d., Accessed May 30, 2023. <https://static1.squarespace.com/static/58056b68f5e2316903750b43/t/58095e5a579fb3b75eae950b/1491938148026/moe-sogi-policy-guide.pdf>

⁸⁷ SOGI 123, "British Columbia SOGI Education," B.C. Ministry of Education, n.d., Accessed May 30, 2023. <https://bc.sogieducation.org/>

Some youth participants expressed hesitancy about openly talking about gender identity with support workers. It is possible that this hesitancy suggests that youth are aware that situations could become uncomfortable or even unsafe should in-depth conversations about gender identity occur with someone who may not understand or be supportive. This may have been the case for Robin (see page 37) whose social workers continued to use their legal name because they didn't explicitly ask that social workers use their chosen name and pronouns and yet, in the spaces Robin sought out care, they were intentional in the use of their pronouns, trans femme gender expression and chosen name.⁸⁸ Further, for both Robin and another 2STNBGD young person, social workers thought they may be using a trans femme identity to access women-centred services in Vancouver's Downtown Eastside. This assumption is disrespectful and frames these youths' gender identity as primarily transactional. It is clear that, as well as learning basic information about trans and non-binary identities and how to respect names and pronouns, service providers need to hear about the experiences and complexity of 2STNBGD young peoples' lives and identities as a means of understanding their perspectives, struggles and triumphs.

2STNBGD children and youth are also sometimes made to wait for referrals to be placed by their social worker, if the social worker does not believe that the gender identity will be consistent or that a different support need must be addressed first. There is a persistent narrative that gender transitions, especially in younger children, may be a fad or related to peer pressure; however, recent research has found that 94 per cent of transgender children who socially transitioned before the age of 12 were persistent in this identity five years later.⁸⁹ Similar findings of 2SNTBGD identity persistence after beginning puberty blockers and/or hormone treatments have been found.

However, workers in child-serving systems may arbitrarily defer connecting children to gender-affirming care due to lack of knowledge of the persistence of gender variance. For example, RCY has received injury reports for one child who expressed to his foster parents and guardianship social worker that he would like to transition to male. He was told that he would need to live this gender identity for six months before a gender clinic referral would be considered. However, after nine months, the referral had still not been submitted and the youth was told that he had to present as male to his entire foster family before the referral would be made. This may have not felt safe for the youth, as he previously said his foster parent had misgendered him and laughed at him. He also told his social worker that he found it hurtful that, when she discussed him with his foster parents, she used the incorrect gender and pronouns. These delays to refer children and youth are particularly problematic given that the current wait-lists for a first appointment to discuss medical gender-affirming care can be up to a year at the BC Children's Hospital Gender Clinic.

“Except for my current therapist ... I have never made it through an entire relationship with a mental health professional without being misgendered. So yeah, I find that they lack even the basic knowledge a lot of the time, and that lack of knowledge makes them put me in the educator seat when I'm actually the one accessing services.”

— Non-binary/gender fluid, third gender, 23 Vancouver Island

⁸⁸ Femme describes gender expressions and/or social and relationship roles that are perceived as being feminine or refers to a person who embodies these qualities. The person may or may not identify as trans or gender diverse.

⁸⁹ Kristina R. Olson, Lily Durwood, Rachel Horton, Natalie M. Gallagher, and Aaron Devor, “Gender identity 5 years after social transition,” *Pediatrics* 150 no. 2 (July 2022): e2021056082. <https://doi.org/10.1542/peds.2021-056082>

In addition to the need to ensure service providers have training regarding gender diversity, some youth mentioned that intake forms for mental health and other services should be updated to allow youth who have yet to legally change their name and/or gender marker to note their chosen name and pronouns. This is especially important because, while the B.C. government has changed the requirements to make it easier for young people over age 12 to legally change their gender, youth under age 19 still require approval from their legal guardian to do this. Along with changing intake forms, policies should be in place that ensure the name and pronouns young people provide are respected by staff. The Ministry of Education's student information system is used by all schools to track and report on all students in the province. Currently, the "gender" field must be entered as it appears on official documents. There is a possible "gender identity" field but this is an optional district-owned field and information entered is decided by district policy.⁹⁰

Throughout the research, analysis and interviews for this report, some social workers and other child-serving workers stood out as they creatively and effectively affirmed 2STNBDG children and youths' gender identities. For example, one social worker obtained approval to provide gender-affirming menstrual products to a 2STNBDG youth who was experiencing acute gender dysphoria during his monthly cycle. On the whole, however, support workers' lack of knowledge about gender diversity and lack of understanding of the lives of these young people has contributed to their overall feelings of being unsupported and disrespected.

Trans Care BC

Trans Care BC provides information and resources related to transgender health and provides clinical tools and resources to health care professionals. Trans Care BC is a part of the Provincial Health Services Authority (PHSA) and provides information and resources to service providers, including those working with youth.

While Trans Care BC is situated within health care specifically, the organization's health navigation team helps ensure Two Spirit, trans and non-binary people of all ages and their families access many forms of gender-affirming health care as close to home as possible. Trans Care BC offers information and support on a diverse range of issues including: sexual and reproductive health; ID and name change; binding, packing, tucking and padding; mental health and wellness support; peer support; community grants and more.

In addition, Trans Care BC offers education on gender basics, and can assist in understanding the language used when talking about trans identity, gender, sexual orientation and health.

Trans Care BC is an arm of the PHSA, which is responsible for the provincial coordination of transgender health services in the province.

⁹⁰ Operations and Standards Committee, "MyEducationBC Standards manual: A manual for managing student information," Victoria B.C.: Ministry of Education, recent update: April 2023, Accessed May 30, 2023. <https://mytrainingbc.ca/myedbcstandards/#admission>

Finding: 2STNBDG children often face delayed or impeded access to gender-affirming care, making them especially vulnerable

SARAVYC’s literature review found that access to gender-affirming care is associated with lower levels of depression and yet stories from 2STNBDG children and youth and analyses of RCY data make clear that many of these young people are experiencing delayed or denied referrals and extensive wait-lists and delays when referred for services. This is especially concerning given that, in analyzing the 2013 Trans PULSE project, with a sample of 433 transgender individuals, Bauer et al. found that, *“suicide prevalence [...] was clearly linked to participants’ stage of medical transition with those at the highest risk being those who were planning to transition but had not yet begun, and the lowest being among those who had completed a medical transition.”*⁹¹ As Dr. Jake Pyne, assistant professor in the York University School of Social Work, told RCY: for youth in need of medical gender-affirming supports, *“... delay is the new denial.”* Research has shown that trans and gender diverse youth who access medical gender-affirming care earlier in puberty demonstrate better mental health and sense of well-being than those who begin treatment later in adolescence.⁹² In New Zealand, social workers are required to be *“especially mindful of tamariki [children] who have needs relating to gender identity before they reach adolescence”* and to ensure they support such young people *“to access the appropriate services and support.”* A longitudinal study of 55 transgender young adults who had received puberty blockers in adolescence found that, in young adulthood, the gender dysphoria had been alleviated and the well-being of the transgender young adults was similar to or better than cisgender young adults.⁹³

This report’s data analyses show that youth with multiple support needs tend to have a higher percentage of injuries connected to wait-lists or lack of resources.

Almost every critical injury reported to RCY for a 2STNBDG child or youth with a wait-list/lack of service concern was experienced by a child or youth with a mental health challenge (98 per cent). RCY Advocates have reported calls regarding or from 2STNBDG children and youth who have not been able to access needed mental health services because of wait-lists. Similarly, 82 per cent of the injuries were related to youth with CDBC.

Gender Clinic, BC Children’s Hospital

The Gender Clinic at BC Children’s Hospital (BCCH) accepts referrals up to a patient’s 17th birthday. A team of endocrinologists, endocrine nurses and social workers works in partnership with BCCH, community mental health professionals, Trans Care BC and the Vancouver Coastal Health Authority’s BC Transgender Clinical Care Group.

The clinic’s key purpose is to deliver endocrine care, including puberty blockers and gender-affirming cross-hormone therapy, to 2STNBDG youth. A readiness assessment must be completed. The clinic offers remote visits with annual in-person contact. In addition, BCCH provides Indigenous Health Advocates to assist Indigenous families visiting the hospital, including the Gender Clinic. The Gender Clinic has a visioning process underway, looking at adding services such as online educational sessions for youth and caregivers, parental support and in-person family gatherings.

As of May, 2023, the wait-list for a new consultation was six months, although it can be more than a year for a non-urgent referral. Approximately 300 young people are on the wait-list.

⁹¹ Bauer, “Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada.”

⁹² Janet Y. Lee and Stephen M. Rosenthal, “Gender-Affirming Care of Transgender and Gender-Diverse Youth: Current Concepts,” *Annual Review of Medicine* 74 (January 2023): 107-116. <https://doi.org/10.1146/annurev-med-043021-032007>

⁹³ Annelou L.C. de Vries, Jenifer K. McGuire, Thomas D. Steensma, Eva C.F. Wagenaar, Theo A.H. Doreleijers, Peggy T. Cohen-Kettenis, “Young adult psychological outcome after puberty suppression and gender reassignment,” *Pediatrics* 134 no. 4 (October 2014): 696-704. <https://doi.org/10.1146/annurev-med-043021-032007>

Given the outsized number of 2STNBGD children and youth experiencing mental health concerns, suicidality, self-harm, CDBC and substance use, the lack of timely connection to services is particularly concerning.

2STNBGD youth with whom SARAVYC spoke also reported long wait-lists and delayed care. One participant said:

“I wanted this specific surgeon. So that took about another year. And then [the surgery was] delayed because of COVID. I had a [surgery] date, and then it was cancelled and pushed ... [so] my top surgery actually took over two years for me to get.”

— Trans man, 23, Metro Vancouver

Avery was deeply impacted by being wait-listed for critical supports. As described in their story on page 32, their family sought out an autism assessment in Alberta, given the 18-month wait-list for private assessments and up to three years for public assessments in B.C. The diagnosis was needed for Avery to access CYSN services. After a suicide attempt in 2021, Avery was wait-listed for in-patient support at the Maples. Avery was also on a two-to-three-year wait-list for a new autism assessment through the Interior Health Children’s Assessment Network (IHCAN). In 2022, after waiting nearly a full year, Avery was admitted to the Maples. Finally, while hospitalized at the Maples, they were waiting to transition to a resource when they completed suicide. It is clear that throughout Avery’s short life, they were not provided with important services in a timely and comprehensive manner.

Avery’s parents also said that when Avery was connected to gender resources, the process felt rushed and insufficient. Rushed appointments indicate the pressure of wait-lists, as strained capacity can lead to quick and infrequent appointments without time to ask questions and alleviate concerns. A further consideration for 2STNBGD children and youth is that they may wait lengthy periods of time before ‘coming out’ to their parents or caregivers. Pullen Sansfaçon found that this wait, coupled with long wait-lists once they have been referred for services, can lead 2STNBGD children and youth to express a “*considerable sense of urgency in obtaining care.*” Thus, what may feel interminably slow to a youth may feel rushed to their parents or caregivers. They suggest that “*in order to address this urgency, professionals could seek strategies that mitigate delays, including discussions with other providers who have knowledge of the youth ... It is also very important to explain to the young people that delays or clinic policies are not intended to question or challenge their gender identity.*”⁹⁴ As is discussed further in the next finding, parent- and caregiver-directed education and supports can be important resources to help alleviate parental or caregiver concerns and allow for space for them to ask questions and process the change that their child or youth is undertaking.

This report’s Circle of Advisors, which includes many B.C. clinicians with direct practice knowledge, emphasized the concern that wait-lists were putting 2STNBGD children and youth at risk. Wait-listing youth rather than providing early interventions also means that care is reactive rather than proactive. Bauer et al. argue that the increased risk of suicidality in transgender people while waiting to access medical gender-affirming care “*calls into question the safety of clinical practices that delay transition treatments until depressive symptoms or suicidality are well-controlled, and of procedural practices that require*

⁹⁴ Annie Pullen Sansfaçon, Julia Temple-Newhook, Frank Suerich-Gulick, Stephen Feder, Margaret L. Lawson, Jennifer Ducharme, Shuvo Ghosh, Cindy Holmes and the Gender-Affirming Care Team, “The experiences of gender diverse and trans children and youth considering and initiating medical interventions in Canadian gender-affirming speciality clinics,” *International Journal of Transgenderism*, 20 no. 4 (August 2019): 382.

or result in long delays in the medical transition process, but also suggest need for supports for those who may feel suicidal while in the process of transitioning.”

2STNGBD children and young people in B.C. need access to comprehensive care that is both wraparound and timely.⁹⁵

“In the wake of the passage of Florida’s discriminatory ‘Don’t Say Gay or Trans’ bill, extremist politicians and their allies engineered an unprecedented and dangerous anti-LGBTQ+ misinformation campaign that saw discriminatory and inflammatory ‘grooming’ content surge by over 400% across social media platforms.”

Human Rights Campaign press release, Aug. 10, 2022, <https://www.hrc.org/press-releases/new-report-anti-lgbtq-grooming-narrative-surfed-more-than-400-on-social-media-following-floridas-dont-say-gay-or-trans-law-as-social-platforms-enabled-extremist-politicians-and-their-allies-to-peddle-inflammatory-discriminatory-rhetoric>

Finding: The mental health of 2STNGBD children is best supported through intervention into stigma-related stressors alongside therapeutic supports

A surge in transphobic and anti-gender diversity rhetoric and misinformation is apparent both in the United States and in Canada.^{96,97} According to the American Human Rights Campaign and the Center for Countering Digital Hate, hateful social media campaigns – many of which focus specifically on children and youth – have soared by more than 400 per cent since the passage of Florida’s so-called “Don’t Say Gay or Trans” bill in spring 2022. As these campaigns have received increasing publicity, they have gained widespread traction, including in B.C. Exposure to this kind of messaging can have a direct impact on the mental health of 2STNGBD children and youth.⁹⁸ Hughto et al. found that *“more frequent exposure to negative depictions of transgender people in the media was significantly associated with clinically significant symptoms of depression [...] anxiety [...] and global psychological distress.”*⁹⁹ One youth interview participant reported directly witnessing a public demonstration of this backlash in a suburban area not far from Vancouver:

“There were these protestors, and they had these massive signs about how gender ideology is ‘grooming’ kids. And I think that type of ideology ... those thoughts are so harmful to youth.”

— Non-binary/genderqueer, 16, Fraser Valley

⁹⁵ Bauer, “Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada.”

⁹⁶ Cassandra Kislenko, “It’s pretty dire: Canada’s problem with transphobia,” *ANTIHATE.CA*, April 28, 2023. https://www.antihate.ca/canadas_problem_with_transphobia

⁹⁷ Anthony Izaguirre and Brendan Farrington, “Florida expands ‘Don’t Say Gay’: House OKs anti-LGBTQ bills,” *Associated Press News*, April 19, 2023. <https://apnews.com/article/desantis-florida-dont-say-gay-ban-684ed25a303f83208a89c556543183cb>

⁹⁸ An Pham, Anthony R. Morgan, Hannah Kerman, Katie Albertson, Julia M. Crouch, David J. Inwards-Breland, Kym R. Ahrens, and Parisa Salehi, “How are transgender and gender nonconforming youth affected by the news? A qualitative study.” *Journal of Adolescent Health* 66 no. 4 (April 2020): 478-483. <https://doi.org/10.1016/j.jadohealth.2019.11.304>

⁹⁹ Jaelyn M.W. Hughto, “Negative transgender-related media messages are associated with adverse mental health outcomes in a multistate study of transgender adults.”

Stigma-related stressors (e.g., discrimination, transphobia, lack of acceptance, peer victimization) that a child or youth asserting their gender identity experiences can directly impact their mental health. This means that addressing a child's mental health concerns in isolation from their gender exploration or without addressing the stress of prejudice may be unsuccessful. Goldhammer, Crall and Keuroghlian found that, "... multiple stigma-related stressors experienced by gender minorities may produce symptoms and behaviors that can mimic or be consistent with certain diagnostic criteria for borderline personality disorder."¹⁰⁰ They argue that gender incongruity can be misdiagnosed as a personality disorder and suggest adopting a therapeutic approach that "... addresses minority stressors and [...] occur[s] within an [gender-]affirming health care environment" rather than an emphasis on the diagnosis of a potentially pathologizing disorder. Bauer et al. found that transgender people experiencing high levels of transphobia were more likely to express suicidality than those that did not. They also found that parental support can be a protective factor for transgender youth.¹⁰¹

Many interview participants expressed how the transphobia they faced from those around them, and the accompanying stress and fear, compounded the effects of the transphobia they experienced from mental health professionals – which, in turn, exacerbated the mental health issues for which they were seeking treatment:

"For people who are trans or non-binary and maybe don't come from families that support them the same, or maybe they don't have friends who understand them, that could be the push that sends them over the edge."

— Non-binary/genderqueer, 16, Fraser Valley

"There is a lot of hate where I am. It is very scary for me to leave my house most days. There's a lot of violently transphobic people around me. And it definitely feels like a lot of times, every time I leave my house, I have to protect myself in order to be myself, which is not easy. And having to close a lot of doors on family members who don't understand and refuse to respect me."

— Transmasculine, non-binary, 20, northern B.C.

Finding: The mental health and well-being of 2STNGBD children is supported through intentional establishment of safe, respectful and affirming school, community and therapeutic environments

Feeling understood and supported in school and community was described as important by SARAVYC's youth interview participants. Some participants said that interacting with other young people with similar gender identities, backgrounds and experiences with government care, mental health and/or substance use was one way of receiving this support, which had a positive impact on their lives. Two youth were placed in government care with other trans youth – one in foster care, the other in a group home. Both spoke positively about these experiences as helpful, though for different reasons. For one,

¹⁰⁰Hilary SM Goldhammer, Cary Crall, Alex S Keuroghlian, "Distinguishing and Addressing Gender Minority Stress and Borderline Personality Symptoms," *Harvard Review of Psychiatry*, 27 no. 5 (September/October 2019): 317-325. <https://doi.org/10.1097/HRP.0000000000000234>

¹⁰¹Bauer et al., "Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada."

seeing another trans person was a “mirror” that showed him he was not alone, even though gender was not a topic of conversation and, for the other, they enjoyed talking with someone else who understood what they were going through.

Similarly, some participants who had sought care for mental health and substance use stressed the importance of being able to access safe spaces in which they could openly talk about their experiences and connect to other gender diverse people. Both 2STNBGD youth counsellors and peers were named as helpful: *“My counsellor is a queer, trans, neurodivergent social worker. And of course we get along so well, and I find that really fulfilling.”* (Non-binary/gender fluid, third gender)

RCY has seen some social workers note this importance and attempt to connect 2STNBGD children and youth with peer groups. One youth told her social worker that she did not have any friends or connections with people her age and she felt a sense of isolation. The social worker’s goal was to connect her with a 2SLGBTQ+ community group for youth.

Interestingly, when asked about helpful mental health support they had accessed, one youth participant described a high school Gay-Straight Alliance (GSA) club, even though it was not a “mental health” resource *per se*.¹⁰²

“I like support groups that talk about mental health-related around this subject ... it was a club for LGBTQ+ to just come and talk about the community and things around the subject and open up about it. It was a very positive experience. Everyone was very caring, kind, accepting. It was great.”

— Gender-questioning, 18

In a study with 58 LGBTQ youth in North America, Porta et al. found that the youth described GSAs as important places to find emotional connection, support, safety and belonging.¹⁰³ However, schools can also be where 2STNBGD children and youth experience transphobia and bullying, as SARAVYC found in its literature review and as RCY has seen when reviewing injury reports. One social worker noted that conflict with peers and being misgendered in the school setting was upsetting for the 2STNBGD youth on her caseload. The social worker noted that recently the principal and vice principal at one young person’s school *“own[ed] up for their mistake not supporting [the youth] when he was harassed at the school.”* The social worker noted that this was a very meaningful repair for the youth, who had not felt safe at school since the harassment had happened.

Transphobia experienced in school can be implicated in a 2STNBGD child or youth’s substance use. Keuroghlian et al. cite research from a national study that found that *“35% of transgender people who*

Bright Spot – QMUNITY

QMUNITY is a non-profit organization based in Vancouver that works to improve queer, trans and Two Spirit lives. It provides a safe space for 2SLGBTQIA+ people and their allies to fully self-express while feeling welcome and included. QMUNITY’s Youth Program consists of group drop-in spaces, a Bras, Binders, and Breast Forms Exchange Program, one-on-one support, and referrals and resources for 2SLGBTQIA+ youth ages 25 and under.

¹⁰²GSAs – also known as Gay-Straight Alliances or Gender/Sexuality Alliances – are student-led organizations intended to provide safe and supportive environments for LGBT2SQ+ and questioning youth and their allies.

¹⁰³Carolyn M. Porta, Erin Singer, Christopher J. Mehus, Amy L. Gower, Elizabeth Saewyc, Windy Fredkove, and Marla E. Eisenberg, “LGBTQ youth’s views on gay-straight alliances: Building community, providing gateways, and representing safety and support,” *Journal of School Health* 87 no. 7 (June 2017): 489-497. <https://doi.org/10.1111/josh.12517>

experienced school-related verbal harassment, physical assault, sexual assault, or expulsion reported using substances to cope with transgender – or gender nonconformity-related – mistreatment.”¹⁰⁴

New Zealand looked at how schools might be made safer and produced a resource for schools to support transgender, gender diverse and intersex students. *Making Schools Safer* pays specific attention to the intersectionality of gender diverse students. And in Australia, the *LGBTIQ Student Support Policy*, developed by the Victoria Department of Education and Training, includes a required gender-affirming student support plan to support gender diverse students. The policy states that development of the plans should be student-led and student-centred and, where possible, include parents/carers.

In addition to connecting with peers, another youth mentioned that he found a combination of various social supports to be helpful when dealing with substance use, including support from queer and trans communities, which he described as being very helpful in making connections with friends. For those seeking help related to substance use, some participants described having youth-focused support as more effective and comfortable than the majority of other groups predominantly attended by adults. One youth described an extremely positive experience with a substance use peer support group that was not only aimed at youth rather than adults but also included a critical mass of LGBTQ+ people:

“It was beautiful. It was wonderful. There was a lot of freedom. And because we all understood each other – a lot of us were trans and a lot of us were queer – it was just inviting and open. And you knew that you could talk about addiction, but you could also laugh with those people. And you knew that you could talk about the systemic issues that are in place that made us need to turn to addiction.”

— Immigrant, non-binary/gender fluid, third gender, 23

In contrast, another youth accessed group cognitive behavioural therapy for their mental health and found the experience to be extremely negative, describing it as mostly “middle-aged moms” and said that one of the issues they faced was participants continually disrespecting their identity (Transmasculine, non-binary, 20). Another youth interviewed had experienced substance use groups primarily attended by “middle-aged working-class ... cis-men” who would be uncomfortable when this participant spoke about the relationship between their substance use struggles and their gender identity (Non-binary/gender fluid, third gender, 23).

Bright Spot – Genderpraatjes (Genderchats)

Genderpraatjes is a volunteer- and expert-staffed online, phone and email support line for gender diverse children and young people in the Netherlands. It operates after school hours and on weekends. Although youth-focused, parents may also contact Genderpraatjes for guidance. Clients can access the service in Dutch or English to ask questions about gender and gender identity, anonymously and without judgement. Directly supported with funding from the Ministry of Health, Welfare and Sport, Genderpraatjes is operated by the non-profits Transvisie and Transgender Netwerk Nederland (TNN, a small but very active volunteer advocacy group). <https://genderpraatjes.nl/en/> Accessed May 30, 2023.

¹⁰⁴Alex S. Keuroghlian, Sari L. Reisner, Jaclyn M. White, and Roger D. Weiss, “Substance use and treatment of substance use disorders in a community sample of transgender adults,” *Drug and Alcohol Dependence*, 152 no. Jul 1 (July 2015): 139-46. <https://doi.org/10.1016/j.drugalcdep.2015.04.008>

Bright Spot –**B.C. Transforming Connections: A trauma-informed and attachment-based program to promote sensitive parenting of trans and gender non-conforming youth**

"Connect is a trauma-informed and attachment-based group program for caregivers of at-risk adolescents developed by Marlene Moretti, Professor and Canada Research Chair at Simon Fraser University (SFU), in collaboration with government stakeholders and mental health practitioners. [The program] has been shown to reduce parent-teen conflict. Teens benefit from increased attachment security and improved mental health and well-being. Researchers at SFU have adapted this program to create Transforming Connections for caregivers of transgender and gender non-conforming youth ... Discussions related to gender included: coming out, connecting with peers, affirming pronouns/names, medical transition, parental reactions and concerns about safety and mental health. Caregivers said that learning about attachment improved their understanding of their teen and their gender journey and themselves as a caregiver. All parents reported applying the ideas discussed in the group, and the majority indicated that their relationship with their teen had improved ..."

See: Dangaltcheva, "Transforming Connections: A Trauma-Informed and Attachment-Based Program to Promote Sensitive Parenting of Trans and Gender Non-conforming Youth."

