Brief Points on
The Transgender Condition
and The Consequences of Related Bills.

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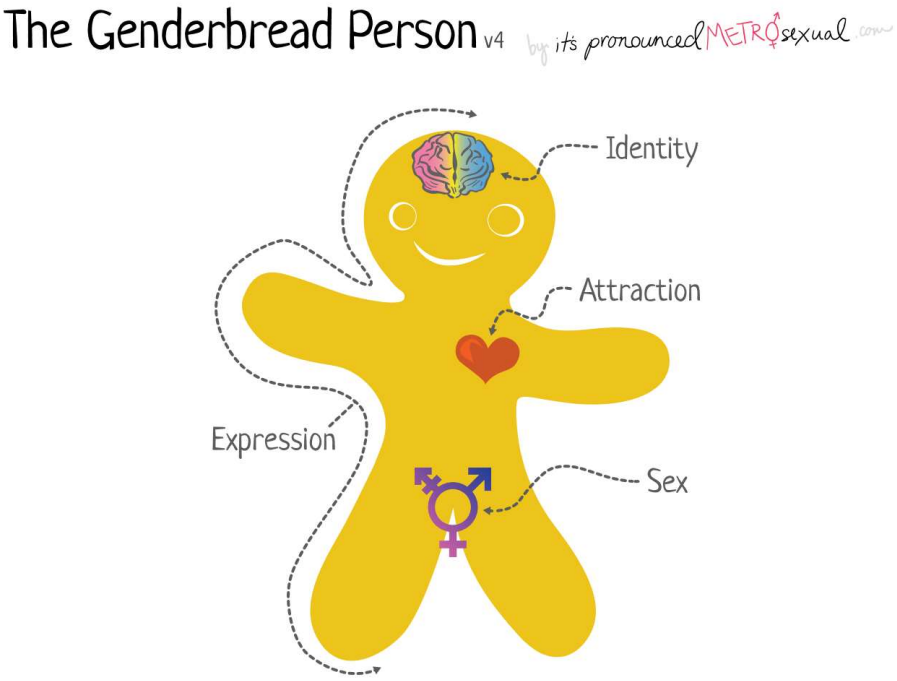
1. Terminology

