Sexual Orientation and Gender Identity Conversion Practices

ISSUES PAPER NO 31

SUBMISSION BY
Coalition of Activist Lesbians (Australia) (1999)
COAL

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About COAL

The Coalition of Activist Lesbians Australia (Inc.) (COAL) is a not for profit, national advocacy organisation formed in 1994 to work towards ending discrimination against lesbians. COAL is community based, unfunded and operates with a human rights and women-centric framework to protect lesbian human rights, and to support lesbians across six state and two territory jurisdictions to participate in activities for positive social change.

The inception of COAL in 1994 coincided with plans to represent Australian lesbians at the 1995 UN 4th World Conference on Women in Beijing. COAL was the only Lesbian-specific NGO in the world at that time to be UN-accredited, both with the Economic and Social Council (ECOSOC) and with the Division for the Advancement of Women.

In addition, COAL co-hosted the first-ever international lesbian space at the 1995 NGO Forum of the Commission on the Status of Women. However, some hopes were not realised at the Conference. As reported on the ABC, “For those who sought recognition of lesbian rights, not only was 'sexual orientation' dropped from the document…but lesbians at the Conference experienced a high level of 'hate and ignorance' from some participants” (ABC *Women Out Loud*, 16 September 1995).

COAL successfully lobbied, with other organisations, for the Australian Government to sign the Optional Protocol to the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) in 2009. In August, 2010, COAL participated in the 63rd UN DPI/NGO Conference in Melbourne. (DPI/NGO is the United Nations Department of Public Information (DPI), the central source of information about the UN and its work)

Mission

The mission is to work towards ending discrimination against lesbians and advocate on behalf of Australian lesbians, on many issues, to all levels of government. COAL aspires to be part of a society where respect for differences, the rule of law, the dignity of all humans and human rights practices are shared.

Objectives

COAL protects the rights and improves the lives of lesbians in Australia by:

- Monitoring Australian, state, and territory governments, and the public and private sectors to ensure implementation of principles inherent in international covenants, including freedom of speech and rights to association.
- Lobbying for legislative and policy changes to include the women-focused rights of lesbians, including writing submissions to government. (See Appendix A)

- Delivering conference and seminar presentations, seminar participation, community education
- Promoting equitable inclusion of lesbians regardless of race and culture, socio-economic status, ability and health status, age, geographical location, and religion.
- Promoting participation and equity for lesbian women in public, private and community sectors.
- Informing and educating people about lesbian human rights through training, lectures, conferences, workshops, fora, submissions and publications.
- Producing research papers about: lesbian health; violence against lesbians; lesbophobia; and lesbian domestic violence.
- Delivering national and international conference papers on lesbian human rights; lesbians' invisibility in research and policy documents on women's health issues, including mental health, at all levels of government; and discrimination in aged care.
- Encouraging lesbians to represent themselves via their art and other cultural works.

To achieve these objectives and fulfil our United Nations accreditation obligations, COAL networks internationally, nationally and locally, with other lesbian, women's, and general community groups. It works to identify and promote positive approaches in human rights, social inclusion, youth affairs, health, housing, workforce issues, ageing issues, education, anti-discrimination/equal opportunity and other areas.

For many years before COAL was formed, some members of COAL were involved with researching, advocating on behalf of, and directly supporting lesbians experiencing discrimination and harassment. The current committee includes a University Professor, a lecturer in Social Work in a Rural Health School, a geneticist with PhD in Biological Sciences, a retired Associate Professor of Sociology, a social researcher with a PhD in Women and Gender studies.

Reference

ABC Radio. (16 Sep 1995). *Women Out Loud*

SUMMARY and RECOMMENDATIONS

COAL is a national, lesbian specific organisation which is not affiliated with any LGBTQA+ organisation. Many lesbians have lived through oppressive times of medical treatments based on ideologically informed medical consensus and legal punishments to convert us to heterosexuality. We object to and reject any legislation about sexual orientation or gender identity, which is not founded on science and evidence, and which compromises the human rights of children and adults.

The evidence of current harms to adults in relation to sexual orientation or gender identity, is meagre. This is not true in the case of minors. There is strong and increasing evidence of life long harms to children undergoing gender affirmation practices. COAL supports the findings of the recent UK High Court case (Bell v Tavistock 2020). Keira Bell, as a minor, had been transitioned to a trans identity with puberty blockers, cross-sex hormones. At 20 she had both breasts removed. The Court found in Bell's favour: the treatments used at the gender clinic are experimental, lacked a scientific evidence base. Further minors are highly unlikely to have the capacity to consent to them.

As a result of the High Court decision, these treatments have already been withdrawn from publicly funded gender clinics in the UK. This judgment is directly relevant to the drafting of any Tasmanian laws. We are dismayed as SOGI conversion practices laws and clinical consensus, rather than evidence, are used to remove children from parents who object to the drug treatments of gender affirmation. A chilling parallel to the human rights abuses of lesbians in the 1970s and 80s

The current conversion practices laws in other jurisdictions have ignored harmful outcomes such as changing same-sex attracted minors into heterosexuals. They have all specifically **excluded** these same gender affirmation practices on minors, from definitions of conversion practices. Tasmania has the opportunity to remedy the dangers and flaws in other models of legislation presented in the TLRI Issues Paper, by removing gender identity from new laws, and recognising age, consent and science are central to sound, human rights-based legislation in this area.

The concepts of sexual orientation and gender identity are highly contested. Our position on the meaning of sexual orientation is at odds with peak LGBTQA+ groups, such as the stakeholders listed for the Tasmanian SOGI legislation. Clarity and the avoidance of ideological assumptions in the meanings of these two terms is the basis for good law, especially when criminal sanctions are contemplated.

There are further warnings and evidence of harms to children in other reviews in the UK, Sweden and the US. In particular the dramatic sex ratio reversal with the rapid rise in the number of teenage girls distressed about their female bodies. Many, like Keira Bell, are lesbian/same sex attracted. Through transition they or their parents, tried to change their sexual orientation to heterosexual. This is sexual orientation conversion therapy on minors when measured against the criteria of false claims and false publications discussed in the TLRI

issues paper. The alarming evidence of irreversible harms and misdiagnosis, is found in the numerous first-hand stories of detransitioners, This evidence must be part of framing conversion practices laws, especially for minors.

Tasmania already has laws to protect minors from making decisions with life- long consequences, such as prohibitions on getting tattoos and certain body modifications, even with parental consent. The life-long harms of gender affirmation practices, are much more severe and irreversible than those from tattoos. There are clear parallels with the human rights framework of Intersex organisations (IHRA, 2020) and advocacy for **no** medical interventions for psychosocial reasons, on children with intersex variations, until they are sufficiently mature to fully understand the consequences on their future adult lives.

Therefore, Tasmania must be the first State to enact laws that safeguard minors from harmful practices associated with gender affirmation and include it as an unscientific conversion practice in relation to sexual orientation. At the same time, children distressed about their birth sex, must be provided with the very best evidence- based health care, to manage their distress and their mental wellbeing.

RECOMMENDATIONS

1. Define Conversion practice as*: acts or statements that attempt to change or suppress a person's sexual orientation or gender identity.*

2. Define sexual orientation as: *the enduring pattern of emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a different sex, the same sex or both sexes.*

3. Defer any new laws about gender identity until they can be drafted to take into account the evidence of misdiagnosis, harms to children of some treatment protocols, and ways to safeguard children's human rights.

4. Remove gender identity from new laws and draft laws specific to medical treatment of children to include gender identity and intersex.

5. Framing new laws about sexual orientation to cover the instances of health professionals, who act on the wishes of parents to transition their lesbian or gay child to a trans identity, due to negative attitudes about homosexuality.

6. Ensure the voices and evidence from detransitioners are included in the framing of SOGI laws.

7. Restrict any new laws to sexual orientation and include "*gender affirmation*" practices on minors as a conversion practice in relation to sexual orientation

8. Restrict any legislation on sexual orientation to minors (under 18s) as in the ACT, Germany and 19 states in the US

9. Apply the laws only to health professionals, as in QLD

10. Parental consent to a conversion practice on a child should not be permitted. Note in UK case, the decision is removed from parents by stopping the harmful treatments – puberty blockers, cross-sex hormones and surgery for minors.

11. Prohibit the advertising of conversion practices by any one, on any communication channel.

12. Tasmania follow the recommendations in judgment of the Bell v Tavistock case about the experimental nature of gender affirmation and ensure its information and services to children by LGBTQA+ organisations and government departments, provide accurate information.

13. Prohibit of the publication of false claims and distribution of materials containing false information, in relation to SOGI medical and support treatments by both government and community groups.

14. Review the language and terminology used in any laws about sexual orientation to ensure it is consistent with Federal legislation

15. Ensure any language in SOGI laws is scientifically accurate, unambiguous and precise.

References

Bell v Tavistock 2020. *R (Quincy Bell) and A v Tavistock and Portman NHS Trust, and others* [2020] EWHC 3274**).**

IHRA, 2020. Intersex Human Rights Australia. https://ihra.org.au/

BACKGROUND AND KEY CONCEPTS

COAL welcomes the Tasmanian governments interest in and commitment to the health and wellbeing of people in LGBT communities. The opportunity to make a submission to the TLRI is much appreciated, particularly as some of the content of the proposed laws is contested from both within and outside LGBT communities by a wide range of people and organisations.

Collectively, we have many years of lived experience of harms from laws and medical treatments. Those laws denied both our human rights and access to many services and benefits enjoyed by heterosexual people and couples. Shocking medical treatments were based on medical consensus and asserted lesbians (and gay men) were mentally ill and dangerous to children. (Camp Ink 1973)

We also live within the cultures of lesbian communities throughout the country, including Tasmania and across the lifespan. This means we have insider knowledge of the social and political forces at work within them. This insider knowledge has always informed our advocacy. (See Appendix A for other submissions made by COAL).

The material and discussion in this submission is quite extensive because COAL offers the TLRI a lesbian-specific perspective on the background and possible consequences of a new conversion practices law. Much of the material relates to one of the terms of reference to

> *Review and consider statements, policies and laws relevant to SOGI conversion practices in Australia and elsewhere*

Further, based on our past experiences, we know much of this material will not have been presented by peak LGBTQA+ bodies and stakeholders.

COAL has serious concerns about any practices based on medical consensus and ideology, rather than science and the norms of evidenced- based medical practice. In the decade from 1974, there was an upsurge in the number of custody cases involving lesbians who had left heterosexual marriages. The State via the Family Court supported the medical consensus of health experts, that women attracted to other women suffered from a serious mental illness (Jennings 2012). All the adverse decisions resulted in deep trauma to lesbian mothers, their children and their partners (Rivers 2013).

The expert “evidence” placed before the court, meant many lesbian mothers lost custody of their children on the grounds they were either psychologically unfit to mother, too dangerous to be around children or endangered the heterosexual development of their children. (Jennings 2012) We know firsthand of the lifelong harms done when medical consensus about sexuality and gender, becomes codified in laws and uncritically adopted by States in legislation and the Family Law Court.

The “mental illness” consensus was also codified in professional diagnostic documents such as the DSM manual and through professional treatments and education in public and private health facilities. Homosexuality was listed as a mental illness in DSM-I until 1973, the DSM – Diagnostic and Statistical Manual – is the American Psychiatry Association’s standard classification of mental disorders, and is still the standard reference used in Australia. It is also the reference

which codifies the clinical diagnostic criteria for *gender dysphoria* in children and adults. (See Q9).

Older lesbians harmed by these practices know that the concretisation of medical opinion being accepted into law, obscures critical facts and shuts down dissenting views. Today, we are faced yet again with dissent being shut down and clinical consensus already being incorporated into Conversion Practices laws. Laws which directly affect children distressed by their birth sex and often their same-sex sexuality. No other area of health policy which alerts the public to well-established harms to children, is stigmatized and dismissed as "transphobic", in an attempt to prevent critical evaluation of the policy and practices and the framing of legislation.

Here in Australia, even the British court's judgment regarding the Tavistock Centre, has been branded as transphobic. Sally Goldner, the media representative for Transgender Victoria, said:

> *I find this totally inconsistent. I see the decision transphobic in that it fails to recognise the lived expertise of Trans and Gender Diverse people. (Lewis, 2020)*

This is despite the fact that the young lesbian claimant in the case spoke entirely from her lived experience as a child and adult. No LGBTQA+ organisation provided any support to Keira before, during or after the case.

This submission primarily focusses on the 'L', or Lesbian, part of the LGBTQA+ acronym, rather attempting the logical impossibility of being inclusive of every community in the acronym. COAL believes autonomous lesbian views should always be sought by governments in the development of legislation that both directly and indirectly directly affects their rights and wellbeing. To date, no State government has invited a lesbian specific group to be a stakeholder, despite our insider knowledge and professional expertise.

If the human rights of lesbians are to be respected in practice, our views and experiences need to be respected and valued as much as those of generic and more politically powerful or government funded LGBTQA+ organisations. The inability of peak organisations to include and represent lesbians of various ages, was the original motivation for the formation of COAL as a standalone, autonomous lesbian organisation. Even as recently as 2017, at the European Lesbian Conference, the recurring theme was the 'dilution' of the 'L' and of lesbian issues in the LGBTQA+ movement. (European Conference Report 2017*)*

COAL holds significantly different perspectives and theoretical understandings on a number of crucial aspects of Conversion Practices Bills. In addition to issues of robust science, one of these is the issue of informed consent to gender affirming treatments in children and the role of parents. The definition and nature of gender identity itself in children as well as the irreversibility of the treatments are discussed further in Questions 1 and 2, while the political influence of a global transgender movement, provides the contemporary context to most of the submission.

LGBTQA+ politics and policies, have increasingly conflated and confused biological sex with social stereotypes and social expectations (gender) and treated them as interchangeable. This is key to many of the arguments made in this submission. Combining sexual orientation and gender

identity in the same law is also the origin of tensions and contradictions in those laws, especially in those which exclude gender affirmation as a conversion practice.

There is now unequivocal evidence of harms from a recent UK High Court case, which reviewed the practices related to gender transition and minors. In the 38-page ruling, the court deemed medical treatment by the NHS Gender Identity Service, for gender dysphoria, "experimental" and lacking an adequate scientific basis. It also noted that doctors neglected to properly explain the known long-term effects of puberty blockers and cross-sex hormones to teens. Further, the judges expressed doubt about the capability of underage youth to give informed consent to have their fertility and sexual function, permanently damaged. (Bell v Tavistock 2020)

Whilst this case was not conducted in Tasmania, the treatment practices for minors are those adopted by the four publicly funded children's gender clinics in Australia. Those same practices are also advocated for by professional bodies such as The Australian Psychological Society, to the exclusion of any other treatment options (APS 2020)

It is imperative that the TLRI give very serious consideration to this judgement, review the evidence in that case and reconsider the claims of LGBT peak bodies of the need to introduce laws which codify these specific practices. Much of the evidence and argument presented in this submission is related to the life- long harms of gender affirmation treatments and misdiagnosis, especially for female children and same sex attracted teens.

Unfortunately, the common practice of legislators to consult with LGBTQA+ conglomerates, has led to numerous problems in the framing of Conversion practice laws elsewhere and in the terminology used. Problems which are discussed in detail below.

Throughout this submission the term ***lesbian*** is used. COAL's position is that the word lesbian, refers to females who have an enduring sexual, emotional and romantic attraction to other females. In short, females who are same sex attracted. Just like others groups addressed by the proposed laws, lesbians expect and claim the right to name and define ourselves and our sexual boundaries.

We recognise that some women call themselves gay, queer, camp or bent and that sometimes terminology such as sexual minority, LGBTQA+ or same-sex attracted is used. While this may be seen as inclusive, it can place lesbians in an inferior social or political situation, sometimes bordering on invisibility. It is more respectful to use *lesbian*, a precise, unambiguous term.

We cannot and do not speak for bisexual people, gay men, transgender persons or intersex persons and firmly believe that organisations dedicated specifically to each one of those groups are best placed to speak about their particular concerns.

As lesbian women, our social, economic and political capital is mediated by **both** being born and raised female, as well as our same sex orientation. The term **lesbophobia** is used in this submission to accurately describe specific hostilities towards and denigration of lesbians. It originates from **two** sources: being born female (sexism/ misogyny), PLUS being same sex attracted (homophobia). The experiences of young lesbians who have detransitioned,

demonstrate the part it can play in their gender dysphoria and decision to transition, as well as how pervasive it is, especially on line. (See Appendix C, D, E for some first-hand stories)

Some political context

Who would have thought that the lesbians and gays fought for the freedom NOT to conform to damaging female or male stereotypes and heterosexuality, would now have to resist an ideology which asserts, that anyone who does not conform to those stereotypes needs to be fixed by medically transitioning to another gender. The difference from the 1960s is that it is mostly teenage girls who are NOW pressured to change their bodies with hormones and surgeries and adopt a trans identity. Earlier it was gay men who were criminalised to encourage heterosexuality.

These seriously incompatible positions on non -conformity and liberation, have led to many breakaway groups from peak LGBTQA+ organisations. There has been a rapid increase in the number of LGB groups and Alliances around the world as more countries legally cement the assertion that sexual orientation is based on gender identity and not biological sex in anti - conversion therapy laws (LGB Alliance UK, 2020). These very different understandings mean same sex attracted perspectives are frequently not acknowledged by law makers. This is the case in QLD, ACT and Victoria where same sex orientation is defined without any reference to biological sex. This means natal males with penises are now legally included in the meaning of the word lesbian.

Whilst new LGB groups have left traditional rainbow organisations, over the denial of same sex attraction and conversion of same- sex attracted young people, Intersex groups have also left these peak bodies. The ”I” has been recently been dropped from the LGBTQA+ acronym overseas and in Australian states, including Tasmania.

This has occurred for other reasons related to incompatible perspectives. Firstly, some in the transgender movement argue that Intersex variations are proof of a third sex. (Carpenter 2019). Secondly, LGBTQA+ organisations have often confused and conflated the terms *intersex and trans.* (Carpenter 2020). Finally, the ethical and human rights framework of Intersex organisations does not support surgical and drug interventions on children, whilst LGBTQA+ organisation do. Children with intersex variations have long been subject to irreversible treatments and life- long consequences which they cannot possibly understand or assess as minors and such intervention are strongly opposed. (Carpenter 2019).

COAL argues this third fundamental principles must underpin new laws about sexual orientation and gender identity. However, these basic concepts need critical examination, because how they are defined influences every aspect of any proposed laws.

BASIC TERMS – SEXUAL ORIENTATION AND GENDER IDENTITY

SEXUAL ORIENTATION

Sexual orientation is a contested term. The definition in Federal laws, such as the Sex Discrimination Act, is at odds with the definitions used in the Conversion Practices Laws in QLD, ACT and Vic. The Federal laws use verifiable science-based language, while the conversion laws of the States, use language devoid of references to sex and derived from the transgender movement.

In the *Sex Discrimination Act:*

> ***sexual orientation*** means a person's sexual orientation towards:
> (a) persons of the **same sex**; or
> (b) persons of a **different sex**; or
> (c) persons of the **same sex** and persons of a **different sex.**

The word woman is used in relation to pregnancy and breast feeding.