Finding: Lack of parental, familial and peer support increases risks for 2STNBGD children and youth, however there are limited opportunities for families, peers and allies to learn ways to provide affirming support and nurturance

Research has shown that trans children who are supported and affirmed in their gender identity show similar levels of depression as their cisgender counterparts and only marginally higher levels of anxiety.^{105,106} Parental support has been found to be associated with less depression and higher life satisfaction in trans adolescents.¹⁰⁷ Bockting et al. found that peer support is a "... *factor of resilience in the face of actual experiences of discrimination.*"¹⁰⁸ The importance of mentor supports can also be seen in how 2STNBGD children and youth feel more supported when child welfare workers take their gender identities and expressions seriously.

Given, the strong correlation between parent support and positive mental health, parent interventions can be key to educating parents about gender diversity and how best to support their children. There are models to learn from in Canada and other jurisdictions. Parents of Gender Diverse Children (PGDC) is an NGO that receives funding from the Victoria State government in Australia. The organization's services and resources are available across Australia. Services for parents include: peer

¹⁰⁵Olson et al., "Mental Health of Transgender Children Who Are Supported in Their Identities."

¹⁰⁶Dangaltcheva, "Transforming Connections: A Trauma-Informed and Attachment-Based Program to Promote Sensitive Parenting of Trans and Gender Non-conforming Youth."

¹⁰⁷Lisa Simons, Sheree M. Schragar, Leslie F. Clark, Marvin Belzer, and Johanna Olson, "Parental support and mental health among transgender adolescents," *Journal of Adolescent Health* 53 no. 6 (December 2013): 791-793. <https://doi.org/10.1016/j.jadohealth.2013.07.019>

¹⁰⁸Walter O. Bockting, Michael H. Miner, Rebecca E. Swinburne Romine, Autumn Hamilton, and Eli Coleman, "Stigma, mental health, and resilience in an online sample of the US transgender population," *American Journal of Public Health* 103 no. 5 (May 2013): 948. <https://doi.org/10.2105/AJPH.2013.301241>

support; information on parenting a gender diverse child; referrals to community agencies and service providers in each state; and advocacy, including legal referrals. PGDC also offers professional development sessions and media liaisons to improve awareness of and services for gender diverse children in jurisdictions across Australia.¹⁰⁹ The Family Acceptance Project® is a “*research, intervention, education and policy initiative*” developed by researchers at the San Francisco State University. Its focus is to promote well-being for LGBTQ2+ and transgender children and youth “*in the context of their families, cultures and faith communities.*” The project team has implemented a Family Support Model, which it describes as the “*first of its kind.*”

The linkage between the alleviation of stigma-related stressors and the addition of protective factors in a 2STNBDG young person’s life is key to better outcomes for these youth and must be explored further.

Bright Spot – PROUD2BE LGBTQ2S+ Support Programs

The community-based agency, Family Services of the North Shore, provides services such as counselling, support, and education across the North Shore. The organization has made a strong impact on families and caregivers of 2STNBDG children and youth through its PROUD2BE LGBTQ2S+ Support programs and counselling. One such program is the Parents of Gender-Diverse Children support group. This is a virtual drop-in program for parents of gender-diverse youth, facilitated by counsellors, and is a safe and judgment-free space for parents to connect, ask questions, and learn more about how to support their children. In 2022, the program supported 12 to 18 parents weekly.

The PROUD2BE programming also offers Be Yourself, in-person programming for youth ages 16 to 24 who identify as queer, trans, non-binary, Two Spirit, and/or questioning. Youth enjoy playing games, watching movies and making art together, among other activities.

Finally, the PROUD2BE Education Event series is an important source of information for families. These events feature speakers with lived experience, professional panel discussions, workshops and support for gender-diverse, gender-questioning, and LGBTQ2S+ children, youth, their families and professionals. Some of the offerings in 2022 included a Medical and Professional Experts Panel, Voices of Young Adults Panel and a Parent and Caregiver Event. In 2022, the PROUD2BE programs for LGBTQ2S+ youth and their parents reached 500+ people through the online Education Series and Parent drop-in program. Family Services of the North Shore notes that parents are seeking out the PROUD2BE services more than ever.

<https://www.familyservices.bc.ca/find-support/lgbtq2s-support/>

https://www.familyservices.bc.ca/wp-content/uploads/2022/06/FSNS_ANNUALREPORT2022_WEB.pdf

¹⁰⁹“Resources” *Parents of Gender Diverse Children*, n.d. Accessed May 30, 2023. <https://www.pgdc.org.au/resources>

Finding: 2STNGBD young people with multiple support needs are receiving siloed supports

RCY advocates for a whole-system approach to children and youth who face myriad challenges, including multiple diagnoses, as it is understood that co-occurring issues are linked. As found in the analysis of the critical injury data, a cohort of 2STNGBD children and youth experience frequent multiple critical injuries and there are similar characteristics across this cohort and within their experiences. For 34 2STNGBD children and youth in this report, RCY received 10 or more injury reports for each young person. Most of these children and youth had experienced co-occurring CDBC and mental health challenges, while half of them experienced CDBC, mental health challenges and substance use issues. In the exploration of lifetime issues of interest, it was identified that this cohort has multiple support needs. Regrettably, the responses of child-serving systems to these young people highlight a system focused on siloed supports and/or an emphasis on ‘fixing’ mental health challenges or substance use before allowing a child or youth to access gender-affirming care, without reflection on the possible interdependence of these challenges and gender dysphoria/incongruity.

For example, 2STNGBD youth may be told they need to stabilize their mental health and/or substance use before being connected to gender-affirming health care. One child in RCY’s analysis was told that he must be six months free of self-harming before starting hormone treatment and his pediatrician said he needed to lose weight before accessing hormones. Additionally, following his hormone readiness assessment, he was told he needed three months of emotional stability before beginning hormone treatment.¹¹⁰

Another concern brought forward by the Circle of Advisors is the potential lack of inclusivity in hormone or other gender-affirming readiness assessments for neurodivergent 2STNGBD children or youth. As identified in the RCY data analysis, 95 of the 198 2STNGBD children and youth were recognized as having a suspected or confirmed diagnosis of a mental disorder or disability, with the majority of these diagnoses identified as neurodivergence. These findings highlight the importance of recognizing the rights of 2STNGBD children and youth who may not meet normative requirements for gender-affirming care (e.g., neurotypicality, stable mental health, reduction in challenging behaviours) to have their gender identity respected and appropriate accommodations so that they can access gender-affirming care (e.g., restructured hormone readiness assessments). However, this must also be coupled with an understanding that affirming gender diversity does not mean neurodivergence or other disorders will be ‘fixed’ once gender-affirming care is obtained. This is a potentially harmful narrative that replicates a common notion that neurodivergence is something to be fixed rather than accommodated alongside a youth’s gender-affirming needs.¹¹¹ Or, equally harmful is the simplistic notion that autism and gender diversity cannot co-occur and, instead, autistic people may simply be ‘fixated’ on the opposite gender as a fleeting obsession that shouldn’t be supported by parents or support workers.¹¹²

¹¹⁰A hormone readiness assessment is an evaluation conducted by a health care professional to determine if a patient is ready to begin hormone therapy.

¹¹¹Jake Pyne, “‘Building a person’: Legal and clinical personhood for autistic and trans children in Ontario.” *Canadian Journal of Law and Society/Revue Canadienne de droit et société*, 35 no. 2 (November 2020): 341-365. <https://doi.org/10.1017/cls.2020.8>

¹¹²Sharon Kirkey, “Are autistic children more likely to believe they’re transgender? Controversial Toronto expert backs link,” *National Post*, Jan. 12, 2017, Updated March 21, 2017. <https://nationalpost.com/health/are-autistic-children-more-likely-to-believe-theyre-transgender-controversial-toronto-expert-backs-link>

While in some cases other support needs will decrease after a child is connected to gender-affirming care, research has also shown that autistic symptoms could actually increase, as the person with autism no longer feels they must mask their neurodivergence or their gender identity.¹¹³ Research has also shown that addressing one support need in isolation from others may be unproductive, and that better outcomes result when co-occurring diagnoses are supported together. Further, Keuroghlian et al. argue that “[substance use disorders] among transgender people are increasingly viewed as downstream consequences of internalized and enacted transphobia.”¹¹⁴ James Kelly, executive director of Vancouver’s Peak House, told RCY that he has worked with 2STNBDG children and youth who were supported in accessing gender-affirming care prior to receiving substance use treatment services and, in these cases, their substance use decreased even before beginning substance use interventions.¹¹⁵ Kelly says, “Their distress was lifted as a result of gender-affirming care, resulting in reduced instances of problematic substance use.”

Bright Spot: New Zealand

Youth One Stop Shops (YOSS) include wraparound health and psychosocial services in a single location for teens and adolescents ages 12 to 24. Although services provided vary somewhat based on location, YOSS are typically staffed by specialized nurses, doctors, social workers and youth health workers. They are well-established and regularly evaluated by government. YOSS are managed at the local level and, depending on services offered, receive funding from various sources including HealthNZ. Some are independent NGOs. Gender-affirming health care, as well as mental health and social services for young people with complex health and/or developmental concerns, can be accessed through YOSS. Families may also access supportive services at some YOSS locations.

Avery (see story page 32) was described by their social worker as saying that their main goal was to stabilize their mental health so that they could receive gender-affirming care. It is likely that a component of their mental health instability was coping with their gender incongruity. Another youth was told by their social worker that they would not be provided gender-affirming equipment until they engaged in behaviour modification by decreasing their substance use. And another youth was confused that his gender-affirming medical doctor could not also provide methadone, but instead the youth would need to add a different doctor to his care team.

Youth participants interviewed by SARAVYC reported a shortage of substance use services for young people, with most being targeted at adults and not specialized for 2SLGBTQ+ people. Substance use services should be age-appropriate and de-stigmatize both addiction and 2STNBDG identities. One participant provided an example of how such services should look by referencing an existing program (PRISM Wellness in Victoria):

“They’re all about approaching substance use and HIV and STDs and education from the lens of harm reduction and queer history. And I really think they’re a great lens of showing how our communities are intertwined, both communities of drug users and communities of queer and trans folk.”

— Immigrant, non-binary/gender fluid, third gender

¹¹³Jake Pyne, “Autistic disruptions, trans temporalities: A narrative “trap door” in time,” *South Atlantic Quarterly*, 120 no. 2 (April 2021): 343-361. <https://doi.org/10.1215/00382876-8916088>

¹¹⁴Keuroghlian, “Substance use and treatment of substance use disorders in a community sample of transgender adults.”

¹¹⁵Peak House is a voluntary, 10-week, live-in treatment program for youth experiencing problems with drugs, including alcohol. Peak House “About” n.d. Accessed May 30, 2023. <https://peakhouse.ca/about/>

Some interview participants expressed frustration around the convoluted process of accessing health services and the ways those services are disconnected from each other:

“It needs to be wraparound care ... I know we have a lack of doctors in Canada. But ... I need to walk through the door and immediately be connected to all services that could be impacting me as a trans person. And you can't have me going to 12 different facilities ... It needs to be one place, because youth struggle so much to navigate the system right now.”

— Non-binary/gender fluid, third gender

A Pathway to Hope and Foundry Centres

The Ministry of Mental Health and Addictions (MMHA) was established in 2017 in recognition of the fragmentation and inconsistent delivery and oversight of mental health and addictions services in B.C. In 2019, government released a strategic document setting out a new vision for B.C.'s mental health and addictions care, *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia*. Although *A Pathway to Hope* does not acknowledge 2STNBGD children and youth and their unique care needs, one of the key elements in the plan is the development of Foundry Centres in various B.C. communities. Sixteen Centres and a virtual counselling option have been established, and 12 additional sites will be identified in the fiscal year. The Foundry Centres are primarily hosted by community-based organizations and are described as offering “multiple services in one location” to assist youth between the ages of 12 and 24 and their caregivers to “find someone to talk to, get support from a care provider and connect with friendly experts to help navigate health and social services, resources and programs. All centres deliver free, respectful, non-judgmental, and strength-based services in a youth-friendly space.”

Some youth, RCY Advocates and Analysts have identified specific Foundry Centres as being particularly strong in providing gender-affirming and supportive environments and care. RCY's observation is that there is important learning to be had from these organizations as the new centres are being established.

As the Circle of Advisors noted, there is also a concern that current practices of assessments for medical-affirming care may not be culturally or neurodivergent-inclusive. RCY has seen young people who initially turn away from engaging with BC Children's Hospital's Gender Clinic and it may take more than one attempt for a 2STNBGD youth to engage in readiness assessments. For example, one youth for whom RCY received injury reports was described as having met with the BCCH gender clinic but “did not want to engage in conversation and shut down.” However, he expressed interest again in being connected to gender-affirming supports and asked his social worker to refer him to a youth worker from Foundry and a doctor for a medical assessment.

By doing away with the siloed approach and having wraparound services that address multiple needs – including community and social supports – it is possible to connect young people to additional services which, in turn, makes navigating the health care system much easier. Hand in hand with this approach would be ensuring that health care providers and government care workers are knowledgeable about and respectful of different gender identities, and familiar with gender-affirming care and referral processes.

Youth interviewed for this report described the helpfulness of wraparound care. One participant described a clinic where one of the doctors acknowledged that the participant's struggles with mental

health were due, in part, to their inability to access gender-affirming care. “He got me back on a plan to get me to where I wanted to be on hormones. And he sent out a referral for top surgery for me.” (Non-binary/gender fluid, third gender, 23) Another participant accessed a youth clinic that provided wraparound care with staff who were knowledgeable about gender diversity:

“[The clinic is] for mental health. It’s for physical health. There [are] registered nurses there that can help you out with anything ... it’s very inclusive. They have many outlets of inclusive training and people ... it’s really nice.”

— Trans man, 17

Youth participants reported limited but positive experiences with wraparound care in which they received intersectional care when accessing services that were narrower in scope. One participant recalled that while he was accessing mental health care, “One staff member gave me some of her son’s clothing, which ... was really nice because I didn’t have any guy’s clothing. And I couldn’t go out to buy any.” (Trans man, 23, Metro Vancouver) This participant also expressed gratitude for staff who seemed to know when it was appropriate to bring up his gender identity:

“It wasn’t really mentioned that I was trans, which I appreciate. It’s not the biggest thing about me, and I don’t want that to be the identifier of who I am as a person. Having people kind of know but not always talk about it was really helpful for me.”

A participant described a positive experience they had at a clinic with a harm reduction focus. Due to an acknowledgement of social determinants of health at the clinic, this young person seemed to feel less stigmatized not only for their substance use but also for the other forms of marginalization they experienced in their life: “It was refreshing to see addiction portrayed in a way that was kind of destigmatizing and inclusive. ... [and] to see an environment acknowledging the systemic issues that cause addiction as opposed to labeling addiction as ... ‘you’re a bad person.’” (Non-binary/gender fluid, third gender, 23).

Some participants’ positive experiences with accessing gender-affirming care similarly seemed to rely on the help of one knowledgeable and supportive medical professional, or one person willing to go out of the way to help.

“My psychiatrist was really nice, actually. She was actually the one that diagnosed me with gender dysphoria. She was really kind, really accepting. Everything that I would have needed from a psychiatrist. My counsellor is really, really great with the trans youth in town ‘cause she specifically counsels trans youth. ... She advocates to hell and back for a lot of us, just to make sure that we are receiving the care that we need.”

— Trans man, 17, northern B.C

“After seeing the way I had been treated and denied, [my general practitioner] put himself at risk and liability and became the first gender doctor in our town to prescribe hormones to anyone ... and so he prescribed them to me, and he was extremely careful.”

— Non-binary/gender fluid, third gender

It is clear that the failure of child-serving systems to embrace a whole child approach is a disservice to 2STNBGD youth with multiple diagnoses and/or neurodiversity. These young people deserve an improved system that upholds their rights to express their gender and to wraparound care.

Finding: Culturally relevant wraparound supports are missing for 2STNBGD children and youth and their caregivers

RCY's data show that the most common type of legal arrangement associated with injuries for 2STNBGD young people are the voluntary agreements – VCAs and SNAs. Children and youth on these agreements are more likely to be Indigenous, and there is also a higher number of first- and second-generation immigrants (together totalling 64 per cent). Robinson found that LGBTQ “*youth of color may be more likely to be in congregate care settings, in [residential treatment centres] and in other public settings such as mental hospitals and emergency shelters.*” He goes on to write that “*Systems are often not built to accommodate intersecting identities and experiences, and youth of color who are LGBTQ may be detrimentally impacted, especially in achieving placement permanency, by these systemic shortcomings.*”¹¹⁶

To avoid bringing these youth into care, research shows the need for more culturally relevant supports for caregivers and the youth.¹¹⁷ In addition, the youth who participated in the SARAVYC interviews were very clear about the need for these types of supports. In New Zealand, an assessment tool is used to identify and record the needs and risk factors of young people in care. The gender and sexual identity section of the Identity and Culture Practice Tool considers cultural safety in light of a young person's intersecting identities (e.g., gender diverse and Indigenous), their support network and their medical, social and emotional needs.

Leah, Dame, and Lane argue that nurses – and by extension all clinical workers – can alleviate stress and create cultural safety in health care settings by learning about Indigenous cultures, recognizing the impact of intergenerational trauma from residential schools and practising a trauma-informed

Bright Spot – Western Australia Intersectional Approach to Supporting Gender Diverse Aboriginal, Torres Strait and Culturally and Linguistically Diverse Young People

Western Australia's child protection *Casework Practice* manual offers specific guidance on how best to support the well-being of gender diverse Aboriginal, Torres Strait and culturally and linguistically diverse children and youth in care. The manual explains that intersectional discrimination experienced by gender diverse young people in these communities leads to heightened risks of psychological harm.

The guidance addresses:

- prioritizing connections to allies, role models and cultural supports within young people's cultural communities
- considering sexuality and gender identity when developing care plans and Cultural Support Plans (including the potential impact of engaging with gendered cultural practices, gender-based relationships, knowledge transfer, and safe return to country; and
- consulting with the young person, their family and allies within their community to develop a Cultural Support Plan, including mandatory, recorded consultation with an Aboriginal practice leader or relevant senior Aboriginal officer who is trusted by the young person.

¹¹⁶Brandon Andrew Robinson, “Child welfare systems and LGBTQ youth homelessness: Gender segregation, instability, and intersectionality,” *Child Welfare* 96 no. 2 (2018): 40 <https://www.jstor.org/stable/48624543>

¹¹⁷Peter Gamache and Katherine J. Lazear, “Asset-based approaches for lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit (LGBTQI2-S) youth and families in systems of care,” *FMHI Publications* 1 (Summer 2009). https://digitalcommons.usf.edu/fmhi_pub/1

approach.¹¹⁸ Indigenous Two Spirit and trans participants were clear that positive experiences with mental health and substance use services involved receiving care that was culturally appropriate and/or provided by someone with a similar background/identity.

Two Spirit participants shared their concern about health care providers and foster parents not being aware of what Two Spirit is and recommended an education component for those providing services.

One Two Spirit participant recommended that awareness of one own's biases is really important:

“Be aware of our own implicit biases and recognize that we all have those. And taking the steps to be culturally humble in our responses. And just committing to be present with that individual and connect, I think can really open the door.”

— Two Spirit, 24, Vancouver

Another expressed that understanding of the Indigenous community among service providers is important:

“She knows that addictions are more prevalent in Indigenous communities. But she knows there's reasons for that. She's very – she minored in Indigenous studies or something And so it's really nice when you ... can just talk about a situation. And they're, like, ‘Oh, I understand.’ You really feel heard.”

— Non-binary and Two Spirit, 22, Okanagan

Similarly, other participants expressed the positive experience they had when they were involved in seeing an Indigenous counsellor during high school:

“She's, like, ‘I don't know much about your gender identity. But my son's going through the same thing.’ And they were learning as a parent, but they were also learning to help me as well. So they talked with their son ... read books and went online, help groups. And ... they went with the way of our people, of learning about gender identity through our own people. So it was just done properly, and it felt like they actually were trying.”

— Trans male to female, 23, Fraser Valley

Urban Native Youth Association (UNYA) – 2-Spirit Collective

UNYA supports Indigenous youth by providing a diverse continuum of advocacy, preventative and support services that respond to their immediate and long-term needs. The organization offers more than 20 programs, including the 2-Spirit Collective. The Collective provides support, resources and programming for Indigenous young people ages 15 to 30 who identify as 2-spirit or LGBTQ+ and for those who are questioning their sexual or gender identities.

The 2-Spirit Collective offers non-judgmental, supportive spaces to get together and explore identities. This is done through events, ceremony, workshops and collaboration with other programs, both at UNYA and with other organizations in the community.

The 2-Spirit Collective works to create a positive, inviting space for all 2-Spirit and LGBTQ+ youth across UNYA's programs and services. 2-Spirit and LGBTQ+ resources are available at UNYA and online, providing information on housing, medical information, legal advocacy, community events and updates on what's happening in the 2-Spirit and LGBTQ+ community.

¹¹⁸Leah Carrier, Jessy Dame, and Jennifer Lane, “Two-Spirit identity and Indigenous conceptualization of gender and sexuality: Implications for nursing practice,” *Creative Nursing* 26 no. 2 (May 2020): 96-100. <https://doi.org/10.1891/CRNR-D-19-00091>

The Indigenous youth also expressed the importance of connecting with their own community as one of the recommendations to improve health care and other systems for Two Spirit youth. As one participant said:

“So when you don’t get to participate in your community and you don’t have resources to connect into that community and [for] your needs be met where you’re at as a Two Spirit person, then there’s even less of that kind of foundational wellness for you to have. Which is going to almost automatically lead to other health concerns and mental health issues and many other things.”

— Non-binary, Two Spirit, 22

They also said that they kept dropping out of mental health services and the only thing that helped them was being with an Indigenous counsellor:

“Until I met a counsellor that was Indigenous when I was almost 17 ... And then I started accessing services more frequently because I realized I had a bit more of a choice on who was providing me with counselling ... I had one counsellor who was also mixed race. And so that was really ... that was the counsellor that kind of flipped me on, okay, I’d always been in and out of counselling. But I’ve never enjoyed it or felt like it was really helping me. And then it was the first time that I’d not felt like I’d had to basically justify my existence or my identity because he was just kind of, like, ‘Yeah, no, okay, I get it ... it’s hard being mixed and feeling like —’ Like, that was the first time I had a counsellor that understood trying to feel like you belong to so many different communities and the way that that can affect your identity if you’re not feeling grounded. If you’re not feeling like you know where that community is.”

Youth also shared how connecting with their culture and other 2STNBGD youth in school helped them to thrive, and the loneliness they felt when they did not have that peer support. One participant even attributed their lack of attending group therapy or treatment due to lack of peers:

“But ... I do struggle with attending things, just because I often am both the only queer or visibly queer and brown person in the room. So, there’s just – I’ve had just sometimes poor experiences with ... either racism or transphobia.”

— Non-binary and Two Spirit, 22

In contrast, when a participant had support from other Two Spirit people, or role models, it really helped them to identify with their own identity:

“So, for me I needed to reconnect with the community and culture to feel strength in my own Two Spirit identity. So, seeing someone who was Two Spirit or meeting other people who are Two Spirit, I could talk about things with them I couldn’t talk to other people with. So that was important.”

— Two Spirit, 22, Okanagan

RCY data analysis found instances of Indigenous 2STNBGD children and youth being connected to Indigenous mentors or programs. For example, a group home manager sought out and was provided information about a possible Two Spirit, Métis mentor as well as several culturally relevant Internet resources. Another youth was clear that they did not want to be connected to CYMH but requested cultural supports and was connected to a Two Spirit Elder to discuss their gender identity. Another youth who was struggling with substance use was connected to two Elders to engage in traditional healing (e.g., sweats), and another young person with substance use challenges had a strong connection to an Elder, which led to them agreeing to attend a detox program.

Finding: 2STNBGD children and youth need housing supports that emphasize belonging and safety

Children and youth in care often experience housing instability through multiple placements and through placements that are a poor fit which, ultimately, can lead to feelings of not belonging and to homelessness when they age out of care. These issues are not unique to 2STNBGD young people and have been highlighted in previous RCY reports. In the report *From Marginalized to Magnified: Youth Homelessness Solutions from Those With Lived Expertise*, released in 2020, one youth said:

“Group homes can be unsafe and there are sometimes bad people who can be bad influences. We are trying to find a connection and someone to trust. When you age out, the system pretends like they are helping you but, when you need them, they are nowhere to be seen. We lose all of our supports.”¹¹⁹

Youth also said that in some cases they were re-traumatized, abused and faced oppression and discrimination when they were brought into care.¹²⁰

Through reviewing RCY data, the findings in SARAVYC’s report, the literature reviews and direct engagement with young people, it is clear that the issue of housing supports is key in the lives of all youth in care in B.C. and may be especially amplified among 2STNBGD children and youth.