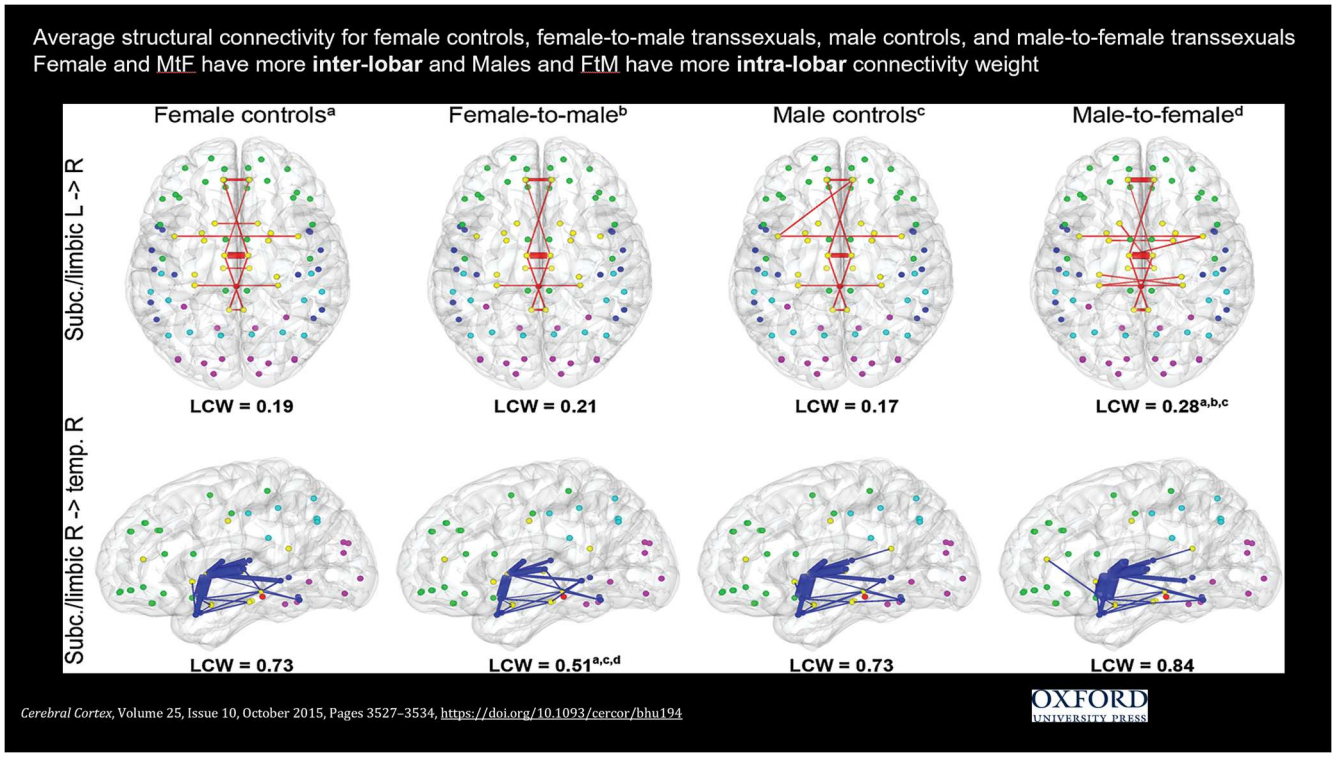


2. What does it mean to be a woman/man? Transgender?

Complex efforts underway to define complex sociological, anthropological, economical, physiological, psychological, spiritual and religious concepts that, in certain cultures, or circumstances, are not even binary. Neuroimaging studies – see below

- Transgender condition is a **real medical condition** – in many aspects akin to a congenital malformation– the medical term is **Gender Incongruence**. The Manual of International Statistical Classification of Diseases and Related Health Problems (ICD-11) eliminates the term "transsexualism" and replaces it with the term "Gender Incongruence ". This new terminology will no longer be part of the chapter on mental disorders (chapter 6) but a new chapter is created (chapter 17) called "conditions related to sexual health".

- Imaging studies clearly reflect the reality of this condition: the brains of transgender people present as the brains of their gender identity, and not as the brains of their assigned gender at birth(Hahn et al., 2015).

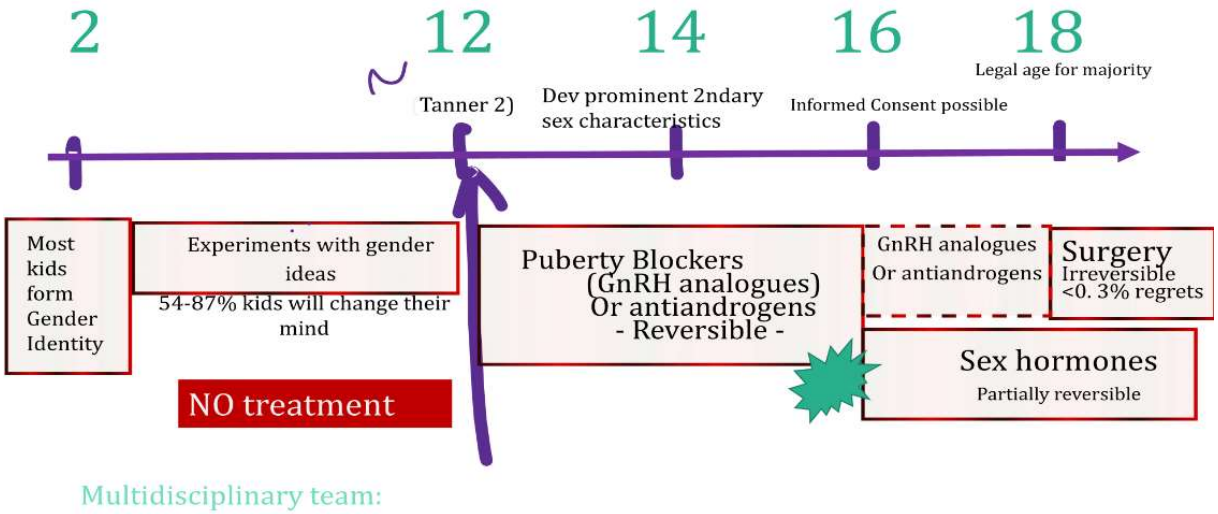


- The mental distress that some transgender people experience as a result of Gender Incongruence condition + non-affirming conditions = Gender Dysphoria in the Diagnostic and Statistical Manual of Mental Disorders DSM5 (available on APA website at https://dsm.psychiatryonline.org/)

3. Transgender Healthcare is a thorough process, sanctioned by decades of research and data gathering, and facilitated by well-established protocols.