However, the QLD Conversion Therapies Bill in section 213E, defines sexual orientation very differently:

> *sexual orientation, of a person, means the person's **capacity** for emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a **different gender**, the **same gender** or more than **1 gender**.*

In the AIFS glossary, the *internal feeling* definition of a woman is adopted, and actual biology is removed for instance:

> ***Lesbian: an individual who identifies as a woman** and is sexually and/or romantically attracted to other **people who identify as women*** (AIFS 2019).

In other words, a natal male who feels themselves to be a woman is now included in the category and definition of a lesbian. A lesbian as a same-sex attracted female, or female homosexual as in the Sex Discrimination ACT is defined out of existence and replaced by any individual, male or female. This view is a basic belief in gender identity ideology.

Similarly,

> ***Heterosexual:** an individual who is sexually and/or romantically attracted to **the opposite gender*** (AIFS ,2019).

In other words, a natal man is defined as heterosexual if he is attracted to a natal male who now identifies as a woman. This is because "woman"" (opposite gender) is defined to include both biological females and natal males based on a claimed innate feeling rather than a physical sexed body.

The above definition of lesbian actually excludes nearly all same-sex attracted lesbians. Lesbians are not attracted to male bodies and it is for THIS reason we have been persecuted

and subjected to conversion therapies over the past century. Most women don't "identify" in terms of having a strong innate feeling of themselves as female or male, in the way transgender people speak of. We are women, we don't identify into the category woman. Laws which codify the belief that male genitals can be female (eg girl dick) is disrespectful, an attack on the autonomy of lesbians and a threat to their participation in social and political life. It is imperative that any Tasmanian laws do not contribute to the silencing and demonising of lesbians by using language that ignores and dismisses same sex attraction.

Research in the areas of sexuality, shows that a self-proclaimed identity-based definition of lesbians is grossly inaccurate, lacks clarity and precision needed in law, and fails to respect the language lesbians use to describe themselves, as suggested by the AIFS**.** A UK study investigating lesbian experiences of sexual partners, found:

- 98.8% of women defined themselves as **lesbians** with the others defining themselves as queer or bisexual
- 98.8% would not consider a transwoman (natal male) as a sexual partner
- 50% reported they had been banned from their LGBT groups for maintaining their same-sex view about lesbian relationships (Wild 2019).

There is further evidence that lesbians' sexual attractions, along with those of heterosexual females and males, are not based on the ***gender*** **identity** of potential partners (Blair and Hoskins, 2018). They reported that 87.5% of people **would not** consider dating a trans person, irrespective of their particular sexual preference and just 1.8% of heterosexual women and 3.3% of heterosexual men would consider dating a trans person of the same sex. The discussion failed to consider how the results actually demonstrated how much the sexed body of the partner (not the gender identity) really matters when it comes to sexual attraction. Instead, the authors concluded these results demonstrated extreme levels of transphobia among heterosexuals and homosexuals.

Given how the language associated with lesbian life and sexuality is now contested and has negative real-life consequences, COAL urges the TLRI to use definitions and language that respects the lived experience, bodily autonomy and self-definitions of lesbians born female and of gay men born male. That is, to adopt definitions that are accurate, unambiguous and precise. Such characteristics would seem essential for the interpretation and implementation of conversion practice laws about sexual orientation.

COAL considers the conflation of sex with gender in the very definition of sexual orientation a serious flaw in any legislation, such as that in QLD, the ACT and VIC. Politically it prioritises a gender identity belief system over the self determination of lesbian women and the demonstrated biological basis of sexual attraction in the vast majority of the population.

Same-sex accurately describes our sexual orientation, same gender identity does not describe the same concept. For the purpose of the Bill, it is essential that the definition clearly describes the people who are to be protected by the Bill. As lesbians **do not describe** or experience their sexual orientations as an attraction to male bodied people identifying as a woman (same gender

attracted) they are in effect excluded from any laws using this definition. A bill based on preventing the harms of conversion to same-sex attracted people to become heterosexual, needs to include the concept of sex.

Lesbians experience much discrimination as women whose sexual orientation is towards the same sex in a male-dominated society. The conflation of between gender identity and sex means that lesbians must accept that a transwoman is a woman and a lesbian as a matter of fact.

Susan Hawthorne (2020) concludes her chapter “Breaking the Spirit of the Women’s Liberation Movement: The War against Biology” with a list of reasons why sexual orientation should be at the centre of legal and social discussion rather than gender identity. Among them are:

• Sexual orientation challenges gender normativity.
• … the rights of those born female are protected (Hawthorne 2020 p. 216).

Lesbians have been re-defined unilaterally by others, as same-gender-attracted, and the new definition is being imposed on lesbians by governments using political perspectives hostile to the material reality of lesbians’ same-sex attraction.

The real-life impact of this is that a lesbian who chooses not to form a romantic or sexual relationship with someone who is male-bodied but identifies as a woman can pilloried as a hateful transphobe, as in the case of Ariella Scarcella (Lewis 2020). We believe that attempts to compel women to believe that male genitals can be female is a form of sexual assault, an attack on the rights of lesbians and a threat to their very existence. (LGB Alliance UK). It is a clear example of lesbophobia by governments and LGBTQA+ organisations. It is the term same-sex which provides lesbians with the benefits and protections of those laws and instruments.

Other sex-based definitions of sexual orientation

The emphasis in the QLD definition is on an individual’s internal **capacity** to be attracted, not the person who is desired. Nor is there any understanding that sexual orientation can only be ascertained overtime, ie by a pattern of attraction. This aspect is included in widely accepted definitions (APA 2019). Consequently, in definitions used in the models in the issues paper, a person’s **capacity** for a one- night stand would indicate their orientation. This does not seem to be behaviour within the scope of a conversion practices law.

The American Psychological Society definition is:

> *Sexual orientation refers to the **sex of those** to whom one is sexually and romantically attracted. Categories of sexual orientation typically have included attraction to members of one's own sex (gay men or lesbians), attraction to members of the other sex (heterosexuals), and attraction to members of both sexes (bisexuals)*

Sexual orientation: one's enduring sexual attraction to male partners, female partners, or both.

WHO (2021) defines sexual orientation as:

> *a person's physical, romantic, and/or emotional attraction towards other people. Sexual orientation is distinct from gender identity. Sexual orientation is comprised of three elements: sexual attraction, sexual behaviour, and sexual identity. Sexual orientation is most often defined in terms of heterosexuality to identify those who are attracted to individuals of a different sex from themselves, and homosexuality to identify those who are attracted to individuals of the same sex from themselves*

Implications of Definitions

Our same-SEX orientation is why conversion practices have been directed at us for over a century ie we do not have sexual relationships with men. It is why our human rights are still abused. It is why 14 countries still have the death penalty for lesbian sexuality (OutRIght 2016). It is why Iran criminalises lesbians but encourages gender transition by those same lesbians (OutRight 2016) and displays state-sponsored lesbophobia.

It is the desexed definition of lesbian sexual orientation that has led to an increased level of public denigration of lesbians at LGBTQA+ events and from organisations. Disappointing, given the strong role lesbians played in establishing and developing the lesbian and gay rights movement from the 1970s on. Disturbing because young same-sex-attracted women now see and hear so much vitriol about same-sex attracted lesbians, from within the rainbow communities. This negative perception and abuse is reported in the stories of detransitioners and teens with ROGD (see Appendix B, C and D).

> *When I did transition, people stopped shouting "Lesbians!" at us in the street, because I looked more male. There are double standards about appearance too. When I didn't shave my legs my classmates bullied me. Later, when I identified as a trans man, it suddenly became completely OK, because men don't have to shave their legs. That felt really freeing and transition felt like the right thing for me*.
> https://www.facebook.com/posttrans/?hc_location=ufi

Lesbians wanting to participate in Vancouver Dyke March in 2018 were told:

> *if any of our signs, banners, or t-shirts included the venus symbol — representing "woman" — (the two interlocked venus symbols have always meant lesbian) or "XX," symbolizing the female sex chromosome, we would have to remove them.*

The reason? a contradictory one - the woman symbol used by lesbians was not trans inclusive, and this dyke march was an inclusive one. But obviously, not inclusive of same-sex attracted lesbians. (Cormier 2018).

Arielle Scarcella, an American lesbian YouTuber with 630,000 subscribers was *no platformed* by the organisers of the 2020 Sydney Gay and Lesbian Mardi Gras. The reason? Arielle was to speak on lesbian sexuality and has a video episode entitled 'Dear Trans Women, Stop Pushing "Girl Dick" On Lesbians'. Tania Safi, queer icon of Buzzfeed withdrew from the panel, saying "*I do not agree with Arielle's transphobic and biphobic beliefs*". (Lewis 2020) A change.org.com petition was organised and within 2 days the only specifically lesbian event was removed because Arielle believes lesbians have the right to define themselves as same-sex attracted.

The demonising of same-sex attraction by LGBTQAP+ organisations is authoritarian and deeply concerning because it impinges on our basic rights of freedom of association, freedom of opinion and the right to impart information to young same-sex attracted women.

This incident, and many others indicate how contested the meaning of sex, lesbian sexuality and sexual orientation are in the everyday world and communities we lesbians live in. Most of this denigration is quite invisible to those who are not living inside of our communities here in Australia and elsewhere. It is not conservative groups, or faith-based groups who engage in direct action to invalidate lesbian identity and selfhood,or try to guilt trip lesbians into accepting natal males as sexual partners. It is the powerful, often government funded LGBTQAP+ organisations.

COAL notes that these organisations and their allies are the ones regularly invited to the table as the stakeholders when legislation about lesbians and gay men is being developed. However, they do not represent our views, nor our experiences of ourselves and our bodies as lesbians. As the LGB Alliance (2020) in the UK says:

> *We are a group of lesbians, gay men and bisexuals who, by and large, have spent our entire lives campaigning for equality for people with same-sex sexual orientation.*
> ***Aims***
> 1. *To advance the interests of lesbians, gay men and bisexuals at a time when we are under threat from concerted attempts to introduce confusion between biological sex and the notion of gender.*
> *2. To amplify the voices of lesbians and to highlight the dual discrimination we experience as women who are same-sex attracted in a male-dominated society…*
> *3. To protect children and young people from being taught unscientific gender doctrines, particularly the idea that they may have been born in the wrong body, which may lead to life-changing and potentially harmful medical procedures.*
> *4.To promote respectful freedom of speech and informed dialogue.*

These aims are consistent with the human rights framework of COAL. Therefore, COAL recommends the following definition of sexual orientation underpin conversion practices laws:

> Sexual orientation an **enduring pattern** of romantic or sexual attraction (or a combination of these) to persons of the opposite sex, the same sex or to both sexes These attractions are generally subsumed under heterosexuality, homosexuality, and

bisexuality, while asexuality (the lack of sexual attraction to others) is sometimes identified as the fourth category**.**

GENDER IDENTITY

This is the second key concept of proposed law changes, and like sexual orientation has contested meanings and different meanings in different States and under Federal Laws.

In the *Sex Discrimination ACT*, Gender identity is defined as:

> ***the gender-related identity****, appearance or mannerisms or other* ***gender-related characteristics*** *of a person (whether by way of medical intervention or not), with or without regard to the person's designated sex at birth.*

This avoids defining the key word gender, and so the definition lacks clarity and is somewhat circular: gender identity is gender related identity, and gender related characteristics.

In the glossary of the Australian Institute of Family Studies (AIFS,2020), it is defined as:

> ***an inner sense*** *of oneself as man, woman, masculine, feminine, neither, both, or moving around freely between or outside of the gender binary.*

In other words, biological sex (male/female) and social behaviour are conflated in this version. Sex means biological female or male, while feminine and masculine refer to the social constructed expectations and stereotypes of the two sexes. It also denies the fact that humans are a sexually dimorphic species, ie there are only 2 sexes, female and male and intersex variations are not a third sex.

The Queensland Human Rights Commission (2020) provides an extremely broad definition:

> ***Gender identity*** *means a person's understanding of themself as male or female, both, or neither. It affects how they perceive themself, and what they call themself.* ***Gender identity can be a fixed and unchanging characteristic for some, however it can also be fluid or evolving for others.***

If gender identity is evolving and fluid, then no medical interventions ought to be performed on minors. How would a health professional be able to decide if a child's (or even an adult's) gender identity had stopped evolving and diagnose a newly fixed recently innate identity requiring the child undergo transition interventions? How can health professionals be certain that their medical interventions were not going to change or suppress the direction of the evolution or fluidity of the child's gender identity?

Kidshelpline in Australia, has a definition that denies the idea of a fixed gender identity:

> *Gender identity is about how you* ***personally experience*** *your own gender. Your gender can be shown through your identity (eg. labels, pronouns), body (eg.*

> *appearance) and expression (eg. how you act, how you dress).* ***Gender identity is not fixed and exists on a spectrum*** (Kidshelpline, 2020).

This definition of a **changeable** gender identity, contradicts the definition the RCH Gender Clinic's:

> *Gender is how an individual identifies in society* – ***their innate sense of being male or female*** (RCH, 2020).

This definition posits a biological (innate) and fixed basis to an inner sense or feeling of being male or female, as does the American Psychological Association**:**

> ***A person's deeply-felt****,* ***inherent sense*** *of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics. Since gender identity is internal, a person's gender identity is not necessarily visible to othe*rs (APA 2020).

It would be difficult to clinically diagnose that a prepubescent child had an inherent sense of being genderqueer, demigender, intergender, trigender, polygender or any one of a multitude of new gender identities, and then devise any medical interventions, or even determine what the purpose of any intervention might be, or whether that gender identity had been suppressed.

The World Health Organisation on the other hand, states it is social and learned behaviour, not innate

> *Gender is the characteristics of women and men that are socially constructed, while sex refers to those that are biologically determined. People are born female or male, but learn to be girls and boys who grow into women and men****. This learned behaviour makes*** *up* ***gender identity*** *and determines gender roles* (WHO, 2021).

So again, there are vastly different views about a concept fundamental to proposed new laws. World Health Organisation retains the separation of sex (biological) and gender (the socially constructed and learned behaviour) while the RCH and others opt for an innate, fixed characteristic based on an inner feeling. This belief in an innate feeling of being a particular sex underpins the gender affirmation approach to gender transition for both children as young as 4 years old and adults alike. Crucially a belief in only a fixed gender identity is also the basis for recent conversion practices laws in Australia that deliberately **exclude** transition as a conversion practice, even for minors.

If gender identity could be shown to be innate and fixed (immutable), then enacting laws banning some treatments for the suppression of an innate characteristic of a person might seem reasonable. Despite children and adults declaring they have been born in the wrong body, or a boy saying he has a girl brain, there is no scientific evidence to support such claims.

However, if gender identity is not fixed nor innate, but learned or evolving or fluid, then there would seem to be no rationale for any laws about suppression or change of the gender identity of children. Above all extreme caution needs to be exercised by lawmakers in order to avoid adopting unscientific assumptions and an ideology as the conceptual basis of new laws about conversion practices. The Issues Paper itself warns of the problems of ideology and law making.

This lack of clarity and precision about the exact nature of gender identity, is the origin of many false positives/misdiagnoses of a trans identity among children, as well as regret among adults who transitioned as mature adults. The obvious evidence against the ideological belief of a fixed and innate characteristic, is found in the experiences of detransitioners who have transitioned their gender identity, at least twice, but have been seriously harmed in the process (See Appendixes B, C, and D).

Further, the fact that both the Tasmanian and Victorian Self Identification legislation allows people to change their gender identity every 12 months, certainly provides evidence that undermines any notion of a fixed innate gender identity in those laws. Adopting a different meaning in Conversion practices laws is simply contradictory.

These conceptual and definitional contradictions are additional reasons COAL recommends separating sexual orientation and gender identity in any law changes. In fact, until such times as there is clarity and a scientific basis to the definition of the term *gender identity*, no laws ought to be changed.

The proliferation of ‘identities’ also works to divide communities and divides those who need a collective voice to be able to stand up for themselves. The powerful have always understood the principle of divide and conquer. With ‘identity’ at the centre of political positioning, collective action is made more difficult (Hawthorne 2020 pp.4-5). It is why COAL advocates from a human rights framework.

Conclusion

At this point lawmakers must heed the words of 23 year old Keira Bell after her successful case against Tavistock and its gender affirmation treatments:

> *I am delighted at the judgment of the court today. It was a judgment that will protect vulnerable young people. I wish that it had been made for me before I embarked on the devastating experiment of puberty blockers. My life would be very different today.*
>
> *My hope was that outside of the noise of the culture wars, the court would shine a light on this harmful experiment on vulnerable children and young people These drugs seriously harmed me in more ways than one and they have harmed many more particularly young girls and women…*
>
> *I call on society to accept those who do not conform to sex stereotypes – not to push them into a life of drugs and concealment from who they truly are. This means*

*stopping the homophobia, the misogyny and the bullying of those that are different. (*Bell, K 2020)

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QUESTION 1

1.1 THE WORKING DEFINITION.

> *Sexual orientation and gender identity (SOGI) conversion practices means:*
>
> *(a) acts or statements;*
>
> *(b) that are aimed at changing, suppressing, or eradicating the sexual orientation or gender identity of another person; and*
>
> *(c) are based on a claim, assertion or notion that non-conforming sexual orientation or gender identity is a physical or psychological dysfunction that can be suppressed or changed.*

COAL draws on both the Queensland and ACT legislation to define the subject of conversion practices to be covered by criminal legislation as a protected person, who includes:

- a child (under 18 years),
- a person with impaired capacity for making decisions about a particular service, and
- a person with an impairment "that is likely to significantly limit the person's ability to understand a particular service offered by a health service provider"

To this should be added the ACT legislative statement: "The recipient's consent, or the consent of the recipient's parent or guardian, is no defence."

Concerns about the working definition

A clear distinction between the terms sexual orientation and gender identity must be maintained throughout.

> *Lesbians and gays are not trans. Nor is sexual orientation the same as gender identity. These terms are not in the same category. Sexual orientation refers to women of the same sex attracted to or having sex with women (lesbians); and men attracted to or having sex with men (gay); and men and women attracted to or having sex with both women and men (bisexual). In many instances these individuals and groups challenge patriarchal gender normativity* (Krishnan 2018, See also Q9).

By their mere existence, neither do they conform to the dominant sexual orientation-heterosexuality. However, by contrast, the term transgender,

> *. refers to individuals who want to perform the stereotyped behaviours of the opposite sex: cross-dressers (men dressing as women), 'transwomen' (men who claim to be women but share none of the culture of growing up female and living in a female body). What transgender people who take on feminine gender do, is to reinforce*

gender stereotypes. (Krishnan 2018, pp. 442-453). See also Q9 about stereotypes in clinical diagnoses.

Clause (c)

Clause (c), is has a number of negative, possibly unintended consequences. The word AND just before clause (c) is very significant and can have the effect of permitting biomedical practices that are harmful, as long as there are no negative claims or ideas expressed. So, any change or suppression practice that was not related to some notion of negativity or dysfunction would be outside the definition of a conversion practice and permitted.

This may well capture parents and guardians who want to adopt a watchful waiting approach to their child's psychological distress and who reject the non-scientific idea that a trans identity is fixed or innate, even in children of all ages. Further these parents (Littman 2018, Shrier, 2020) know their children may have pre-existing or co-morbid psychological issues such as anorexia, depression or are on the autism spectrum. They do not believe a biomedical approach that gender affirmation is safe or appropriate for their child. They do express so called "negative" notions about the origins of their child's distress, such as social media or friendship groups immersion rather than a belief in an innate trans identity (Shrier 2020).