As noted in the data analysis, the majority of 2STNBGD children and youth in care are living in staffed resources or group homes. As highlighted in RCY’s recent report *Missing: Why are children disappearing from B.C.’s child welfare system?*, released in April, those spaces are not always places that cultivate belonging, which is a specific human need for successful life outcomes. For example, one 2STNBGD young person for whom RCY has received multiple critical injury reports told their social worker that they experienced racist and homophobic statements in the staffed resource they were living. They expressed similar concerns in their next staffed resource and attempted to complete suicide because they did not want to live there. Another youth was often missing from her placement because she feared a youth in the home and instead stayed in women’s shelters.

In some cases, there are no suitable placements for 2STNBGD young people with multiple support needs. Without enough foster homes and residential resources that can provide specialized care, caregivers are told that the child or youth must remain at home or in hospital. For Avery (see story page 32), work had begun to create a suitable placement while they remained in hospital, but this placement was not available before Avery completed suicide. Another young person has stayed in hospital for more than a year because a specialized resource has not been located or developed that can meet their complex needs. In December 2022, their sadness from being hospitalized over the holidays led to significant and reoccurring acts of self-harm.

SARAVYC found that shelters and group homes are often sex-segregated, with trans and non-binary youth placed in male- or female-only spaces based solely on their sex assigned at birth. These placements are justified by staff or service providers as a “safety precaution.” As SARAVYC found, being forced to live in spaces that do not align with gender results in negative experiences for these young people and is particularly challenging for non-binary youth as there is often no alternative to these binary spaces. Research on housing specifically

¹¹⁹Katherine McParland, “From Marginalized to Magnified: Youth Homelessness Solutions from Those with Lived Expertise” (Victoria, B.C.: Office of the Representative for Children and Youth), Feb. 21, 2020. <https://rcybc.ca/wp-content/uploads/2020/02/Final.From-Marginalized-to-Magnified.pdf>

¹²⁰McParland, “From Marginalized to Magnified.”

designed to support LGBTQ2S+ youth shows it can create more of a sense of safety and space where youth can explore their identities and connect with valued peers that may develop into ‘chosen families.’¹²¹

RCY’s Advocacy team found that of the calls about 2STNBDG children and youth received between April 1, 2018 and Dec. 31, 2022, one of the primary concerns was a child’s housing or living arrangement. As noted earlier, calls expressed concerns about: the quality of care a young person was receiving in their group or foster home; a young person wishing to leave or stay at their current placement; and placement instability, including being unhoused.

Housing and all its many facets – how, where or with whom – can impact a young person’s long-term life chances and outcomes. As described on page 37, Robin experienced 20 moves with their family and six disrupted placements while in government care. Newhook et al. found that “*Unstable housing was the most consistent and significant variable associated with barriers to medical and mental health care due to gender identity*” and femme-presenting transgender youth are particularly at risk.¹²²

And yet, despite the risks, some 2STNBDG youth may prefer unstable housing to that offered by child protection agencies. Robin rarely sleeps in the staffed resource they have been assigned, instead mainly accessing shelter supports in

Vancouver’s Downtown Eastside designed to serve women, including trans women and non-binary people. Another young person also preferred accessing women-centred services in the Downtown Eastside. This youth was turned away from some of these preferred services because they were mandated only to serve adults. These spaces, designed to support self-identified women who were often using substances and engaged in survival sex, were preferred spaces to the living arrangements supported by MCFD. In the RCY report *Missing: Why are children disappearing from B.C.’s child welfare system?*, “push and pull” factors are described for why a youth might leave their placement.

Bright Spot – B.C. Encompass Fox House

Encompass Support Services Society is a non-profit agency providing inclusive services in Langley, Aldergrove and Surrey, including family mediation and reunification, youth homelessness and street outreach, supportive youth housing, clinical counselling, parenting support, and health and wellness supports.

In partnership with MCFD, Encompass provides specialized supportive youth homes, including Fox House, a longer-term program for Two Spirit, trans, non-binary, and other gender diverse young people between 12 and 19. Youth staying at this house are connected with programming through Foundry Langley (operated by Encompass) and other community resources including Friends of Dorothy (drop-in program for youth identifying as part of the LGBTQ2S+ community) and primary care delivered by a doctor with a background supporting youth in the LGBTQ2S+ community. Youth also have access to educational and skill-based programming and counselling. Fox House aims to successfully support youth in an inclusive living environment, where staff help youth assess their needs, attain their goals and connect them to appropriate resources.

In 2022, Encompass supported nearly 270 youth across its programming. As Encompass expands services at Foundry Langley, on-site access to gender-affirming care will be added with nurse practitioners and physicians.

¹²¹Alex Abramovich and Lauren Kimura, “Outcomes for youth living in Canada’s first LGBTQ2S transitional housing program,” *Journal of Homosexuality*, 68 no. 8 (July 2021): 1242-1259. <https://doi.org/10.1080/00918369.2019.1696102>

¹²²Elizabeth A. Johns, Harry Jin, Colette L. Auerswald, and Erin C. Wilson, “Sociodemographic factors associated with trans*female youth’s access to health care in the San Francisco Bay area,” *Journal of Adolescent Health*, 61 no. 2, (August 2017): 259-261. <https://doi.org/10.1016/j.jadohealth.2017.02.013>

Push factors are often described by youth who are not living in family-based care.

In the report, RCY raised concerns that:

*“many young people who are placed in staffed homes are not receiving the skilled, quality therapeutic care that they need and are experiencing further trauma and unbelonging. Young people are taking themselves out of these situations and seeking care, nurturance, belonging and often distraction and ‘numbing’ of pain elsewhere.”*¹²³

Pull factors are described as those that draw a youth to leave their placement and find connection elsewhere. This may be due to a desire for connection to family, friends, community and culture.¹²⁴ For Robin and the other youth, they may have felt pushed out of their placements and pulled toward spaces that felt safer and more inclusive.

A research study with 283 sexual and gender minority youth who were unhoused and engaging in survival sex found that *“many spoke about the benefits of living authentically and being able to finally be themselves, something they could not do living at home. Participants also expressed that they developed close connections with people on the street. These individuals provided support and protection [...] that were lacking in their family environments or particular social service agencies.”*¹²⁵ Similarly, SARAVYC’s literature review found that *“Despite the risks, some trans and nonbinary youth choose to live on the streets rather than live at home, in government care, or in a shelter due to the amount of transphobic violence and harassment they face in those settings [...] and research conducted in the U.S.A. has shown that street-involvement can allow youth to develop a sense of community with other street-involved trans and nonbinary individuals of all ages.”* (p.30)

It is crucial that an environment is created where housing and the issues of belonging and safety are prioritized for 2STNBGD youth so that they do not feel the need to seek out places of belonging that may be more dangerous.

Interview participants spoke of experiencing transphobia and non-supportive caregivers in their placements, and suggested RCY recommendations about housing for youth in care, including creating more spaces for 2STNBGD youth in group homes, unannounced visits by the social worker to the foster parents’ home as a quality-of-care check, and ensuring caregivers are knowledgeable about gender diversity and supportive.

“When it comes to the foster system, probably have more rooms for transgender youth because one room, out of let’s say 10 or 12 rooms, that’s not really proportioned to how many transgender people [there] are.”

— Non-binary young person, 21

¹²³Representative for Children and Youth, *Missing: Why are children disappearing from B.C.’s child welfare system?*, p. 19.

¹²⁴Representative for Children and Youth, *Missing: Why are children disappearing from B.C.’s child welfare system?*

¹²⁵Edward J Alessi, Brett Greenfield, Dean Manning, Meredith Dank, “Victimization and resilience among sexual and gender minority homeless youth engaging in survival sex,” *Journal of Interpersonal Violence* 36 no. 23-24 (December 2021): 11236-11259. <https://doi.org/10.1177/0886260519898434>

“For those who come to MCFD with a hope of having a home-like feeling and feeling safe with them, they should be able to talk about their gender identity with them ... and have them be progressive with it so that we do not spread hate within those types of areas. It would be very important to the youth who grew up around unsupporting parents and peers.”

— Gender-questioning, 18, northern B.C.

On the other hand, one participant who had been in foster care described what it was like to feel safe. This youth had been placed with a family who had experience caring for trans youth and explained that knowing *“the family had interacted with trans people and knew how to do that ... was really nice.”* (Trans man, 23) Through this knowledge and experience, the foster family seemed to be able to create a welcoming environment for and build connections with the gender diverse youth in their care. Abramovich and Kimura argue that *“an LGBTQ2S competent trauma-informed approach should be integrated into all aspects of mental health support in youth housing programs.”*¹²⁶

One bright spot that B.C. could consider is a program that the government of New South Wales, Australia funds. This is a housing and case management program that provides independent transitional housing with case management for young people ages 17 to 25 and case management for those ages 12 to 25. Case management includes: advocacy; gender-affirming care referrals; assistance with finding and maintaining housing; support to stay in school or begin studies; financial and life skills building; legal assistance; and mental health and primary care support.

Finding: Limited B.C. government policies exist to specifically support 2STNBGD children and youth and their caregivers

As indicated by the data and research compiled and reviewed for this report, B.C.’s 2STNBGD children and youth who become involved in the child-serving systems need supports and recognition that they are not currently receiving. A comprehensive review of publicly available policy and programming at the provincial ministry and regional health authority levels in B.C. found that little information is available in the public domain that relates specifically to supporting 2STNBGD children and youth.

Areas reviewed included child welfare, health services, substance use services, mental health services and education. Most programs supporting 2STNBGD children and youth and their caregivers are provided by community-based non-profit organizations, which may or may not receive government funding. The policy and program review did not look at non-government entities.

With respect to ministry-level policy, only MCFD has a published policy relating specifically to *“gender identity, gender expression and sexual orientation”* that is specific to youth, and the Ministry of Education and Child Care has a high-level policy on diversity in schools, referring to *“sexual orientation, gender identity and expression.”*¹²⁷ Across all policy, standards and guidelines at MCFD, there appears to be consensus that relevant and affirming care must be provided for gender diverse youth. However, some ministry program areas provide more direction than others. In some cases, there is reference made

¹²⁶Abramovich “Outcomes for youth living in Canada’s first LGBTQ2S transitional housing program.”

¹²⁷Sexual orientation refers to terms such as lesbian, gay, straight, and queer which are based on patterns of emotional, romantic, and/or sexual attraction to groups of people. Sexual orientation terms are commonly (but not always) defined by the gender(s) of the people that the individual is attracted to. Sexual orientation also refers to a person’s sense of identity based on those attractions, related behaviors, and membership in a community of others who share those attractions; for example, pansexual, bisexual, heterosexual.

to gender diverse youth more generally, but policies and standards do not appear to provide specific information on how to best serve and/or support youth who identify as gender diverse. (See Appendix 3 for a summary of MCFD policy and practices.)

Changes in practice and form development have important ripple effects into how data for 2STNBDG youth is collected, interpreted and communicated across ministries. RCY's data analysis identified that limitations in how gender identity is captured in forms impacts the effectiveness and nuance of gender identity at an aggregate level. When the forms intended to capture children's and youth's experiences as written by social workers and other child-serving workers are limited to a single-variable box or opt-in responses, there is a high risk of information being left out of important aggregate reviews to help better inform practice and systemic change.

Provincial and regional health authorities' current service plans indicate that adoption of a "*Gender-Based Analysis Plus*" lens is a key priority, however there are no references to gender diverse youth, specifically. Similarly, the First Nations Health Authority and regional health authorities have equity, diversity and inclusion portfolios, but information, tools and resources provided online are not specific to gender diverse youth. Island Health and Vancouver Coastal Health provide minimal programming that pays attention to gender identity, but participation is not limited to gender diverse youth. The PHSA is where most of the work to support gender diverse youth is seen, primarily with Trans Care BC and the Gender Clinic at BCCH. Without specific policies and robust programs that target supports for 2STNBDG children and youth in B.C., these young people will continue to be more likely to suffer harms and are less likely to reach their full potential.

In addition to the review of available B.C. policies and programs, *The Standards of Care for the Health of Transgender and Gender Diverse People Version 8 (SOC-8)*, developed by the World Professional Association for Transgender Health, was also reviewed. *SOC-8* was published in 2022 and replaced *SOC-7*, published in 2011. Key changes in the newer version include "*advances in clinical knowledge and appreciation of the many health care issues that can arise for transgender and gender diverse people beyond hormone therapy and surgery ... and move to gender-affirming care for the whole person,*" as stated in the document. Of note in *SOC-8*, the guidance related to adolescents and children has been significantly revised and enhanced, in recognition that "*this age group has unique developmental and gender-affirming care issues.*"¹²⁸

It is worth noting that in California, the state government's role is almost entirely policy-focused. Legislation ensures that the rights of gender diverse children and young people are upheld, and also guides the provision of programs and services. There is a long history of protective legislation in California, with some Acts established in the early 2000s.¹²⁹ The Representative would like to see B.C. – and, indeed, Canada – move in a similar direction to promote equity and human rights for 2STNBDG children and youth.

¹²⁸Eli Coleman, et al., "Standards of care for the health of transgender and gender diverse people, Version 8," *International Journal of Transgender Health* 23 suppl. 1 (September 2022): S1-S259, pp. 58-59. <https://doi.org/10.1080/126895269.2022.2100644>

¹²⁹A list of legislation pertaining to LGBTQ youth in California is available from the California Judicial Branch website: California Courts, "*Laus and Policies Protecting LGBTQ Youth from Discrimination,*" California: California Courts, the judicial branch of California, Feb. 27, 2022. <https://www.courts.ca.gov/documents/BTB25-5I-03.pdf> Accessed May 31, 2023.

Finding: Geographic location matters when it comes to accessing gender-affirming services

The review of available gender-affirming services in B.C. and anecdotes from the young people interviewed make it clear that where a person lives in the province matters if they hope to access these services. The inaccessibility of information, convoluted processes of applying for or getting a referral and, in some cases, lack of gender-affirming services in a particular geographic region negatively impact a youth's pathway to transitioning with support and can lead young people to seek out unsafe forms of care (e.g., unsafe chest binding practices, unsupervised hormone access and usage).¹³⁰

More than 10 per cent of B.C.'s population lives in rural communities. B.C.'s rural population is considered distinctly remote with many communities identifying as Indigenous.¹³¹ RCY's data analysis identified more than 40 2STNBDG youth who are connected to SDAs that support rural communities in North Central and Thompson Caribou Shuswap. SARAVYC's literature review found that *“geographic factors, such as distance from urban centres, can make finding specialized gender-affirming care difficult”* (p. 12). These challenges can be further exacerbated by concerns about confidentiality in small communities.¹³² On the other hand, the high cost of living in urban areas of B.C. can make it difficult for 2STNBDG youth to remain in areas where more gender-affirming services are available. SARAVYC suggests that access to telehealth and online health interventions can mitigate some of these geographic constraints.

Many youth interviewed had difficulties when navigating the health care system, especially when it came to gender-affirming care. Some participants described spending a lot of time and energy searching for care, only to be rejected by unsupportive general practitioners or denied access due to their geographic location. For one youth in northern B.C., even after being connected to services following many months on a wait-list, transportation remained a critical issue in connecting him to a gender clinic that could support his medical transition. One young person emphasized the importance of improving access to safe gender-affirming services provided by professionals:

“[Making] things more accessible can really help so many people. Not only [to] be who they are and feel comfortable and help boost their mood and gender euphoria and bring down a lot of the depression and fear a lot of us have.¹³³ But it can also help eliminate the danger of finding other ways to cope with it [like] dangerous binding methods that leave a lot of us with bruised ribs and lung issues or [buying] knock-off estrogen and testosterone online. It is another way to help save trans lives.”

— Transmasculine non-binary, 20, northern B.C

¹³⁰Binding is a practice of compressing one's chest to create a more androgynous or masculine appearance.

¹³¹Statistics Canada, “Population growth in Canada's rural areas, 2016 to 2021,” Ontario: Canada, Feb. 9, 2022.

<https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021002/98-200-x2021002-eng.cfm>

¹³²Carmen H Logie, Candice L. Lys, Lisa Dias, Nicole Schott, Makenzie R. Zouboules, Nancy MacNeill, Kayley Mackay, “Automatic assumption of your gender, sexuality and sexual practices is also discrimination’: Exploring sexual healthcare experiences and recommendations among sexually and gender diverse persons in Arctic Canada,” *Health and Social Care in the Community* 27 no. 5 (September 2019): 1204-1213. <https://doi.org/10.1111/hsc.12757>

¹³³Gender euphoria is the term used to describe the feeling of joy brought on by gender-affirming experiences, such as new clothing, name change, pronoun use, or seeing media representation that aligns with how one sees themselves. Definition from: QMUNITY's 2022 Queer Glossary, https://qmunity.ca/wp-content/uploads/2023/01/Queer-Glossary_2022_Digital.pdf

Providing 2STNBGD youth easy access to gender-affirming services could ensure their physical safety and improve their mental health. Consideration and thought should be given to a number of flexible options to providing accessible sources of gender-affirming care (e.g., clinics, mobile doctor's offices, online referrals), as this care should be available regardless of whether youth live in urban, suburban or rural areas. As one youth said:

"I wish that there were more trans-friendly doctors around, especially gynecologists ... 'Cause for trans men it's really hard to find a trans-friendly gynecologist in northern B.C. 'cause they just don't exist. And whenever they are here, they're never here for very long. They usually move away after a couple of months. So, it's hard to access that kind of care ... we're often left in the hands of uneducated medical professionals. And it makes it really difficult and uncomfortable to access [that kind] of care."

— Trans man

Bright Spot – B.C. Northern Gender Health Clinic – Blue Pine Clinic

The Northern Gender Health Clinic at Prince George's Blue Pine Clinic provides specialized health care to trans clients who live in the Northern Health region. These services are provided by a team that includes physicians, nurse practitioners, nurses, social workers, mental health clinicians and pharmacists. To support the assessment and transition process, the Northern Gender Health Clinic also collaborates with pediatricians and mental health professionals.

Services provided by the clinic include: hormone readiness assessment; hormone therapy; education and support for primary care providers (focus on out-of-town patients); referrals for surgical readiness assessments; and counselling for trans youth, adults and their families. The clinic can support children and youth of any age to coordinate appropriate referrals to specialized mental health clinicians and pediatric endocrinologists.

Recommendations

An Urgent Call to Action for Public Commitment from the B.C. Government

This report lays out a clear rationale for B.C. to make a public commitment to ensure that the rights of 2STNBGD children and youth are upheld – that they are free from discrimination and stigma, are safe and cared for, and have access to the services and supports that they need to thrive and experience belonging.

This call to action is presented in the context of recent evidence of an increase in hate speech and harms toward – and political and societal discrimination against – trans and other gender diverse children and youth in Canada and around the world.^{134,135,136,137}

To support this vision, the Representative recommends:

1. That the Ministry of Attorney General identify opportunities to enhance legislative and/or regulatory protections for 2STNBGD children and youth to address disinformation and discrimination and lead the drafting and passage of these protections.

The Attorney General to examine the need for legislative and/or regulatory changes by March 31, 2024 and enact required changes by March 31, 2025.

The Representative calls on all ministries with mandates that support the well-being of children, youth and their families/caregivers to address issues of service silos and to ensure that 2STNBGD children and youth are affirmed and supported through coordinated care and support.

Therefore, the Representative recommends:

2. That the Ministry of Health take lead responsibility for the ongoing design and implementation of a cross-government commitment to gender-affirming care by:
 - a. guiding a cross-ministry and partner structure and process that involves, at a minimum, the ministries of Education and Child Care, Children and Family Development, Mental Health and Addictions, all five regional health authorities, the First Nations Health Authority, the Provincial Health Services Authority (including BC Children’s Hospital Gender Clinic and Trans Care BC) and other community and public partners.

The Ministry of Health to establish appropriate structures and processes by Oct. 31, 2023.

¹³⁴Human Rights Commissioner “*From hate to hope: Report of the Inquiry into hate in the COVID-19 pandemic*,” (Victoria B.C.: British Columbia’s Office of the Human Rights Commissioner), March 2023.

¹³⁵Regional Overview United States & Canada January 2023, “United States: Anti-LGBT+ events continue to see high involvement of far-right militias and militant social movements,” The Armed Conflict Location & Event Data Project, Feb. 3, 2023. <https://acleddata.com/2023/02/03/regional-overview-united-states-canada-january-2023/>

¹³⁶The European Region of the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA-Europe) found that 2022 was the most violent year for LGBTQI+ people across 54 countries in Europe and Central Asia. Similar rises in violence and hate were also found in North America in 2022. See: ILGA-Europe’s Annual Review Team, “Annual Review of the Human Rights Situation of Lesbian, Gay, Bisexual, Trans and Intersex People in Europe and Central Asia,” ILGA-Europe, 2023. <https://www.ilga-europe.org/report/annual-review-2023/>

¹³⁷Killian Kinney, Taylor E. Pearson, Julie Ralston Aoki, “Improving ‘Life Chances’: Surveying the Anti-Transgender Backlash, and Offering a Transgender Equity Impact Assessment Tool for Policy Analysis,” *Journal of Law, Medicine & Ethics*, (2022) 50, no. 3, (Fall 2022): 489-508. <https://doi.org/10.1017/jme.2022.89>

- b. consistent with ministerial commitments, forming a set of principles – including trauma awareness, cultural safety and relevance, equitable and inclusive access across the province, and intersectional service provision – that will guide a coordinated approach across ministries as they create action plans for gender-affirming care for 2STNBGD children, youth and their families.

Ministry of Health to confirm a set of principles by Feb. 29, 2024.

3. The ministries of Health, Education and Child Care, and Mental Health and Addictions, establish action plans and timelines for the incorporation of these principles into their policies, education/training protocols and materials, practice guidelines and parental/familial/peer support services.

Ministries to present action plans to RCY by June 30, 2024.

4. Respecting the findings in this report and given the evidence of the connection between gender-affirming care and positive mental health, that the Ministry of Mental Health and Addictions review the service delivery linkages and mental health and substance use service access needs of 2STNBGD children, youth and their families to ensure that the upcoming revision to the action plan for *A Pathway to Hope* incorporates new plans, guidance or protocols.

Ministry of Mental Health and Addictions to update its action plan by March 31, 2024.

A Specific Call to Action for MCFD

The Ministry of Children and Family Development has legislative responsibilities for the safety and well-being of children and youth in receipt of designated services, and the Representative is therefore making the following specific recommendations to MCFD. The Representative first wants to acknowledge the changes currently occurring in Children and Youth with Support Needs, Youth Transitions, Family Preservation, and Specialized Homes and Support Services transformation projects. The findings in this report need to be considered as these transformative frameworks are finalized.

Current policies and practice guidelines for gender diverse children and youth are neither sufficient nor consistent across MCFD service lines. The research along with the voices of 2STNBGD children and youth in this report urgently call upon MCFD to ensure that staff are trained and supported to deliver quality services that are timely, culturally safe and relevant, inclusive and equitably accessible in every Service Delivery Area.

The Representative therefore recommends the following:

5. That MCFD establish an action plan and timelines for the incorporation of the principles developed under the leadership of the Ministry of Health into its procurement, policies, education/training protocols and materials, practice guidelines and parental/familial/peer support services, across all service lines, ensuring staff feel knowledgeable and capable in providing gender-affirming care to 2STNBGD children and their families.

MCFD to create action plan and timelines by June 30, 2024.

6. That MCFD create a minimum of two provincial positions to provide specialized practice consultation and support to MCFD staff, caregivers and out-of-care care providers involved in the care of 2STNBGD children and youth.

MCFD to create positions by April 30, 2024 and fill these positions by Sept. 30, 2024.

7. That MCFD provide foster parents with the supports and specific training they need to provide gender-affirming care for the 2STNBGD children and youth in their care. These supports and training opportunities to be made available to out-of-care providers and adoptive parents.

MCFD to develop supports and training by Dec. 31, 2024 and implement supports and training by June 30, 2025.

8. That MCFD ensures all residential resource contracts for staffed resources include requirements for policies that are specific to gender-affirming care. Contracts to include terms that require mandatory training to ensure that staff provide appropriate care that protects 2STNBGD children and youth from discrimination in the resource and ensures their safety.

MCFD to complete contract updates and improvements by March 31, 2024.

TRANS, NONBINARY AND TWO SPIRIT YOUNG PEOPLE'S EXPERIENCES OF GOVERNMENT CARE AND HEALTH SERVICES IN BC



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Stigma and Resilience
Among Vulnerable
Youth Centre



THE UNIVERSITY
OF BRITISH COLUMBIA

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Introduction

The Stigma and Resilience Among Vulnerable Youth Centre (SARAVYC) was tasked by the Office of the Representative for Children & Youth (RCY) to investigate the experiences and needs of transgender (trans) and nonbinary youth in BC and produce a report summarizing these findings. As part of this work, we conducted two literature reviews, each focused on a key topic:

1. The mental health and substance use-related needs and access to care of trans and nonbinary youth in general
2. The experiences and needs of trans and nonbinary youth who have experienced housing instability or government care.