The treatment for Gender Dysphoria according to the standards of care of
American Medical Association (AMA),
American Psychiatry Association (APA),
American Association of Child and Adolescent Psychiatrists (AACAP),
American Academy of Pediatrics,
Pediatric Endocrinology Society,
Endocrinology Society,
American College of Obstetricians and Gynecologists (ACOG),
follow the Standards of Care 8 of WPATH – an international multidisciplinary team of clinicians, researchers and stakeholders who have most expertise and have conducted most and longest studies in the domain of transgender care. Bans of evidence-based medical care like current bills have been strongly condemned by professional associations: AACAP, AMA, APA, etc.

There are several **misunderstandings** that I would like to clarify, because some provisions in the current bills address non-existent situations. The figure below may help visualize the **real timeline of the regular transgender care.**



Important **milestones** in a child's life –
Delays in the healthcare system functioning can have disastrous consequences!!

a. Minors have **NEVER** received gender-affirming surgeries in our state.
b. Pre-puberty children are **NOT** prescribed puberty blockers or sex hormones.
c. Puberty blockers' actions block the development of the secondary sexual characteristics, allowing the youth to undergo thorough diagnostic evaluation, mental health evaluation and follow ups. **NO** sex hormones (gender affirming hormones) are prescribed without mental health supervision. Allowing natural sexual development causes severe distress and irreversible physical changes, very difficult to correct later.
d. **NO** gender affirming surgery is done without thorough **mental health evaluation** and/or **treatment** and **follow up**.
e. The whole transition **process takes many years**, and the youth is under close supervision from a multidisciplinary team, with **parental consent.**
f. All transgender care is documented so the whole transgender health domain gains from the collective experience at state, national and international levels. There are extremely few conditions where such close and transparent collaborations are possible.
g. There have been **misleading articles** that advanced ideas like rapid onset gender dysphoria (L Littman 2018) that the journals and the professional associations have since proven to be based on biased data and faulty methodology.
h. "**Let's wait until they reach maturity, they are confused**." While providing at least some type of gender-affirming care has impressive benefits – see below, withholding gender-affirming treatment is an active choice with severe consequences.

4. Consequences of not receiving care -

The stats are sobering: this inner despair translates into feeling inadequate, less than everybody else, unable to enjoy many activities in our binary world (very similar to the definition of depression), worrying about their future and how they will ever play by the society's rules, and being the subject of thorough bullying like only kids (or insensitive adults) can provide. Several sources summarized in 2020(Price-Feeney et al., 2020):

- Lifetime prevalence of depression in transwomen at 51%, 48% for transmen.
- Anxiety lifetime prevalence at 40% for transwomen, 48% transmen.
- PTSD up to 42% in trans adults.
- Serious suicide ideation 87% and suicide attempts 41% (general population suicide attempts are 0.2%.)
- In LGBT Youth, discrimination doubles the risk of suicide. Youth's ideation about suicide is 3 times that of their peers (up to 65%) and attempted suicide rate is 4 times that of their peers (see attachment below).
- Our own youth data - North Dakota LGBTQ+ School Climate Report (2021) Faye Seidler.

Suicide:

- 61.6% Seriously considered attempting suicide
- 48.5% Made a plan to attempt suicide
- 33.3% Attempted suicide

Mental Health

- 84.6% Do not turn to adult when feeling sad, empty, hopeless, angry, or anxious
- 26.7% Have no idea who to talk to when experiencing distress
- 51.7% Can identify one adult to talk to if they have a problem
- 61.1 % Reported bad mental health for one week or more each month.

Bullying

- 45.6% Experience electronic bullying
- 59.6% Experience bullying on school property
- 8.7% Straight students bullied due to perception they were LGBTQ+

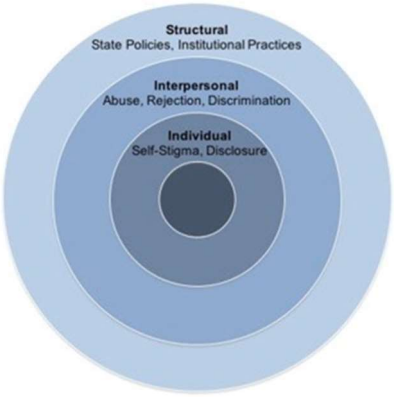
Sexual health

- 21.3% Have had sexual thing done to them they did not want
- 9.8% Texted, e-mailed, or posted electronically a revealing or sexual photo
- 13.4% Have had sex

Are these people intrinsically damaged in some way?! The answer is clearly **NO**: once they get gender-affirming treatment, be that surgery or just hormones**, their mental health becomes actually better than that of the general population(de Vries et al., 2014)!!**

Furthermore, if they receive social affirmation, one adult in their environment respecting their preferred nouns, etc, their suicide likelihood rate goes down by 70%.