If this clause were to be adopted, parents opting for a watchful waiting approach or other non-biomedical approaches, would be guilty of suppressing the trans identity of their child. These parents often are aware that at least 85% of children who believe they have the wrong body, change this belief as they mature, if there are no bio- medical interventions or social transitioning (Kearns 2020, Biggs 2021, Zucker 2018, Brunskell-Evans 2017).

We are quite aware, the inclusion of clause (c) is consistent with the aims of the APS and RCH who both state any approach other than gender affirmation will harm the child, despite evidence to the contrary and the findings of the Judicial Review (Bell 2020, Appendices B, C, D).

In terms of **sexual orientation**, this clause would capture those parents who **don't** want a lesbian and gay child and proceed to have them transitioned. There is evidence of a level of homophobia among some parents seeking the biomedical treatments of gender affirmation, so their children appear heterosexual (see below). It is essential that this situation of sexual orientation conversion by parents be covered in the new laws.

COAL suggests, these contradictory outcomes can be resolved by confining the conversion practices laws to sexual orientation and introducing separate laws covering gender identity. This would make the laws consistent with the evidence base offered by the TLRI Issues Paper, about the harms of treatments to convert people to heterosexuality and the need to avoid ideology.

Only verifiable evidence about SOGI must be used to formulate the working definition and justify new laws to cover both sexual orientation and gender identity. There is no evidence of widespread harmful practices to suppress or change the gender identity of adults. The need has not been established. However, when it comes to children under going gender affirmation to a trans identity, there is a verifiable base of evidence showing irreversible and lifelong long

harms. Some of these have been confirmed by a Judicial Review by the High Court in the UK (Bell 2020).

Non-conforming Sexual Orientation

This term is not used in any other legislation, or any glossary of LGBTQA+ terms. It would be impossible to define accurately and precisely enough to have any effect in law. Clause (c) overall has not been included in other legislation.

What does non-conforming sexuality mean, who decides what is conforming and what sexuality is non-conforming? Conforming to what sexuality/ies exactly? This is a term based on subjective and ideological opinion, which ought to have no place in any legislation.

The term non-conforming sexual orientation is offensive because it attempts to impose a binary – conforming V non- conforming on sexual orientation. Is bisexuality non-conforming or conforming? According to whom?

As lesbians we could be considered to "conform" to same-sex attraction as our sexual orientation. This interpretation would **exclude** us from coverage by new conversion practices laws. Lesbians would have to agree that they had a *non-conforming* sexual orientation, and we don't. Further, the word non-conforming sexual orientation is just inappropriate and offensive to lesbians in this context. We totally reject others unilaterally defining and labelling our sexuality.

The clause as it stands is also likely to place at risk, those health practitioners supporting detransitioners and desisters, as they work through the complex of psychological issues that led the young person to initially seek a trans identity via biomedical interventions.

1.2 GENDER AFFIRMATION CAN BE A CONVERSION PRACTICE ON MINORS

In all other Australian Conversion practice laws, the majority of the content is devoted to the defining what is NOT a conversion practice. This comes about because including sexual orientation and gender identity in the same laws, creates a stark contradiction. These Bills have to prohibit biomedical practices as conversion on same-sex-attracted people, but at the same time allow and condone major biomedical practices on children and people with distress about their birth sex. Allowing gender affirmation using a biomedical treatment protocols, not only exposes children to extensive harms but in many cases, results in the suppression of the sexual orientation of same-sex-attracted youth. This is very difficult to reconcile in one law.

In the case of minors this is unacceptable, especially when consent and Gillick competence are examined. Tasmania has a duty of care to protect minors from harm and their rights under the Convention of the rights of the child. The many harms (see below) have arisen because the biomedical model of gender affirmation is based on a belief and assumption that gender identity is fixed and unchangeable in the same way as sexual orientation. This belief has been promoted by a political movement with strategies to capture the policies of major institutions such as the law and education. The false assumption requires sexual orientation and gender

identity be separated in laws, greater clarity of terms and concepts and critical evaluation of the evidence.

COAL believes the outcomes of practices, such as harms, must inform decisions about what is a conversion practice. The physically harmful outcomes of gender affirmation on children are now well documented (Biggs 2021) and include the removal of both breasts and sterility. If the *outcome* is the suppression of same-sex attraction and if a practice is not based on scientific evidence but false claims, then it is a conversion practice.

In addition, the intent of gender affirmation practices for children is to provide a medical pathway which suppresses either same-sex attraction, in the case of lesbians, or opposite-sex attraction in the case of heterosexuals, before the child has the capacity to understand the implications of the treatment practices. The intent at the gender clinics in Australia and major professional bodies such as the APS, is to transition children to a trans identity starting from as young as 3 or 4 years old, based on gender affirmation as the only treatment option.

1.2.1 PHYSICAL HARMS

1.2.1.1 Puberty Blockers (PB) (See also Appendix E for summary of research papers)

A judicial review by the High Court of the UK found unequivocally that puberty suppression/blocking for gender dysphoria is experimental treatment on children (Bell 2020).

'*it is right to call the treatment experimental or innovative in the sense that there are currently limited studies/evidence of the efficacy or long-term effects of the treatment'* (para 148)

The harms and effects of PB include the following (Biggs 2021):

- They are not certified as a safe or effective treatment for gender dysphoria by the manufacturers
- Bone density is decreased
- IQ is lowered by 10 points.
- They are used to chemically castrate sex offenders, a manufacturer approved use, unlike use for gender dysphoria, the effect on teens sexual life and function is unknown
- Olson-Kennedy (2017) a physician at a Los Angeles gender clinic, states that emotional lability and significant behavioural changes are serious side effects
- PB put girls into menopause and shuts down their ovaries. "*Menopause is bad enough when you're menopause-age, but when you're fourteen and you're having hot flashes, memory problems, insomnia, and you feel like crap, it is really terrible.* This is a *really common* effect of the current treatment protocol. (Olsen Kennedy 2017)

1.2.1.2 Cross-sex hormones (CSH)

CSH have lifelong effects which are not reversible. For young girls these include:

- lowering of their voice

- the growth of facial hair
- changes to the skin
- severe pelvic pain is common after 18+ months on testosterone (Olson-Kennedy 2017)
- genital dysphoria sets in two-three years after starting on testosterone, which also negatively impacts the health of female sexual organs, causing vaginal, cervical, and uterine atrophy and pain on orgasm. (Olson-Kennedy 2017)

1.2.2 FALSE CLAIMS

COAL supports the criteria of false claims, as outlined in the Issues Paper, forming part of how a conversion practice is defined. In relation to gender affirmation for minors there are several crucial false claims.

1.2.2.1 PB lower risks of suicide

The newly appointed Assistant Secretary of Health in the US government, Rachel Levine is a male who identifies as a woman. They stated that puberty blockers are *extremely safe* and beneficial to children who have supportive families and that children without access to such medical intervention have significantly more mental health problems. (Woman Are Human 2021)

In Australia, the director of RCH Gender Services, Melbourne makes the same false claim in the Australian Standards of Care:

> *Avoid causing harm. …when considering different options for medical and surgical intervention, with the withholding of gender-affirming treatment potentially exacerbating distress and increasing the risk of self-harm or suicide* (Telfer, Tollit & Pang 2018).

These serious claims are not supported by international scientific research, nor the evidence presented and accepted by the UK High Court. That evidence also included the association between puberty blockers and impairment in brain development, and significantly higher risks of heart attacks and blood clots. As a result of the scientific evidence, the High Court recommended no access for children under 16 to puberty blockers (Bell 2020).

The claim of a **lower risk of suicide** and self-harm is a very powerful one influencing parental decisions to consent to unscientific biomedical practices on their children:

> *The real concern was the statistics on suicide... I didn't want my son to be one so I supported him in the decisions ahead and informed him as best as possible. – Father of 10-year-old trans boy* (QCH 2019).

However, further evidence has now emerged from research conducted by the Tavistock itself (the defendant in the Bell case) showing this is false claim. In their study of patients on PB there was a significant **increase** in the first item of the psychological scale, "*I deliberately try to hurt or kill self*"' (Biggs, 2021).

1.2.2.2 PB effects are reversible and provide a pause button

The RCH website repeats this false claim:

> 1. Puberty suppression
>
> *As **they are reversible in their effects**, should an adolescent wish to stop taking them at any time, their biological puberty will resume*. (RCH Gender Service)

The effects are certainly not all reversible and many effects have not yet been studied and their use is quite recent (Biggs 2021, Brunskell-Evans 2020, see appendix E).

The other claim is PB are **a pause button** to give children a breathing space before considering CSH. The World Professional Association for Transgender Health states:

> *Their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition [to living as the opposite sex] by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment."*

The UK judgment emphasized that:

> '*the vast majority of children who take PBs move on to take cross-sex hormones, that Stages 1 and 2 are two stages of the one clinical pathway and once on that pathway it is extremely rare for a child to get off it'* (para 136. Bell Judgment 2020).

The judgment states that the evidence shows the claim that puberty suppression provides a "breathing space" is false. The Health Research Authority has acknowledged that the rationale for puberty suppression, **is in fact lifelong physical transition not a pause** (Biggs, 2019)

A study reported by Tavistock itself, showed only 1 child of 43 did not progress to CSH after being prescribed PB. This means the sexual orientation of the child will be suppressed, often before it has even had a chance to be experienced or develop stability (Biggs 2021).

For instance, Martos, Nezhad & Meyer (2015) found females reported their first same-sex *relationship* when they 19.1yrs old while for males they were 17.7yrs old. While bisexuals reported their first same-sex *attraction* when they were nearly 3 years older (16.5 yrs) than gay boys or lesbians.

Such research when considered against the outcomes of PB and CSH on minors, indicates gender affirming medical interventions do change or suppress their developing sexual orientation. Interfering with the sexual development of tweens and teens is an unacceptable abuse of their right to the highest attainable standard of sexual health and to pursue a satisfying, safe, and pleasurable sexual life. And as discussed below it is currently impacting more on young lesbians and female bisexuals.

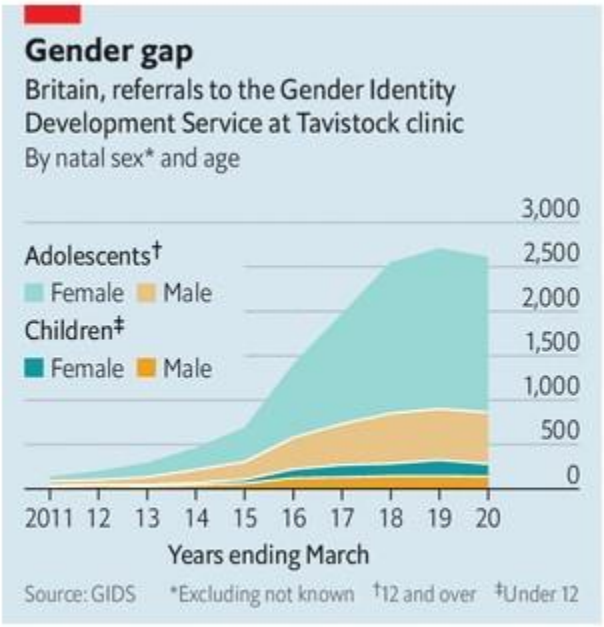
1.2.2.3 A FIXED INNATE GENDER IDENTITY

The RCH and APS approach, like that implemented by many clinicians at GIDS UK, appears to be driven more by political ideology than the clinical needs of presenting children. In part, this trend is rooted in the unscientific idea that everyone—including children—has an innate gender identity, akin to a religious soul, that one discovers, nurtures and must alter one's biological body to fit it.

1.3 Suppression of same-sex attraction by gender affirming practices.

Since no one actually knows what causes a youth with childhood gender dysphoria (GD) to resolve their dysphoria (usually in puberty), professionals cannot claim that hormone blockers—which affect hormonal exposure to the youth's brain (hormones that are critical to normal brain development), won't alter the gender identity, sexuality, cognitive function, personality, or long-term health of the young person.

An outcome of gender affirming "care" can be the suppression of same-sex attraction in girls. This is partly the result of misdiagnosis of rapid onset gender dysphoria (ROGD) among increasing numbers of teenage girls attending gender clinics compared to young children, ie patients who are of an age of developing an awareness of their sexual orientation. This ROGD group seems to experience higher rates of desistance and possibly regret. They identify as trans as teenagers, but eventually outgrow GD**.** This trend is the same in Australia but the data by age and sex is not available from Australian clinics and therefore remains unexamined (Kenny 2020).



The evidence of suppression of, or change to, same-sex attraction is from researchers, clinicians who have previously worked at the Tavistock gender clinic, former patients

themselves and health professionals who support detransitioners (those who have identified as the other sex and been treated with biomedical interventions, but then changed back to their birth sex) and desisters (those who have identified as the other sex but did not proceed with biomedical treatments, before reconciling with their birth sex).

Some youths are very sure of their trans identification and they must receive the highest quality evidence-based care and support. At the same time, a fixed transgender identity is simply not true of all young people, according to desistance stats and real-world observation. The difficulty is clinicians are unable to diagnose which small minority of unconventional children will persist in their trans identification as adults and which ones (the majority) will outgrow their gender dysphoria (Steensma et al 2013). Even using the clinical criteria (see Q9) does not provide a diagnosis with any degree of certainty or reliability. Yet, further evidence of how lesbians can have their sexual orientation suppressed - being wrongly diagnosed and treated as having a trans identity.

1.3.1 Research

The clinical indicators (see Q9) of gender dysphoria catch many “tomboys” and “sissy girls”, whether they are same sex, heterosexual or not yet aware or have a stable sexual orientation. However, numerous studies show that if children who might be less stereotypical in their activities and preferences **are not** subjected to social transitioning and treated with biomedical interventions, the majority will desist and many will grow up to be lesbian, gay or bisexual (Kearns, 2018, see Appendices B, C, D).

There are multiple recorded cases of teenage girls (many lesbians, but also bisexual and heterosexual females), who were put at risk of unnecessary medical interventions that have permanently altered their bodies (see Appendices B, C, D). Many did not have childhood GD when they presented with ROGD (Littman 2019). Even though they did meet the diagnostic criteria for gender dysphoria under DSM-V (persistent for 6 months), they later fully desisted or detransitioned.

1.3.2 Clinicians

35 clinicians at the UKs largest gender clinic have resigned in the past 3 years over ethical concerns about the use of only model of treatment (The Telegraph 2019). Dr. David Bell, a senior consultant at the Tavistock & Portman NHS Trust was approached by 10 GIDS staff who had grave ethical concerns including inadequate clinical assessments, patients being pushed through for early medical interventions, and GIDS’ failure to stand up to pressure from trans activists. He resigned his position (Bell D 2020).

A major concern was the number of same-sex-attracted girls being transitioned because of homophobic parents and their own internalised lesbophobia.

One former clinician of Tavistock said:

"It is converting people into heterosexuals...We had so many families who would talk about not wanting their daughters to be lesbians. They also said that *young people* '*repeatedly' shared a sense of 'disgust' that they might be gay* (Bannerman 2019).

A clinician in the US reported:

The detransitioners I see in my practice are all female, and they are all in their early twenties. At the time they became trans-identified, many were suffering from complex social and mental health issues.

Since detransitioning, most now understand themselves to be butch lesbians. In our work together, they traced complex histories of coming to terms with their homosexuality. Some faced vicious homophobic bullying before they announced their trans identification.

Dismissing detransition as a "panic" stirred up by biased media outlets does a grave disservice to the real men and women. It isn't good science—or good journalism—to ignore a category of people simply because their pain is politically inconvenient (Marchiano, 2020).

COAL urges Tasmanian law makers not to ignore them either.

1.3.3 Detransistioners in their own words

The majority of detransitioners are young women. The average age at which they detransition is 24.5 years. When they consented to gender affirmation treatment there was no serious exploration as to whether they could understand the lifelong consequences of their treatments. This issue of consent was the basis of Keira Bell's case against the Tavistock clinic. Their sexual orientation is not being considered as central or even relevant, as the assumption is that if a child says they feel like, or want to be the other sex, then they are, and the assumption is that this gender identity will not change.

Lesbians can be unconventional in many ways, but often it can be expressed as a rejection of the stereotyped femininity associated with of heterosexuality. Unfortunately, this unconventionality in dress and interest has been pathologized and incorporated into the diagnostic criteria for gender dysphoria. This in turn has led to misdiagnoses of lesbian minors as having a trans identity and practices which suppressed their sexual orientation, ie a conversion practice.

Please consult the Appendices for evidence from a number of countries, of how lesbians were often wrongly diagnosed as having a trans identity and how internalised homophobia was never explored as a reason for their distress about their bodies.

A few stories from detransitioners on the Post Trans website:

A) *came out as bi when I was 14, later as a lesbian at 15. I remember being okay with being a tomboy until I got to high school. I started hanging out with other trans kids*

(By the end the trans kids outweighed the gay kids) and I later came out as non-binary. I thought that that would make me feel better. I was told that if you don't fit in with certain gender stereotypes, you might be non-binary or agender or whatever. It really confused me because I feel like I wasn't a girl, but I didn't want to be a boy either.

Transgender identity offered me an explanation for why I was wrong. I've felt different my whole life. I never felt like I was really a girl because I never seemed to be able to act like the other girls acted.

B) *When I was 6 years old, I cried and screamed because I didn't want to wear a dress. When I was 9, I begged my mother for a football. She said, "No, football is for boys". At school kids made fun of me for acting like a boy. I was told the way I was wrong, that I needed to behave like a girl.*

I grew to resent my female body. I hated being a woman. Unlike many detrans women, I lived many years as a butch lesbian woman before transitioning at the age of 34. It seemed like I was drowning, and my dysphoria became unbearable. The only way out I could see was transition.

It's been the hardest and most humbling thing I've ever had to do in my life, but I'm glad everyday that I detransitioned. I'm a mother, a wife, a lesbian and I'm sure people still think I don't act like a woman. But I know now that I'm not wrong, they are.

C) I grew up in a city in southern Germany. My childhood was great until I joined a GNC-phobic and later homophobic school in my early teen years. I became anorexic, later depressive and suicidal. I met a trans guy and I thought all those trans ideas would just solve every problem I had. I took T for 3 years, had a mastectomy and changed my legal name. Due to mastectomy I have constant pain and I regret doing it. I don't think the talk with the doctor about the risks of surgery was informative.

My emotions were suppressed by T, I realized I was not happy. So I stopped T, tried to face my internalized lesbophobia and I am now trying to change my legal name back. I think it's important that more GNC (gender non- conforming) people talk about their experiences in everyday life and that it does not automatically mean they're trans.

D I went to a single-sex school where I was surrounded by only girls for 3 years. I never "felt like" other girls. Lesbians were feared and so the thought that I could be one didn't dare cross my mind. I despised the way boys looked at me after puberty and I covered my body as much as possible and developed an eating disorder.

I felt like my body was wrong. I began struggling with depression and anxiety and it was soon after this that I discovered the online trans community, who enabled my feelings of self-hatred and led me to believe that transitioning was the cure to all my problems.