We also conducted a series of analyses using data from the 2019 Canadian Trans Youth Health Survey (CTYHS), and the 2018 BC Adolescent Health Survey (BCAHS) to augment the findings from these two literature reviews. Funded by the Canadian Institutes for Health Research, the CTYHS was conducted in 2014 as the first large-scale national survey of trans and nonbinary youth in Canada and involved 923 youth between the ages 14 to 25 from nearly all provinces and territories. The CTYHS includes a range of questions about youths' home and school life, physical and mental health, access to health care, and gender identity. The survey was updated and repeated in 2019, where it was completed by another 1,519 trans and nonbinary youth across Canada. The BCAHS, developed and distributed by McCreary Centre Society, is a population-based survey administered to adolescents in grades 7 to 12 (ages 12 to 19) in public schools across BC. It contains similar questions to the CTYHS about home and school life, health and risk exposures, but as a general school health survey, it does not include the same detailed focus on specific issues for trans and nonbinary young people. When the survey was administered in 2018, it was completed by more than 38,000 youth, with 1000+ students indicating they were trans, non-binary, or questioning their gender, and these were the focus of our analyses.

Two Spirit Indigenous young people may also be included among trans and nonbinary youth in BC, although the term does not fit precisely with Western concepts of gender diversity or sexual minority orientations and can include either or both. We found very little published literature about their experiences. Therefore, guided by consultation with our longstanding SARAVYC Two Spirit Advisory, we worked with an Indigenous research associate from McCreary Centre Society to conduct separate analyses focused on the Two Spirit youth in the BCAHS. We also conducted interviews with 6 Indigenous Two Spirit and gender diverse young people who are or had been in government care or accessed mental health or substance use services in BC, to learn deeper insights about their experiences.

This report summarizes the information from the two literature reviews and the survey data analyses about trans, nonbinary, and Two Spirit youth, and includes quotes from our interviews with gender diverse and Two Spirit young people.

Terminology Used in this Report

This is a field in which terminology can shift rapidly; terms viewed as acceptable at one time may be seen as offensive just a few years later (e.g., “transsexualism”). Terms can also differ not only over time but also across generations (e.g., usage of terms like “queer”), geographically, and within and across populations and subcultures. We have chosen to use “trans and nonbinary” to include a wide array of identities that are held among Canadian youth who are not cisgender. See Table 1 for how we defined these and other key terms for this review.

Table 1 - Definition of Terms

<i>Term</i>	<i>Definition</i>
trans(gender)	Anyone who has a binary gender identity (e.g., boy/man, girl/woman) that is different from the social gender associated with their sex assigned at birth OR anyone who has a nonbinary gender identity and identifies as transgender
cisgender	Anyone who has a binary gender identity (boy/man, girl/woman) that is aligned with the sex they were assigned at birth.
nonbinary	Anyone who has a gender identity that is not exclusively boy/man or girl/woman. Examples include, but are not limited to: nonbinary, genderqueer, genderfluid, agender (without gender), and neutrois.
Two Spirit	A term coined by Indigenous 2SLGBTQ+ leaders for Indigenous people who embody diverse sexualities, gender identities, roles and/or expressions
youth	In BC: someone under the age of 19 years old.
gender-affirming services	Services that help affirm one’s gender identity, usually by facilitating recognition of one’s gender by others. Includes gender-affirming healthcare as well as legal and social gender affirmation (e.g., changing one’s name or gender marker on identifying documents such as ID cards, birth certificates, etc.)

<i>Term</i>	<i>Definition</i>
gender-affirming healthcare	<p>Healthcare that is specific to gender affirmation. Examples include: puberty blockers, hormone therapy, and surgeries such as facial feminization surgery, “top” surgery (e.g., mastectomy, breast augmentation), and “bottom” surgery (e.g., vaginoplasty, phalloplasty). This can also include counseling related to gender.</p> <p>[Note: this may also be called “gender confirming care,” “gender specialty care,” or other similar terms.]</p>
gender-competent healthcare	<p>Healthcare that is not necessarily specific to gender affirmation but that is welcoming and safe for trans and nonbinary people. Examples include: primary care providers who use their patients’ affirmed names and pronouns and do not assume that any medical problem is the result of being trans.</p>
government care	<p>Includes involvement with child protective services; living in government housing (including foster homes, group homes, and transitional housing); or incarceration/juvenile detention.</p>
street involvement	<p>Includes any form of housing instability, including living in a squat, one’s car, the street, or a shelter as well as experiences of being housed but financially unstable and/or retaining connections to the streets (e.g., engaged in survival sex or drug dealing).</p>
unstably housed/ experiencing housing instability	<p>Lacking stable living conditions, often due to financial instability or other reasons. Includes being street-involved/homeless, relying on the shelter system, and/or struggling to remain housed as a result of financial difficulties</p>
resilience	<p>There are various definitions for this term, including a more individualized concept, the “ability to “do well in the face of pain and/or adversity” (Asakura, 2019), as well as process or environmental concepts, i.e., resilience as supportive relationships or environments that help people experiencing adversity or trauma to survive and thrive (Masten & Cichetti, 2016)</p>

Methods

Literature Reviews

We conducted two literature reviews that focused on different but related topics:

- Review 1: mental health and substance use needs and access to related health care among trans and nonbinary youth in general.
- Review 2: trans and nonbinary youth in government care.

The original target population for both reviews was trans and nonbinary youth under the age of 19 years in British Columbia. Two Spirit youth were also included, though we acknowledge that the term Two Spirit is not strictly a description of gender identity alone and can encompass sexuality and other culturally specific identities, attributes, and/or roles in one's community.

A brief preliminary search yielded few BC-specific studies; therefore, we expanded both reviews to include trans and nonbinary youth from across Canada. Studies that included young adults 19 years of age or older (up to 29 years) were also included, as long as they were focused on participants' experiences either a) during adolescence (rather than early childhood) or b) as they aged out of government care. For Review 2, due to the narrow focus of the topic and the limited research, studies conducted in the USA were also included.

Because this is a rapidly changing field, the reviews were limited to studies conducted within the past 5 years (Review 1) or 10 years (Review 2). The time frame was expanded for Review 2 due to a smaller amount of research in this area.

Survey Data Analyses

Analyses were conducted using data from the 2019 CTYHS and the 2018 BC AHS which compared trans and nonbinary youth who have experienced government care¹ to a) cisgender youth who have also experienced care and b) trans and nonbinary youth who have never experienced government care. Similar analyses were conducted using 2018 BC AHS data which compared Two Spirit youth who had been in government care to a) Two Spirit youth who had never been in care and b) Indigenous youth who had experienced government care but were not Two Spirit. Only youth under the age of 19 were included in the analyses.

Youth Interviews

Although thematic analysis of the interviews was provided to the Office of the Representative for Children Youth for their main report, some quotes from those interviews are included in this report where they reflect the findings or recommendations.

1 For the BC AHS, this includes foster care, custody centres, and youth agreements; for the CTYHS, this includes foster homes, group homes, and staying in custody care.

Results

Review 1: Mental Health and Substance Use Needs and Access to Care

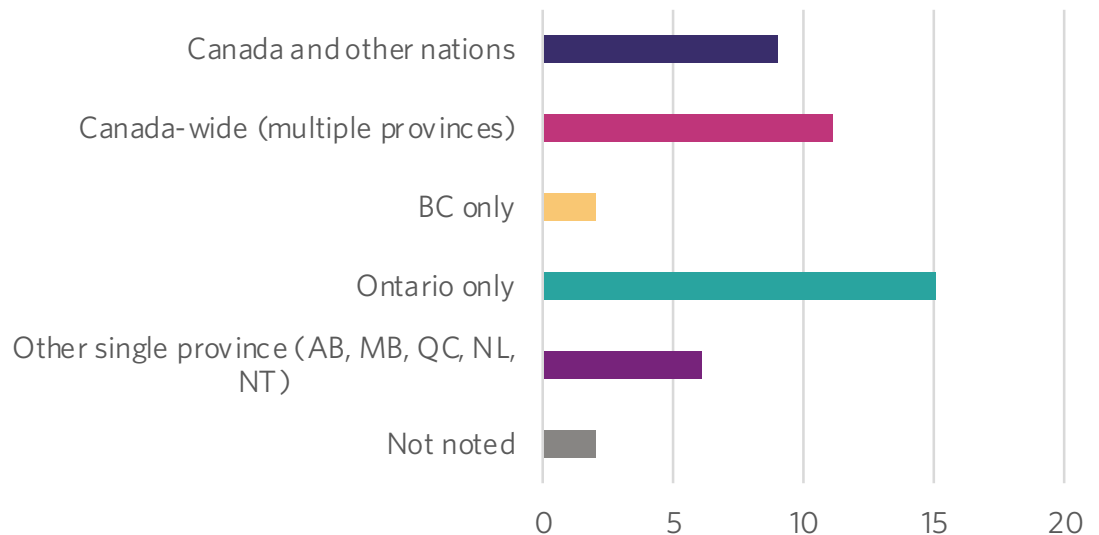
Study Characteristics

Literature Review: Overview

Of 310 studies reviewed, 45 studies (19 quantitative, 17 qualitative, 9 mixed-methods) were included in this review. All studies included at least some Canadian trans and nonbinary youth. Most study participants lived in or near major urban centres, particularly Toronto, Montreal, and Vancouver. While

relatively few studies were conducted exclusively in BC, British Columbian trans and non-binary youth were well represented in the studies that drew on nationwide samples (e.g., the CTYHS, from which nearly 1 in 4 participants were from BC). The figure (right) offers a detailed breakdown of the regions in Canada for all studies.

Study Locations for Review 1



Roughly half (22) of the studies included only youth under the age of 19 years old; the others included youth or young adults up to a maximum of 29 years of age. Many youth

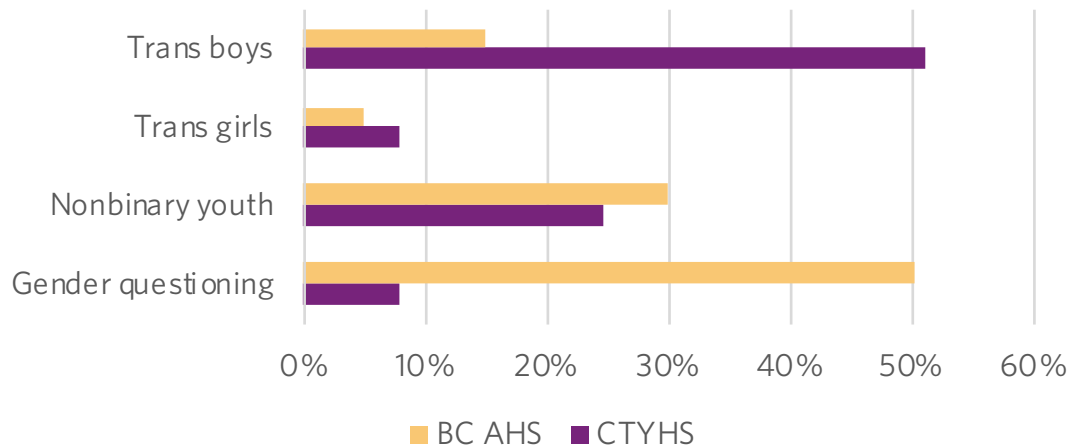
participants were recruited through gender specialty clinics, online via social media, or through community organizations or outreach programs serving trans and non-binary youth. While some studies included cisgender heterosexual youth as a comparison group, most were comprised exclusively of trans and non-binary youth or 2SLGBTQ+ youth; see figure (left) for details.

Gender Identity and Sexual Orientation of Participants for Review 1 Studies



CTYHS and BC AHS Results: Demographics of trans and nonbinary and questioning youth

BC AHS vs. CTYHS: Gender Minority and Questioning Youth



Trans and nonbinary youth under age 19 comprised 565 participants in the CTYHS and 935 in the BC AHS. The CTYHS included predominantly trans boys and nonbinary youth (76% total), with trans girls and gender-questioning youth comprising the remaining quarter. The BC AHS also had relatively few trans girls, and had a much greater proportion than the CTYHS of questioning youth who made up half of all youth in the sample who did not identify as cisgender. See the bar chart (above) for details.

About one-third of trans and nonbinary youth in the BCAHS identified exclusively as white, with over half identifying as a person of colour (POC), whereas most trans and nonbinary youth in the CTYHS identified exclusively as white (77%), with only 23% identifying as POC. About one-quarter (23%) of the trans and nonbinary youth who participated in the CTYHS were living in BC. Another 20% were from ON, 27% from the Prairies (AB, SK, and MB), 12% from QC, and about 18% from the Atlantic Provinces (NL, NB, NS, and PEI) with <1% from the territories

General State of Mental Health of Trans and Nonbinary Youth

Compared to their cisgender counterparts, Canadian trans and nonbinary youth have experienced more negative mental health outcomes, including but not limited to: anxiety, depression, suicidal ideation and suicide attempts, self-harm, and disordered eating (Veale et al., 2017b; Watson et al., 2017). A nationwide study of Canadian trans and nonbinary youth found that “mental health problems were highly prevalent among the sample, with almost three-quarters reporting non-suicidal self-injury in the past year, over one-third having attempted suicide in the past year, and 45% and 28% reporting extreme stress and despair in the past 30 days, respectively” (Veale et al., 2017a, p. 212).

There was some limited evidence that, among trans and nonbinary youth, there may be differences by gender identity for certain mental health outcomes. One study found that trans and nonbinary youth who had been assigned female at birth showed more symptoms of internalizing disorders (like anxiety or depression) than those who had been assigned male (Buttazzoni et al., 2021). Another found that trans boys/men reported fewer instances of vomiting to lose weight compared to nonbinary youth (Watson et al., 2017). A nationwide survey of trans youth in 2014 found that transgender boys/men and nonbinary youth were most likely to report self-harm (Veale et al., 2017b). However, another found no differences in diagnosed mental health conditions between TGE youth assigned female at birth vs. assigned male at birth who were seeking gender-affirming care (She et al., 2020). Few studies have examined these subgroup differences, possibly because of sample size limitations.

Impact of Stigma and Discrimination on Mental Health for Trans and Nonbinary Youth

Across Canada, trans and nonbinary youth with more experiences of enacted stigma experienced worse mental health than trans and nonbinary youth with fewer such experiences (Veale et al., 2017; Veale et al., 2017a). One study found that enacted stigma experiences were positively associated with disordered eating behaviors (binge eating, fasting, and vomiting to lose weight) for 14 to 18 year old trans and nonbinary youth (Watson et al., 2017).

"A lot of times it [request to use affirmed name/pronouns] was met with a sigh and an eye roll, which doesn't help when you're in there already feeling suicidal and shitty."

-nonbinary trans masc, 20 years old,
Northern BC

Being misgendered (being referred to by the wrong gender pronouns) was described by youth in qualitative studies as a highly stressful and frequent experience that contributed to poor mental health. Fear of misgendering or anti-trans prejudice was linked to avoidance of medical care and to missing school (Heard, 2018; Asakura, 2019).

Resilience and Adaptive Coping

Most trans and nonbinary youth demonstrate aspects of resilience despite facing stigma and discrimination across multiple domains (e.g., family, community, societal). While most research is still focused on negative outcomes, some common themes were found across the relatively few articles that measured positive aspects of trans and nonbinary youths' development.

One study that was focused exclusively on resilience (Asakura, 2017) found the following examples of ways trans and nonbinary youth demonstrated resilience:

- ensuring personal safety (e.g., leaving an abusive home);
- asserting their personal agency (e.g., insisting on use of affirming pronouns);
- cultivating meaningful relationships (e.g., finding supportive teachers);
- “un-silencing LGBTQ” by speaking out against bigotry and refusing to internalize negative messages about their gender identities; and
- Finding collective power with other LGBTQ2S people.

“It’s more than just name and pronouns. I want you to see me differently than you do before.”

-trans man, 17 years old,
Fraser Valley

A study with trans and nonbinary youth in Quebec found that these youth engaged in two main resilience strategies: affirmation strategies (such as educating others and raising awareness) and survival strategies (such as avoidance of potentially dangerous people or situations or “passing” as cisgender) (Pullen Sansfaçon et al., 2021a). This echoed the findings in the Asakura 2017 study as well as a finding in another study in which trans and nonbinary youth reported “performing” – pretending to be cisgender and/or behaving in stereotypically “male” or “female” ways – to access needed resources such as housing or medical care (James, 2021).

Another study focused exclusively on how LGBTQ2S youth coped with online negativity (Craig et al., 2020a), finding that youth used multiple strategies that demonstrated resilience, such as using platform features to block or report negative comments, educating people about LGBTQ2S issues, and redirecting their attention to other sites or activities.

One study noted that some trans and nonbinary youth are forced to learn resilience and coping strategies due to marginalization on other axes, such as citizenship status or racialization, and employ those strategies as they navigate systems that are not gender-affirming; for example, a first-generation Asian-Canadian youth described the ways that he had advocated for his parents, who did not speak English (Asakura, 2017).

Some studies highlighted some effective resilience strategies chosen by trans and nonbinary youth that may be labelled by others as “maladaptive” when not understood in the context of the often-hostile environments that trans and nonbinary youth must navigate. For example, one such youth described threatening suicide to escape an unsafe living situation temporarily, knowing she would be taken to a secure facility for evaluation and kept for at least one night

(Asakura, 2019). Some trans and nonbinary youth may avoid necessary medical or mental health care because their prior experiences of healthcare settings have been ones in which they experienced hostility and discrimination (Clark et al., 2018b). In schools, trans and nonbinary youth described walking out of unaffirming classrooms rather than risk the mental health consequences of being constantly misgendered by teachers and peers (Asakura, 2019).

Protective factors that foster resilience processes among Canadian trans and nonbinary youth include:

- access to “safer spaces,” like school-based Gender and Sexuality Alliances (GSAs) or online spaces in which they can safely express their gender identities (Asakura, 2017; Asakura, 2019);
- adult support and mentorship (e.g., a teacher who followed a trans and nonbinary youth on their walk to the local high school to be sure they were not harassed by peers (Asakura, 2019));
- supportive families or family connectedness (Veale et al., 2017a; Asakura, 2019)
- school connectedness, or school belonging and caring teachers (Veale et al., 2017a; Travers et al., 2020)
- peer support and lack of peer antagonism (Travers et al., 2020);
- access to factual information about other LGBTQ2S people (Austin et al., 2020);
- access to “queer literature” - being able to see people like themselves in books and magazines is associated with better mental health among trans and nonbinary youth and may have implications for school and local libraries (Asakura, 2017);
- rejecting the internalization of negative attitudes about trans and nonbinary people (James, 2021; Veale et al., 2017a);
- being able to “give back” and help other LGBTQ2S youth (e.g., by providing information and resources, advocacy efforts, and/or through research participation) (Austin et al., 2020; Travers et al., 2021);
- ability to make changes to legal documents (Asakura, 2017);
- access to “wealth, stable housing, and food security” (Travers et al., 2021).

“I wouldn’t change anything [despite losing friends and family] because I do now have wonderful friends who support me, and I built my own family because of it.”

-transmasc, 20 years old,
Northern BC

Gender-affirming Medical Care as Mental Health Care

Access to gender-affirming medical care was found to be associated with decreased negative mental health outcomes (e.g. self-harm, depression) in quantitative studies and was described by trans and nonbinary youth in qualitative studies as critical to their mental health (Pullen Sansfaçon et al., 2019a; Pullen Sansfaçon et al., 2018; Abramovich and Kimura, 2021). Numerous barriers exist to accessing gender-affirming medical care across Canada, including in British Columbia . Canadian youth (and their parents, in studies that have included them) report that this process can be slow due to two main factors. The first is practices intended to delay access to gender-affirming medical care out of concern that youth will regret their decisions later in life. The second is long waits to receive care due to a shortage of gender-specific or gender-competent care providers and/or clinics in one's area; a lack of parental support; and intersecting axes of marginalization and/or privilege such as socioeconomic status or socially assigned race (Clark et al., 2018, 2020a; Heard et al., 2018; Newhook et al., 2018; Pullen Sansfaçon et al., 2019, 2021; She et al., 2020; Sorbara et al., 2020).

“And I know a lot of people who go online and get some really probably dangerous knock-offs of estrogen and testosterone....it is so overwhelmingly important to give us these resources where we're not having to go through dangerous means to get even the tiniest sliver of gender euphoria or confidence or to just not be stuck in the body that we were given.”

-nonbinary transmasc, 20 years old, Northern BC

Delayed access to gender-related care has been associated with increased risk of negative mental health outcomes (Sorbara et al., 2020). Practices that delay access to gender-affirming medical care include *gatekeeping*, which refers to the requirement that certain conditions be met before gender-related care will be provided (e.g., referral letter from a mental health provider, full family support or parental consent from both parents, completion of outdated assessments that ask about “cross-gender identification,” etc.). Requiring specific diagnoses, such as gender dysphoria, before providing gender-affirming care may not only lengthen the time it takes youth to access gender-affirming medical care but may also be inappropriate; a study that conducted chart reviews of trans and nonbinary youth who had presented for clinical care at a gender clinic found that only 42% had been diagnosed with gender dysphoria; the authors stated “this discrepancy furthers the debate that labeling all transgender people with a psychiatric diagnosis (gender dysphoria) is incongruent with a

modern understanding of gender” (She et al., 2020). In another study that included parents of youth seeking gender-affirming medical care, a parent echoed this sentiment, declaring, “Grouping in [trans healthcare] with...mental health disorders... leads you to believe it must be something that needs fixing....I don’t have to go to a mental health provider to get birth control or hormone replacement therapy if I needed or wanted and I don’t think transgender people should have to either” (Newhook et al., 2018, p. 9).

Contrary to claims made by opponents of gender-affirming care for trans and nonbinary youth, there was no evidence in the literature to indicate that Canadian youth who successfully accessed gender-affirming medical care regretted their decisions. One study that explicitly asked about regret found that none of the 35 trans and nonbinary youth interviewed regretted receiving gender-affirming care (Pullen Sansfaçon et al., 2019). In fact, this study found that access to puberty blockers was associated with greater optimism and ability to focus in school among trans and nonbinary youth. However, some trans and nonbinary youth did experience negative mental health outcomes when the process took so long that they developed secondary sex characteristics associated with their sex assigned at birth, which decreased their ability to be socially affirmed in their gender identity. One study found that youth who presented early in puberty for gender-affirming medical care were 4 to 5 times less likely to have depressive or anxiety disorders than those who did not receive gender-affirming medical care until late puberty (Sorbara et al., 2020). This study also found that youth who presented early in puberty vs. later in puberty for gender-affirming care took approximately the same amount of time to present for care after recognition of “gender incongruence.” This could indicate that youth with earlier exposure to LGBTQ+ communities and/or language describing their gender may be able to seek gender-affirming care sooner and therefore have better outcomes.

Gatekeeping by adults with power over trans and nonbinary youth can have even greater negative effects for nonbinary youth. One study found that, while only about 13% of nonbinary youth sought hormone therapy compared to 52% of binary trans youth, “they were more likely than binary youth to report experiencing barriers to accessing hormone therapy when needed” (Clark et al., 2018a, p.158). In another, four of the five nonbinary youth had faced parental resistance to getting gender-affirming medical care (Clark et al., 2020). Nonbinary youth may feel the need to fit into a binary “trans narrative” to gain access to care such as puberty blockers or hormone therapy, and therefore may have to “oversell” how strongly they identify with the gender socially positioned as “opposite” the one they were assigned at birth (Pullen Sansfaçon et al., 2021b).

Wait lists for gender clinics were cited by both youth and parents (in studies that included trans and nonbinary youths’ parents) as barriers to care; for parents in one study, this was their top concern, followed by their child’s mental health (Newhook et al., 2018). Because such clinics specialize in treating trans and nonbinary youth, they may be viewed as more

gender-competent than general clinic environments by trans and nonbinary youth and/or their caregivers (Pullen Sansfaçon et al., 2019), which may contribute to high demand for their services. A Manitoba study of trans and nonbinary youth seeking care at a

gender clinic found that the average wait time was 114 days (Heard et al., 2018). Geographic factors, such as distance from urban centres, can make finding specialized gender-affirming care difficult. In one study, both nonbinary and binary youth identified being unable to find a doctor to prescribe hormones as their primary barrier to gender affirmation (Clark et al., 2018a). In another, rural youth in the North cited distance from gender-affirming care as a barrier (Logie et al., 2019).

British Columbia's Infants Act of 1996 allows minors to consent to their own health care if their provider determines they have the capacity to understand the risks and if the care is in their best interests (Infants Act, n.d.). However, *parent/guardian support is still a key facilitator of access to gender-affirming care*. A study that included both trans and nonbinary youth and parents of trans and nonbinary youth found that youth with the lowest levels of parent support experienced more systemic barriers to hormone therapy (Clark et al., 2020). Parents can also provide financial support for costs not covered by the provincial health care system, such as readiness assessments for hormone therapy. These additional costs beyond what is funded by the provincial health system is a barrier for youth and/or their families with limited financial resources.

Healthcare: Importance of gender-competent care in non-gender-specific clinical settings

Multiple studies found that trans and nonbinary youth had low confidence in their primary care doctors' trans competency. In one, three-quarters of trans and nonbinary youth said their family doctor was NOT knowledgeable about trans health (Newhook et al., 2018). Only a quarter were comfortable talking to their doctor about their gender identity. In another study of trans and nonbinary youth who had avoided medical care, 84% worried about misgendering, 74% worried about invasive transition-related questions, and a third were concerned about being actively belittled or laughed at (Heard et al., 2018). These concerns

"And I was so fucking annoying. I called that office probably once every two or three days. And I would be, like, 'Hello, when am I-- do you know when surgery is opening up? Do you know when I can get in?' And I think after me calling too many times they were just sick of me."