The concept of Minority Stress(Hatzenbuehler, 2009; Hatzenbuehler & Pachankis, 2016) - The environment – related stressors – will cause chronically high levels of adrenaline, coupled with internal stress – expectation of rejection. When coping is maladaptive (which is the normal case), society unsupportive and one internalizes the negative cognitions (stigma). The result is psychopathology, despite the fact that the individual's condition is NOT pathological.



Stigma as a multi-level construct

5. Consequences of receiving gender affirming care are overwhelmingly positive

More data pertinent to mental health issues in the transgender people and how gender-affirming measures and care influence those

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Factors that influence mental health in youth

Family acceptance/rejection - cca **26%** of the variability (Khaleque & Ali, 2017)

Gender Affirming Care: Comprises – (see timeline in pamphlet)

- **Social-Affirming Measures**– pronouns, school records, hospital records, legalization of name, etc
- **Gender-Affirming Hormone Therapy** (GAHT)- recommended only after 16 yo, sex-hormones – (partially reversible) – odds of depression decrease, quality of life increases significantly in meta-analysis (Baker 2021)- youth and adults, (Green 2022,) – youth, (Turban 2022)- youth
- **Gender-Affirming Surgeries** – Only after age 18 - top surgery more often: 25% of TGNC, bottom surgery less frequent - (Almazan & Keuroghlian, 2021) - 2015 US Transgender Survey
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For a **comprehensive list of studies that led to the statements of recommendations** from this chapter (CH 2 Global Applicability – in Standards of Care v8 of wpath.org/soc8) see the scanned page Appendix 1 at the end of this document.

Mental health stats for baseline before treatment– worldwide and US – see source for stats Appendix 2

Transgender (TG) Mental Health:

Depression: 51% trans women, 48% trans men;

Anxiety: 40% trans women, 48% trans men;

PTSD: 17.8-42% have PTSD;

Suicide attempts – general population 4%; LGB adults 11-20%, transgender adults 41%

Suicide ideation youth – 38-65%

Suicide attempts – 30-40%

After treatment, the mental health of the transgender people is better than that of their peers due to the mandatory psychotherapy

<u>Baseline mental health stats for ND</u> –2021 ND LGBT+ School Climate Survey – Faye Seidler

ND Data LGBT+ youth

Suicide: 61.6% Seriously considered attempting suicide

48.5% Made a plan to attempt suicide

33.3% Attempted suicide

Mental Health

84.6% Do not turn to adult when feeling sad, empty, hopeless, angry, or anxious

26.7% Have no idea who to talk to when experiencing distress

51.7% Can identify one adult to talk to if they have a problem

61.1 % Reported bad mental health for one week or more each month.

ND Comparative Data Between LGBT+ and Straight Youth

Suicide – LGBT+ Youth Are:

222% More likely to consider attempting suicide

270% More likely to plan suicide attempt

354% More likely to attempt suicide

Mental Health – LGBT+ Youth Are:

22.0% More likely to not turn to adult to turn to when feeling distress

37.8% More likely to have no idea who to talk to when experiencing distress

21.4% More likely to not be able to identify one adult to talk to if they have a problem

192% More likely to report bad mental health for one week or more each month.

Selected studies

(Khaleque & Ali, 2017) – Family acceptance/rejection account for cca 26% of the variability in youth mental health outcomes - **meta-analysis** of 551 studies (48% unpublished (!) and 52% published). The studies were conducted over period of 42 years, from 1975 through 2016. They represent an aggregate sample of 149,440 respondents, including males and females, children and adults. Respondents were taken from 31 countries on five continents.

(Baker et al., 2021): – **meta-analysis** of 20 studies, number participants 20 - 1331 from 8 countries + European Network for the Investigation of Gender Incongruence (ENIGI) – depression scores decreased significantly in all studies, regardless of the scales used (BDI II, Zung, HADS, SCL-90 R, PHQ 9 etc.) quality of life increased, tendency to lower suicide rates.

(**Green et al., 2022)** –2020 **survey** of 34,759 lesbian, gay, bisexual, transgender, queer, and questioning youth aged 13–24, including **11,914 transgender or nonbinary youth**.

Half of transgender and nonbinary youth said they were not using GAHT but would like to, 36% were not interested in receiving GAHT, and 14% were receiving GAHT. Parent support for their child's gender identity had a strong relationship with receipt of GAHT, with nearly 80% of those who received GAHT reporting they had at least one parent who supported their gender identity.