I experienced an awful depressive episode and realised that transitioning had not fixed any of my problems. I ***went to therapy for the first time in my life and realised that I was an autistic butch lesbian****. I realised that I was never meant, or needed to "feel like" other girls and that I could be my own authentic self – and still be female. After years of self-hatred and denial, I'm finally getting to know my autistic, masculine, female self, and I love her.*

E) *After finishing high school (5 years ago) I was burnt out and directionless, things began to unravel, and at about that time I also admitted to myself that I was attracted exclusively to women (I am still having so much trouble with this). I degraded myself. I felt such disgust for my female body and assumed others would too. I did not expect or feel deserving enough to be treated as human, and assumed others also saw little worth in me. I have considered how the shame of my sexuality may be linked to the shame of my female body.*

1.4 Consent of the child or parent

Can children consent to sterility and potentially losing their adult sexual function and pleasure when they are 12 or 15? A female child of 12 might well have to decide on the sperm donor for her eggs, if she wants to have children because PB followed by CSH is likely to make her sterile. Fertilised egg storage is called fertility preservation by gender clinics. The High Court judges emphasized the 'enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication' (para 150). Therefore GIDS—and private clinicians in the UK, who wish to prescribe PB for treating gender dysphoria—will have to seek a court order for each individual patient. These issues are discussed further in Q2.

1.4.1 Breaches to the Rights of the Child

Breaches of the rights of the child is another factor COAL considers important when deciding which are and which are not harmful conversion practices for LGBT minors

1.4.11 CRC Article 19: Right to be protected from all forms of physical and mental abuse

Clinicians are unable to tell (diagnose) which children will outgrow their childhood/ adolescent distress and those who won't. They are also unable to tell which young children will develop a same-sex sexual orientation. 85% of young children will outgrow their distress if they are not socially transitioned, and do not have any medical or surgical gender affirming treatments (Kearns 2018).

The risks of misdiagnosing young lesbians as trans, is high, possibly as high as 85% The actual physical and mental harm to the many children who would have outgrown their dysphoria if not subjected to gender affirmation, is therefore high and apparent in

detransitioners' experiences. The Conversion practices bills in QLD, ACT and Vic, are deeply flawed as they do not offer children any protection from the harms caused by misdiagnosis and biomedical practices based on experimental treatments. Quite the reverse, these practices endorsed by those laws.

1.4.1.2 CRC, Article 13- Right to seek, receive and impart information

Any bill must not criminalise the imparting of any information to children or their parents that contradicts the gender affirmation model. The QLD and ACT laws risk this outcome. The current approach of Gender clinics denies children, including adolescents and their parents, vital information and education on their sexual and reproductive health and futures, as well as any information about health, social and legal issues related to detransition.

The APS and Australian standards of professional practice specifically deny children the right to information **about non-drug treatments** options such as watchful waiting, which the APS considers conversion therapy.

1.4.1.3 Article 24 Right to the highest attainable standard of health – (See also Appendix E)

The affirmative model prevents the achievement of the highest attainable standard of health for children, especially adolescents, by medicalising psychological distress and pathologising behaviour that is not stereotypical. The model relies on clinical consensus and unscientific assumptions. By ignoring the evidence on persistence, desistence and detransition, in the framing of laws, this right is compromised and adversely affects young lesbians in particular.

Based on this evidence, COAL recommends removing gender identity from new laws and establishing a new law covering the medical treatment of children in Tasmania, including children with intersex variations. This is essential as the evidence demonstrates that gender affirmation is a conversion practice that suppresses or changes the sexual orientation of minors. Above all the rights of children need safeguarding by Tasmania.

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QUESTION 2. CONSENT ISSUES

All of the Australian and global legislative initiatives in the SOGI area, are occurring in a larger cultural and social context of a political movement, the transgender movement (American Psychological Association) is also referred to as the gender identity movement. Issues of consent are contingent upon the assumptions being made about the very nature of sexual orientation and gender identity by this movement.

Depending on those assumptions and definitions, age can be a crucial factor. We would argue a primary object of the Tasmanian legislation must be to ensure the Rights of the Child are protected and to prevent harms to minors. The sexual orientation and identities of children develop throughout their teen years, which places them at much greater risk of harms from misdiagnosis than say, midlife adults. The complex array of issues regarding consent and age and their interaction, is a further reason to separate sexual orientation and gender identity in legislation.

2.1. Consent by Adults

We find some merit in right of adults to bodily autonomy ("my body my choice") adopted in the German model. This is the standard basis of the "informed consent model" used for medical treatments and procedures. Adults are generally presumed to have capacity to consent, unless there is a reason to be concerned about their ability to make a decision.

Such consent of course relies on scientifically based medical information about the benefits and risks of treatment options being communicated and understood. The condition of consent unfortunately has NEVER been met in the history of "curative" treatments for homosexuality. Instead, consent has relied on the medical/clinical consensus of the day. This in turn was influenced by the dominant ideologies of the day. Lifelong, often irreversible and damaging medical and surgical treatments were consented to. (Camp Ink, 1973). Many adults consented to terrible surgical and psychological procedures because of, and in an attempt to avoid the suffering, criminalisation, discrimination and shunning they experienced for being same sex attracted. There are very similar themes in the reasons detransitioners give for deciding to try to change their sex (see Appendices B, C, D).

The long history of treatments to change the sexual orientation of lesbians and gay men, demonstrates the extreme dangers of basing a diagnosis/ treatment on popular, but unscientific ideological beliefs. Many of our members have direct experience and memories of the times when lesbianism was medically and legally considered a mental illness. (Waite, 2015). The medical and health professionals during those times, were neither immune nor detached from ideological beliefs such as homosexuality was abnormal and needed to be cured. In fact, those professions were central to promoting such practices as lobotomies and reproducing them through medical education and professional organisations (Caruchet 2019).

Today some public health professionals are responsible for promoting the idea that distress about your birth sex can be cured by medical and surgical interventions offered by children gender clinics.

Given the living history and lived experience of lesbians, there are 4 principles, needed in addition to standard informed consent principles used for medical treatment (Hayson 2019):

1. The diagnosis has near certainty of being accurate.
2. The procedures/ treatments being offered are based on scientific evidence and a body of established research.
3. The likelihood of serious irreversible harm is known and negligible.
4. The person giving consent has the capacity to understand the risks, as well as the short- and long-term consequences of the treatment

For adults over 21, with gender dysphoria, only 1 of these would be partially met. In the case of gender dysphoria in children**, none** of these conditions can be met. This is why COAL recommends separating sexual orientation from gender identity, in order to safeguard children from conversion of their sexual orientation and/or their identity. Sexual orientation and gender identity are two very different aspects of human behaviour and identity.

Similarly, Intersex organisations rightly argue on human rights and ethical grounds, for laws to be based on the following principles:

- The reversibility of the procedure
- are there significant risks that *a wrong decision might be made* (either as to the minor's present or future capacity to consent, or about what are the best interests of a child who cannot consent, or the procedure being proposed before all relevant factors are manifest);
- can grave consequences flow from the decision for medical treatments (Carpenter, 2020).

In the case of gender dysphoria in children, there is ample evidence that the risk of misdiagnosis and the wrong decision is high (Shrier 2020, see Appendix B, C, D).

2.2 CONSENT AND CHILDREN

2.2.1 Other laws and circumstances

In Australia, specific legislation regarding the medical treatment of children exists only in South Australia (SA) and New South Wales (NSW), with legislation for the rest of the country, including Tasmania, being common law based on a 1986 English House of Lords judgment

(Gillick v West Norfolk and Wisbech Area Health Authority) (Choahan 2018). The Gillick case was also used in the judgment of *Bell and Ors v Tavistock.*

One group of children who are subject to medical treatments, are those born with intersex variations. Intersex people are subjected to medically unnecessary surgeries, hormonal treatments and other procedures in **an attempt to change their appearance to be in line with gendered societal expectations of male and female bodies** *without their full and informed consent*. The root causes of these human rights violations and abuses include harmful gendered stereotypes, spread of inaccurate information, stigma, taboos, and pathologization of difference (Carpenter, 2020). It needs to be noted that in the case of gender dysphoria, **not** conforming to gendered stereotypes forms part of the confirmation of the condition and gives rise to medical interventions.

IHRA strongly argue that

> *decisions regarding 'normalising' surgical or medical procedures on intersex children should not be left to either medical practitioners or parents alone, and that there be no medical interventions until the person is mature enough to understand all the complexities and likely consequences of one course over another* (Carpenter 2020).

This position is reflected in Recommendation 11 of the Anti-Discrimination Commissioner of Tasmania:

> *That treatment or any intervention primarily undertaken to modify or 'normalise' the visible or apparent sex characteristics of children for psychosocial reasons be classified as 'special medical procedures', and require consent of a Tasmanian board or tribunal such as the Guardianship and Administration Board informed by experts on gender and sex diversity* (Anti-Discrimination Commissioner, Tasmania 2016).

This ethical and rights position on medical procedures on children for psychosocial reasons, has placed Intersex organisations directly at odds with the trans identity movement. Put simply Intersex organisations see medical and drug treatments of intersex children as harmful and a breach of their human rights, because minors are not fully mature and cannot fully understand the life-long consequences of any hormones or surgeries.

On the other hand, LGBTQA+ lobbyists committed to gender affirmation practices, advocate to governments, including Tasmania, for the opposite. Drug and medical treatments for children as young as 9 are excluded as harmful practices and legislated for as the ONLY treatment option. Such human rights contradictions were not easily resolved within LGBTQA peak bodies, and so Intersex organisations have separated from the legislative and ideological agendas of LGBTQA+ institutions and groups. And yet, so much of the material produced by LGBTQA+ institutions and groups use the intersex condition as a rationale for treating gender dysphoria as a medical condition.

COAL would recommend adopting the principles of the IHRA in relation to the consent of minors and any treatment options for gender dysphoria.

2.2.2. Consent to tattoos and body modifications by minors

Tasmanian Law deals with consent by minors in a number of areas involving their bodies: sex, alcohol and tattoos and body modification. Of particular relevance is the issue of tattoos, body piercings and body modifications. As with tattoos, gender affirmation practices result in irreversible life-long changes.

In Tasmania it's a criminal offence for a tattooist to ink someone under 18 years. In addition, body-piercers aren't allowed to give teenagers under 18 years piercings in intimate areas, even if teenagers have parental permission. Intimate areas are nipples and genitalia. (Legal Aid Tasmania). These laws were introduced to protect the welfare of young people, and to help avoid regrets. They came into effect under changes to the *Police Offences Act 1935,* in 2014. Basically, lifelong decisions like getting a tattoo, should only be made by adults.

The main arguments for such laws, are that young people under 18 are still developing both cognitively and physically, and the activity can result in permanent and life- long changes to the body. In addition, there can be serious health effects from piercings and other body modifications. The health risks of getting an intimate piercing appear to be high (Lee, Vangipuram, Petersen & Tyring 2018). So, when the medical risks of intimate piercings are considered, there appears to be complete justification for the ban.

Minors are not considered to have the maturity to understand the life-long consequences of getting a tattoo and body modifications but in gender clinics in Australia and under proposed new laws in Tasmania, minors are considered to be mature enough to consent to procedures that will make them sterile and in need of lifelong medications of cross-sex hormones. Such glaring contradictions between the laws covering tattoos etc and the proposed Conversion Practice law which would condone and support the medical and surgical interventions of gender affirmation for children, are not sustainable from a rights perspective.

This is despite the fact that the same realities of a minor's cognitive development and inability to understand life- long consequences of their actions, apply to both tattooing and gender affirmation interventions with children. In addition, there are different but significant health risks to children in both instances. The recent Bell case tested the claim that a child has the capacity to consent to the standard gender affirmation treatments at Tavistock (*Bell & Ors v Tavistock)*. Was Keira Bell of an age where she could fully understand the implications of the treatments for her adult life?

2.2.3 SAFEGUARDING CHILDREN and capacity to consent

World's First Judicial review of consent of minors to gender transition (gender affirmation practices)

The first judicial review of the ability of minors to consent to the practices associated with gender transition was conducted by the High Court in the United Kingdom - *Bell and Ors v Tavistock* (2020) It needs noting that the first Australian clinic to treat children distressed about their birth sex was only established in 2014. It was at the Royal Children's Hospital (RCH) Melbourne (Kenny, 2019) where Tasmanian children were treated until recently. It has been followed by children's clinics in Queensland, Sydney and Perth. There is now a Tasmanian Gender Service (TGS) for children and their families, who experience gender related issues. It is a specialised service which works closely with the Gender Service at the RCH and links with other specialist services across Australia (Tasmanian Gender Service, DHS 2019).

Bell chose a judicial review rather than a medical negligence approach. This made her personal circumstances (and those of other people) even less salient to the process and outcomes, which didn't involve any compensation payment to her for the lifelong harms she has suffered. In this UK case, the claim rested on one question: whether children and young persons can give informed consent to the administration of gonadotropin-releasing hormone agonists (GnRHa), i.e. puberty blockers.

The claimants argued:

- *inter alia*, that a child under 18 years was not competent to give such consent;
- that the information provided by the defendants to their patients was insufficient to ensure informed consent;
- that the absence of procedural safeguards and the inadequacy of information provided was an infringement of the children's rights under Article 8 of the European Convention on Human Rights. (see Q3 for further discussion of breaches of the Rights of the Child).

Gender clinics in Australia treat children with the same protocols reviewed by the 3 member panel of the High Court. The Court concluded that it is highly unlikely that a child aged 13 or under would ever be Gillick competent to give consent to being treated with puberty blockers and very doubtful that children aged 14 and 15 could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent.

The court said:

> *"it is not our role to adjudicate on the reasons for persistence or otherwise of GD. However, the nature of this issue highlights the highly complex and unusual nature of this treatment and the great difficulty there is in fully understanding its implications for the individual young person. In short**, the treatment may be supporting the persistence of GD in circumstances in which it is at least possible that without that treatment, the GD would resolve itself."***

In fact, there are numerous studies, supporting this conclusion of the court. (Zucker 2018, Cantor 2016)

The High Court confirmed that *Gillick* competence was the correct approach to adopt for under 16s asking for treatment. They emphasised that a child under 16 would need to understand the immediate and long-term consequences of puberty-blocking treatment. The court said that children also need to understand how limited the evidence was for determining the efficacy or purpose of the treatment, and the fact that the vast majority of patients proceed to the use of cross-sex hormones, and its potential life changing consequences for the child.

In Australia puberty blockers are often administered around 10 or 11 years of age. The High Court held that in order for a child to be competent to give informed consent to puberty blockers, the child would have to understand, retain and weigh the following information:

- the immediate consequences of the treatment in physical and psychological terms;
- the fact that the vast majority of patients taking puberty blocking drugs proceed to taking cross-sex hormones and are, therefore, a pathway to much greater medical interventions; (Puberty blockers followed by cross-sex hormones, on the evidence, was determined to be one treatment, not two distinct steps as claimed by Tavistock and RCH Melbourne)
- the relationship between taking cross-sex hormones and subsequent surgery, with the implications of such surgery;
- the fact that cross-sex hormones may well lead to a loss of fertility;
- the impact of cross-sex hormones on sexual function;
- the impact that taking this step on this treatment pathway may have on future and lifelong relationships;
- the unknown physical consequences of taking puberty blocking drugs; and
- the fact that the evidence base for this treatment is as yet highly uncertain.

The Court highlighted the difficulties a child would face in understanding and weighing up this information about their lives as adults. The court took a different approach to young people aged between 16 and 18, because there is a statutory presumption that these young people can give valid consent. However, the court said that clinicians may well regard these as cases where the authorisation of the court should be sought before starting treatment with puberty blocking drugs, given the long-term consequences and the experimental nature of it.

COAL strongly endorses and supports the findings of the judicial review and urges the TLRI to use this judgment to defer any legislation on gender identity.

In Australia there is an acknowledgement that this treatment pathway is based on *clinical consensus*, not evidence-based medicine, despite the history of attempts to cure homosexuality. For instance, The Australian Standards of Care developed by RCH state:

> *The standards are based primarily on clinician consensus, along with previously published standards of care, treatment guidelines and position statements* (Telfer et al, 2018*)*.

However, its experimental nature is not acknowledged and has not resulted in any action by law makers to protect children. Quite the reverse, law makers have specifically excluded gender affirmation/transition as a harmful conversion practice. Further health professionals in gender clinics, along with LGBTQA+ organisations advocate for gender affirmation to those same law makers. As discussed earlier the living history of lesbians means we are extremely critical and sceptical of any medical practice related to sexual orientation and identity based on *clinician consensus**.***

2.3 OTHER REVIEWS of Gender Affirmation Practices and consent

No Federal or State body in Australia, has conducted a review of the evidence base for gender affirmation treatments on minors. However, major reviews have been conducted overseas amid widespread concerns about the rapidly increasing number of children being diagnosed with gender dysphoria as well as the complete reversal of sex ratios of cases occurring prior to 2014, showing at least 75% are now female (Kenny, 2020).

In a commissioned review of the evidence base for puberty blockers and cross-sex hormones in 2019, Professor Carl Heneghan, director of the Oxford University Centre for Evidence Based Medicine, concluded that they are 'an unregulated live experiment on children':

> *Children are not small adults; their changing body composition requires careful dosing; their physiology creates unique challenges that increase risks, and off-label use may lead to serious and life-threatening consequences. In my view, given the paucity of evidence, the off-label use of drugs that occurs in gender dysphoria largely means an unregulated live experiment on children. The collection and evaluation of evidence, particularly when it comes to ensuring their safety, s****hould therefore be a priority. It is not*** **(Bannerman, 2019).**

In Sweden, shortly before the bill to lower the surgical sex reassignment minimum age from 18 to 15, was due to be debated in parliament, it was shelved. The Board of Health and Welfare was ordered to reassess the evidence. The Swedish Paediatric Society supported their National Medical Ethics Council's review of gender dysphoria, expressing concerns about the affirmative model and need to safeguard decision-making by young people with the condition. This follows the finding of Sweden's Board of Health and Welfare, of a 1,500% rise between

2008 and 2018 in gender dysphoria diagnoses among 13- to 17-year-olds born female (Orange, R .2020).

In December, the government also asked the Swedish Agency for Health Technology Assessment, to review the scientific research into the recent surge in teenagers reporting gender dysphoria. They reported there was very little research either into the reasons for the increase, or the risks or benefits of hormone treatment and surgery.

> *"The physical and psychological maturation process of children and adolescents is individual, but for most people, it involves searching for and experimenting with their identities; this is natural and needs to be done with nuanced support by the child's relatives. Society's rules need to balance children´s own rights against the necessity to protect them. Giving children the right to independently make life-changing decisions at an age when they cannot be expected to understand the consequences of those decisions, lacks scientific evidence and is contrary to established medical practice"* (Swedish Paediatric Society 2019)

This is in accord with the legal precedent for greater caution set in the *Bell and Ors v Tavistock and Portman* (2020) judgment handed down in December 2020.

The legal and health discussions in Sweden have shifted very quickly following these governmental reviews, where an identity ideology in health care has been replaced by a return to evidence based medicine. One of the changes has been growing divisions between trans activists. Aleksa Lundberg, a trans woman and longstanding activist, apologised for not having been sufficiently open about the depression she had felt after her operation, saying:

> *I would probably not undergo corrective surgery if I had the same choice today, and I want to apologise to those who perhaps needed to hear that story earlier* (Orange, R 2020).