-nonbinary and third gender, 23 years old,
Vancouver Island

were realistic: 100% of participants in that study had endured one or more of these negative experiences in health care.

“When you’ve repeatedly been denied, when your family doesn’t use your pronouns, when your school don’t use your pronouns, when left and right people ignore your identity, and then you try to take your own life...So I don’t know, for me that was it. It was just the repeated me seeking out support, me deciding that I can’t be here anymore because of the lack of support. And even those situations being met with the same lack of support, the same lack of knowledge and care and denial of my identity.”

-nonbinary and third gender, 23 years old, Vancouver Island

Comfort with health care providers is another realm in which nonbinary participants had worse outcomes than their binary trans counterparts. Nonbinary youth were less likely to have a family doctor or for their family doctor to know about their trans identity or experience (Clark et al., 2018b). They also “felt less comfortable speaking with new doctors and family doctors about their trans status and trans-specific health care needs” than binary trans youth (Clark et al., 2018b, p. 163).

A major concern of trans and nonbinary youth across several studies was a phenomenon referred to by trans people as “trans broken arm syndrome” (Knutson et al., 2016), by which providers with low trans competence tend to assume that any given health problem a trans or nonbinary person has (for example, depression or obesity) is related to their being trans, no matter how unlikely that may be—including a broken arm. Indeed, trans and nonbinary youth with diagnosed mental health conditions

“And it took a long time because I was using drugs. So they didn’t want - and with my mental health history, they didn’t want to approve me for testosterone because they thought I would regret it or that it would exacerbate my mental health symptoms or something like that.”

-trans man, 23 years old, Fraser Valley

have reported avoiding mental health care out of concern that providers will consider their trans identity part of their mental illness (Pullen Sansfaçon et al., 2018); in one study, nearly half (47%) had done so (Clark, et al., 2018b).

On a more positive note, comfort with and being “out” as trans and/or nonbinary to one’s family provider was related to better mental health *and* better general health, as was having any doctor who knew their trans status (Clark, et al., 2018b). The more comfortable trans and nonbinary youth were with their provider, the less likely they were to have foregone mental health care and physical health care (Clark et al., 2018b). Researchers studying health outcomes among trans and nonbinary clients at a youth mental health clinic found that a high proportion of the centre’s total clientele identified as trans and/or nonbinary, which was attributed partly to the youth wellness centre’s reputation for being a safe space for these youth that included “a transgender support group, LGBTQ+ staff and a self-referral stream” (Wang et al., 2020, p. 370). The *self-referral* option at this clinic was more likely to be used by trans and nonbinary youth than cisgender youth (Colvin et al., 2019). The self-referral pathway may enable trans and nonbinary youth with unsupportive parents to confidentially seek and receive mental health, substance use-related, or gender-affirming care. This may be particularly helpful because there is some research evidence that trans and nonbinary youth without family support may have higher mental health care needs than those with more supportive families (e.g., Ryan et al., 2009; Veale et al., 2017a; Westwater et al., 2019). In one study of trans and nonbinary youth, nearly half (46%) of the youth in the study reported that they would not have participated in the research if parental or guardian consent was required (Cwinn et al., 2021). Those who would not have participated had more negative attitudes about their sexual and gender identity, less family support, lower levels of help-seeking intentions, and higher levels of negative feelings overall.

An additional barrier to gender-competent care may be the experience of marginalization along racial and/or ethnic axes, which may discourage trans and nonbinary youth of colour from seeking services even with relatively gender-competent providers or centres. While no studies explicitly addressed disparities in access to health care between trans and nonbinary youth of colour and white trans and nonbinary youth, a few studies (that included both trans and nonbinary and 2SLGBTQ+ youth) found disparities in access to 2SLGBTQ+-specific social support depending on young people’s racial identities. Trans and nonbinary youth of colour in one qualitative study expressed frustration that most LGBT services catered primarily, if not exclusively, to white trans people’s needs, or tended to be mainly staffed and attended by white trans people (Abramovich & Kimura, 2021), which discouraged them from using these services. In another study, 2SLGBTQ+ youth of colour described being “ignored” and “rejected” by other 2SLGBTQ+ youth; one Asian youth described not feeling like he had social support until he found a group specifically for LGBTQ+ Asian youth (Asakura, 2017).

Communities: Trans and nonbinary and 2SLGBTQ+ (Youth) Communities

In several qualitative studies, trans and nonbinary youth described being able to connect with other trans and nonbinary youth (and more broadly, 2SLGBTQ+), whether in person or in virtual spaces, as contributing to better mental health and resilience (Abramovich and Kimura, 2021; Asakura, 2017; Austin et al., 2020; Pullen Sansfaçon et al., 2018). Connections to other trans and nonbinary youth, whether in-person (e.g., at community centers or in GSAs at school) or online (e.g., in game rooms, on social media, or in group mental health or substance use interventions), can facilitate positive coping and social support.

“...you knew that you could talk about the systemic issues that are in place that made us need to turn to addiction. And you knew you wouldn’t be judged for that the same way you would if you were in an A.A. meeting with a bunch of truckers.”

-nonbinary and third gender, 23 years old, Vancouver Island

In one study, youth described the 2SLGBTQ+ youth community as a “mirror” that helped them feel less alone in world and as if the burdens of stigma and discrimination were shared (Asakura, 2017). Similar results were reported by another study, whose participants described feeling greater senses of hope, confidence, and belonging after interacting with other trans and nonbinary youth online; one of their participants noted, “it’s one thing to be part of a group, but it’s another to actually interact with said group” (Austin et al., 2020, p. 39). Trans and nonbinary youth in an LGBTQ-specific transitional housing program cited planned programs (e.g. guest speakers) and staff-run special events (e.g., a Pride barbeque)

as important to fostering community (Abramovich & Kimura, 2021). Youth of color, however, expressed that they also needed to see more queer and trans BIPOCs (Black, Indigenous, and People of Colour) staff in that program, highlighting the need for community and support from others experiencing multiple forms of marginalization. Similarly, youth of color in another study noted that they felt excluded from some 2SLGBTQ+ spaces based on their racial identity or experiences (Asakura, 2017).

Communities: School Communities

School environments are critical to the well-being of trans and nonbinary youth, particularly with respect to GSAs, peer relations, and support (or lack of support) from adults and friends.

Negative school-based factors

Across several studies, school climates as a whole were described as largely cisheteronormative (favoring cisgender and heterosexual lives as the norm) and “rife” with

unnecessarily gendered systems and structures (Munro et al., 2019). These climates included widespread and repressive gender norms (Peter et al., 2016), binary-gendered washrooms and change rooms (Porta et al., 2017a; Veale et al., 2015), and insufficient support from adults affirming their gender (Travers et al., 2020). One trans and nonbinary youth described living in fear of exam days due to a system that printed his legal name along with his assigned sex marker: “They also pass around the attendance during the exam time and me sitting there all I can think of is... if somebody were to happen to look at my name and see an F[emale] beside it, like, my whole life could be just completely turned upside down.” (Munro et al., 2019). Approximately 80% of transgender and 70% LGB participants reported hearing transphobic, homophobic (e.g., “that’s so gay”), or gender-essentialist comments (e.g., about male students not acting masculine enough) in their schools on a daily or weekly basis (Peter et al., 2016).

Positive School-based Protective Factors

That said, trans and nonbinary youth described pockets of affirmation and safety in schools (e.g., GSAs, supportive individual adults, friends) in several studies. School connectedness has been linked to multiple positive outcomes for trans and nonbinary youth. A nationwide study of 923 trans and nonbinary youth found that, among a subset of 210 youth ages 14-18 years, those who experienced greater school connectedness had lower chances of having experienced extreme stress or extreme despair in the past month (Veale et al., 2017a). In the same study, trans and nonbinary youth who perceived that their friends cared about them had a quarter of the odds of attempting suicide in the past year compared to those who did not (Veale et al., 2017a). Another analysis of the same sample found that transgender youth age 14-18 years with higher levels of school connectedness had lower odds of having disordered eating in the past year (Watson et al., 2017). Importantly, a study that conducted qualitative interviews with trans and nonbinary youth in the greater Vancouver area found that supportive school policies were not seen by youth as nearly as important as supportive school personnel (Travers et al., 2020).

Across multiple studies, school-based Gender and Sexuality Alliances (GSAs)² were consistently referred to by trans and nonbinary youth as places where they felt supported and safe (Asakura, 2017, 2019; Eisenberg et al., 2018; Lapointe & Crooks, 2018; Porta et al., 2017b). GSAs provided multiple benefits, particularly the chance to interact with other 2SLGBTQ+ youth. GSAs were cited as facilitating youth resilience in part by fostering their ability to navigate more hostile contexts and serving as “recharge stations.” (Asakura, 2017). In one qualitative study, trans and nonbinary youth expressed that they had benefited greatly from multiple aspects of a 17-session 2SLGBTQ+-specific mental wellness program delivered through their GSA, finding it to be “a venue for self-reflection, exploration, and affirmation”

² May also be referred to as “Gay-Straight Alliances” (older term), Sexuality And Gender Alliances (SAGA), or other school-specific names that are less explicit about their support for 2SLGBTQ+ youth (e.g., “Rainbow Alliance”).

(Lapointe & Crooks, 2018), p. 309. Another way that GSAs can create “downstream” positive impacts is by serving as “gateways”—connecting youth to supportive adults (e.g., the group advisor and allies within the school), local community resources (e.g., guest speakers from a health centre), and the larger 2SLGBTQ+ community (Porta et al., 2017b).

Communities: Local Communities

Relatively few studies focused explicitly on trans and nonbinary youths’ local environments. One study involved going on “walk and talks” with LGBTQ+ youth from British Columbia, during which youth pointed out or took the researchers to places that were salient to them as supportive (Eisenberg et al., 2018). Community organizations were viewed as supportive and/or safe when they indicated sensitivity to the needs of trans and nonbinary youth, such as by asking for and using affirmed pronouns, or if they eliminated/upended gender norms, as in a swing dance program praised by one BC-based youth: “it wasn’t, like, ‘oh, the men lead, the women follow.’ It’s like. . . ‘people who want to learn to lead and people who want to learn to follow.’ And that was really nice. . . it was all, like, gender mixed.” (Eisenberg et al., 2018, p. 978). Trans and nonbinary youth may also view community spaces as safe if they provide resources geared towards sexual or trans and nonbinary communities, such as by stocking a local LGBTQ+ publication (Eisenberg et al., 2018).

Trans and nonbinary youth, like all youth, experience greater health in neighbourhoods and communities in which they can actively participate, such as through youth sports or civic engagement. LGBTQ+ youth in a transitional housing program, many of whom were trans and nonbinary youth, “reported wanting more opportunities to participate in group activities in the community, such as going to the park together or camping,” and cited sports participation in the community as a source of mental health and physical wellness (Abramovich & Kimura, 2021, p. 1252). This may indicate the need for more collaboration between LGBTQ+-specific community organizations/groups/resources and the communities in which they are situated.

Communities: Rural Communities

Trans and nonbinary youth in rural areas may have additional needs and/or vulnerabilities compared to their more urban counterparts. Rural location may reduce access to care among some trans and nonbinary youth for both *geographical* (e.g. limited services such as gender clinics, broadband access) and *social* reasons (e.g., few to no other trans and nonbinary youth in one’s school, concerns about confidentiality if they were to disclose to their provider, with whom they may interact in other ways in a small community) (Logie et al., 2019).

In a study of rural sexual minority and trans and nonbinary persons in Arctic Canada, a trans young adult bemoaned the fact that he had to fly to Edmonton for a health assessment as “pretty crazy. We should have professionals here that can help in one sense or another, like what if I needed immediate care? I’d be fucked” (Logie et al., 2019, p. 1207). This need to

travel for definitive care was echoed by parents in Newfoundland, one of whom commented, “Most supports are not available in our community so it means travelling to larger centres 2+ hours from home” (Newhook et al., 2018, p. 8). These findings from other provinces may be generalizable to remote areas of BC, where trans and nonbinary youth may face similar obstacles to timely gender-based and/or mental health care if providers in rural areas are perceived as unable or unwilling to provide trans-competent and gender-affirming care. In another study of access to care, a BC youth lamented that they had “no psychiatrists that I could access and no one that I knew that could prescribe hormones... So, I needed to go elsewhere. And I know people that live in [town] that have to travel 8 hours to see the people that they need to, which is incredibly expensive and not accessible to all” (Clark et al., 2020, p. 140).

Communities: Online Communities

The internet was described as a vital lifeline for trans and nonbinary youth across multiple studies. One researcher was struck at the number of trans and nonbinary youth tying their online experiences to their mental health, saying “The vast number of responses explicitly or implicitly describing the life-saving nature of their online experiences is particularly compelling given that participants were not asked about suicidality or mental health” (Austin et al., 2020, p. 41). Online environments were credited with providing multiple critical supports by trans and nonbinary youth, including:

- access to other trans and nonbinary (and LGBTQ2S+) people, especially youth (Austin et al., 2020; James, 2021; McInroy et al., 2019; Pullen Sansfaçon et al., 2018)
- access to information about gender and sexuality, including terminology to describe one’s experience (Austin et al., 2020; James, 2021; Pullen Sansfaçon et al., 2018)
- places to “try on” new pronouns/names with lower stakes than at school or home (Pullen Sansfaçon et al., 2018)

One study of LGBTQ+ youth (nearly half of whom identified in a way classified as transgender or “gender nonconforming”) found that those who spent more time online were more involved in online LGBTQ+ communities, and were also more likely to feel safe and supported in those communities (McInroy et al., 2019). This same study found that nearly two-thirds of participants had accessed sexual health information online, and 87% had accessed LGBTQ+ blogs and social media sites online. [*For more on accessing health interventions and services online, see “COVID-19 Pandemic” subtheme below*]

It bears noting that the internet is also a place where trans and nonbinary youth can also experience enacted stigma, most notably through negative comments aimed at them or trans and nonbinary people more broadly. Trans and nonbinary youth may also face malicious “outing” (divulgence of their gender minority status without their consent), “doxxing” (sharing of their personal information online), or other forms of stigma and discrimination

(Craig et al., 2020a). However, no studies found these risks sufficient to outweigh the benefits of online interactions for trans and nonbinary youth. Indeed, some studies found that negative online experiences provided opportunities to demonstrate both individual and collective resilience (Craig et al., 2020a; James, 2021). Coping strategies include avoidance of sites that trans and nonbinary youth know could trigger negative emotions, responding to bullies by fighting back or attempting to educate, using platform features such as blocking specific users, seeking/providing support from/to other trans and nonbinary youth (Craig et al., 2020a).

Family Environments (Households of Origin)

A nationwide study found that trans and nonbinary youth and “gender non-conforming” youth were more likely to have adverse childhood experiences (ACEs) in multiple categories, including emotional neglect, emotional abuse, and living with a family member with mental illness (Craig et al., 2020b). In another study, the term “negative neutrality” was coined by one study participant to describe a lack of explicit, active parental support (Pullen Sansfaçon et al., 2018, p. 197); this parental stance was found to contribute to delayed access to gender-affirming health care and negative mental health impacts for trans and nonbinary youth. Across studies, youth spoke of this lack of parental support as a major driver in their mental health, as did this youth from BC: “I think that if my parents were more supportive, and if society was more understanding, then I’d live much more comfortably. I’d be so much happier. I would have been so much happier. I wouldn’t have been so confused, and I wouldn’t have hated myself so much.” (Clark et al., 2020, p. 141).

Of note: we could find *no* studies of Canadian trans and nonbinary youth that examined the association between relationships with and support from siblings or extended family members and trans and nonbinary youths’ mental health or substance use. The current literature focuses on parent-child relationships only, so almost nothing is known about how extended family systems and/or sibling responses to trans and nonbinary youths’ gender identities affect their wellbeing.

Theme: Greater Effects of System-wide Disruptions

Subtheme: COVID-19 Pandemic

The COVID-19 pandemic has worsened conditions that already were creating barriers to mental health and substance use care for trans and nonbinary youth or created new problems affecting their mental health.

Two studies found evidence of disparities in access to physical and mental health care among trans and nonbinary youth compared to cisgender youth. One, a study of clinic-involved youth in Toronto during the early days of COVID-19-related lockdowns, found that 72% of trans and nonbinary youth had experienced *disruption of services* related to mental health

and substance use due to COVID-19, vs. only 26% of cisgender youth (Hawke et al., 2021). Similar disparities were seen for disruption of physical health services (36% vs. 11%), which for trans and nonbinary youth could include gender-affirming care, the disruption of which could have serious negative mental health repercussions given the robust data linking gender affirming care to positive mental health outcomes. Indeed, another study reported that 64% of trans youth had to delay or cancel gender-affirming medical appointments during the pandemic, with 50% having to delay or cancel surgery, which negatively impacted their mental health (Abramovich et al., 2021). Hawke et al. (2021) also found that 63% of trans and nonbinary youth reported unmet need for mental health and substance use-related services vs. 28% of cisgender youth; however, it is not clear whether this number represents a change from pre-COVID conditions. Interestingly, this pattern of COVID-related disruption also held for sports and recreational programs (75% for trans and nonbinary youth vs. 49% of cisgender youth).

Apart from access to care, the pandemic seemed to *worsen mental health in general* for trans and nonbinary youth. Hawke et al. (2021) found that trans and nonbinary youth had over 2.5 times the odds of clinically significant mental health problems during COVID than cisgender youth and about 25% lower odds of family support during COVID. One reason for the disparity in mental health may be because lockdowns cut trans and nonbinary youth off from peers and community support organizations; this could be especially devastating for trans and nonbinary youth in less-than supportive family environments. These findings were echoed in a study of 61 2SLGBTQ+ youth at risk of or experiencing homelessness during the pandemic, the majority of whom identified as trans or nonbinary; in this study, 81% of youth reported engaging in non-suicidal self-injury and 36% reported attempting suicide since the start of the pandemic (Abramovich et al., 2021). This study also found that trans and nonbinary youths' mental health was often made worse by the social isolation they experienced in lockdown; 97% of respondents reported feeling lonelier than they did pre-pandemic.

The COVID-19 pandemic did prompt *more widespread use of telehealth*, which could be quite beneficial for trans and nonbinary youth living in remote areas or for those who may be hesitant to change providers after moving for fear of not finding a gender-competent provider. One paper described the process of delivering a cognitive behavioural therapy program for LGBTQ+ youth (AFFIRM) through online videoconferencing software, including how it helped a trans participant in a rural area where there were no LGBTQ+-specific services (Craig et al., 2021b). Another study found that trans and non-binary youth accessed the following services virtually: mental health care (66%), case management (49%), crisis services (43%), and legal services (34%) (Abramovich et al., 2021). This study found that the benefits of virtual services were that youth were able to save money on transit, along with feeling less socially anxious and worried about how they were perceived in public with regard to their gender;

however, inconsistent internet access and a lack of support and privacy at home made virtual services less accessible for some youth.

One study examining the effect of the COVID-19 pandemic on trans and nonbinary youth made a particularly interesting finding: that trans and nonbinary youth “did not report significantly different mental health or substance use scores compared with cisgender youth prior to COVID-19” but that trans and nonbinary youth reported “significantly higher intra-COVID-19 scores for mental health challenges” *during* the pandemic (Hawke et al., 2021, p. 182), which supports the findings of the other studies that trans and nonbinary youth have been disproportionately affected by the disruptions caused by the pandemic.

Subtheme: Natural Disasters/Climate Emergencies

While only one study explicitly addressed this topic, it is noteworthy for both its methodological implications and its findings regarding trans and nonbinary youth mental health, particularly considering the catastrophic flooding seen in BC during 2021. In a longitudinal study of secondary students in Fort McMurray, AB in the 3 years after the devastating wildfire of 2016, researchers found that negative mental health outcomes post-wildfire were starker for nonbinary youth (those who indicated “other” for their gender) than for youth who identified as male or female (M.R.G. Brown et al., 2021) [Note: the study did not ask about sex assigned at birth, so the authors could not determine whether there were differences between cisgender and binary transgender youth]. These outcomes included higher scores on scales measuring symptoms of PTSD, anxiety, depression, and suicidal thinking and lower scores for resilience, self-esteem, and quality of life.

Substance Use

Only 2 of the 45 studies with sufficient Canadian trans and nonbinary youth in their samples to be included in this review focused *exclusively* on substance use, and those included mostly adult LGBTQ+ people. An additional 9 studies examined *both* mental health and substance use.

“I don’t know if they just didn’t know the signs of addiction or they just thought I was dysfunctional. But no one in my high school who was an adult in my life or a mental health professional could recognize I was suffering from addiction. And I had no idea I was suffering from addiction.”

-nonbinary and third gender, 23 years old, Vancouver Island

Desire for Harm Reduction Models

A study involving interviews with LGBTQ+ youth and staff at an LGBTQ+-only transitional housing program found that youth and staff expressed frustration at the abstinence-only policies related to substance use: “Staff indicated that program and resource constraints were barriers holding YMCA Sprott House from becoming a full-fledged harm reduction facility (i.e., having an on-site nurse), and thus they [could only] adopt a harm reduction ‘lens’ instead” (Abramovich & Kimura, 2021, p. 1255).

Trans and Nonbinary Youths’ Desires for Effective Substance Use Interventions

The two substance use-specific studies were from the same lab and asked youth specifically about what they would want to see in smoking cessation interventions for LGBTQ+—both online and group—based (Baskerville et al., 2017, 2018). Trans and nonbinary youth wanted interventions to depict not only different gender expressions but also people of different body shapes and BIPOC youth: “I don’t want to see young gay males...I want to see people who don’t have representation. I want to see a black trans woman...” (Baskerville et al., 2018, p. 8). Trans participants wanted an app where they could reach out specifically to other trans/ trans & BIPOC folks for support (Baskerville et al., 2017). This was a highly salient theme and was echoed in other studies – trans and nonbinary youth very much want to connect with other trans and nonbinary youth.

“...there’s a lot of racism within addiction services sometimes with Indigenous people. I know that in the past when...I go to the hospital and stuff they try to wait me out assuming that I’m on something or drug seeking. And so sometimes I do get some of those attitudes.”

-nonbinary and Two Spirit, 22 years old, Okanagan

LGBTQ+ youth in *general* (including trans youth) wanted such an intervention to have the following additional attributes (Baskerville et al., 2017, 2018):

- be low-cost or free, easy to get to or use, and not take too much time;
- include other activities besides smoking;
- be uplifting/inspiring/positive;
- provide specific coping mechanisms to resist the urge to smoke; and
- include some sort of rewards/incentives

Alcohol, tobacco, and marijuana use

One study found that nonbinary youth were more likely to report weekly alcohol use, but the effect disappeared once sex assigned at birth was controlled for which the authors chose to do because their nonbinary participants were disproportionately assigned female at birth (82%) (Clark et al., 2018a). Nonbinary youth in this study were also more likely to report smoking in the past month than binary trans youth, and this effect varied with assigned sex at birth (nonbinary assigned male: 44%, nonbinary assigned female: 28%; trans boys: 25%; trans girls: 12%).

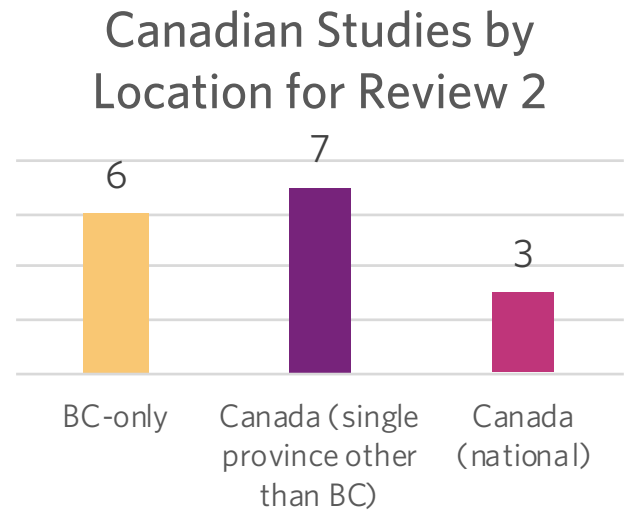
Other Substance Use

Two studies referenced more generalized “drug use problems” or “substance use disorder.” One of these performed separate analyses for nonbinary youth and for those who preferred not to disclose their gender, finding alcohol/substance use was “higher in...those with other gender identity vs. females/males, and in those who preferred not to say vs. females/males.” (M.R.G. Brown et al., 2021, p. 10). Only one study explicitly assessed use of specific substances besides alcohol, tobacco, or marijuana among trans and nonbinary youth (Hawke et al., 2021). Interestingly, this study, which focused on substance use during the COVID-19 pandemic, found no statistically significant difference between trans and nonbinary youth and cisgender youth in use of substances either before or during COVID-19 (Hawke et al., 2021).