Use of GAHT **decreases odds of recent depression by 73%** and **seriously considering suicide by 74%** compared to those who wanted GAHT but did not receive it. For youth under age 18, GAHT was associated with decrease in the odds of recent depression by 61% and of a past-year suicide attempt by 62%.

Table 5. Multivariate adjusted logistic regression of gender-affirming hormone therapy on depression and suicidality among transgender and nonbinary youth

	Overall sample		Ages 13–17	
	aOR (95% CI)	*p*-value	aOR (95% CI)	*p*-value
Depression	0.73 (0.61–0.88)	<.001	0.61 (0.43–0.86)	<.01
Seriously considered suicide	0.74 (0.62–0.88)	<.001	0.74 (0.52–1.03)	.08
Attempted suicide	0.84 (0.66–1.07)	.16	0.62 (0.40–0.97)	.04

Adjusted for age, socioeconomic status, census region, gender identity, sexual orientation, race/ethnicity, parent support for gender identity, gender identity-based victimization, gender identity conversion efforts, and history of puberty blocker use.

aOR = adjusted odds ratio; CI = confidence interval.

(Turban et al., 2022) Gender Affirming Hormone Therapy GAH accessed in youth influences mental health outcomes adults

Past year suicidal ideation **decreases by 40%** if accessed GAH age 14-15**, by 50%** if accessed GAH by 1-17 and **by 80%** if accessed at >18y (benefit is huge in youth, and even ore so in adults)

Past year severe suicide attempt – decreases by **220%** if accessed between 16-17yo

Lifetime illicit drug use also decreases

	Participants who Accessed GAH											
	N = 12,598											
	Accessed GAH at Age 14 or 15				Accessed GAH at Age 16 or 17				Accessed GAH at Age ≥ 18			
	n = 119				n = 362				n = 12257			
	OR (95% CI)	p	aOR (95% CI)	p	OR (95% CI)	p	aOR (95% CI)	p	OR (95% CI)	p	aOR (95% CI)	p
Suicidality (Past 12 months)												
Past-year suicidal ideation [a]	0.5 (0.3–0.7)	.0001	0.4 (0.2–0.6)	< **.0001**	1.0 (0.8–1.2)	.73	0.5 (0.4–0.7)	< **.0001**	0.5 (0.5–0.6)	< .0001	0.8 (0.7–0.8)	< **.0001**
Past-year suicidal ideation with plan [b]	1.3 (0.8–2.4)	.31	0.8 (0.4–1.6)	.58	1.1 (0.9–1.5)	.41	0.9 (0.7–1.2)	.49	0.8 (0.8–0.9)	< .0001	0.9 (0.8–1.0)	.09
Past-year suicide attempt [c]	1.0 (0.5–2.2)	.99	0.4 (0.2–1.1)	.08	1.4 (1.0–2.0)	.04	0.9 (0.6–1.4)	.79	0.8 (0.8–0.9)	.002	1.0 (0.9–1.1)	.89
Past-year suicide attempt requiring inpatient hospitalization [d]	––	––	––	––	2.2 (1.2–4.0)	.01	2.2 (1.2–4.2)	.01	1.4 (1.1–1.7)	.002	1.2 (0.9–1.5)	.26
Mental Health & Substance Use												
Past-month severe psychological distress (K6 ≥ 13) [c]	0.5 (0.3–0.7)	.0004	0.3 (0.2–0.4)	< **.0001**	0.6 (0.5–0.8)	< .0001	0.3 (0.3–0.4)	< **.0001**	0.4 (0.3–0.4)	< .0001	0.6 (0.5–0.6)	< **.0001**
Past-month binge drinking [e]	1.6 (1.1–2.3)	.02	1.6 (1.0–2.4)	.04	0.8 (0.6–1.1)	.17	0.9 (0.6–1.1)	.27	1.2 (1.1–1.2)	< .0001	1.2 (1.1–1.3)	< **.0001**
Lifetime illicit drug use [f]	1.8 (1.2–2.6)	.003	1.5 (1.0–2.2)	.08	1.2 (1.0–1.6)	.08	1.3 (1.0–1.6)	.07	2.1 (1.9–2.2)	< .0001	1.7 (1.6–1.8)	< **.0001**

Mental health outcomes of transgender adults who recalled access to gender-affirming hormones (GAH) during various age groups. Reference group for all analyses is participants who desired GAH but did not access them. All models adjusted for age, partnership status, employment status, K-12 harassment, and having experienced gender identity conversion efforts.