2.4 Misdiagnosis of gender dysphoria or self -diagnosis of trans identity

The Melbourne Gender Clinic settled a number of claims by former patients for misdiagnosis of their condition, in 2009. They all underwent genital surgery, as part of the medical protocol based on medical consensus about gender identity disorders and the need for surgical interventions (Stark, 2009). The issue of correct diagnosis with *near certainty* is compounded in the case of children and adolescents.

The evidence shows same-sex attracted girls and children who don't conform to stereotypes in their appearance or interests, are being misdiagnosed as transgender. This results in conversion of their sexual orientation (Lucy Griffin et al. 2020)

Excluding gender affirmation treatments in the examples of legislation in the Issues Paper, ignores the growing level of false positives among teenage girls, and detransitioners. (Detrans Canada 2020; Marchiano 2020).

There are the lifelong harms and human rights breaches when a social justice issue intrudes into healthcare practices. There is no evidence that gender clinics believe there is any reason behind a young person presenting as transgender, other than that the child is transgender. There are no diagnostic procedures to untangle ‘gender dysphoria’ from underlying issues unconnected with ‘gender’ so that an accurate diagnosis can be made with confidence.

2.4.1 Young Lesbians

Today, there is evidence that many teenage females are presenting at gender clinics are being misdiagnosed as being gender dysphoric and having a trans identity (See Q9, for the clinical diagnostic criteria for gender dysphoria (GD) in children). The clear evidence of misdiagnosis is the growing number of detransitioners like Keira Bell, a lesbian, speaking up and forming support groups (See Appendix B, C, D).

This is despite how difficult it is for a young person to come out and say they made a mistake and no longer have a trans identity. Even more difficult in a cultural and social climate that once was welcome, but then becomes hostile and abusive to detransitioners (Mainwaring, 2020; Stella, 2016).

> *It’s important to remember that Keira Bell herself is a fucking evil person who overtly endorses conversion therapy for trans kids (*Zinnia 2020).

The social and psychological harm is compounded by the public messages promoted by trans identity activists about girls and women who detransition when they realise that gender transitioning was not a solution to the distress and discomfort they felt about being female and/or same- sex attracted.

A Tshirt for sale and a flag with the same message at a “Pride” event in the US (Goyangi 2020).

In Australia, minors are considered Gillick competent to provide consent to irreversible invasive medical practices as part of gender affirmation (Jowett Mathews 2020). However, it is anticipated the High Court judgment will now protect minors from experimental medical interventions in the UK and across Australia.

The proposed Conversion practices laws in Tasmania is the opportunity for this State to protect psychologically distressed minors from misdiagnosis of their gender identity and sexual orientation, and undergoing a form of conversion of their sexual orientation.

Consent to the TI procedures has emerged as a major ethical problem that can cause harm. A recent example is Lachlan Watson, a 19-year-old popular celebrity, who has self-harmed and had a mastectomy, came out as a lesbian at thirteen, then identified as a transman, and then at age 17 stopped identifying as trans to identify as non-binary. She has publicised the whole process, winning many fans and likely influencing many young women to accept transgenderist ideas and practices (Lee 2018; Weinstock 2020).

Older lesbians see how young lesbians are being encouraged to think they were born in the wrong body and that they are really male and would be happier if they transitioned. Many are same sex attracted but this sexual orientation is being ignored and changed to a "heterosexual "one, in the process of affirming a trans identity. (Bannerman, 2019, Griffin et al 2020)

The social rejection of young same sex attracted females and the dominance of transgender ideology, have led them or their parents to consent to gender affirming medical treatment in the belief that their psychological suffering or social discomfort will be resolved.

> *When I was younger (14), I always felt like I had to make a choice. I knew that I was a girl who liked other girls. But because of what I was taught, I felt like the only way you could like another girl is if you were a boy.*
>
> Jaah Kelly transitioned and is now a lesbian detransitioning at age 18 (Robertson, 2019).
>
> *At age 18, I started seeing a bunch of transgender men's "success stories" on Instagram. The trans men talked about how something had always "felt off" with them, and they said people couldn't tell they had been the opposite sex after their transition. Their stories all seemed to have a happy ending—and it made me rather jealous.*
>
> *Here I was getting frowned upon for holding hands with my girlfriend in public, feeling like I'm constantly being judged by everyone, while transgenders could date their same-sex significant other while looking like the opposite sex. I resented that and began to envy the transgenders. I looked into it for myself.*
>
> *Everything I read was in favor of transitioning. ...I can't wrap my head around all that I've done to myself in the last two years, much less the "help" that some health care professionals have done to me. Two years ago, I was a healthy, beautiful girl heading*

toward high school graduation. Before long, I turned into an overweight, pre-diabetic nightmare of a transgender man. (Sydney 2019),

Some of the sources of false positives in diagnoses of a trans identity are highlighted in a study by Littman with 256 parents whose adolescents and young adults had rapid onset gender dysphoria (ROGD) (Littman, 2018) Note: the sample size for this study is considerably larger than that of the main Victorian research study of adults used to justify changes in legislation around sexual orientation and gender identity in Australia.

A primary finding was the role of social media and peers, evidenced by the fact that the girls in a friendship group all decided around the same time, they were really born in the wrong body or meant to be boys. Littman found 41% of teens were **not heterosexual** before identifying as trans. Given the incidence of "non-heterosexuality" in the general population is estimated at around 4%, this is a large over representation of this population (Perales, F and Campbell, A). It also means 59% were heterosexual and transition would result in changing their sexual orientation to be a homosexual man.

Historically, we know it is difficult to change a person's sexual orientation, hence legislation banning attempts to change it. Therefore, most of the 41% of these teens, may well detransition, once their frontal lobe cortex has fully developed (in their early twenties) to fully understand the lifelong consequences of their consent to gender affirmation treatments. This was the case for Keira Bell who was same sex attracted before gender affirmation treatment and is a lesbian after detransitioning.

The other significant finding of the Littman study was 62.5% of teens, had been diagnosed with at least one mental health disorder or neurodevelopmental disability (autism) prior to the onset of their gender dysphoria and 80.4% had zero indicators from the DSM-5 diagnostic criteria for childhood gender dysphoria.

Autism is another source of misdiagnosis of a trans identity and discussed in in relation to the co-complainant in the Bell case. "Mrs A," is the mother of a 15-year-old girl with ***autism*** also raised concerns about consent and the treatment for her daughter. Professor Gillberg, a global expert on autism provided evidence that girls who are autistic or anorexic appear more likely to say they want to become boys. He also criticised the practice of giving puberty blockers to the many autistic youngsters who are now presenting as transgender. He said it was common for autistic young people to have both general and gender-related identity problems. He stressed that until recently the 'vast majority' of these young people learnt to deal with these issues with psychological support. However, autistic youngsters are now being wrongly convinced they have gender dysphoria from information they read online (Dale, 2020).

Young people and adults with an intellectual disability are also vulnerable to misdiagnosis, when a self proclaimed trans identity is made. Research looking at intellectual disabilities and gender dysphoria is limited and mostly involved young people with ASD. There is no specific evidence base or guidelines to assist professionals working in this field. (Bevan and Laws 2021) In line with the general population, more people with an intellectual disability are presenting to gender identity clinics. Bevan and Laws (2021) suggest:

> *There are a number of possible reasons for people with intellectual disabilities presenting with issues related to gender such as: a means of escape, perhaps from life or their disability, to control anger, lack of fulfilling relationships or conflict arising from non-heterosexual orientation.*

2.5 PARENTS

Cases of conversion practice by parents

Mother of trans child actor Kai Shappley (age 9) said:

> *I remember even thinking this kid might be **gay**. And I thought that that could not happen—and that **would not** happen. We started praying fervently. Prayers turned into googling conversion therapy, and how to make Kai not be like this.* (Shappley 2021)

Instead, these parents discovered transgender sites, a psychologist and opted to transition their boy child at around 4 years old. Is this an example of a conversion practice by a parent?

Today in Iran, homosexuality (i.e same sex attraction, not same "gender" attraction) is still a criminal offence. (OutRight International, 2016). The mandatory punishment for the rubbing of female genitalia between two or more women, is 100 lashes. Flogging is a punishment for other same-sex conduct such as passionate kissing. Any same-sex act between two men is subject to "31 to 74 lashes" (OutRight, 2016).

The prevailing view among healthcare professionals in Iran is that homosexuality is a psycho-sexual illness and gender transition is a solution. This belief system is promoted by families, medical schools and universities, and complements the government's official position codified in law. However, Iranian doctors and families often persuade, or even coerce, lesbians to undergo sex reassignment surgery.

They do this because while Iranian law criminalizes same-sex relations for men and women, the law does not criminalise transgenderism and trans individuals are authorised to undergo sex reassignment surgery, at the government's expense. (OutRight, 2016, p. 22)

As one lesbian reported:

> *I can't forgive this urologist, for trying to convince me that I was a man. After only one exam, he decided that I was a trans man and had to immediately start hormone therapy. As soon as I walked into his office, he greeted me by "Hello my dear trans client."" I was only 17 years old at the time and was too vulnerable [to handle this], especially after that unsuccessful love affair* (OutRight 2016, p. 22).

This is but one example of lesbophobia and how same sex attraction of lesbians can be suppressed by the medical profession and a government via the State promotion of trans identity ideology or the homophobia of parents, or both. The case of Iran demonstrates clearly that the social (family), legal and political context deeply affects the unseen forces influencing "consent" to irreversible medical treatments and surgeries. As already noted, families in Western countries likewise, opt for gender transition with State support, rather than have a lesbian or gay child.

In Australia, these are the same drug treatments and surgeries which have been excluded from conversion practices/therapies in the Bills of QLD, ACT and Vic because they are "consented" to by either a child's parent or the child themselves. No State in Australia has provided any safeguarding of these children, so it is imperative Tasmania rectify these flaws in any legislation it enacts.

The lengthy summing-up of the evidence in the Bell case, reflects the concerns COAL has held for the past 10 years, as insiders of the lesbian community. We have watched the dramatic changes in the sex ratios in children being diagnosed with gender dysphoria and the appearance of Rapid Onset Gender Dysphoria (ROGD) in teenage girls. We have watched as butch lesbians in our communities have been transitioned into trans boys and men, then presented as heterosexual. This is a stark reminder of our history and the forces which promote heterosexuality.

2.6 Professional bodies and disregard of safeguarding of children and consent

The Australian Psychological Society (APS) is the main professional body which actively promotes the affirmation model to governments the exclusion of any other care treatment, such as watchful waiting advocated by Zucker (2018).

The APS has dismissed the evidence from desisters, detransitioners and the increasing incidence of ROGD among teenage girls. Their media statement in September 2019 said:

As a professional organisation committed to evidence-based practice, the APS ***opposes any forms of mental health practice that are not affirming of transgender people*****.**

The treatment Guidelines for gender dysphoria in Australia have been produced by the staff of The Royal Children's Hospital Gender Clinic in Melbourne. They state:

> *The standards are based primarily on clinician consensus, along with previously published standards of care, treatment guidelines and position statements, and data from a limited number of non-randomised clinical studies and observational studies* (Telfer, et al 2018) *Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents*.

This is an extremely worrying admission that in Australia, the treatment of children is based on clinical consensus, not evidence. Consensus medicine to date has proved to be very damaging to lesbian and gay people, and is unlikely to be a legally defensible basis for legislation. This is why COAL recommends removing gender identity as an exclusion from any legislation, and including drug and medical interventions on minors as a form of conversion practice.

Unfortunately, the Australia Standards of Care continue to ignore the evidence of such reviews, stating:

> *Supporting TGD children requires a developmentally appropriate and gender-affirming approach*
>
> *Avoid causing harm. …when considering different options for medical and surgical intervention, with the withholding of gender-affirming treatment potentially exacerbating distress and increasing the risk of self-harm or suicide* (Telfer et al 2018).

Similarly, the Australian Psychological Society, (APS) website provides the following information for parents:

> *Affirm your child's expressed gender. It is essential to their child's wellbeing that parents, caregivers and families support the child and affirm the child's gender. Mental health professionals can:*
>
> *Assist with access to gender-affirming medical treatment. Having the option of treatment in the form of hormone blockers (to delay puberty) or gender-affirming hormones can have a significant positive impact on the mental health of TGD children in particular.*

COAL also notes that the APS advocates strongly to governments around Australia for the codification of gender affirmation in legislation such as that being developed for Tasmania:

> *A role for psychology*
>
> *. They also have a key role to play in advising and advocating to State and Federal Governments for the rights and needs of transgender people. Mental health professionals in general have made valuable contributions to state and federal inquiries that have sought to address inadequacies in legal and policy frameworks as they apply to transgender people. Such inquiries are likely to continue to occur, and psychologists have an important role to play in making submissions that endorse affirming approaches.* (Riggs 2018)

There has been no such advocacy for the protection of same sex attracted youth in legislation. These statements must be considered against the UK judicial review. COAL strongly opposes the position of the APS to advocate for only gender affirmation in conversion practices legislation and to criminalise any other approach to treatment because of serious concerns about consent, age and scientific evidence.

When legislative clauses state exemptions from the meaning of a conversion practice, include references to *reasonable professional judgement*, or *clinically appropriate assessmen*t, *safe and appropriate*, or *compliance with professional obligations,* the basis of the judgement of legality would seem to rest with professional bodies.

The expert sources for assessing *reasonable professional judgement* etc would be the Australian Standards of Care and the Australian Psychological Society. Both these professional organisations oppose any care or treatments approaches that are not gender affirming for children. This professional opposition can have the effect of leaving health professionals in breach of the legislation if they do not affirm a child or teens claimed gender identity. It also has the effect of overriding a parent's rights to object to gender affirming treatment when the child is "consenting" to it.

The lack of scientific bases of medical treatments for gender dysphoria and the issue of consent by minors was central to the Bell judgement, and is therefore highly relevant to any legislation, regardless of country. It is vitally relevant because the *gender affirmation model*, is the only treatment model currently promoted by LGBTQA+ organisations in Australia and unfortunately, they are listed as major stakeholders in the consultation process for new Tasmanian laws.

2.6.1 Rights of the Child

Within the ideology of gender affirmation for children, any other approach to the care of dysphoric children is considered directly or indirectly as "conversion therapy". We contend this is a serious breach of the rights of the child to medical care of high quality based on scientific evidenced based practice. In addition, the lack of accurate scientific information about the treatment pathways breaches a basic principle of giving informed consent. Finally, and most importantly, claiming that non-invasive and non-affirming care constitute conversion therapy, highlights the importance of age in any legislation.

> *The admission of the lack of evidence for changing same sex attracted girls into trans boys, in the Standards of care (Telfer et al 2018*) is quite spectacular and offers no protection to extremely vulnerable children. We urge the Tasmanian government to exercise a duty of care to uphold the 1989 Convention on the Rights of the Child (CRC), in relation to consent and gender transition

2.6.2 Parental Rights

The issues of parental consent and age depend on how conversion practices are finally defined in the Bill. Concerns were expressed by the ACT Law Society about the reach of that Bill. They pointed out it risked criminalising parents who took a non-interventionist approach.

Mr Coe said the new law had "the potential to send well-meaning parents and teachers to jail." Children and adolescents depend on the care and support of trusted adults and especially parents, teachers and others to help them in their development to adulthood. In this legislation there is no room for a child to safely question or explore their identity with their parents unless it's in just one direction," he said. "This bill will mean that the only support that [young people] can receive from parents or teachers is active encouragement to pursue a transition. (Doherty and Roy 2020).

The working definition of conversion practice in the Issues Paper would have very similar effects for parents who want other care options, such as wait and see. COAL argues neither children nor their parents ought to be able to consent to the unproven experimental treatments associated with gender affirmation.

It needs to be noted that the professional and legal support of gender affirmation in Queensland, has resulted in court orders to remove a child from parental care so that cross-sex hormone treatment can proceed.

The teenager was removed from her parents after a judge ruled them to be 'abusive' for not letting her start cross-sex hormones to transition into a transboy. The teenager was removed from her family by police, at 15-years-old, after discussing suicide online about a year ago. “The authorities say we will not allow her to change gender, so it's dangerous for her to come back to our house because we will mentally abuse her — they want us to consent to testosterone treatment,' her father said (Lane 2020).).

The mother explained family and friends has been shocked, “they just can't believe that it happens in Australia.” The couple said they knew their child had been depressed and in need of help but wanted a review from an independent psychologist. They wanted the psychologist to consider any possible underlying causes and to look into non-invasive treatment options. 'It's controversial because different doctors can come up with different diagnoses and different treatments, so for parents to seek a second opinion before going along with irreversible treatment is wholly appropriate,' their lawyer said” (Lane 2020).

This real-life case demonstrates all too clearly, why COAL recommends removing gender identity from the legislation and, at the very least, removing the ability of children and parents to consent to gender affirmation practices. This case is terrifyingly similar to cases in the1960s-1980s where the children of lesbians were permanently removed on court orders because of unproven risks of abuse and influence over the child’s sexuality, by mothers deemed mentally ill, solely because they were lesbians. Mental illness was the clinical consensus of the time (Jennings 2012)

Now parents can be deemed abusive if they choose not to follow the “’experts” standards of gender affirmation. A dangerous treatment based on clinical consensus. A great deal more consideration must be given to any law changes and definitions of conversion practices, that could result in court orders against parents because they do not accept the unscientific clinical consensus on trans identity treatments for adolescent girls.

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QUESTION 3

Have you been involved in or offered, or are you aware of, any forms of SOGI conversion practices in Tasmania? If so, what were the effects on you, or the person exposed to them?

In this section, COAL discusses sexual orientation (SO) and "gender identity "(GI) conversion practices separately. We argue that "gender identity" (GI) conversion practices need to be treated separately. They deserve a separate inquiry of their own because of complex issues that involve methods and effects different from SO conversion and the recent Judicial review in the UK. We use the term ***Trans-Identity*** (TI)**,** instead of gender identity (GI), as a more accurate form of language that avoids conflating sex and gender.

TI services are a major concern because of the harmful effects they have as SO conversion practices. We argue that TI conversion practices include not only those that seek to ***prevent*** TI "transition" (as included in the Tasmanian SOGI issues paper) but also TI services themselves that ***promote*** transgender "transition", in particular the "affirmative model" and its practices. For example, a young lesbian who claims a male identity after treatment in a gender clinic may continue to be sexually attracted to lesbians but has lost her lesbian identity to now perform a heterosexual orientation. Similarly, a heterosexual man who claims a female gender identity, with or without bodily modifications, may claim to be a lesbian and cause harm to lesbians and other women.