Review 2: Unstably Housed Youth and Youth in Government Care

Literature Review: Overview

A total of 30 studies (16 conducted in Canada and 14 in the USA) were included in this review. Most participants lived in major urban centres – such as Toronto, Montreal, New York City, and Los Angeles and were recruited through community organizations/outreach programs and shelters. 22 of the studies included cisgender youth, while 8 focused solely on trans and nonbinary youth. In terms of racial and ethnic characteristics, Canadian studies had mostly white participants, while those in the USA had mostly youth of colour. 27 out of the 30 studies included youth over the age of 19 years old, with the remaining 6 studies focused on youth under 19.



Themes: Housing Instability and Government Care

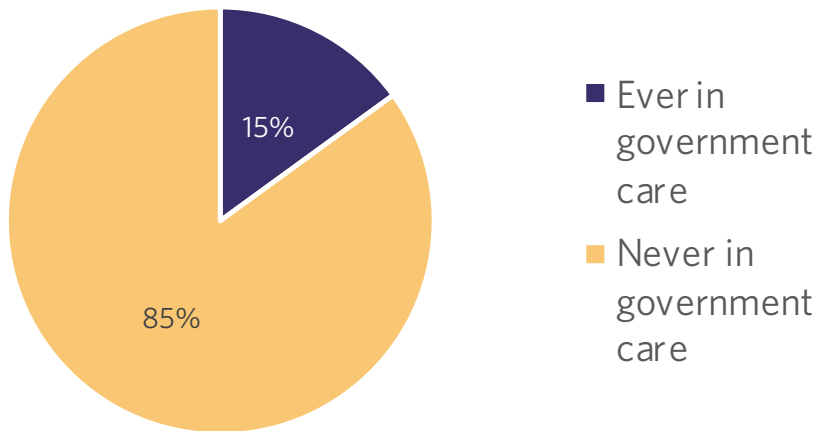
Literature Review Results: Trans and Nonbinary Youth in Care and on the Streets

Data from the CTYHS show that among Canadian trans and nonbinary youth, around 5% had lived in a foster home, 4% had lived in a group home (with more youth in BC having lived in group homes compared to the other provinces), and 6% had been in custody care (Taylor et al., 2020). One report found that among Indigenous youth in BC who had experienced government care, 13% were Two Spirit and 3% were trans and/or nonbinary (Tourand et al., 2016). However, there is little information available about the role intersecting identities – such as Indigeneity and gender identity – play in youths’ involvement in government care. The National Youth Homelessness Survey revealed that that 2% of Canadian homeless youth are transgender and 3% are nonbinary (Gaetz et al., 2016). Crucially, government care seems to function as a form of unstable housing: while living arrangements tend to fluctuate for all youth in government care regardless of gender identity, trans and nonbinary young people often experience less stability and more foster placements than their cisgender counterparts (Mountz et al., 2018); moreover, involvement in government care may serve as a gateway into other forms of housing instability, with data from the National Youth Homelessness Survey showing that 56% of homeless trans and nonbinary youth had been in foster care, and that 71% had been involved with child protective services compared to just 57% of their cisgender counterparts (Gaetz et al., 2016). One USA-based study even found that, among LGBT youth, 38% of trans and nonbinary youth had become unstably housed upon aging out of care compared to 12% of their cisgender LGB peers (Baker et al., 2018). Trans

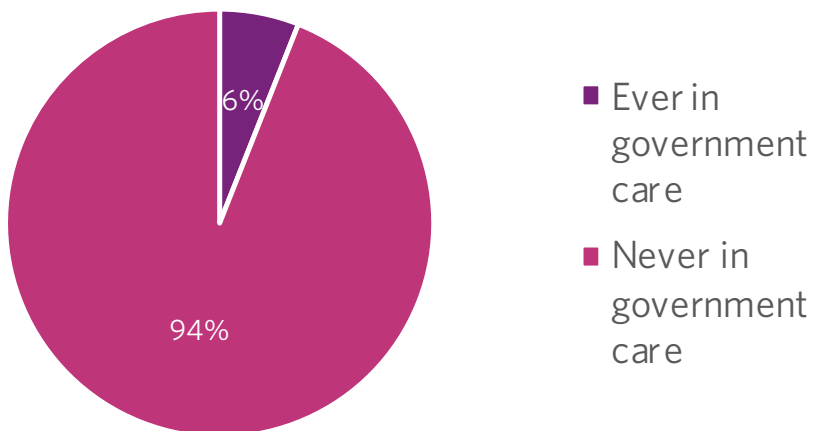
and nonbinary young people who have been involved in government care typically become street-involved after either a) running away from or b) ageing out of care, but regardless of whether they have experienced government care or housing instability, trans and nonbinary youth are rarely able to stay in a given living situation for long due to discrimination and abuse (Côte & Blais, 2021).

BC AHS and CTYHS Results: Trans and Nonbinary Youth in Care

BC AHS: Trans & Nonbinary Youth



CTYHS: Trans & Nonbinary Youth



When it comes to the BC AHS, 15% of trans and nonbinary adolescents under 19 years old had experienced some type of government care (which includes foster care, custody centres, and youth agreements) in their lifetime. There was a total of 4341 adolescents under 19 years old who identified as Aboriginal, Indigenous, First Nations, Inuit, or Metis. Of those, 4% were Two Spirit, 15% reported having ever experienced at least one type of government care, and 1% reported both being Two Spirit and having ever been in government care.

As for the CTYHS, 6% of trans and nonbinary young people had experienced some type of government care (which includes foster homes, group homes, and staying in custody care) in their lives.

Themes: Preceding Instability, Abuse, and Trauma

Literature Review Results: Abuse and Violence in the Home

Parental acceptance plays a key role in housing instability: for example, one study of trans and nonbinary youth in Ontario found that none of the youth with parents who supported their identities had ever experienced housing instability, while nearly half of those with unsupportive parents had at least once (Travers et al., 2012). Trans and nonbinary youth who are unstably housed or in care often come from households characterized by violence,

abuse, substance use, and economic instability, with many having witnessed and/or been victims of domestic violence (Côte & Blais, 2021). Among Canadian homeless youth, 80% of trans and nonbinary youth – compared to 74% of cisgender girls and 54% of cisgender boys – had experienced some form of abuse in childhood (Gaetz et al., 2016). USA-based studies have examined the role of trans and nonbinary youths’ household circumstances in their

trajectories through government care in more detail. For example, intergenerational trauma may play a key role in the victimization of these adolescents at home: substance use and mental health issues are more marked among parents who have themselves experienced government care, incarceration, and/or housing instability, which increases the likelihood that they will engage in neglectful and abusive behaviour that results in their own children ending up in care or on the streets (Mountz & Capous-Desyllas, 2019).

Literature Review Results: Abuse and Violence at School

In addition to these traumatic experiences at home, trans and nonbinary youth often experience bullying and harassment at school. Data from the National Youth Homelessness Survey show that, throughout their lifetime, 54% of nonbinary homeless youth had been bullied frequently at school compared to just 38% of homeless cisgender boys (Gaetz et al., 2016). These negative school experiences may be further compounded by the presence of a learning disability and/or ADHD: 57% of homeless nonbinary youth having been tested for ADHD and 59% of all homeless trans and nonbinary youth having been tested for a learning disability, indicating that these youth displayed learning-related challenges that were obvious enough for school staff to recommend them for testing (Gaetz et al., 2016). When paired with a difficult homelife, these negative peer interactions and learning-related challenges in school environments can become so stressful that trans and nonbinary adolescents end up leaving their lives behind and becoming street-involved (Côte & Blais, 2021). Research conducted in the USA shows that trans and nonbinary adolescents in foster care are frequently forced to change schools as they move from one placement to the next, leading to difficulties adjusting to new school environments as they face victimization and bullying for their marginalized identities, while lacking supportive relationships within or outside of school (Mountz et al. 2019).

“When I lived with [my relative] she had moved in someone...He had bullied me for dressing like a boy and would always wreck on me for being different and acting not the way I was supposed to be. I remember a lot of torment every single day until I had left.”

-gender questioning, 18 years old, Northern BC

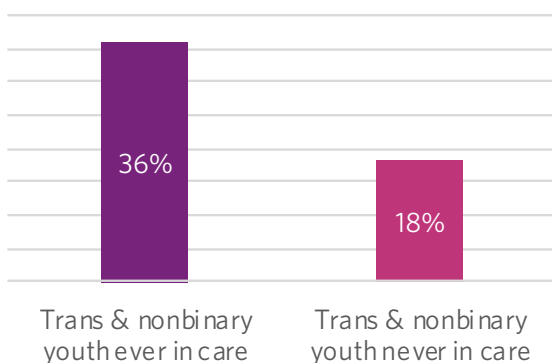
BC AHS Results: Abuse and Violence

A greater number of trans and nonbinary adolescents who had experienced government care reported physical and/or sexual abuse compared to trans and nonbinary youth who had never been in care: nearly half had experienced either physical or sexual abuse – with 27% having experienced sexual abuse and 28% having been physically assaulted by schoolmate. By comparison, a third of trans and nonbinary youth who had never experienced government care reported physical or sexual abuse, with 17% having experienced sexual abuse and 16% having been assaulted by a schoolmate. Such elevated levels of violence from other students also appear when comparing trans and nonbinary adolescents who have experienced care to their cisgender peers: 72% reported being teased, excluded, or assaulted by a schoolmate compared to just 1% of cisgender youth who had experienced government care. Trans and nonbinary adolescents who had experienced government care also reported lower feelings of both family and school connectedness compared to trans and nonbinary adolescents who had never experienced government care and cisgender youth who had experienced government care.

Among Two Spirit youth, 48% had ever been physically abused, and 40% had ever been sexually abused. Additionally, 4% of Two Spirit youth who had ever been in care reported they seldom or never felt safe in their community or school. Sixty-nine percent reported being teased, excluded, physically attacked, or assaulted while at or on their way to school in the past year. Moreover, a greater proportion (12%) of Two Spirit youth with care experience reported being physically assaulted three or more times at or on their way to or from school in the past year compared to both Two Spirit youth without this experience (4%) and other Indigenous youth ever in care who were not Two Spirit (6%).

CTYHS Results: Abuse and Violence

CTYHS: Experienced Sexual Assault



Unlike the BC AHS, the CTYHS measured sexual assault³ and sexual abuse⁴ separately. When it comes to the results for sexual abuse, nearly three quarters of trans and nonbinary young people who had been involved in care had experienced sexual abuse compared to little over a third of those who had never been involved in care.

³ Question in survey: “Have you ever been physically forced to have sexual intercourse when you did not want to?”

⁴ Question in survey: “Have you ever been sexually abused? Sexual abuse is when anyone (including a family member) touches you in a place you did not want to be touched, or does something to you (or makes you do something to them) sexually which you did not want.”

Themes: Re-Experiencing Instability, Abuse, and Trauma After Leaving Home

Literature Review Results: Leaving Home

For many trans and nonbinary young people, it is a combination of interpersonal dysfunction, discrimination, and abuse which forces them to leave home and either a) enter government care or b) become street-involved. More trans and nonbinary adolescents run away from or get kicked out of their homes than cisgender youth. Data from the 2018 BC AHS show that 19% of transgender boys, nonbinary youth, and gender-questioning youth, as well as 29% of transgender girls, had run away from home at least once in the past year compared to just 9% of cisgender girls and 7% of cisgender boys (Saewyc et al., 2021). These data also show that 12-13% of trans and nonbinary adolescents had been kicked out of their home within the past year compared to 6% of cisgender girls and 5% of cisgender boys (Saewyc et al., 2021). As one USA-based study showed, many youth cite chronic abuse and rejection (including queerphobia) as the main reason for running away/getting kicked out of the home (Robinson, 2018b). Similarly, among the 50% of Canadian homeless trans and nonbinary youth who had left home before the age of 16, most attributed their leaving to parental conflict and abuse (Gaetz et al., 2016).

“When I was in the different homes [while in government care] I lived with a lot of people who were very stunted in their growth of gender identity who did not talk to me about it. And if I brought it up they wouldn’t really touch on the subject and were not willing to learn.”

-gender questioning, 18 years old,
Northern BC

Trans and nonbinary youth are frequently forced to move from one living arrangement to the next (e.g., from one foster home to another foster home, or from one shelter to the streets to another shelter) due to queerphobic violence and harassment, only to re-experience violence, harassment, discrimination, and rejection similar to that of their household of origin from the adults responsible for their care. Similarly, trans and nonbinary youth may experience the same form of bullying and stigmatization from shelter/group home residents that they had previously faced in hostile school environments.

Literature Review Results: Undertrained and Overworked Shelter/Government Service Workers

Shelter staff are often undertrained and overworked, such that they feel unsure as to how to interact with trans and nonbinary youth in an understanding and respectful manner (Abramovich, 2014). As such, when an altercation occurs, shelter staff may have difficulty recognizing an attack as being homophobic/transphobic in nature rather than just a

disagreement/fight between residents (Abramovich, 2014). As for government care, some trans and nonbinary young people report being forced to wear clothes that align with their gender-assigned-at-birth or being deadnamed and misgendered by child welfare workers and in courts despite asserting their affirmed name and pronouns (Pullen Sansfaçon et al., 2018; Office of the Child and Youth Advocate Alberta, 2017; Coolheart & Brown, 2017).

Literature Review Results: Sex-Segregated Spaces Shelters and Government Care Homes

Shelters and group homes are often sex-segregated, with trans and nonbinary youth being placed in male- or female-only spaces according to their sex assigned at birth. Such segregation policies are justified by staff/service providers as a “safety precaution” – for example, they might defend this arrangement by stating that AFAB trans and nonbinary young people would be at a higher risk of victimization in an all-male space (Abramovich, 2014). However, across the literature, virtually all trans and nonbinary youth criticized and described having negative experiences with these policies, as they are often forced to live in spaces that do not align with their gender – which is especially challenging for nonbinary youth, as there is often no alternative to these binary spaces – or denied placement in gendered shelters and transitional/group homes altogether (Abramovich & Kimura, 2021). Some young people even describe having to effectively “de-transition” in order to access all-male or all-female shelters and have a place to sleep for the night – for example, in a study conducted in Toronto, one transfeminine youth describes the humiliating experience of being forced to present as male in order to obtain a safe place to sleep for the night at a male-only shelter (Abramovich, 2014). Many shelters do not have gender-neutral washrooms, making those spaces a source of extreme stress, anxiety, and danger for trans and nonbinary youth, who are often forced to use washrooms that correspond to their sex assigned at birth (Abramovich & Kimura, 2021).

“The group home was probably my worst experience ...I had to be placed with the girls at the time ‘cause I’m assigned female at birth. So that was really hard for me because I felt like I wasn’t being seen for what my identity was. And...it made me feel really bad about myself.”

-nonbinary, 22 years old,
Fraser Valley

Themes: Nuances of Street Involvement

Literature Review Results: Choosing Street-Involvement

Despite the risks, some trans and nonbinary youth choose to live on the streets rather than live at home, in government care, or in a shelter due to the amount of transphobic violence and harassment they face in those settings (Abramovich, 2014), and because the sex-segregated structure of most shelters and government care facilities makes it extremely difficult for trans and nonbinary youth to access and feel comfortable in these spaces (Abramovich & Kimura, 2021). Free of dress codes, strict gender-segregation, and gender-policing authority figures (such as parents, foster parents, government care workers, and shelter staff), the streets offer trans and nonbinary youth a form of liberation they might not experience otherwise, and research conducted in the USA has shown that street-involvement can allow youth to develop a sense of community with other street-involved trans and nonbinary individuals of all ages, including trans and nonbinary adults who can serve as role models (Shelton, 2016).

"I was on a voluntary care agreement when I turned 16. So I went into an emergency group home, and I stayed there for a few months. And then I was transferred to a foster care placement. And I stayed there until I left of my own accord, like I ran away. And then I was kind of homeless for a while...Like, I found that the [foster] family was very welcoming."

-gender questioning and gender nonconforming, 18 years old, Northern BC

Literature Review Results: Financial Instability, Street-Involvement, and the Law

While the streets can provide a sense of freedom and community, the financial precarity that comes with housing instability often forces youth to engage in illegal/dangerous activities, which only increases their exposure to victimization and exploitation. The National Youth Homelessness Survey found that 39% of street-involved Canadian trans and nonbinary youth (between the ages of 13-24 years old) rely on illicit activities - including theft, drug dealing, breaking-and-entering, and sex work - to make a living (Gaetz et al., 2016).

CTYHS Results: Survival Sex

Data from the CTYHS show that 14% of trans and nonbinary adolescents who had been in government care had traded sex for food, shelter, drugs, or alcohol compared to 4% of trans and nonbinary youth who had never experienced government care.

Literature Review Results: Access to Gender-Affirming Services

Depending on the competency of workers and service providers, trans and nonbinary young people may have little/no access to gender-affirming resources through shelters/government institutions. Many shelter workers lack adequate training to be able to help trans and nonbinary youth navigate services related to legal, social, and/or medical transitioning, despite the fact that access to gender-affirming resources is crucial for the mental health, wellbeing, and safety – of many trans and nonbinary youth (Abramovich & Kimura, 2021). As an example: many community programs and shelters use youths' personal information as it appears on their legal ID, which causes problems for trans and nonbinary youth whose names and/or gender marker have not been – or cannot be – legally changed (Abramovich, 2014). This lack of legal recognition also limits youths' access to shelters, as they are forced to either allow service providers to misgender/deadname them or disclose their gender identity in the hopes that said providers will use the correct name and pronouns, which can prompt service providers to make overtly transphobic remarks and/or insist on using the name/pronouns that align with these legal documents (Pullen Sansfaçon et al., 2018).

Literature Review Results: Involuntary Psychiatric Hospitalization

One form of institutionalized care which appeared sporadically throughout the literature is psychiatric hospitalization. In a study described in an RCY report on the psychiatric hospitalization of youth in BC, 61% of the 107 youth who had experienced a) a critical injury that had been reported to the RCY⁵ and b) at least one psychiatric hospitalization in their lifetime were trans and nonbinary youth (Representative for Children and Youth, 2021). In the same report, a small group of young people described their experiences with involuntary psychiatric hospitalization under BC's Mental Health Act, a policy which allows for individuals to be hospitalized and administered psychiatric – including pharmacological – treatment against their will. These trans and nonbinary youth describe these experiences as overwhelmingly negative, with some even being denied access to gender-affirming care

When I went into the hospital [for emergency mental health care]...they took my binder from me because they thought it was some kind of safety risk. I don't personally understand how. It's very hard to strangle yourself with a binder. Yeah, so they took it from me in the emergency room, and then I was kind of in a gown with people all around. So I was extremely uncomfortable.

-trans man, 23 years old,
Vancouver/Fraser Valley area

5 Between April 2018 and October 2019.

- for example, one transfeminine youth was forced to stop taking hormones, as hospital staff had assumed her mental health symptoms were the result of HRT despite her insistence to the contrary (Representative for Children and Youth, 2021). Similarly, in a qualitative study of 24 trans and nonbinary young people in Quebec, two participants described being taken off hormones against their will after hospital staff misattributed their negative mental health symptoms to HRT (Pullen Sansfaçon et al., 2018). Moreover, the stress of being stripped of their autonomy and denied access to gender-affirming treatment may cause trauma that worsens trans and nonbinary youths' mental health in the long-run.

Literature Review Results: Physical Health and Mental Health

Much of the literature on the physical health of trans and nonbinary youth focuses on unstably housed young people rather than those in care; regardless, trans and nonbinary adolescents frequently report worse physical health than their cisgender peers. Among runaway youth, 29% of trans and nonbinary youth reported poor/fair physical health compared to 16% of cisgender girls and 11% of cisgender boys (Ferguson et al., 2021). Among unstably-housed youth, 57% of those who are trans and nonbinary reported poor/fair physical health compared to 42% of cisgender boys (Ferguson, 2018). A similar pattern was found when it came to mental health: in BC, 74% of unstably-housed trans and nonbinary young people reported poor/fair mental health compared to 58% of cisgender girls and 42% of cisgender boys (Ferguson, 2018), as did 39% of runaway trans and nonbinary youth compared to only 13% of runaway cisgender boys (Ferguson et al., 2021). Those unstably-housed trans and nonbinary youth were also more likely to report having at least one mental health condition, harmful levels of stress, a history of self-harm, and suicidality compared to their cisgender male peers (Ferguson, 2018).

BC AHS Results: Physical Health, Mental Health, and Substance Use

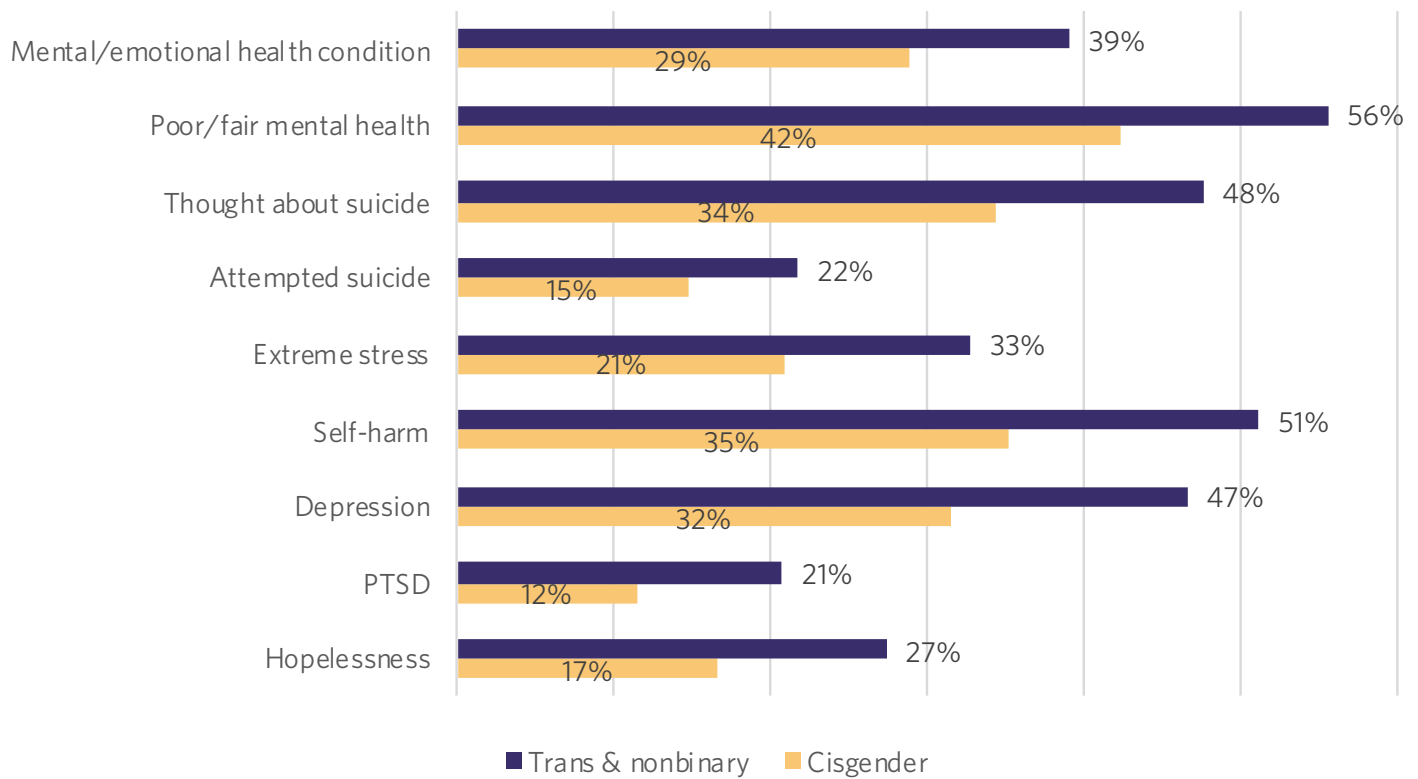
When it comes to physical wellbeing, 23% of trans and nonbinary adolescents who had never been involved in government care were unable to afford enough food compared to 37% of those who had been in care. Similarly, among those who had experienced government care, more trans and nonbinary youth reported going to bed hungry (37%) compared to their cisgender peers (28%), along with having a medical condition or disability (63% vs. 42%, respectively) and poor/fair physical health (41% vs. 32%, respectively).

Regarding the physical health of Two Spirit young people with government care experience, 63% rated their health as good or excellent and 15% had a long term or chronic medical condition. Moreover, a larger proportion (53%) of Two Spirit youth with care experience reported going to bed hungry at least some of the time because there was not enough money for food at home compared to Two Spirit youth without care experience (31%) and other Indigenous youth ever in care (27%). Finally, over half of Two Spirit youth who had ever been in government care reported taking part in organized sports in the past year.

“And because that system is so under funded, the food allowance is so small, so the foods you get are often not nutritious. They’re quick, fast food. And so I guess there’s just this genuine disinterest in what you can get, and that’s based on the fact that there’s just no funding in that system. So then you just kind of don’t really care about food. You don’t even think about what goes in your body.”