Abbreviations: OR (odds ratio), aOR (adjusted odds ratio), 95% CI (95% confidence interval).

[a] Model also adjusted for gender identity, sex assigned at birth, sexual orientation, race/ethnicity, family support of gender identity, educational attainment, and total household income.

[b] Model also adjusted for sexual orientation, race/ethnicity, educational attainment, and total household income.

[c] Model also adjusted for gender identity, sex assigned at birth, sexual orientation, race/ethnicity, family support of gender identity, educational attainment, total household income, and having received pubertal suppression.

[d] Model also adjusted for family support of gender identity. Only one participant in the GAH < 16 group endorsed a past–year suicide attempt requiring inpatient hospitalization, precluding calculation of an aOR for this outcome.

[e] Model also adjusted for gender identity, sex assigned at birth, sexual orientation, family support of gender identity, educational attainment, and total household income.

[f] Model also adjusted for gender identity, sex assigned at birth, sexual orientation, race/ethnicity, family support of gender identity, and educational attainment.

https://doi.org/10.1371/journal.pone.0261039.t002

(Almazan & Keuroghlian, 2021) - 2015 US Transgender Survey, the largest existing data set containing comprehensive information on the surgical and mental health experiences of TGD people. The survey was conducted across 50 states, Washington, DC, US territories, and US military bases abroad. A total of 27 715 TGD adults, outcomes psychological distress (Kessler Psychological Distress Scale), past month binge alcohol

After adjustment for sociodemographic factors and exposure to other types of gender-affirming care, undergoing 1 or more types of gender-affirming surgery was associated with **lower past-month psychological distress** (aOR, 0.58; 95% CI, 0.50-0.67; *P* < .001), past-year smoking (aOR, 0.65; 95% CI, 0.57-0.75; *P* < .001), and **past-year suicidal ideation** (aOR, 0.56; 95% CI, 0.50-0.64; *P* < .001).

Table 2. Association Between History of Gender-Affirming Surgery and Mental Health Outcomes[a]

Variable	aOR (95% CI)[b]	*P* value
Severe psychological distress (past month)[c]	0.58 (0.50-0.67)	<.001
Substance use		
Binge alcohol use (past month)[d]	0.83 (0.72-0.96)	.01
Smoking (past year)	0.65 (0.57-0.75)	<.001
Suicidality (past year)		
Ideation	0.56 (0.50-0.64)	<.001
Attempt	0.65 (0.47-0.90)	.009

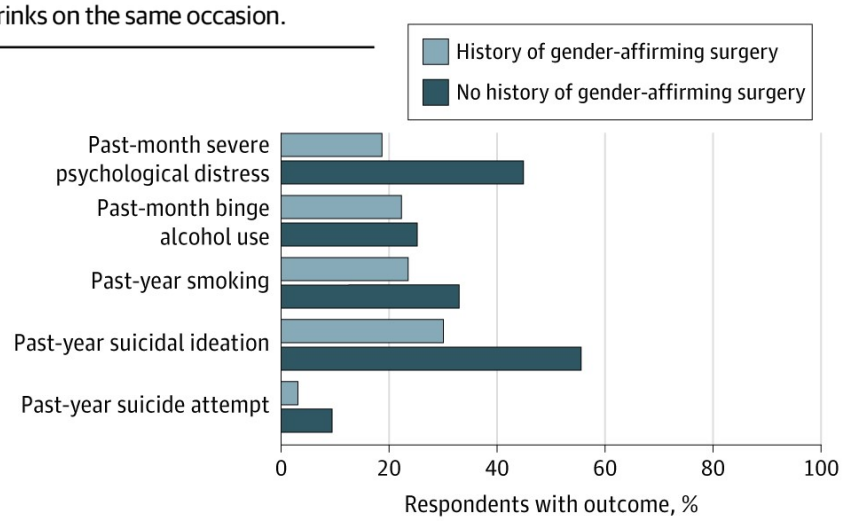
Abbreviation: aOR, adjusted odds ratio.

[a] Adjusted for age, education, employment status, family rejection, gender identity, health insurance, household income, race/ethnicity, sex assigned at birth, sexual orientation, history of gender-affirming counseling, pubertal suppression, and history of gender-affirming hormone therapy.

[b] Reference/control group (n = 16 401) is composed of individuals who desired at least 1 type of gender-affirming surgery but had not received any surgeries. Exposure group (n = 3559) is limited to respondents who had their first surgery at least 2 years prior to submitting survey responses.

[c] Defined as a score of at least 13 on the Kessler Psychological Distress Scale.