Furthermore, harm needs to be considered not only to the person whose sexual orientation or trans-identity is the target of conversion practices. When lesbians, bisexuals or gay men do not accept the trans-identity of another person, there is potential to hurt not only the trans-identified person but also those LGB people who do not accept trans ideology. For example, trans identified men have been the centre of controversy when they claim the right to access lesbian or women-only space. The long-running Michigan Women's Music Festival in the US was popular among lesbians and women who came from Australia and elsewhere around the world to attend. However, after 40 years the organisers closed it in 2015 (Ring 2015), because of highly contested controversies over trans identified men's access. The week-long festival had been widely inclusive of women, including some transmen and transwomen. It became the target of trans activists' claims that organisers were "trans-exclusionary" because of the organisers focus on "the experience of being born and living as female" and their feminist aim to "resist—and what we will never stop fighting—is the continued erasure and disrespect for the specific experience of being born and living as female in a patriarchal, misogynist world" (Vogel 2014). In Tasmania and elsewhere in Australia, political and social lesbian groups who restrict membership to natal women face similar threats to our ongoing existence. Some lesbians have told us that this has been "extremely distressing" because they are forced to act like their social group is a "secret society," preventing them from reaching out to isolated lesbians, similar to the oppressive times when homosexuality was illegal. In addition, COAL is aware of many lesbians and other women who have experienced, and continue to be subjected to, verbal and physical abuse, vindictive litigation, and threats to the viability of their

business and/or careers because they have publicly questioned gender ideology (Anonymous 2020; Inman 2020).

SO conversion practices include TI services based on the affirmation model. Because of their harmful effects, we call for abolition of SO conversion practices.

3.1 Traditional SO conversion practices

Australian Greens leader, Dr Bob Brown, is a high-profile example of a Tasmanian who has been subjected to a form of SO conversion practice. When he moved to Tasmania in 1972, homosexuality was a criminal offence with a penalty of up to 20 years gaol. It was decriminalised in Tasmania only in 1997, 22 years after South Australia had led the way in 1975 ("Timeline" 2015). Soon after he arrived in Tasmania, Bob Brown decided to undergo psychological aversion therapy, and had to travel to Sydney to obtain treatment. As for most of these conversion methods, it did not work. He came out as gay in 1976, the same year Exodus International established itself in the US, with the aim of converting gay Christians to heterosexuality (McKenzie-Murray 2018). Sexual orientation conversion is still being promoted in Tasmania today (Hill, 2020), but we are unaware of the extent.

It is hard to estimate the incidence of SO conversion in Australia or elsewhere and yet, in the past few years, strident calls for banning SOGI conversion practices have suddenly emerged nationally, with the publication of an Australian report two years ago that claimed to be "responding to LGBTI conversion therapy" (Jones et al 2018). Legislative moves towards this goal have rapidly ensued in various States and Territories, with Tasmania being the latest. Recently, Sandy, Powell & Hiscock (2020) drew on Jones et al (2018) to call for conversion practices to be banned nationally. However, neither Sandy, Powell & Hiscock (2020) nor Jones et al (2018) have collected or provided any direct empirical evidence that SOGI conversion is a significant enough problem in Australia to call for legislative action. Jones et al (2018) stated "at least ten organisations in Australia and New Zealand currently advertise the provision of conversion therapies" with a footnote that sourced their estimate from a newspaper article (Tomazin 2018) that stated "Fairfax Media has found about 10 groups (ministries) that still operate."

The Australian report by Jones et al (2018) relied on data from a UK national LGBT survey, borrowing their data to claim an equivalent rate of "about 10% of LGBT Australians are still vulnerable to harmful conversion therapy practices." However, the UK research design was poor. Researchers had not separated SO from TI conversion practices and, indeed, had not even provided a definition of conversion practices to the survey participants (Government Equalities Office 2018). There was also poor collaboration with other researchers. For example, another UK study done in the same year collected demographic statistics on sexual orientation but did not consider conversion practices (Office for National Statistics 2018).

The small amount of data available has shown that religious conversion practices have declined. Until recently, there were two umbrella Christian organisations in Australia known to carry out SO conversion therapy: Renew Ministries, based in Melbourne, and Exodus Asia

Pacific (McKenzie-Murray 2018). However, they appear to have merged after the parent organisation of Exodus International in the US closed in 2017 (Tomazin 2018). The Christian conversion movement began operating in Australia in the early 1970s and became widespread by the 1980s. They mobilised conversion practices—both formal and informal and in various settings—aiming to change or suppress homosexual orientation. They were based on a view of homosexuality as a disorder or illness caused by childhood trauma that could be healed. This view was shaped by expert opinion, such as by members of the American Psychiatric Association which diagnosed homosexuality as a disorder until 1973. The classification was weakened and then finally removed from the DSM (Diagnostic and Statistical Manual) in 1987 (Tomazin 2018).

SO conversion practices emerged in reaction to the gay liberation movement born in the 1960s, spread as a worldwide ex-gay movement in the 1970s, and apparently grew significantly from the early 1990s when it became strongly associated with conservative Protestant and other Christian religions, although Hinduism, Islam Buddhism and Judaism may also be involved (Jones et al 2018: 12-15). In contrast, it was also in the 1990s that conversion practices became widely discredited among health and allied professionals (American Psychiatric Association 2020) and today the Australian Psychological Society and regulatory bodies such as the Australian Health Professionals Regulatory Authority prohibit them. As a result, Jones et al (2018) state that the ex-gay movement modified its language to emphasise the client's agency. According to survivors, sexual orientation conversion practices continue to be carried out "underground" today, mainly within religious organisation (SOGICE Survivors 2020).

IESOGI (The United Nations Independent Expert on protection against violence and discrimination based on Sexual Orientation and Gender Identity 2020) has described a range of SO conversion methods: medical (surgery has been largely replaced by treatment with hormones, steroids or other medications, psychotherapeutic ((healing childhood trauma, aversion methods such as with electric shock, methods that associate sexual pleasure with heterosexual fantasies), and faith based (from informal pastoral care, prayer, sermons, textual studies, restricted access to service positions through to banishment from the community, physical violence, exorcism and celibacy) (IESOGI 2020:10-13; SOGICE Survivors 2020). In addition, conversion services can be highly profitable—no doubt a strong incentive for some to continue to offer them (IESOGI 2020: 78).

We argue that surgery is being revisited via TI "transition" methods. There are reports of increasing numbers who later desist (do not proceed with full "transition") and detransition (regret undergoing full transition and stop treatment) (Marchiano 2020; Detrans 2020). However, it is difficult to estimate numbers. Research published so far has the usual problems of long-term studies in that it is difficult to maintain contact with many original participants and so their results are not reliable and there were no significant numbers of children until very recently. For example, de Cruyper et al (2006) were only able to survey 56 (52%) out of 107 people who had sex reassignment at their clinic and the authors acknowledged that "this implies a bias that is difficult to avoid," yet reported "(t)he majority of the study group (86%) was (very) happy, even after several years." The authors' conclusion is not valid for the total

number of people recruited into their study. Similarly, Smith et al (2004) were able to only include 136 (72%) participants out of the 188 who had earlier completed hormone treatment.

The effectiveness of SO conversion practices is also hard to estimate. A review of relevant scholarly research found that about 20% (12/46) of respondents reported SO conversion therapy was ineffective and/or harmful. Only one found “successful” results, but it was biased as all participants were religious and the data was from self-reports (Cornell University 2017). It should be noted that most participants in studies have been adult White males with religious beliefs, and many early studies were based on outdated understandings of homosexuality as an illness, discredited psychoanalytic theories and/or unscientific religious ideas. The few scientifically rigorous studies found harmful effects that include loss of sexual feeling, depression, suicidality, and anxiety (American Psychological Association 2009). Such effects are far from minor and support our call for the abolition of SO conversion practices In Tasmania.

3.2 TI services as conversion practices

We detail our concerns here that the TLRI Issues Paper considers TI conversion methods ***only*** in terms of efforts to convert (de-transition) a trans-identified person back to their birth sex. This produces a serious omission: ***affirmative models that support trans-identified people to transition to a new identity (TI transition) are themselves a form of SO conversion therapy.*** Both conversion practices have harmful effects, which we outline below.

3.2.1 History and Politics of Nomenclature and its Effects

The rise in gender ideology has brought with it a rise in the number of different “genders” with which people identify. An extreme example is of 100 different “genders” and 70 different prefixes that can be added found on Tumblr (Dude 2020), making uncountable variations of “gender.” The Australian Bureau of Statistics noted a smaller range of genders provided in its 2016 census. For a total population of 23,401,890, 10,040 gave responses to the sex question that were other than male or female. Of those, the ABS estimated only 1,260 (5.4 %) were valid and intentional, suggesting people generally do not take contemporary ideas about gender fluidity seriously. The range of genders given within this “other” category are shown in Table 1 (below).

Table1: Descriptors for Persons Reporting Diverse Sex/Gender Identity 2016

	Persons(b)	%
Intersex/Indeterminate	40	3.2
Trans male	70	5.5
Trans female	100	7.5
Transgender not elsewhere classified	170	13.2
Non-binary	220	17.3
Another gender	230	18.1
Other not further defined(c)	440	34.9
Persons	**1 260**	**100.0**

Source: Australian Bureau of Statistics (2016)

The most recently published results of the online Australian Sex Survey, carried out in July to September 2016, illustrates a wider range of genders Australians may choose. The 2016 survey found people claiming 31 different genders including the traditional “man” (about 60%) and “woman” (32%) (see Table 2 below).

Table 2: Frequency of participant by gender identification term

Gender term	Frequency	Percent
Agender	11	0.15
Androgyne	7	0.09
Androgyny	4	0.05
Bigender	27	0.36
Cis female	145	1.94
Cis male	91	1.22
Cisgender	4	0.05
Demiboy	5	0.07
Demigender	3	0.04

Demigirl	14	0.19
Female to male	5	0.07
Gender nonconforming	21	0.28
Genderfluid	43	0.57
Genderqueer	31	0.41
Intergender	4	0.05
Intersex	2	0.03
Male to female	2	0.03
Man	4496	60.11
Nonbinary	23	0.31
No gender	6	0.08
Pangender	6	0.08
Poligender	2	0.03
Third gender	1	0.01
Trans man	6	0,08
Trans woman	15	0.20
Transperson	9	0.12
Transexual	7	0.09
Transgender man	28	0.37
Transgender woman	33	0.44
Trigender 2	2	0.03
Woman	2404	32.14

Source: Whyte, S, Brooks, R C & Torgler, B 2018, “Man, Woman, “Other”: Factors Associated with Nonbinary Gender Identification,” *Archives of Sexual Behavior,* 47, Table 3, p 2402.

The sample for the 2016 Australian Sex Survey was unrepresentative of the general population and was biased towards people who identify as gender diverse. However, the researchers noted that "self-identifying as nonheterosexual appeared to be associated with both male and female preference for nonbinary identification." Moreover, "younger females (relative to younger males) and non-heterosexuals (relative to heterosexuals) were more likely to identify as nonbinary" (Whyte et al 2018, pp 2397,2401).

This implies that, at least for younger people, gender and sexuality tend to affect each other; perhaps feeling different from the heterosexual norm leads to questioning one's gender, or vice versa. This apparent conflation is highly pertinent to our argument that at least some young people are influenced by gender ideology to undergo TI transition as a "willing" participant in SO conversion to the heterosexual norm.

The psychiatric categorization of "gender identity" has been highly controversial, even among health practitioners and people who identify with a "gender identity" different from their biological sex assigned. During heated debates ten years ago, prior to deciding on how to categorise these conditions in the next issue of the DSM (Diagnostic and Statistical Manual), a major review concluded:

> *the decision on the categorization of GIVs (Gender Identity Variants) cannot be achieved on a purely scientific basis, and that a* ***consensus*** *for a pragmatic compromise needs to be arrived at that accommodates both scientific considerations and the service needs of persons with GIVs* (Meyer-Bahlburg 2010, emphasis added)

As we show below (Question 9), definitions have become highly politicised and polarised as a powerful "gender identity movement" has developed. Consensus reached for the most recent issue of DSM (DSM 5) has not resolved competing knowledge claims among health professionals but, regrettably, has been judged adequate by those working in gender clinics (see Section 2.2.3)

A history of the political landscape of the gender identity landscape begins with the term "transsexual," coined in the 1950s and applied to people (mainly men) who wanted to change their sex (Jeffreys 2014). Medicalisation of the phenomenon resulted from the continuing medical and scientific interest in sexuality that had developed with the establishment of clinical medicine in the 18th and 19th centuries. Institutionalised scientific and medical knowledge were a means for those professions to exert power, successfully constructing homosexuality and other "perversions" not as moral weaknesses (eg sodomy) but as psychopathologies outside the heterosexual norm, which became problems to be studied, categorised and managed in populations (Foucault 1990). Harry Benjamin's book *The Transsexual Phenomenon* (1966) popularised the idea of transsexualism.

According to Jeffreys (2014), there was a "move (from sex) to gender" after Virginia (previously Bruce) Prince coined the term "transgender." A crossdressing heterosexual man in the US, he did not want to be identified as a transsexual or a homosexual and sought acceptance of what had become stigmatised as a paraphilia, or sexual fetish. Transvestitism was first listed in DSM II in 1968 under "sexual deviation," along with homosexuality (Meyer-Bahburg 2010).

During the 1960s and 1970s, while gays and lesbians were trying to free ourselves from medicalisation, transsexuals formed closer alliances with practitioners in medicine as they demanded hormone and surgical treatments (Bullough 2006 cited in Jeffreys 2014). Changes in attitude toward transition were consolidated under the influence of health professionals such as Harry Benjamin, John Money, and Robert Stoller (Drescher 2013).

In the mid-1960s, the first medical school-based transsexual clinic was opened at Johns Hopkins Hospital in Baltimore, MD, but closed in 1979, a few years after the appointment of Paul McHugh, chief of psychiatry from 1975 to 2001, who brought "old school" ideas that being transgender is largely a psychological problem of "guilt-ridden homosexual men," not a biological phenomenon (Nutt 2017). However, the same year that Harvard closed its gender clinic the Harry Benjamin Gender Dysphoria Association was formed.

In 1980, DSM 3 created the new category of Gender Identity Disorder (GID) covering subcategories of transsexualism, GID of childhood, and Atypical GID, all placed in the group of Psychosexual Disorders. A revised version DSM 3R released in 1987 contained an expanded list of GIDs: transsexualism, GID of childhood, GID of adolescence and adulthood non-transsexual type, and GID NOS (not otherwise specified) (Meyer-Bahlburg 2010). In 2013 the DSM 5 edition removed GID, replacing it with Gender Dysphoria, thus replacing the notion that it is a pathology with one of an emotional response of distress to discordance between a sense of identity and the body (Russo 2017). In 2017, Denmark became the first country to formally remove the classification of a mental illness.

Bilek & Ceallaigh (2016) have warned about the dangers of "medical transgenderism" that has widened its domain from adult bodies to include treatment of gender non-conforming children. They describe how, with little supporting evidence and wide promotion in global digital media and driven by a transgender-medical-industrial complex, medical transgenderism has rapidly colonised many areas of life, including the media, government regulatory bodies, legal systems, schools and the workplace. With religious-like fervour, it has overcome child safeguarding traditions, pathologizing what is often a child's healthy expression of fluid identities into mental illnesses such as Gender Identity Disorder (GID) and now Gender Dysphoria (Bilek & Ceallaigh 2016).

Bilek (2020)'s in-depth research has described the formation and operation of the gender identity movement as a "gender identity industry" with a focused approach that has enabled it to gain a powerful global reach. For example, in the 1990s a global movement began to extend antidiscrimination legal protections to "gender identity," and a comprehensive and international human rights legislative approach developed in the 2000s, including the establishment of the Yogyakarta Principles (2007), followed ten years later by the *Yogyakarta Principles Plus 10* (2017). Both documents were produced by a group of experts in human rights law together with representatives of lobby groups and other individuals (identified as experts in sexual orientation and gender identity).

The story of the Yogyakarta Principles is one of high politics. The documents came into being through the international stage of the United Nations, where homosexuality had proved contentious (especially among Muslim countries). Sanders (2008) has described the process

of change in the UN attitude, beginning with the decision of the Human Rights Committee in 1994 in Toonen v Australia. Usually, a committee of experts giving advice to the UN, this time the Committee ruled that:

> *the criminal provision was in conflict with the right of personal privacy set out in the Covenant. It also ruled that discrimination on the basis of sexual orientation was a form of discrimination on the basis of 'sex.' The criminal law was in breach of the Covenant for that reason as well* (Sanders 2008, p 2).

Sanders (2008) described the UN's next softening of its approach to homosexuality when, in 2006, it began to grant consultative status to LGBTQI organisations, to allow them to participate in the work of the UN, along with the thousands of other groups already granted consultative status. COAL was one of them. Sanders (2008) identified key players in soon after producing the Yogyakarta 2007 document: Louise Arbour, the UN High Commissioner for Human Rights, who networked with LGTBI groups nationally; The International Service for Human Rights and the International Commission for Jurists; and individuals such as Chris Sidoti, Philip Dayle, and Michael Flaherty, a member of the UN Human Rights Committee; with other carefully selected representative from 25 different countries. The meeting was not an official UN committee, and to minimise conflict further, the document was designed to show that

> *no "new rights" are being proposed, only the application of existing principles to the situation of LGBTI individuals. The argument that activists are proposing "new rights" has been a major argument of the opponents, particularly those from the Organization of the Islamic Conference*. (Sanders 2008, p 6)

More recently, the Yogyakarta principles have been used to drive the gender industry agenda in the formation of another key document, one filled with political strategies and prepared by a coalition of lawyers (Dentons, the largest transnational legal company in the world), an international LGTBQI group (the International Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI) Youth & Student Organisation (IGLYO)), and a Canadian-based multimedia conglomerate (a *pro bono* program TrustLaw of Thomson Reuters Foundation) (Dentons, IGLYO & Thompson Reuters Foundation 2019).

In 2017 the Harry Benjamin Gender Dysphoria Association was renamed the World Professional Association for Transgender Health (WPATH). That year was also when Stephen Whittle became President of the organisation after a two-year term as President Elect (Devor 2021). WPATH was truly Whittle's creation, complementing his career trajectory as a trans-identified man long involved in political gender identity activism (Bosenterfer 2020). Attracted to girls from an early age, as Stephanie Whittle she found non-acceptance at home for her lesbian sexuality and began her "gender transition in 1975 at the age of twenty years. After university graduation she found it difficult to hold down a job, eventually deciding to return to university to gain a law degree so as to better fight discrimination. Whittle cofounded the UK trans rights group Press for Change that played a key role in establishing the Gender Recognition Act 2004 and the Equality Act 2010 in the UK (Bosenterfer 2020) and was one of the expert signatories to the Yogyakarta Principles (2007). An OBE in 2005 and appointment

as Professor of Equalities Law at Manchester University in 2006 moved Whittle away from an activist and more towards an academic and "establishment" identity ("Staff Profile. Prof Stephen Whittle" 2021). Whittle can be seen as a key player in the global gender identity movement's focus on legal change that has led to Denton's central role.

One strategy for furthering the gender identity cause described in the Denton's document is "(t)ie your campaign to more popular reform" (Dentons, IGLYO & Thompson Reuters Foundation 2019, p 20). The success of this strategy had already been proven in the worldwide LGBTQI movement, which linked "gender identity" (TQ) with sexual orientation (LGB), which was beginning to find public acceptance, and with an intersex condition (I), which has little to do with sexuality but is a medically accepted sex-identified anomaly. More recent evidence of a similar move is in the global call for legislative controls of SOGI conversion therapy, such as in Tasmania now, following similar action in ACT, Queensland and Victoria.