-Two Spirit, 24 years old, Vancouver

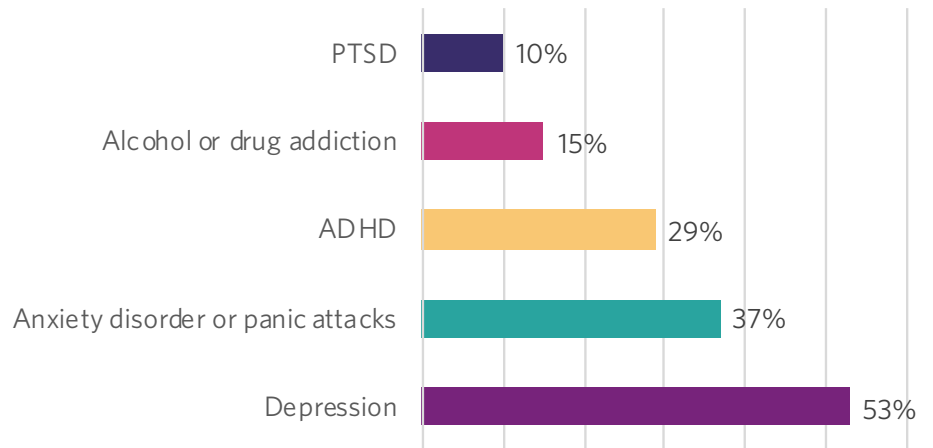
BC AHS: Mental Health Among Youth Ever in Care



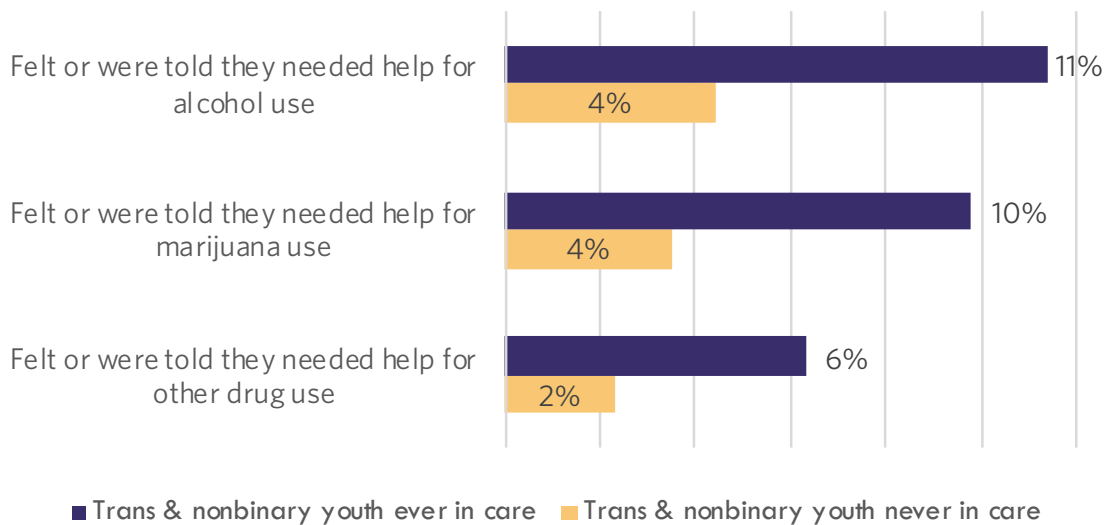
In terms of mental health, 21% of trans and nonbinary youth who had experienced care reported having PTSD compared to 9% of trans and nonbinary youth who had never experienced care. Among youth who had experienced government care, 39% of trans and nonbinary adolescents had a mental or emotional health condition compared to 29% of cisgender adolescents, with 56% rating their mental health as poor/fair compared to 42% of cisgender youth. Suicidality was also higher among trans and nonbinary youth who had been in care compared to their cisgender counterparts.

When it comes to Two Spirit adolescents, about half of those who had experienced government care rated their mental health as good or excellent, and over a third reported having a mental health or emotional condition. Among Indigenous youth with government care experience, significantly more Two Spirit youth reported having depression compared to their Indigenous peers who were not Two Spirit (53% vs. 37%). A quarter of Two Spirit youth who had been in government care reported feeling extreme stress in the past month, and over one in ten had experienced extreme despair. Moreover, about half had seriously considered suicide, 27% had attempted suicide in the past year, and 52% had self-harmed in the past year.

BC AHS: Mental Health Conditions Among Two Spirit Youth Ever in Care



BC AHS: Needed Substance Use Help



There were differences between groups when it came to substance use among BC AHS respondents as well: 20% of trans and nonbinary adolescents who had been in government care had smoked tobacco at least once in the past month (compared to 9% of trans and nonbinary youth who had never experienced care) and 41% had used illicit drugs at least once in their lives (compared to 26% of trans and nonbinary youth who had never

experienced care). Eighteen percent of Two Spirit respondents who had been in care reported they binge drank the previous Saturday; moreover, a third had smoked on at least one day in the past month and 39% had ever used a drug other than alcohol or cannabis. A larger proportion of those with government care experience reported smoking on at least one day in the past month compared to Two Spirit youth without care experience (33% vs. 18%). Additionally, some Two Spirit youth with care experience felt or had been told they needed help for their alcohol use (12%) or their use of a substance other than alcohol or cannabis (5%). Twenty-three percent of Two Spirit youth with care experience reported having felt or been told they needed help for their cannabis use compared to 11% of Indigenous youth ever in care who were not Two Spirit and just 4% of Two Spirit youth who did not have care experience.

"I went [to get help with mental health and substances use]... with a lot of mental health problems and getting zero help, bullying, harassment, other forms of harmful contact with people, I started drinking a lot more. And then I started trying other things. And then I was trying to get help because I was not in a position that I wanted to be. But there was no help for people my age, and no one was willing to kind of point you in the right direction. So I just kept doing what I was doing. The pandemic started and I couldn't go nowhere."

-trans male to female, Indigenous, 23 years old

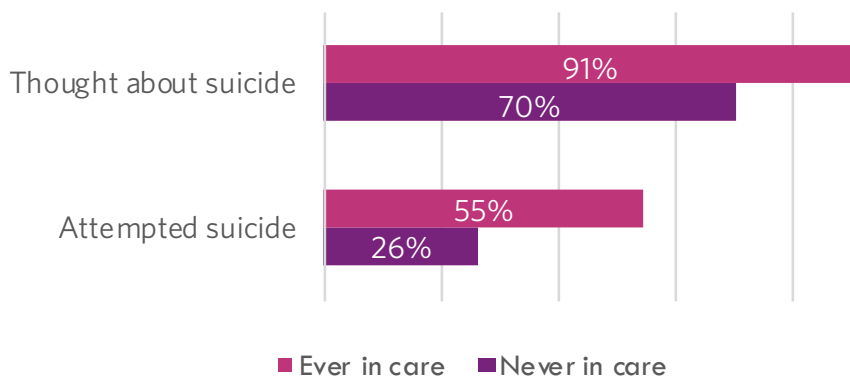
BC AHS Results: Social Support and Connectedness

When rating their feelings of connectedness to family and school, trans and nonbinary adolescents who had experienced government care scored lower on average compared to both those who had never been in care and their cisgender counterparts who had experienced government care. Similarly, Two Spirit youth showed lower school and family connectedness scores compared to their non-Two Spirit peers with government care experience and Two Spirit youth without care experience respectively.

"I struggled for years with depression, anxiety, suicidality. There was a time in my life when I didn't want to live really. And I felt like I was overwhelmed, and I didn't see a true future in my path. I didn't know where I would end up. And there are different paths that I could take, but none of them were very promising. You need so much support in your life obviously. You need support from your family members. You need support from your community. And when you don't have that, I feel really sad. Like, that's-- it's heartbreaking. And I had someone at school who watched me grow and gave me some tough love. I think something that I really-- I did need at the time. I think two-spirit youth and also Indigenous kids need more support in school."

-Two Spirit and nonbinary, 21 years old, Vancouver

CTYHS: Suicidality Among Trans & Nonbinary Youth



CTYHS Results: Physical Health, Mental Health, and Substance Use

Regarding the physical health of CTYHS participants, about a quarter of trans and nonbinary adolescents who had never experienced government care were unable to afford enough food compared to over half of those who had experienced care. As for mental health,

suicidality was higher among those who had experienced government care compared to those who had not experienced care. Overall substance use was also higher among trans and nonbinary youth who had been in government care, with 39% having used illicit substances at least once in their lifetime compared to 20% of those who had never been in care.

Literature Review Results: Access to Healthcare

Despite these disparities when it comes to physical and mental health, trans and nonbinary young people appear to be less likely access healthcare. Among those experiencing “hidden homelessness”⁶ in BC, trans and nonbinary young people were more likely to have forgone physical and mental health care compared to cisgender boys (Ferguson, 2018). Similarly, 21% of trans and nonbinary youth runaways in BC had forgone much needed physical health care – compared to just 10% of cisgender girls and 8% of cisgender boys who had run away from home (Ferguson et al., 2021).

Similarly, 22% of trans and nonbinary youth runaways had forgone mental healthcare compared to 17% of cisgender girls and 5% of cisgender boys, despite reporting worse mental health outcomes (Ferguson et al., 2021), as did 52% of unstably-housed trans and nonbinary youth compared to 36% of cisgender girls and 26% of cisgender boys (Ferguson, 2018). Ferguson et al. (2021) also found these runaway trans and nonbinary youth were more likely than cisgender boys to report avoiding care due to negative experiences with healthcare professionals in the past. Similarly, some trans and nonbinary adolescents involved in the youth justice and other forms of government care describe instances in which they had been misgendered and/or deadnamed by health care providers (Office of the Child and Youth Advocate Alberta, 2017).

“Counselling is so expensive... [especially for] a trans or non-binary person who’s then facing more discrimination if they try to get into a job. To be able to access mental health care, especially when you age out [of government care], you need to be financially stable. And people coming out of government care...don’t have that advantage...I think it’s really messed up that Canada brags about having free healthcare. But that doesn’t include most medications or dental care...or mental health care. Mental health is physical health. If you don’t have mental health care you can’t care for yourself physically either.”

-nonbinary, 25 years old, Vancouver

⁶ Housing instability that excludes staying with family outside the household of origin, staying in a shelter, or sleeping outside.

BC AHS Results: Access to Healthcare

Echoing the literature, our analyses revealed that fewer trans and nonbinary youth who had been in care got the healthcare they needed: 23% of trans and nonbinary adolescents who had experienced government care had forgone physical healthcare compared to 18% of those who had never experienced care. Similarly, among Indigenous youth with care experience, 27% of Two Spirit youth reported missing out on much-needed medical help in the past year compared to 18% of their Indigenous peers who are not Two Spirit.

The BC AHS also revealed a surprisingly large disparity when it comes to one particular type of healthcare: dental care. Significantly more trans and nonbinary youth with government care experience reported having never been to a dentist (18%) compared to their cisgender counterparts (5%) and other trans and nonbinary youth who had never experienced care (4%). This disparity did not appear among Two Spirit young people, with 96% reporting that they had been to the dentist.

CTYHS Results: Access to Healthcare

Among CTYHS participants, 60% of trans and nonbinary young people who had been involved in government care had forgone much-needed medical care compared to 36% of those who had never been involved in care.

Protective Factors

Literature Review Results: Parental Support

In virtually all instances, research reported that living in supportive, stable households or foster placements prevents trans and nonbinary youth from experiencing housing instability – for example, data from the Trans PULSE project in Ontario showed that among the 84 trans and nonbinary young people who were in the process of coming out or had already come out to their parents, all of those whose parents were supportive of their gender identities and expression were stably housed; by contrast, less than half of those whose parents were not strongly supportive were stably housed (Travers, 2012).

Literature Review Results: Compassionate and Competent Child Welfare Workers

Trans and nonbinary adolescents in care report feeling far more comfortable and supported when child welfare workers take their identities seriously and directly ask them for their correct name and pronouns; moreover, in the event that they are accidentally misgendered, youth felt far

“I feel like my social worker was really awesome and respectful of how I presented.”

-nonbinary, 21 years old, Fraser Valley

more comfortable when workers acknowledged their mistake and made a deliberate effort to avoid doing so again in the future (Office of the Child and Youth Advocate Alberta, 2017).

Literature Review Results: Social Support Networks Among the LGBTQ+ Community

Strong social connections with other LGBTQ+ young people serve as a key protective factor for trans and nonbinary youth to feel positive mental health and belonging, as they often feel socially isolated and unsupported within their households of origin, at school, and in foster placements (Côte & Blais, 2021). As mentioned previously, one of the potential benefits of street-involvement was the opportunity for trans and non-binary youth to form connections with trans and non-binary adults. Trans and non-binary adults can serve as positive role models – individuals that unstably housed young people can relate to and gain insight, advice, support, and inspiration from – that they might have never met otherwise (Shelton, 2016).

I feel pretty lucky...like, all my [government care] paperwork was under my birth name, but...[e]veryone still called me by my [chosen] name.

-trans man, 23 years old, Vancouver/
Fraser Valley area

Recommendations: Government Care and Housing Instability

Provide workers and caregivers with adequate 2SLGBTQ+-competency training:

- Workers and caregivers in the child welfare and shelter systems should be provided with mandatory training on 2SLGBTQ+ issues, experiences, and terminology so they are able to use the correct language, identify and discourage other residents displaying homophobic/transphobic behaviour, and interact with youth in a respectful and affirming manner (e.g., Mountz et al., 2018; Abramovich, 2013; Heard 2018).
- Workers should be aware of 2SLGBTQ+ resources and services so that they can provide them to youth – currently, many youth report having to seek these out for themselves, as staff often know very little about LGBTQ+ issues and are therefore uninformed about both these services and the need for them on the part of 2SLGBTQ+ young people (e.g., Office of the Child and Youth Advocate Alberta, 2017; Abramovich, 2013).
- Child welfare agencies should actively recruit foster parents who are either a) openly 2SLGBTQ+ or b) explicit 2SLGBTQ+ allies to ensure safer, more stable placements (Office of the Child and Youth Advocate Alberta, 2017).

Improve the intake process:

- Given that we do not yet know the number of 2SLGBTQ+ youth in Canadian child welfare and shelter systems, such organizations should record youths' sexual orientations and/or gender identities in a confidential and standardized manner during the intake process (Paul, 2020).
- As of June 2017, gender identity and expression have been protected under the Canadian Human Rights Act, making discrimination on the basis of gender identity

and/or expression – including a refusal to use a person’s affirmed name and pronouns – illegal. As an example, in 2021, a nonbinary server working in a restaurant in Gibson, BC was granted \$30,000 by the courts after being fired for asking their co-workers to refer to them by the pronouns they/them (Weichel, 2021). This suggests child welfare and shelter organizations are also required to honour youths’ gender identities and expressions under Canadian law.

- Youth entering the child welfare or shelter system should be given the opportunity at intake to state their affirmed name and pronouns (e.g., Shelton 2016). These organizations, in turn, should have clear non-discrimination policies that ensure youths’ identities will be recognized and supported, regardless of whether they have had a legal name/gender marker change (Abramovich, 2013).

Provide adequate support for youth aging out of care

- Age at which youth are forced to leave care – along with similar age limits resources and supports for adolescents in foster care – should be extended further into young adulthood to give youth adequate time to prepare and develop the life skills required to live independently (e.g., Gaetz et al., 2016).
- More material and social support should be provided for youth transitioning out of care, as many young people who end up socially isolated, unemployed, and/or street-involved/unstably housed after leaving the system (Gaetz et al., 2016).

Improve or eliminate sex-segregated residential spaces

- Transform sex-segregated spaces into gender-segregated spaces: in segregated residential arrangements, allow young people to choose between either the “male” or the “female” space rather than placing them in one or the other according to what they were assigned at birth or their legal gender marker (Mountz et al., 2018).
- Eliminate segregation entirely: create gender neutral living spaces and facilities (e.g., washrooms) that would allow youth of all genders—especially nonbinary youth whose identities exist outside the bounds of “male” and “female”—to live more comfortably (Robinson, 2018a).
 - › While this offers a solution to the issue of exclusionary spaces, we recognize that young people may feel unsafe living in such spaces due to past experiences and current threats of victimization. Therefore, we also recommend these spaces be vigilantly monitored by staff in a way that reduces the risk of violence in these spaces, while also remaining respectful of youths’ personal privacy. For example, bathrooms could have both a) floor-to-ceiling stall doors (rather than flimsy curtains) to allow for complete privacy and b) careful monitoring on the part of staff to ensure youths’ safety.
 - › Training staff to understand the needs of 2SLGBTQ+ youth is vital for creating an environment where a) youth feel comfortable communicating openly with staff about safety concerns or experiences of victimization and b) staff are equipped with the ability to identify instances of queerphobic violence and actively enforce their agency’s non-discrimination policies.
- Increase the number and capacity of all-gender washrooms in public spaces, schools, health care facilities, and other sites meeting basic needs of youth: all public spaces/parks/etc. should have all-gender washrooms, whether single- or multi-use (Asakura, 2019; Pullen Sansfaçon et al., 2021a).

Establish more 2SLGBTQ+-only residential spaces for youth in need

- Currently, there are few 2SLGBTQ+ residential spaces in Canada. Some examples include RainCity Housing (a residential program for unstably housed persons in Vancouver, BC) and Sprott House (a transitional housing program in Toronto, ON).
- More 2SLGBTQ+-only shelters, group homes, and transitional housing should be created (e.g., Ferguson, 2018; Office of the Child and Youth Advocate Alberta, 2017). This would allow more youth to access spaces where:
 - › Their identities are known, respected, and affirmed by both staff and residents;
 - › Knowledgeable adults can connect them to additional 2SLGBTQ+ resources (such as gender-affirming care) and help them access services (such as legal name/gender marker changes); and
 - › The threat of queerphobic violence from cisgender-heterosexual or closeted residents is reduced, making these spaces safer for them.

Foster connections between Indigenous 2SLGBTQ+ youth and supportive adults

- When it comes to Aboriginal young people who have experienced government care in BC, a report by Tourand et al. (2016) found that those with support from teachers and other adults in their lives reported better mental health compared to those who did not have such supports.
- Similar improvements in mental health and wellbeing may be achieved by ensuring that Indigenous 2SLGBTQ+ youth with care experience have the opportunity to form connections with adults who accept, respect, and understand their identities.
 - › In order to provide this much needed support, adult authority figures (including government care workers, foster parents, and health professionals) must be made aware of the unique experiences of youth who are both Indigenous and 2SLGBTQ+ and work to acknowledge all aspects of these youths' gender, sexual, and cultural identities.
 - › Government care workers and other service providers should be aware of resources (e.g., peer groups, cultural centres, 2SLGBTQ+ organizations) that would allow Indigenous youth under their care to connect with Indigenous 2SLGBTQ+ adults and peers in their community.

Recommendations: Identity-Affirming Policies, Services, and Other Supports

Ensure equitable access to gender-affirming services

- Additional efforts should be made to ensure that youth know their current legal rights with respect to accessing and consenting to healthcare in BC and have support in exercising those rights.
- As of January 10, 2022, those in BC who are 12 years or older can change their legal gender marker without approval from a physician or psychologist; however, those under the age of 12 still require approval from a medical professional, and all youth under 19 years old still must have parental consent.
 - › *Approval from a medical professional:* youth in care often face additional barriers when it comes to accessing healthcare, which may make it even more difficult for those under the age of 12 to access a medical professional—much less a gender-

competent one—to approve their gender-marker change.

- › *Parental consent*: youth in care may face additional barriers, as they may not have a parent from whom they can obtain consent, either because their parent(s) are deceased or otherwise incapacitated or—given that many trans and nonbinary youth experience rejection from their households of origin—parent(s) may refuse to consent when it comes to gender-affirming care.
- Under the Infants Act, persons under the age of 19 can consent to medical treatment without the approval of a parent/guardian so long as a medical professional has judged them capable of understanding the treatment they are being given and therefore able to give informed consent.
- › *Both youth and medical providers may not be aware of youths' rights*: efforts should be made to educate both youth and health care providers (particularly those providing gender-affirming, mental health, and/or substance use-related care) on youths' legal rights with respect to receipt of medical care without parental notification. Special attention should be paid to youth in care, who may have even less opportunity to seek out information regarding their legal rights due to the isolated nature of some child welfare and juvenile justice placements.

Adopt a multi-gender, intersectional, and strengths-focused approach to policymaking

- The diverse needs and experiences of young people with various intersecting identities—such as gender identity, sexual orientation, race, ethnicity, socioeconomic status, and culture—must be considered when developing appropriate, inclusive, and effective policies.
- Government policies are often developed within a strictly gendered framework that often does not account for those who exist outside this gender binary. Policymakers should consider the experiences of nonbinary youth, whose needs may differ from those of their binary peers.
 - › For example, requiring schools to allow binary transgender youth to use the gendered facilities that match their affirmed gender is vital for their health, but may not address the needs of non-binary youth for whom binary facilities may cause distress or even be unsafe.

Adopt and enforce policies and practices that encourage schools to create and maintain environments that are safe and affirming for trans and nonbinary youth

- *Gender and Sexuality Alliances (GSAs)*: multiple studies from our review showed that GSAs have the potential to be powerful forces for wellness in the lives of Canadian trans and nonbinary youth (Asakura, 2017, 2019; Eisenberg et al., 2018; Lapointe & Crooks, 2018; Peter et al., 2016; Porta et al., 2017a, 2017b). Given these findings spanning more than a decade, it is critical to support existing GSAs and encourage the creation of GSAs in schools without one.
 - › GSAs may be underused as places where tailored health interventions can be successfully delivered to trans and nonbinary youth. Only one study was found that described implementation of such an intervention, but the results were striking – youth raved about the benefits they reaped in both social support and in developing resilience and coping mechanisms (Lapointe & Crooks, 2018). Such programs may have downstream positive effects on youth health to the extent that they may

enable youth to come out earlier and therefore access gender-affirming care sooner, which has been linked to reductions in suicidality, anxiety, and depression (Sorbara et al., 2020a).

- › In areas where the sociopolitical climate may not allow for creation of GSAs, a possible intermediate step is the creation of “diversity” clubs that create safe spaces for youth experiencing marginalization to gather to support and learn from one another.
- *Teachers and administrator support:* youth in several qualitative studies described the behaviour of school authority figures as critical to their sense of safety and connectedness in school (Asakura, 2017, 2019; Munro et al., 2019; Travers et al., 2020). Even in schools with gender-affirming policies, these authority figures determine whether those policies are effective (Travers et al., 2020). Schools require funding and incentives to provide training, resources, and assurance that, once trained, staff are providing safe and supportive environments in which all youth can have equitable access to a quality education.
- *Other school-related factors:* one study noted that access to “queer media” (e.g., books, magazines, and comics portraying 2SLGBTQ+ youth) was associated with better mental health among trans and nonbinary youth (Asakura, 2017). A youth in this study said that reading LGBTQ non-fiction “is like building a fort. Every single book is a brick and then you build up this fort that can support you”. In rural areas, where access to in-person LGBTQ+ community may be more difficult, such media can provide a virtual community of support. School and local libraries should be supported in offering a variety of media that portray trans and nonbinary youth’s lives in affirming ways.

Develop and Support Infrastructure and Programs to Support Trans, Nonbinary, and Two Spirit Youth

- *Telehealth and Health Interventions:* at least one study suggested trans and nonbinary youth experienced benefits in accessing telehealth and online health interventions for their health care needs, especially those in rural areas (Craig et al., 2021b). Encouraging and resourcing telehealth services focused on trans, nonbinary, and Two Spirit youth could improve access to gender-competent and gender-affirming care, and provide important health promotion opportunities that might be missed among youth who avoid clinical services.
- *Universal High-Quality Broadband Access:* telehealth availability and high-quality online interventions are of little use to youth who cannot reliably access them. Only 40% of British Columbians in rural areas have internet access that meets the Canadian Radio-television and Telecommunications Commission (CRTC)’s target speeds of 50/10 Mbps - a speed necessary to ensure equitable access to information, community, and educational/occupational opportunities (Office of the Auditor General of British Columbia, 2021).
 - › Many trans and non-binary people in rural communities have immense difficulty accessing gender-affirming medical care in rural areas (Eisenberg et al., 2018; Craig et al., 2021b; Newhook et al., 2018). Ensuring adequate broadband internet access in these areas could help trans, nonbinary, and Two Spirit youth access the social and medical support they need. Access to online communities allows them to connect with peers, try new names and pronouns, access resources, learn about gender diversity, and find language to describe their own experiences.

- *Establish wellness centres that focus on young 2SLGBTQ+ people*: wellness centres that cater specifically to young and/or 2SLGBTQ+ people are a promising way of addressing the mental – and potentially physical – health needs of trans and nonbinary youth, especially those who are street-involved (Wang et al., 2020; Colvin et al., 2019).