[d] Defined as consuming at least 5 alcoholic drinks on the same occasion.



Almazan, A. N., & Keuroghlian, A. S. (2021). Association Between Gender-Affirming Surgeries and Mental Health Outcomes. *JAMA Surgery*, *156*(7), 611–618. https://doi.org/10.1001/jamasurg.2021.0952

Baker, K. E., Wilson, L. M., Sharma, R., Dukhanin, V., McArthur, K., & Robinson, K. A. (2021). Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review. *Journal of the Endocrine Society*, *5*(4), bvab011. https://doi.org/10.1210/jendso/bvab011

Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2022). Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. *Journal of Adolescent Health*, *70*(4), 643–649. https://doi.org/10.1016/j.jadohealth.2021.10.036

Khaleque, A., & Ali, S. (2017). A systematic review of meta-analyses of research on interpersonal acceptance–rejection theory: Constructs and measures. *Journal of Family Theory & Review*, *9*, 441–458. https://doi.org/10.1111/jftr.12228

Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PloS One*, *17*(1), e0261039. https://doi.org/10.1371/journal.pone.0261039

Appendix 1

interventions. In many countries, medically necessary gender-affirming care is documented by the treating health professional as treatment for Gender Incongruence (HA60 in ICD-11; WHO, 2019b) and/or as treatment for Gender Dysphoria (F64.0 in DSM-5-TR; APA, 2022).

There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care (Version 8), in TGD people in need of these treatments (e.g., Ainsworth & Spiegel, 2010; Aires et al., 2020; Aldridge et al., 2020; Almazan & Keuroghlian, 2021; Al-Tamimi et al., 2019; Balakrishnan et al., 2020; Baker et al., 2021; Buncamper et al., 2016; Cardoso da Silva et al., 2016; Eftekhar Ardebili, 2020; Javier et al., 2022; Lindqvist et al., 2017; Mullins et al., 2021; Nobili et al., 2018; Owen-Smith et al., 2018; Özkan et al., 2018; T'Sjoen et al., 2019; van de Grift, Elaut et al., 2018; White Hughto & Reisner, Poteat et al., 2016; Wierckx, van Caenegem et al., 2014; Yang, Zhao et al., 2016). Gender-affirming interventions may also include hair removal/transplant procedures, voice therapy/surgery, counseling, and other medical procedures required to effectively affirm an individual's gender identity and reduce gender incongruence and dysphoria. Additionally, legal name and sex or gender change on identity documents can also be beneficial and, in some jurisdictions, are contingent on medical documentation that patients may call on practitioners to produce.

Gender-affirming interventions are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria (e.g., Aires et al., 2020; Aldridge et al., 2020; Al-Tamimi et al., 2019; Balakrishnan et al., 2020; Baker et al., 2021; Bertrand et al., 2017; Buncamper et al., 2016; Claes et al., 2018; Eftekhar Ardebili, 2020; Esmonde et al., 2019; Javier et al., 2022; Lindqvist et al., 2017; Lo Russo et al., 2017; Marinkovic & Newfield, 2017; Mullins et al., 2021; Nobili et al., 2018; Olson-Kennedy, Rosenthal et al., 2018; Özkan et al., 2018; Poudrier et al., 2019; T'Sjoen et al., 2019; van de Grift, Elaut et al., 2018; White Hughto & Reisner, Poteat et al., 2016; Wierckx, van Caenegem et al., 2014; Wolter et al., 2015; Wolter et al., 2018).

Consequently, WPATH urges health care systems to provide these medically necessary treatments and eliminate any exclusions from their policy documents and medical guidelines that preclude coverage for any medically necessary procedures or treatments for the health and well-being of TGD individuals. In other words, governments should ensure health care services for TGD people are established, extended or enhanced (as appropriate) as elements in any Universal Health Care, public health, government-subsidized systems, or government-regulated private systems that may exist. Health care systems should ensure ongoing health care, both routine and specialized, is readily accessible and affordable to all citizens on an equitable basis.

Medically necessary gender-affirming interventions are discussed in SOC-8. These include but are not limited to hysterectomy +/- bilateral salpingo-oophorectomy; bilateral mastectomy, chest reconstruction or feminizing mammoplasty, nipple resizing or placement of breast prostheses; genital reconstruction, for example, phalloplasty and metoidioplasty, scrotoplasty, and penile and testicular prostheses, penectomy, orchiectomy, vaginoplasty, and vulvoplasty; hair removal from the face, body, and genital areas for gender affirmation or as part of a preoperative preparation process; gender-affirming facial surgery and body contouring; voice therapy and/or surgery; as well as puberty blocking medication and gender-affirming hormones; counseling or psychotherapeutic treatment as appropriate for the patient and based on a review of the patient's individual circumstances and needs.