The gender industry's strategic document also recommends drawing on "new soft law instruments (recommendations, resolutions) and normative standards, both universal and regional," including the "most significant non-binding recommendations in the Yogyakarta Principles Plus 10 (Dentons, IGLYO & Thompson Reuters Foundation 2019, p 14). Close examination reveals the following ethically troubling recommendations:

> *1 No eligibility criteria, such as medical or psychological interventions, psycho-medical diagnosis, economic status, health, marital or parental status, or any other third-party opinion, should be a prerequisite for changing legal gender*
>
> *2 Eliminate the minimum age requirement. Where legal recognition procedures require prior medical treatment or investigation, these are often only available at the legal age of maturity and thus discriminate based on the age of the applicant. In other cases, where there is no medical requirement, minors are barred from legal recognition unless they have parental authorization. This remains a huge hurdle for young trans people who are yet to reach the age of maturity" (Dentons, IGLYO & Thompson Reuters Foundation 2019, pp 14-15)*

Both recommendations aim to remove medical, legal and parental restrictions on autonomy, including that of minors. The first appears to exploit past attitudes that hardened against medicalisation of homosexuality in the 1970s after successful lobbying by gay and lesbian rights groups (see below). However, the American College of Pediatricians (2017) still regards gender dysphoria as a psychological condition that usually resolves in late adolescence—that is, it is transient and not innate, as homosexuality is understood to be. Such a "psycho-medical diagnosis" should be a crucial consideration.

Moreover, the second recommendation gives no justification for prioritising legal recognition of TI over medical or psychological investigations, as well as age discrimination over the safeguarding of children. The document is clearly biased towards a legalistic view of the world. We note this position has already been recommended by the TLRI in Part 3 of the final report on Legal Recognition of Sex and Gender 2020.

COAL strongly disagrees with the values expressed in these two recommendations. They do not comply with the UN Convention on the Rights of the Child. For example, Article 6 states that “States Parties shall ensure to the maximum extent possible the survival and development of the child” (United Nations Human Rights Office of the High Commissioner 1989). States enabling and funding the unnecessary medicalisation of children who claim a trans and/or gender identity are inhibiting the development of the child by preventing or interrupting the normal human development process of puberty.

3.2.2 The Epidemic of “Gender Dysphoria

A virtual epidemic has ensued over the past decade, often in children and young people with “co-morbidities” of autism, mental health issues and a history of abuse, with little research or understanding (Ditum 2019; Marchiano 2017; Steinberg & Monahan 2007). Previously, gender dysphoria had occurred mostly in males, sometimes emerging firstly in adolescence. In smaller number of females, it first emerged at an early age of two to four years but mostly resolved by puberty. Only about 20% of childhood-onset gender dysphoria persisted into adolescence and young adulthood (Marchiano 2017). The rapid increase in numbers of young people identifying as trans also brought many more girls into demanding gender clinic services, leading Marchiano (2017) to identify rapid onset gender dysphoria (ROGD) as a new expression of gender dysphoria. Typically affecting teenage girls with no previous history but with other associated problems such as autism, mental health issues and sexual abuse. From her professional experience as a clinical social worker and Jungian analyst, she warned that they were more likely to be harmed than helped by medical transition (Marchiano 2017). This is another warning that supports a cautious medical approach. The warning is borne out by the testimony of a previously TI man, who transitioned to female at 42 years-old, living that way for eight years before realizing he had been a victim of childhood abuse. After detransition, he has been warning of the dangers of encouraging children to believe that a trans identity will help them overcome discomfort with their sexed body, calling it child abuse (Harris 2019).

Worryingly, Australia is following global trends in a sharp increase in numbers wanting to use gender clinics. In the four states of Australia a significant upward trend has been measured in data on the number of children and adolescents enrolled in clinics that offer a gender service (See Figure 2). Victoria reported numbers that more than doubled from 2014 to 2016, however, this data also includes people from Tasmania, where there are no gender clinics (yet). More data needs to be collected and published nationally.

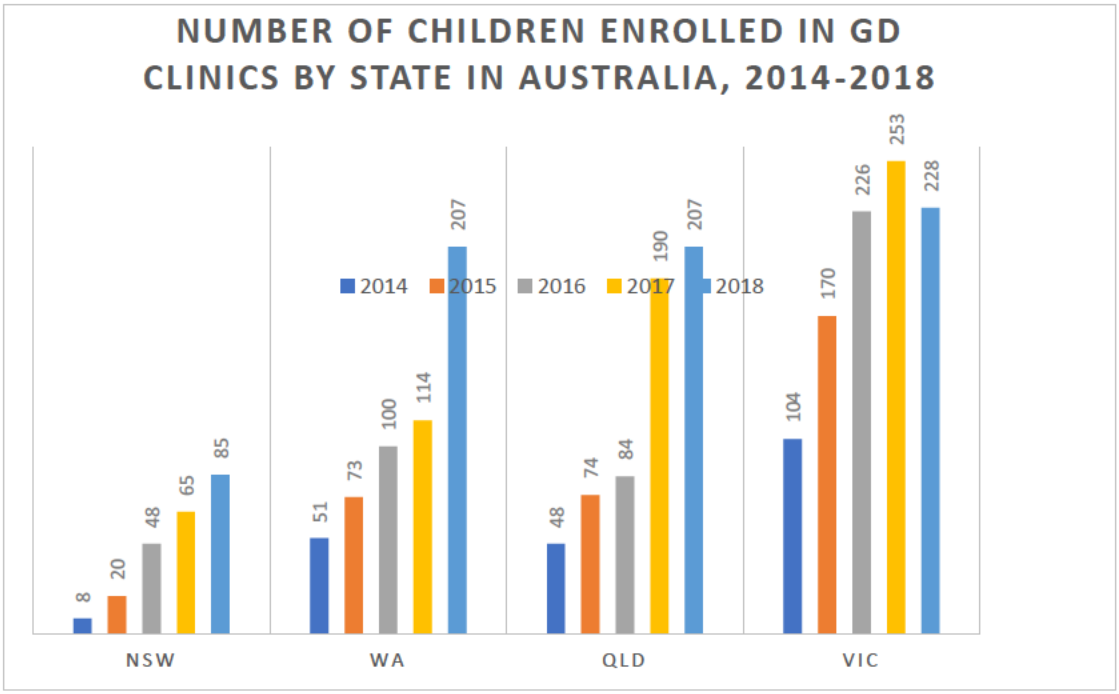

Figure 2

Source: Kenny, D.T. (2019)

Overseas, large increases occurred in the Tavistock Gender Identity Clinic, which recorded an astounding increase in patients from about 200 in 2011/2012 to about 2000 in 2016/2017, with a disproportionate rise in the numbers of girls (from 57% to 69%) and a decrease in boys (from 43% to 31%) (Butler et al 2018).

Littman (2018/9) identified the epidemic as a subset condition of Gender Dysphoria that she called Rapid Onset Gender Dysphoria (ROGD). Comparing ROGD as similar to an eating disorder (Littman 2020), she has hypothesised that it was caused by environmental factors such as peer group influence and the young person's use of social media as well as parent-child conflict and the individual's poorly developed coping skills (Littman 2018/9). Abigail Shrier, a journalist, has researched the phenomenon by extensively interviewing girls who identify as trans and their parents. Like Littman, she concludes that the ROGD phenomenon: "originates not in traditional gender dysphoria but in videos found on the internet. It represents mimicry inspired by internet gurus, a pledge taken with girlfriends—hands and breath held, eyes squeezed shut. For these girls (with no previous history of gender dysphoria), trans identification offers freedom from anxiety's relentless pursuit; it satisfies the deepest need for acceptance, the thrill of transgression, the seductive lilt of belonging" (Shrier 2020).

According to Bilek & Ceallaigh (2016) hormonal and surgical treatments, which can sterilise and maim the child, are offered as a treatment for a manufactured problem--a treatment that shapes and directs the child onto a conservative path that conforms to sex-role stereotypes. TI services have rapidly become available world-wide, providing profits and prestige to the pharmaceutical, medical and "psy" industries (Bilek 2020). Through word of mouth and peer

pressure, non-conforming “tomboys,” lesbian girls and young women are now encouraged to believe that they are abnormal and must transition to the identity of a transman. The effects of such TI transition for a lesbian are that she is also subject to SO conversion to a heterosexual identity.

3.2.3 Harmful Effects of Transition

Concerns have been widely expressed about the adverse effects of hormones administered to girls, boys, young women and men (Barrett 20.16). Puberty blockers (gonadotropin-releasing hormone [GnRH] analogues) suppress the release of sex hormones through puberty. As the child is below the age of consent, her or his parents or guardian’s consent is sought. Immediately, there is a possible danger that homophobic (knowingly or not) parents will be more likely to agree. Administration is by monthly injections followed by regular bone density scans. Other known immediate effects can be emotional difficulties (stress, lowered self-esteem) caused by the child’s peer group developing further. Patients are also usually advised of possible long-term adverse effects such as bone density reduction and infertility (Mayo Clinic 2020).

It is difficult to assess harmful effects of TI transition because of the widespread capture of academic and medical institutions by transgender medicalism. For example, Cornell University reported on a systematic literature review of all peer-reviewed articles published in English between 1991 and June 2017 that assessed the effect of gender transition on transgender well-being. They reported a “robust consensus” that TI transition “, improves the overall well-being of transgender individuals” (Cornell University nd). However, consensus can be gained when a group is captured by an ideology. Compare this positive assessment with that of a medical and cultural watchdog organization, which is critical of the APA and the Cornell review (Gender Health Query 2020). Their detailed analysis of the APA guidelines offers extensive evidence of harms caused by TI transition practices:

> *We are seeing some harm arising from telling young people that biological sex is irrelevant & that gender is a spectrum. “Harm” meaning a glorification of body dysmorphia now viewed as “cool” identities. Harm meaning an increase in stories of transition regret. Harm meaning “queer” youth who seem to have difficulty coping with even minor challenges to their worldviews about their long growing lists of sexual & gender identities & demands to be sexually & emotionally validated by people who don’t agree with identity over biology. Harm meaning any young bisexual who doesn’t want to identify as “pansexual,” or lesbian who doesn’t want sex with MtFs* [male to female: men claiming to be women] *is being called a bigot, an unhealthy form of sexual harassment disguised as social justice, behavior now rife in LGBT youth & even some adult spaces. Harm meaning young people who are so gender/sexually confused they are being put at risk for sexual exploitation by peers & adults online & in real life in “queer” spaces. Harm meaning an obsession with identity in youth culture over accomplishment & human values. We have many examples to justify these statements* (see genderhq.org).

The authors are critical of the APA 'adopting queer theory views of gender as a spectrum when most research showing benefits of transition relate to binary FtM & MtF', rather than non-binary patients. They point out that "mental health is complex & mental health issues should not be rebranded as "identities". Moreover, there is "a huge amount of paranoia in the trans community that is not in line with reality when one examines crime statistics. For example, figures in the UK comparing murders of trans people and murders of women are telling. There were 7 homicides of trans people in a decade (Ingala Smith, 2018) as opposed to approximately 1000 women in the same decade (Femicide Census), cited in Hawthorne 2020, pp. 206-207).

Trans people overall may not be at higher risk for violence relative to other groups such as women in general or black men and the media reported murders, with hyped headlines, often involve situations where they weren't targeted in an anti-trans hate crime." They point to a recent peer-reviewed article that originally claimed benefits after TI transition, only to later revise the results to no benefits after receiving methodological criticisms and a request by the journal to review their findings (Bränström and Pachankis 2019). They conclude by pointing out the harm being caused by prioritising gender identity to the detriment of data collection on biological sex. We agree with them that "(s)cientists, women, gay people, and trans people all need access to proper data"

Biggs (2019) is extremely critical of the Tavistock GIDS studies, pointing out the Patient Information Sheet understated the risks (despite explicitly acknowledging them in the research proposal), their poor-quality analyses, inadequate collection of data, inflating poor results, omission of negative data. He found there was "no evidence that puberty blockers improve psychosocial functioning" and suggested the lack of published results from the experiment suggested it was a pretext for administering unlicensed drugs rather than an attempt to acquire scientific knowledge. By 2015, the GIDS had enthusiastically embraced the use of the puberty blocker but never set up medium and long-term assessments of efficacy and safety. Biggs (2019) concludes that "*using GnRHa to block puberty does not mean pressing a pause button … it is more like pressing fast forward into cross-sex hormones and ultimately surgery, effectively renders the child's future ability to have children, and impairs future sexual function.*

There are also strong doubts about the claim by GIDS that the effects of puberty blockers is completely reversible. Biggs (2019) has accused individuals and organisation of unethical practices, and called for the Tavistock GIDS to release all their data for expert analysis. According to Biggs:

> *The authors (of a Tavistock GIDS report) state reassuringly that bone density did not decline in absolute terms. This is misleading, because growing children need density to increase (Laidlaw 2018). The abstract acknowledges that the children experienced a decline relative to the norm for their age group, and this decline was especially marked for girls. By year three, the average girl on GnRHa had lower bone density than 97.7% of the population in her age group. Surely this raises serious concerns?* (Biggs 2019)

The *Bell and Ors v Tavistock* High Court judgment, exposed the cavalier attitude of the Tavistock GIC, which only began to collect and report on patient data from 2019 despite having

opened its service 20 years previously in 1989. In 2011, it began puberty blocker hormone treatment of children aged 12-15 years in mid-puberty. The GIC first released publicly available data (for 2019/20) nearly ten years later, providing evidence of what most would consider criminal behaviour. Patients as young as 10 and aged up to 18 years were treated with puberty blockers: 26 were 15 or younger while more than 50% were under 16 years of age. Children aged 10 years would have been maintained on puberty blockers until reaching 16 years, when they were started on cross-sex hormones and, if they proceeded to the next step, surgery from the age of 18 years (*Bell and Ors v Tavistock* 2020). COAL considers that this is too young for minors to have the capacity to give informed consent.

Brunskell-Evans' detailed examination of the political pressures exerted on the Tavistock GIC has argued that the issue of consent goes beyond legal assessments. Sharing Bilek's political economy analysis of transgender medicalism, she calls for consent to be considered in terms of:

> *the recent making of 'the transgender child' through the complex of power/knowledge/ethics of medicine and the law of which the child can have no knowledge but within which its own desires are both constrained and incited*. (Brunskell-Evans 2019).

She argues that "the alleged ahistorical transgender child is not a naturally occurring person but a newly emergent, discursively produced historical figure" produced by medicine and the law, together with truth claims derived from queer theory and driven by transactivists. The power of these combined forces has rapidly led to the incorporation of the concept of gender identity in legal and medical institutions across the Western world.

For example, in 2007 the UK Department of Health stated that "trans is not a mental illness", in 2012 the British Psychological Society produced guidelines for trans affirmative therapy, in 2017 the Endocrine Society recommended that the term gender dysphoria should be replaced with the term 'gender incongruence' and by 2018, the Royal College of Psychiatrists supported the declassification of trans as a psychological disorder. All this despite there being a lack of verifiable objective criteria on gender identity disorders (Brunskell-Evans 2019). Despite these pressures, between 73% and 88% of children who seek help at gender identity clinics before the onset of puberty do not complete TI transition once puberty has started (Butler et al 2018), thus saving themselves for further harm. The circumstances for those who first attend a clinic as teenagers, like Keira Bell are quite different.

3.3 Conclusion

COAL, like many other organisations and individuals, has been surprised by the sudden appearance of demands for urgent legislative controls of SOGI conversion practices. The urgency and strength of demands appear to derive from well-funded LGBTI lobby groups that focus on Trans perceived needs, rather than any documented evidence of such needs. Susan Hawthorne summarises the extent to which organisations in favour of TI are funded by a small number of global billionaires. Among them, George Soros (Open Society Foundation), Jon

Stryker (Arcus Foundation), Col. Jennifer Pritzker (Tawani Foundation), Peter Buffett (NoVo Foundation) (Hawthorne 2020 pp. 212-216).

We have shown that SO conversion practices appear to continue being carried out on a small scale, despite widespread acceptance of homosexuality in Australia and professional and public disapproval. It is difficult to estimate their occurrence as they seem to occur secretly within faith-based communities, posing problems for data collection by State agencies because of privacy, and freedom of religion and belief protections. However, some form of legislative penalty, public health advertising and sufficient resources to investigate and prosecute, should reduce the incidence of SO conversion practices further.

We reject the inclusion of GI conversion practices within new laws and have demonstrated that they involve a complex and very different set of issues. Unlike sexual orientation, “gender identity” is not widely understood and accepted here or elsewhere, although transgenderism has recently made inroads into our professional, legal and legislative systems, to gain institutional power for support. We suspect that the national drive for SOGI legislation in Australia is an attempt by trans lobbyists to gain autonomy in their demands for chemical and surgical treatment, even on minors. We urge authorities to resist these pressures.

COAL believes passionately that children need safeguarding and gender clinics in Australia need closer government scrutiny and control with legislation specifically about medical treatments and children.

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QUESTION 4

Do you think that Tasmanian law should be changed to address SOGI conversion practices? If so, should this be through comprehensive reform, amendment or both (a hybrid.

4.1 Little Evidence of Need for Adults

There is little evidence provided in the Tasmanian Issues paper (or in the justifications in the backgrounding papers of other states, such as Queensland) of the ***need*** for legislative change. Documented evidence of harmful practices affecting adults in relation to gender identity, has not been presented at all. Further, the lack of evidence from Tasmania (or other States) in relation to homosexual adults still being subjected to the shocking medical and psychological practices of the past, (for example, see "Brain Surgeons and Other Pills" 1973), means there does not appear to be any need for changes in law to address SO conversion with adults. The proposed laws rely heavily on the Victorian report *Preventing harm, promoting justice: Responding to LGBT conversion therapy in Australia* (Jones et al 2018) which was based on data from just 13 respondents. The SOGICE Survivors group reported primarily on faith based ex-gay ministries (*SOGICE Survivor Statement* 2019) and recommended civil, not criminal, penalties in laws.

As noted in the Issues Paper, evidence of the historical abuses of same-sex attracted women and men abounds. There is no evidence that the now discarded versions of conversion therapy used to attempt to change people's sexual orientation from homosexual to heterosexual such as lobotomies (a surgery involving incision into the prefrontal lobe of the brain), chemical castration (with hormonal treatment), aversion therapy (emetic medications to induce nausea and vomiting), and electroconvulsive therapy i(application of electric shock to the hands and/or genitals), religiously-based intensive group therapies, 'ex-gay' camps, and exorcisms, have ever been systematically practised on those who are transgender (Kenny 2020). This then indicates there is no need for changes to the law in the specific instance of adults.

Further, in Australia, these practices are already considered unethical and outlawed by the professional bodies of doctors and other health professionals. (Kenny 2020). However, the banning of advertising on line or in print material, which is part of the German model, we believe is a more powerful practical and symbolic message of the unacceptability of conversion practices. This is possibly the only law where change is needed in relation to adults and sexual orientation and gender identity. Health promotion based advertising is also likely to be an effective a way to reach faith based communities and highlight the harms of conversion practices.