Work with provincial agencies tasked with disaster preparation and mitigation to consider the impacts of province-wide disasters on trans, nonbinary, and Two Spirit youth

- The COVID-19 pandemic and natural disasters, like the wildfires and flooding that have ravaged the province in 2021 and 2022, are just two examples of emergency situations that disproportionately impact trans and nonbinary youth, especially those who may experience marginalization along multiple axes (e.g., are experiencing transphobic home environments or racial discrimination). Given the increase in wildfire activity in Canada in recent years and projections that this trend will only worsen (Coogan et al., 2019), along with similar predictions of rising incidence of global pandemics (Daszak et al., 2020), the underlying structural factors and social vulnerabilities affecting trans and nonbinary youth must be addressed. As southern BC rebuilds from the flooding of 2021 and the government considers future responses to such disruptive events, the vulnerabilities highlighted in this report should be considered in infrastructure repairs and upgrades (e.g., conversion of washrooms to all-gender ones) and prioritization of restoration of services (e.g., telehealth and the broadband access that enables such services to be accessed) post-disaster.

Limitations/Gaps in the Literature

Government Care

To date, very few studies have focused on trans and nonbinary youth with government care experience in Canada, much less in BC. Research on Two Spirit young people’s experiences with government care was even sparser. Further research is needed to understand the needs and experiences of these youth leading up to, during, and after their time in care, especially when it comes to accessing gender-affirming healthcare/services and navigating the education system in BC.

BIPOC Youth

Little is known about the needs of Indigenous youth who are Two Spirit, trans, and/or nonbinary. Future research should focus specifically on the needs of Indigenous youth (both in rural and urban areas) who do not fit into a colonialist cisgender binary, including how experiences may differ for Indigenous youth who are Two Spirit compared to those who are trans and/or nonbinary but not Two Spirit. When it comes to trans and nonbinary youth in BC who come from other racial/ethnic backgrounds, we know almost nothing – studies from the USA have considerably more racially-diverse samples compared to those from Canada. Understanding the experiences of young people with these intersecting identities is crucial for making improvements to health and social services that address the needs of all youth.

Protective Factors and Positive Outcomes

Most studies focused on disparities, and while it has been critical to document the many ways that anti-trans attitudes and binary gendered systems negatively affect trans and nonbinary youth health in order to address those inequities, limited attention has focused on ways that trans and nonbinary youth are agents in their own lives and the ways this can positively affect not only their health and well-being but that of their communities. A sharper focus on protective factors is needed for the provincial government to anticipate and meet the needs of this growing and vibrant population. Similarly, while we know comparatively little about Two Spirit young people in BC, supporting this population requires a more detailed understanding of both the positive and negative aspects of their experiences and needs.

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TRANS, NONBINARY AND TWO SPIRIT YOUNG PEOPLE'S EXPERIENCES OF GOVERNMENT CARE AND HEALTH SERVICES IN BC

James Sinclair, Eli Glen Godwin, Mauricio Coronel Villalobos, Jessica Tourand, Monica Rana, and Elizabeth Saewyc

Stigma and Resilience Among Vulnerable Youth Centre

Prepared for the Office of the Representative for Children and Youth



Appendices

Appendix 1 – Glossary

RCY is providing a glossary of terms used in this report that some people may not be familiar with. Unless otherwise indicated, these definitions were taken from Trans Care BC’s *Glossary of Terms* that appears on its website related to trans health and services available in B.C.¹³⁸

The Representative also acknowledges that the language and definitions of many of these terms are in flux. While the language used in this report is fixed in time, the correct words and definitions may evolve over time to become more respectful, accurate, or address power structures more effectively.

Assigned Sex at Birth	The legal designation of physical sex assigned to newborn infants at birth, based on the health care provider’s visual assessment of the newborn’s genitalia.
Cisgender	Used in reference to people who feel their gender identity matches their assigned sex at birth.
Gender	Gender has various dimensions (both individual and societal) that interact with and influence one another. This includes (but is not limited to) an individual’s gender identity and gender expression, along with a given society’s constructed gender norms, roles, behaviours, activities and attributes. Gender norms may influence how people perceive the gender of others, along with how they react to what is perceived as gender non-conformity. Trans individuals often experience “gender policing” which can be societal, cultural, community, or family pressure related to enforcing conformity to gender norms at the expense of an individual’s gender identity and expression.
Gender-Affirming Care	Gender-affirming care can be understood as the processes through which a health care system cares for and supports an individual, while recognizing and acknowledging their gender identity and expression. Also describes one’s gender transition.
Gender Binary	A view that there are only two genders (girls/women and boys/men) that are separate and unchanging.
Gender Diverse	Individuals that align with gender roles and/or gender expression that do not match social and cultural expectations
Gender Dysphoria	Distress resulting from a difference between a person’s gender identity and the person’s assigned sex at birth, associated gender role, and/or primary and secondary sex characteristics.
Gender Expression	How one outwardly shows gender; including through name and pronoun choice, style of dress, voice modulation.
Gender Fluid	Individuals that align with a gender that is changeable

¹³⁸Trans Care BC, “Glossary,” n.d., Accessed May 30, 2023. <http://www.phsa.ca/transcarebc/gender-basics-education/terms-concepts/glossary#undefined>

Gender Identity	One’s deeply held, internal sense of self as male, female, a blend of both, or neither; who they internally know themselves to be.
Gender Roles	The socially constructed and culturally specific behaviours (such as communication styles, careers, family roles and more) imposed on people based on their sex assigned at birth. It is important to note that gender interpretations and expectations vary widely among cultures and often change over time. Some cultures have more than two genders, and consequently more than two gender roles. ¹³⁹
2SLGBTQIA+	An evolving acronym for Lesbian, Gay, Bisexual, Trans, Two Spirit, Queer, and additional identities. There are many variations of this acronym. (e.g., LGBTQ, LGBTQ+, 2SLGBTQ+)
Medical Transition	To undergo the medical steps an individual deems necessary in order to more closely align their physical body with their gender identity. This may include hormone therapy and gender-affirming surgeries.
Misgender	To refer to someone (especially a trans or non-binary person) by using a word, like a pronoun or form of address (i.e., sir, ma’am), that does not correctly reflect their affirmed gender identity. The act of misgendering can be done intentionally and with malice, or with ignorance; both are harmful. ¹⁴⁰
Non-binary	This umbrella term refers to diverse people whose gender identity is neither female or male. Some individuals self-identify as non-binary, whereas others may use terms such as Gender Non-conforming, Genderqueer, or Agender. Non-binary people may or may not conform to societal expectations for their gender expression and gender role, and they may or may not seek gender-affirming medical or surgical care.
Puberty Blockers	A group of medications for youth that temporarily suppress or inhibit puberty by suppressing the production of sex hormones and preventing development of secondary sex characteristics.
Queer	A term becoming more widely used among 2SLGBTQIA+ communities because of its inclusiveness. ‘Queer’ can be used to refer to the spectrum of non-heterosexual and/or non-cisgender people and provides convenient shorthand for ‘2SLGBTQIA+.’ ‘Queer’ is also used by some people as a specific identity term when referring to themselves. ¹⁴¹
[gender] Questioning	A term sometimes used by those in the process of exploring their gender or sexual orientation, as well as choosing not to identify with any other label.
Sex	Biological attributes and legal categories used to classify people as male, female, intersex or other categories, primarily associated with physical and physiological features including chromosomes, genetic expression, hormone levels and function, and reproductive/sexual anatomy.
Transgender (Trans)	An umbrella term that describes a wide range of people whose gender identity differs from their assigned sex at birth. Transgender is often shortened to trans, as in this report.

¹³⁹QMUNITY’s 2022 Queer Glossary.

¹⁴⁰QMUNITY’s 2022 Queer Glossary.

¹⁴¹QMUNITY’s 2022 Queer Glossary.

Trans Man	A term that describes someone who is a man, and identifies as trans. Most trans men were assigned female at birth and have since socially and/or medically transitioned to male.
Trans Woman	A term that describes someone who is a woman, and identifies as trans. Most trans women were assigned male at birth and have since socially and/or medically transitioned to female.
Transition	Refers to the process during which trans people may change their gender expression and/or bodies to reflect their gender, including changes in physical appearance (hairstyle, clothing), behaviour (mannerisms, voice, gender roles), identification (name, pronoun, legal details), and/or medical interventions (hormone therapy, gender-affirming surgery).
Transphobia	Ignorance, fear, dislike, and/or hatred of trans people, which may be expressed through name-calling, disparaging jokes, exclusion, rejection, harassment, violence and other forms of discrimination. This may include refusing to use a person's name/pronoun, denial of services, employment and housing.
Two Spirit (2-Spirit or 2S)	<p>An umbrella term used by many Indigenous communities on Turtle Island (North America) to describe people with diverse gender identities, gender expressions, gender roles and sexual orientations. Two Spirit people were included and respected in most Indigenous communities, and were sometimes considered sacred and highly revered. They often took on important roles as healers, mediators and warriors. This term was coined at the 1990 Indigenous Lesbian and Gay Gathering in Winnipeg to create a pan-Indigenous term to collectively refer to the many gender diverse Indigenous identities and to replace offensive non-Indigenous terminology in use at the time. Two Spirit identities, histories, and traditions vary across different Indigenous Nations. Many Indigenous Nations have their own specific terms for Two Spirit people, and individuals who hold these identities may use these terms other than Two Spirit. It is important to use Nation-specific language whenever possible.</p> <p>One of the devastating impacts of colonization was the attempted erasure of Two Spirit people from Indigenous societies due to the homophobic, transphobic and misogynistic values brought over and enforced by European settlers which still affect many Nations today. Despite this, Two Spirit people have survived and their presence continues to grow in size and visibility, reclaiming traditional roles in their communities and strengthening their relationships with their cultures and families. Not all people who are Indigenous and gender/sexually diverse will describe themselves as Two Spirit and this is their right of self-determination. Two Spirit is an identity embodied exclusively by Indigenous people and should never be used by non-Indigenous people.¹⁴²</p>

¹⁴²QMUNITY's 2022 Queer Glossary.

Appendix 2 – Critical Injury Definition and Classifications

Reports are sent to RCY for children/youth who are injured or die while they or their families are or have been receiving reviewable/designated services. These reports are entered into RCY’s proprietary database, CITAR, after an initial review by an Analyst to determine whether the report meets RCY’s legislative mandate. In order to meet the legislative mandate, **ALL** of the following criteria must be met:

1. The child/youth was critically injured or died
2. The child/youth was under 19 years of age at the time of the critical injury or death
3. The critical injury or death occurred within 12 months of the delivery of a reviewable/designated service(s) to the child/youth or their family.

A critical (in-mandate) injury is defined by the *RCY Act* as: *an injury to a child that may*

- a) *result in the child’s death, or*
- b) *cause serious or long-term impairment of the child’s health.*

Where a report does not meet all of the above criteria, it will be categorized as “out-of-mandate.” Both in-mandate and out-of-mandate reports are coded using the following scheme:

RCY Classification Type – INJURY	Incident Types
Emotional Harm (EH)	<p>An injury that may cause an emotional injury to a child/youth. For emotional harm to be considered in-mandate in the RCY classification scheme, it must reasonably be seen as having a potential to cause serious or long-term emotional or psychological harm to the child/youth.</p> <ol style="list-style-type: none"> 1. Clear and direct threats to safety 2. Death of, or violence suffered by another (death of parents, significant caregiver always in-mandate) 3. Use of behaviour management methods (chemical or physical restraints, medical neglect, withholding food, and/or isolation) 4. Kidnapping or abduction 5. Mistreatment/inappropriate behaviours by an approved caregiver or usually trusted person 6. Severe neglect/deprived of health care 7. Alleged perpetrator/involved in criminal activity 8. Pregnancy loss 9. Lost or missing or not living in placement/with family 10. Danger to others (any threats to safety of others including homicidal ideation) 11. Danger to self (psychosis, aggression, destructive behaviours, including non-physically harming self-harming behaviors).

RCY Classification Type – INJURY	Incident Types
Physical Harm (PH)	<p>An injury that caused physical injury to a child/youth which can be self-inflicted or accidental. For physical harm to be considered in-mandate in the RCY classification scheme, it must cause more than minor soft tissue damage.</p> <ol style="list-style-type: none"> 1. Broken, fractured or dislocated bones 2. Head injury 3. Significant bruises 4. Wounds requiring stitches 5. Accidental injuries –Other or unspecified 6. Injuries arising from severe neglect 7. Life-threatening or serious medical conditions (disease, burns, disordered eating, asphyxia, complications of surgery, seizure disorders) 8. Self-harm
Physical Assault (PA)	<p>An injury that caused physical injury to a child/youth which was inflicted by another person. For physical assault to be considered in-mandate in the RCY classification scheme, it must cause more than minor soft tissue damage. Where a physical assault does not cause a critical physical injury and it is relational/ domestic violence, code as Emotional Harm.</p> <ol style="list-style-type: none"> 1. Broken, fractured or dislocated bones 2. Head injury 3. Significant bruises 4. Wounds requiring stitches 5. Gun shot wound 6. Assault – other or unspecified injuries 8. Assault by an approved caregiver or usually trusted person

RCY Classification Type – INJURY	Incident Types
Sexualized Violence (SV)	<p>A sexualized act committed on a child/youth without their consent. This may be a physical act, but it may include non-contact unwanted sexual experiences (such as invitation to touch, luring or threats). Sexualized violence is non-consensual in that the child/youth did not or could not consent, and it is also non-consensual when the child/youth is not able to consent due to age, mental capacity or other factors.</p> <ol style="list-style-type: none"> 1. Sexual exploitation (sexual abuse of a child/youth through the exchange of sexual acts for drugs, food, shelter, protection, life necessities and/or money). 2. Sexual abuse (sexualized violence committed on a child/youth by a person in a position of trust, authority, or dependency). 3. Sexual assault (non-consensual sexual act perpetrated on a child/youth – must involve touch). 4. Sexual Misconduct (non-touching and non-consensual acts e.g., collection and distribution of images, exposure, harassment). 5. High-risk sexual behaviours – sexual activity with multiple partners without using barrier protections, sexual activity with partners that use intravenous substances.
Substance-Related Harm (SR)	<p>The use of drugs, alcohol or other substances in a way that causes a critical injury. For substance misuse to be in-mandate in the RCY classification scheme, it must have led to a possible serious injury or death.</p> <ol style="list-style-type: none"> 1. Drug overdose (illicit drugs such as cocaine, heroin, fentanyl). 2. Overdose – other (unknown or prescribed medications). 3. Severe alcohol intoxication that could have resulted in death or serious injury. 4. Other substance use.
Suicide Attempt, Suicidal Ideation (SASI)	<p>A suicide attempt is defined as a non-fatal attempt to take one’s life. Suicidal ideation refers to thinking about, considering or planning suicide. For these to be considered in-mandate in the RCY classification scheme, the attempt or ideation must have led to a critical injury, or have been intended to lead to a possible critical injury or death.</p> <ol style="list-style-type: none"> 1. Suicidal ideation with close proximity to a potentially injurious means (e.g., expressing the intent to die while holding a knife or a rope). 2. A suicide attempt with injuries that may cause long-term impairment or death (e.g., attempting to overdose in a suicide attempt but being resuscitated). 3. A suicide attempt with non-critical injuries, but the potential, or belief, of a serious injury (e.g., an attempt to jump from a high location where the child was stopped prior to jumping). 4. Suicidal ideation, no attempt and no injury.

Appendix 3 – MCFD Policy and Practice Analysis Summary

RCY requested information from MCFD on all policies, guidelines and practices regarding gender diverse youth. Each document provided by the ministry was reviewed by using key search terms such as gender, gender identity, gender orientation, gender expression, gender diverse, transgender, non-binary and LGBTQ2S+. RCY looked at the material to see whether it addressed these questions:

- What policies exist in relation to working with gender diverse youth?
- What policies and practice guidelines exist in relation to training of staff for working with gender diverse youth?
- Do the policies include any reference to a child’s preferred pronouns and name? Are there any practice guidelines or policy in relation to privacy in relation to a child’s preferred pronouns and name?
- What policy and practice documents exist in relation to placement for children and young people who live in out-of-home placements?

RCY also requested information about training for service providers, caregivers, residential services, placement resources and information systems guidelines for naming and pronouns.

Summary

What policies exist in relation to working with gender diverse youth?

Across all policy, standards and guidelines there appears to be consensus that specific, relevant and affirming care must be provided for gender diverse youth. However, some ministry program areas provide more direction than others. In some cases, there is reference made to gender diverse youth more generally, but policies and standards do not appear to provide specific information on how to best serve and/or support youth who identify as gender diverse. For example, many policies and standards reference the need for staff to be respectful and inclusive of gender identity as well as other identities such as sexuality, religion, etc. in reference to intake, evaluation or quality of services.

Program areas that provide specific policy and/or practice guidelines regarding gender identity include:

- Within child welfare, there are *Practice Guidelines: 2SLGBTQ+ Inclusiveness in Child Welfare Settings*. Other pieces of child welfare policy, including the *Child in Care policy*, refer workers back to these guidelines for reference.
- CYMH has created *Working with Specific Groups of Children and Youth at Risk for Suicide: A supplemental guide for mental health practitioners focused on Indigenous and LBGBTQ+ youth, self-harming practices, and the role of social media in recognizing and responding to suicidal behaviors*, which includes a section on 2SLGBTQ+ youth that discusses gender-affirming care.
- Youth Custody Services also offer specific information in relation to case management for gender diverse youth within its operations information. Most notably, the *Youth Custody Operations Manual* makes reference to the possibility of including young people in decision-making about where they are placed.

Within the *Practice Guidelines for 2SLGBTQ+ Inclusiveness in Child Welfare Settings*, there appears to be little direction on how to access resources for gender diverse youth. The guidelines state that “*when appropriate, know how to access funding for non-typical expenditures such as hair extensions or hair removal, hormones, packers and binders, breast augmentation, as well as funding when a child is ‘coming out’ and requests gender reassignment/meeting the medical health needs of children and youth.*” It remains unclear as to whether there is any opportunity to have MCFD provide financial support in these circumstances.

Overall, CYMH policy references the need for practitioners to be inclusive and equitable by recognizing intersectionality. The policy directs practitioners to apply a Gender-Based Analysis Plus lens to deliver competent, youth-centred, trauma-informed inclusive care.

What policies and practice guidelines exist in relation to training of staff for working with gender diverse youth?

All ministry staff are required to complete Diversity and Inclusion training; however, this is not specific to gender diversity, or working with children and youth.

In response to RCY’s s.10 request, MCFD indicated that some training offerings are required for child welfare practitioners, resource workers and foster caregivers or are recommended for child welfare, CYMH clinicians and other ministry front-line service providers.

- Within most of these training opportunities provided, working with 2LGBTQ+ youth is mentioned or used within a practice example.
- Within the required foundational training for child welfare practitioners, there appears to be additional content including how the lack of cultural safety has impacted youth within the 2SLGBTQ+ community, how workers might provide culturally appropriate services and supports to them, and information on why pronouns matter.

Within the *Practice Guidelines: 2SLGBTQ+ Inclusiveness in Child Welfare Settings*, it seems that the responsibility for developing knowledge and embracing the needs of 2STNBGD young people falls to individual workers. The *Practice Guidelines* state: “*it is recommended that all individuals involved in planning and caring for this population engage in continual education regarding the challenges and specific needs experienced by 2SLGBTQ+ children and youth.*”

It appears that most policy does not require education or training for staff, however there are some exceptions:

- Within the *Youth Custody Operations Manual*, a section on training states that “*the policy is supported by training and education for staff, and if appropriate, youth*”. The *Standards for Safe House Services in British Columbia* requires staff to be well trained in their role, which includes understanding and working with young people who are gender diverse.

Do the policy and practice documents include any reference to a child's preferred pronouns and name? Is there any reference to privacy in relation to a child's preferred pronouns and name?

Within some of the MCFD policy and practice documents reviewed for child welfare, CYMH and some areas of youth justice, it appears workers are encouraged to use a child's preferred pronouns and name.

It appears that the only references to both privacy and pronouns are mentioned in the child welfare practice guide and the youth justice operations manual. The B.C. guidelines for gender and sex data also discuss the importance of privacy when discussing gender identity with young people.

- For the Specialized Intervention and Youth Justice case management system CORNET, the *Youth Custody Operations Manual* states that staff are to verify the young person's preferred name and gender pronouns "(by asking them)" and to ensure that this information is reflected in CORNET and the warrant file. In the s.10 response, MCFD states that CORNET captures gender as female/male/known only.
- The *Practice Guidelines: 2SLGBTQ+ Inclusiveness in Child Welfare Settings* directs the service provider to "ask if the child or youth has situations where it is unsafe for them to be referred to by their preferred name and pronouns" during the intake process and to "treat information about a child's or youth's gender identity as confidential to ensure privacy consistent with MCFD and DAA policies."
- The *B.C. Guidelines to the Gender and Sex Data Standard* suggest that service providers should ask about gender and sex in private spaces and be mindful that trans people including youth, may be with a guardian or care provider to whom disclosure may be dangerous.

In the last year, MCFD adopted the *B.C. Gender and Sex Standard* for some of its case management systems and forms. The *Standard* sets out how to collect sex and gender data by providing a guide for how to collect information and what terms to use. For MCFD, this resulted in changes to the gender data collection practice by shifting away from collecting information on sex (female/male) to gender (woman/girl, boy/man, non-binary or prefer not to answer/unknown).

CYMH uses CRIS as its data management system. The user guideline states that if a client transitions to a new gender and chooses a new name but has not legally changed their name, there is a section where the practitioner can record this information to reflect their preferred name.

What policy and practice guidelines exists in relation to placement for children and young people who live in out-of-home placements?

Overall, policy and practice guidelines and standards state that youth should not be discriminated against based on their gender expression; however, there does not appear to be evidence on how that is supported through resources, training and education. The *Youth Custody Operations Manual* seems to be the only guideline that directs practitioners to include youth in decision-making regarding placement.

Child welfare standards state that children and youth should not be discriminated against in their placement. While the *Standards for Safe House Services* includes a section on evaluating services to provide service that is respectful of a youth's gender identity as well as staff training to ensure that staff have understanding of gender diversity, overall, it does not appear that there is evidence of evaluation of placement services or required training for caregivers providing care to gender diverse young people.

The *Practice Guidelines: 2SLGBTQ+ Inclusiveness in Child Welfare Settings* require the service provider to assess whether a placement is suitable for gender diverse youth. It is unclear if there is training for service providers to make this assessment; whether resources and training are offered to support caregivers to become suitable placements, and there is no indication that a service provider should ask a young person what their wants and placement needs are in relation to their gender identity in order to feel comfortable and safe in their placement.

There appear to be competing priorities in the *Practice Guidelines: 2SLGBTQ+ Inclusiveness in Child Welfare Settings*. The guide states that one in four queer and transgender youth are forced out of their homes due to severe family conflict. It also states that, whenever possible, the need for placement should be prevented by offering the family, child/youth resources and support services. It is unclear what resources and support services are offered to families who are experiencing conflict regarding gender identity.

The *Youth Custody Operations Manual* includes a section on placement that states that transgender/non-binary youth are placed on a unit according to their self-identified gender and that youth are involved in the decision-making process.

Although not required or discussed in policy, it appears that the Maples has taken steps to make its physical space inclusive of gender diverse young people through signage and restructuring the building to move away from gendered spaces. There does not appear to be any information included within policy or practice guidelines in relation to services and support provided.

Acts, protocols, practice guidelines and policies reviewed

- *An Act Respecting First Nations, Métis and Inuit Children and Families*, c. 24, s. 9: Principle Substantive Equality (2019)
- *Chapter 5: Children and Youth in Care Policies*
 - Policy 5.2 Assuming Responsibility for a Child/Youth in Care (2021)
 - Policy 5.4: Working in Collaboration with Caregivers (2021)
 - Policy 5.7 Putting the Care Plan into Action (2022)
- *Practice Guidelines: 2SLGBTQ+ Inclusiveness in Child Welfare Settings* (2020)
- *Standards for Foster Homes* (2021)
 - D.2 Culture and Religion
 - D. Quality of Service Experiences
- *Standards for Staffed Residential Children's Services* (2019)
 - D. Quality of Service Experiences
 - G. Human Resources
- *Standards for Safe House Services in British Columbia* (2002)
 - A.3 Evaluation
 - A.6 Staff Training
 - D.1 Health Care
 - D.7 Sexual Security

Appendices

- *Youth Mental Health Transition Protocol Agreement* (between MCFD, MoH/Health Authorities (2015).
- *CRIS Guideline on Naming Protocols for Transgender Youth* (2018)
- *Child and Youth Mental Health Community Practice*
- *B-1: CYMH Intake Services Policy* (2022)
- *B-14: Transition and Discharge planning* (2021)
- *Working with Specific Groups of Children and Youth at Risk for Suicide: A supplemental guide for mental health practitioners focused on Indigenous and LGBTQ2S+ youth, self-harming practices, and the role of social media in recognizing and responding to suicidal behaviors* (2021)
- *Preventing Youth Suicide: A Guide for Practitioners* (2013)
- *CYMH Service Response Priority Ranking Tool* (2022)
- *Youth Custody Operations Manual* (2021)
- *Maples Adolescent Treatment Center YC650 Medical and Psychiatric Treatment-Emergency and Non-Emergency* (2020)
- *CRIS Use Guideline #1 Recording Assumed Trans-Gender Names in CRIS* (2018) *Province of British Columbia Gender and Sex Data Standard Version 1.0* (2023)

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