Statement 2.2

We recommend health care professionals and other users of the Standards of Care, Version 8 (SOC-8) apply the recommendations in ways that meet the needs of local transgender and gender diverse communities, by providing culturally sensitive care that recognizes the realities of the countries they are practicing in.

TGD people identify in many different ways worldwide, and those identities exist within a cultural context. In English speaking countries, TGD people variously identify as *transsexual,*

Appendix 2

CHAPTER 18 Mental Health

This chapter is intended to provide guidance to health care professionals (HCPs) and mental health professionals (MHPs) who offer mental health care to transgender and gender diverse (TGD) adults. It is not meant to be a substitute for chapters on the assessment or evaluation of people for hormonal or surgical interventions. Many TGD people will not require therapy or other forms of mental health care as part of their transition, while others may benefit from the support of mental health providers and systems (Dhejne et al., 2016).

Some studies have shown a higher prevalence of depression (Witcomb et al., 2018), anxiety (Bouman et al., 2017), and suicidality (Arcelus et al., 2016; Bränström & Pachankis, 2022; Davey et al., 2016; Dhejne, 2011; Herman et al., 2019) among TGD people (Jones et al., 2019; Thorne, Witcomb et al., 2019) than in the general population, particularly in those requiring medically necessary gender-affirming medical treatment (see medically necessary statement in Chapter 2—Global Applicability, Statement 2.1). However, transgender identity is not a mental illness, and these elevated rates have been linked to complex trauma, societal stigma, violence, and discrimination (Nuttbrock et al., 2014; Peterson et al., 2021). In addition, psychiatric symptoms lessen with appropriate gender-affirming medical and surgical care (Aldridge et al., 2020; Almazan and Keuroghlian; 2021; Bauer et al., 2015; Grannis et al., 2021) and with interventions that lessen discrimination and minority stress (Bauer et al., 2015; Heylens, Verroken et al., 2014; McDowell et al., 2020).

Mental health treatment needs to be provided by staff and implemented through the use of systems that respect patient autonomy and recognize gender diversity. MHPs working with transgender people should use active listening as a method to encourage exploration in individuals who are uncertain about their gender identity. Rather than impose their own narratives or preconceptions, MHPs should assist their clients in determining their own paths. While many transgender people require medical or surgical interventions or seek mental health care, others do not (Margulies et al., 2021). Therefore, findings from research involving clinical populations should not be extrapolated to the entire transgender population.

Addressing mental illness and substance use disorders is important but should not be a barrier to transition-related care. Rather, these interventions to address mental health and substance use disorders can facilitate successful outcomes from

Statements of Recommendations

18.1- We recommend mental health professionals address mental health symptoms that interfere with a person's capacity to consent to gender-affirming treatment before gender-affirming treatment is initiated.

18.2- We recommend mental health professionals offer care and support to transgender and gender diverse people to address mental health symptoms that interfere with a person's capacity to participate in essential perioperative care before gender-affirmation surgery.

18.3- We recommend when significant mental health symptoms or substance abuse exists, mental health professionals assess the potential negative impact that mental health symptoms may have on outcomes based on the nature of the specific gender-affirming surgical procedure.

18.4- We recommend health care professionals assess the need for psychosocial and practical support of transgender and gender diverse people in the perioperative period surrounding gender- affirmation surgery.

18.5- We recommend health care professionals counsel and assist transgender and gender diverse people in becoming abstinent from tobacco/nicotine prior to gender-affirmation surgery.

18.6- We recommend health care professionals maintain existing hormone treatment if a transgender and gender diverse individual requires admission to a psychiatric or medical inpatient unit, unless contraindicated.

18.7- We recommend health care professionals ensure if transgender and gender diverse people need in-patient or residential mental health, substance abuse or medical care, all staff use the correct name and pronouns (as provided by the patient), as well as provide access to bathroom and sleeping arrangements that are aligned with the person's gender identity.

18.8- We recommend mental health professionals encourage, support, and empower transgender and gender diverse people to develop and maintain social support systems, including peers, friends, and families.

18.9- We recommend health care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment, while acknowledging psychotherapy may be helpful for some transgender and gender diverse people.

18.10- We recommend "reparative" and "conversion" therapy aimed at trying to change a person's gender identity and lived gender expression to become more congruent with the sex assigned at birth should not be offered.