Fortunately, the general public and politicians now find historical homosexual conversion practices abhorrent and to be condemned, virtually without question or debate. If there are to be legal changes, this is a further reason for a separation of Bills. A different formulation would be much more appropriate than the model Bills of QLD, ACT, Victoria, Malta etc, to send a clear unequivocal message that it is not acceptable to try to change a person's homosexual

sexual orientation. All these bills are flawed and contradictory because each Bill **legalises** drug and surgical practices for gender identity transition, but **bans** these medical practices in relation to sexual orientation. This highlights the stark differences in the SO and GI concepts with respect to lived experiences and bases of sexual orientation and gender identity. They are two completely different concepts and experiences and ought not be treated as one or conflated in the same piece of legislation or in the acronym.

4.2 Need for a Bill to greatly restrict invasive medical gender affirming treatments on children and outcomes that amount to conversion to heterosexuality.

If there is to be legislation, then there needs to be two Bills. Following from our concerns about consent and age (Q2), a second Bill needs to restrict access by minors to affirmation-based gender identity transition practices. Issues of harm from misdiagnosis of gender dysphoria in adults, can be left to other remedies, such as medical negligence or civil suits against religious organisations.

On the other hand, the treatment of children distressed about their birth sex using the affirmation model, involves drug regimes, life-long hormone treatment and frequently radical surgeries. The UK High Court has established that minors are not capable of giving informed consent. The data about ROGD (Littman 2020, 2019) and detransitioners (Detrans Advocacy Network 2020, and Appendix B) provide considerable evidence of lifelong physical and mental harm done to children by treatments for their gender dysphoria—invasive treatments so characteristic of past medical treatments for homosexuality.

Some COAL members have direct experience of being diagnosed as mentally ill and dehumanised by court rulings that removed children from the care of lesbian mothers. Another narrowly escaped from having a frontal lobotomy performed on her. Some of us were there when, belatedly in1984 the Australian Medical Association realised the medical consensus about homosexuality being a mental illness was simply wrong and without scientific basis. We waited until 1990 before WHO also abandoned the previous medical consensus about the need to cure and eliminate homosexuality.

So, it is with great alarm that we are watching history repeat itself, with political pressure from LGBTQA+ lobby groups and some health professionals to use clinical consensus as the basis of new laws, covering gender transition in children; laws that have in several States, already codified experimental drugs and other medical interventions, as legal treatments for children distressed about their birth sex, many of whom suffer the additional social stress of same-sex attraction.

Tasmania is in an ideal position to defer any legislation about gender identity until there is greater clarity, more scientific evidence and a much broader range of stakeholders consulted about any changes to law. It is noted that the following groups with diverse interests in any proposed legislation were not part of the stakeholder consultation:

- Parents of teenagers experiencing ROGD.

- Detransitioners.
- Autonomous lesbian and gay men's groups. LGBTIQAP+ related peak organisations do not represent the diversity of views and experiences in relation to laws which affect lesbians. Autonomous Lesbians and Gay men's groups have been and continue to be excluded as stakeholders in consultations with governments and policy makers. For example,COAL, a national organisation with UN accreditation, was not invited to any stakeholder consultations in QLD, Victoria or Tasmania.
- Psychologists supporting detransitioners.
- Psychologists supporting parents who want treatment options other than gender affirmation for their teenagers in distress.
- Health professionals who are independent of children's gender clinics and WPATH.

It is significant that in November 2020, Finland significantly revised the treatment guidelines for children with gender dysphoria, amid growing concerns globally about the affirmation model of care and ROGD. A systematic review of evidence was conducted by an independent organization, an ethics analysis was conducted, and recommendations made. These are summarised at *Canadian Gender Report*:

1. there is clear differentiation in treatment between early-onset childhood gender dysphoria and adolescent-onset gender dysphoria.
2. they recognize that identity exploration is a natural phase of adolescence and so restrict ANY medical interventions until "identity and personality development appear to be stable" (ie, in the late teens).
3. they prioritize psychotherapeutic **non-invasive interventions as the first course of action "**due to variations in gender identity in minors." Note this would be labelled conversion therapy by the APS and the RCH clinic in Melbourne.
4. Hormone therapy is initiated only if it is ascertained that "identity as the other sex is of a permanent nature and causes severe dysphoria" (ie medically necessary). Note: a **desire** to be the other sex would be discounted.
5. there are "no contraindications" prior to initiation of puberty blocker or cross-sex hormone interventions (ie, all psychological co- morbidities, such as autism, eating disorders, self harm are dealt with).
6. no surgical interventions are allowed for children under the age of 18 (Canadian Gender Report. 2020. *Finland Issues Strict Guidelines for Treating Gender Dysphoria.* https://genderreport.ca/finland-strict-guidelines-for-treating-gender-dysphoria/.

The emphasis solely on gender affirmation has been removed and considered as a last resort, rather than first as at the RCH in Melbourne and in the Australian Standards of Care, written by staff of the RCH (Telfer et al 2018) . The Finnish approach safeguards minors and vulnerable adults.

Following the Keira Bell case, the NHS and Tavistock Trust immediately altered its website, as did Mermaids and the BBC, to de-emphasise puberty blockers and cross-sex hormones and remove the unsubstantiated claims of higher suicide risk if gender was not affirmed. The UK High Court case provides a timely early warning for Tasmania of the litigation that could follow

when unscientific practices on children are permitted and codified under the guise of being anti conversion laws.

Before any changes are made to Tasmanian law in relation to gender identity, it is imperative that overseas evidence and reviews of evidence be recognised. At the very least, any legislative change needs to ensure none of the rights of the child in the Conventions are likely to be breached by codifying unscientific practices related to children suffering distress about their birth sex.

It is imperative that Tasmania ensure the safeguarding of children in any laws regarding gender identity and conversion practices. Tasmanian law also needs to address the damage when harm is done and provide safeguards if harmful side effects of treatments are apparent as a result of treatment services offered to Tasmanian children.

Therefore, COAL recommends deferring any laws related to gender identity until an independent review of the situation of children is undertaken by people in addition to the LGBTQA+ stakeholders involved in the initial consultation.

We have very serious concerns, along with some clinicians**,** that the affirmation model has a side effect of being an unintentional gay and lesbian conversion movement. Jeffreys (2011) has compared gender clinic practices provided to children and young people with eugenics of the past, stating:

Both practices are based on the idea that certain problematic behaviours have a biological basis and can be "cured" by treatments which alter sexual characteristics. … Professionals involved in treating gender identity disorder in childhood are aware that three quarters of the boys referred for diagnosis by their parents will be homosexual or bisexual when they reach adulthood (Jeffreys 2011).

Confirming this analysis, numerous clinicians from the Tavistock clinic, the defendant in the Keira Bell case, have described openly how the day-to-day reality of working in the clinic was one of "conversion" of same sex attracted girls and boys to heterosexuals:

> *"It feels like conversion therapy for gay children," one male clinician said. "I frequently had cases where people started identifying as trans after months of horrendous bullying for being gay," he told The Times.*
>
> *Young lesbians considered at the bottom of the heap suddenly found they were really popular when they said they were trans.*
>
> *Another female clinician said: "We heard a lot of homophobia which we felt nobody was challenging. A lot of the girls would come in and say, 'I'm not a lesbian. I fell in love with my best girlfriend but then I went online and realised I'm not a lesbian, I'm a boy. Phew.'"*
>
> *Several clinicians suspected that some of the "transgender" adolescents were reacting to homophobia at home.*

For some families, it was easier to say, "this is a medical problem, 'here's my child, please fix them!' than dealing with a young, gay kid," a female clinician said.

At the service's "family days", a parent was allegedly heard saying that they did not want their child to have gay friends because they "didn't want them mixed up in that hedonistic lifestyle".

"I would talk about it as an 'atrocity'. I know that sounds quite strong, but it felt as if we were part of something that people would look back on in the future, and ask, what were we thinking? In the future I think there will be lots and lots of de-transitioners who feel their bodies were mutilated as young people and who will ask, why did you let me do this? It is very disturbing." (Bannerman 2019).

COAL recommends a new law to cover the medical treatment of children, with some reference to practices of gender affirmation and intersex. COAL also recommends framing new laws about sexual orientation which would cover the instances of health professionals, who act on the wishes of parents to transition their lesbian or gay child due to negative attitudes about homosexuality.

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Question 5

Should some or all forms of SOGI conversion practices be criminalised in Tasmania? If so, which, if any, should be dealt with as serious (indictable) crimes and which, if any, should be dealt with as less serious (summary) offences?

COAL supports the criminalisation of SOGI conversion practices **only** when the act is carried out by a health professional, and the subject is "a "vulnerable person", including minors. Definitions are most important for this to be effective and our responses to Questions 5 and 6 are based on definitions given in our response to Questions 1 and 9. Importantly the rights of all children in Tasmania must be protected.

5.1 Definitions

Legislation should clearly define the key terms

- "sexual orientation"
- "gender identity"
- "SOGI conversion practices"
- "professional practices that are excluded" and
- "a vulnerable person" (as in the Queensland legislation s 213F).

We have provided definitions in our answer to Question 1 and 9.

It is unnecessary to describe a natal woman or man as "cis women" or "cis man." This reflects language of the trans industry, is designed to erode the long-accepted terms for biological sex of "woman" and "man". It is not widely used beyond queer and "gender fluid" adherents. Similarly we use the scientifically accurate term *of birth sex or natal sex,* and not the ideological term of *assigned at birth* which is derived from the intersex community, where it is an accurate description.

As argued in Q1 and Q2, conversion practices can include a practice by a health service provider that, in the provider's reasonable professional judgement—

(a) is part of the clinically appropriate assessment, diagnosis or treatment of a person, or clinically appropriate support for a person; or

(b) enables or facilitates the provision of a health service for a person in a manner that

is safe and appropriate; or

(c) is necessary to comply with the provider's legal or professional obligations.

5.2 Conventions of the Rights of the Child Must Be Followed

COAL is most concerned that SOGI conversion practices do not contravene the UN Conventions on the Rights of the Child or favour some conventions over others. Conventions and their relevance to our concerns about TI conversion practice are:

Article 6

> *2. States Parties shall ensure to the maximum extent possible the survival and development of the child.*

States enabling and funding the medicalisation of children who claim a "trans" and/or a "gender identity" are inhibiting the development of the child by preventing or interrupting the normal human development process of puberty. COAL does not agree that "gender transition" should be prioritised over the normal puberty processes in a child's development because practices have been and continue to be experimental with little understanding of the gravity of long-term consequences (see our response to Question 3 and Appendix E)

Article 8:

1. *States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognized by law without unlawful interference.*
2. *Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.*

COAL is concerned that Article 8 not be prioritised over the other Articles in the professional practices of those who treat children with gender dysphoria.

Article 9

1. *States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.*

The key issue here is the test of the condition "*necessary for the best interests of the child."* COAL submits that the child's best interests are that they be allowed to develop without chemical or surgical interference and with body positive emotional support*, knowing that 60 to 90% of gender dysphoria in children resolves (ie, desistance)* (Cantor 2016). Moreover, studies consistently show an association between childhood gender dysphoria and homosexuality in adulthood and sometimes bisexuality (Li, Kung & Hines 2017). All studies on gender dysphoric youth confirm desistance can occur without intervention and show that childhood gender dysphoria often resolves in adulthood when the person identifies as homosexual, bisexual or

heterosexual (Drummond et al 2008; Wallien & Cohen-Kettenis 2008; Singhi 2012; Littman 2018/19). See Zucker (2018) for an in-depth defence of desistance and the research on it.

It is not in the child's best interests to set them on a lifelong medicalised pathway, with infertility and reduced life expectancy. The dominant "gender identity" model claims it is unethical to not affirm a child's transgender identity. However, there are no evidence-based studies that show the long-term effects of "gender affirmation" and, indeed, if it is beneficial or harmful. Considering their lifelong medicalised pathway, infertility and reduced life expectancy, "gender affirmation" of gender questioning children should be considered iatrogenic in that it causes at least some harm in the long-term consequences.

> *2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.*

In family law proceedings, parents who disagree with an affirmation pathway for their child have the right to make their views known and have Australian courts place greater weight on the UK High Court judgment

Article 12

> 1. *States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.*

Medicalisation of children.

A child has the right to express his or her views in relation to a self-diagnosis of gender dysphoria. However, his or her views are to be considered in light of their age and maturity. The word "maturity" is key here, and its application upholds the argument that a child is unable to consent to life-altering medical treatment and surgery (with all the complications and side-effects that are known). It is highly unethical to accept a child's decision that would affect the rest of their life without also including mature adult opinion and guidance. Our laws recognise that children are insufficiently mature to vote, drink, drive, have sex, or sign contracts. Question 2 addresses this issue.

Article 14

1. *States Parties shall respect the right of the child to freedom of thought, conscience and religion.*
2. *States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.*

3. *Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.*

Transgender ideology is a system of beliefs that construct a fixed innate "gender identity" that one is born with. For example, the Yogyakarta Principles (2007) state:

> *"Gender identity is understood to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms.'*

Transgender ideology demands that those whose gender identity conflicts with their biological sex and identify as transgender must have their feelings affirmed and be allowed to alter their bodily characteristics so that they align more with their internal feelings. Sex and gender become confused (eg, the common refrain of transgender supporters is "a Trans woman is a woman), and gender rights become the characteristic that needs more protection than healthcare rights. Trans-based rights then come into direct conflict with sex-based rights. We are already observing women's rights being eroded in terms of lesbians 'sex-based rights, where trans-identified males have declared they are lesbian and demanded access to lesbian events and to have sex with lesbians who define their sexuality on the basis of sex, undermining lesbian rights to freedom of thought and identity. Also undermining every woman's right to say no to sex or intimacy when unwanted. Similarly, some trans-identified men seek to identify as mothers, which undermines sex-based maternal rights and the legal category of "mother." Recent declarations supported by the incoming Democrat government in the US show that such traditional and meaningful sex-based language is being silenced (Shrier 2021).

While people who identify as transgender have a right to "freedom of thought, conscience and religion," this must not be prioritised over women's sex-based rights. To find a way to accommodate a conflict between freedom of thought, conscience and religion the ACT legislation states:

> *the right to 'manifest' or 'demonstrate' religion or belief, which would include undertaking conversion practices, impacts others and may thus be subject to reasonable limitation.* (ACT Sexuality and Gender Identity Conversion Practices Bill 2020).

COAL submits that the right to "manifest" or "demonstrate" transgender belief similarly needs to be subject to reasonable limitation when it impacts on the sex-based rights to freedom of thought and conscience of lesbians. Any Tasmanian legislation must acknowledge this.

> ***Article 33***
>
> *States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs*

and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

In transgender clinical practices there is a failure to protect children in the experimental administration of medications off-label for the purpose of interrupting and interfering with the normal bodily process of puberty, with side effects that can cause mental illness, emotional disturbance, self-harm and suicidal ideation to children, in the absence of any research as to the side effects and harms.

5.3 Recommended Legislative Controls

The *ACT Sexuality and Gender Identity Conversion Practices Bill 2020* states:

> *Conversion practices do not include practices that assist a person undergoing or considering undergoing a gender transition, assist a person to express their gender identity, provide acceptance, support or understanding of a person, or facilitate a person's coping skills, social support or identity exploration and development. The Bill also does not prohibit practices in line with professional medical standards. Conversion practices do not include a practice by a health service provider that, in the provider's reasonable professional judgment, is necessary to provide a health service in a manner that is safe and appropriate or comply with the provider's legal or professional obligations (ACT Sexuality and Gender Identity Conversion Practices Bill 2020*)

COAL believes the current gender affirmation practices in gender clinics and elsewhere are unethical, based on an experimental approach and on ideology rather than evidence-based medicine, and abandons the principles of safeguarding children. We anticipate future litigation against gender clinicians similar to the recent judgment handed down in *Bell and Ors v Tavistock and Portman* 2020. Such future action may be not only for medical malpractice but also sexual orientation conversion practices.

A feminist legal interpretation states that the decision is limited to the ruling that:

> *Teenagers under 16 will very rarely have capacity to give informed consent to treatment with puberty blockers, and children of 13 and under almost never. And that even in the case of young persons of 16 or 17, it may be necessary to seek court authorisation to proceed with treatment* (Cunningham 2020).

This ruling has significant effects on obtaining consent for puberty blockers and surgery. The Tavistock Gender Identity Clinic followed gender ideology that parental consent was not enough and that a child's consent was sufficient to initiate clinical action. Their policy conforms to the Yogyakarta Principles Plus 10 Principle 32 (The Right to Bodily and Mental Integrity) which considers only the consent given by the child. This attitude contradicts most standards of medical care based on objective evidence. Transgender practices like those at the Tavistock GIVC and RCH Melbourne, follow the Yogyakarta Principles that minimise parental consent, even though the long-term effects of puberty blockers and surgery offered

are unknown. Bernadette Wren, Consultant Clinical Psychologist at the GIDS, even stated in a 2014 paper that:

> *how do we justify supporting trans youngsters to move towards treatment involving irreversible physical change, while ascribing to a highly tentative and provisional account of how we come to identify and live as gendered? I conclude that the meaning of trans rests on no demonstrable foundational truths but is constantly being shaped and re-shaped in our social world*. (Wren, cited in Cunningham 2020).

Cunningham (2020) also expressed alarm at the Tavistock clinic's inability to provide the court with information on the effects of puberty blockers. COAL shares this sentiment and supports legislation that requires parental consent for any child considering transgender health services. In addition, we support a statement in the legislation on GI clinical practices that clearly states any treatment offered should comply with good standards of evidence-based medicine. This should include information on the effects of the drug(s), surgery and/or other treatments offered.

Any criminal legislative controls should not remove the right of people, harmed by practices and treatments in relation to their gender identity or sexual orientation, to argue for compensation for the harms done. There should also be legislated a means for making a complaint of sexual orientation or gender identity conversion practices., as in the ACT 's legislative precedent

The simplest legislative change may be to amend an existing Tasmanian Act (eg a relevant section in health legislation that covers criminal professional practices) as in Queensland early last year. If this is not possible, new legislation should be enacted as for the ACT.

COAl is guided by the penalties already established in the Queensland and ACT legislation. We believe it reasonable to set a penalty for the offence of conversion practices used against children of up to AU$25,000, or imprisonment for 12 months, or both.

We also support an approach based on civil wrongs, if a complainant seeks compensation (see our response to Question 6).

5.4 Penalties

COAL supports the following criminal penalties against professionals who carry out unethical conversion practices.

Adult (18 year and over): $15,000 fine and 12 months imprisonment

Vulnerable person (under 18 years): $25,000 fine and 24 months imprisonment

Civil penalties? (see ACT Act)

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QUESTION 6

Should some or all forms of SOGI conversion practices be made civil wrongs in Tasmania?

If so, what sort of practices should people be liable for and how should those subject to such practices be compensated?

Again, this depends on the final definition of SOGI conversion practices and definitions of terms and language used in the laws. COAL supports the position of the Survivors report (SOCE 2019) which argues for civil wrongs, rather than criminal as a general principle.

Regardless, COAL suggests no legislation ought to remove the right of people harmed by practices and treatments in relation to their gender identity or sexual orientation, to argue for compensation for the harms done. For instance, in 2009, the Gender Dysphoria Clinic at the Monash Medical Centre settled claims by eight former patients for misdiagnosis of their condition. They all underwent genital surgery as part of the clinic's medical protocol based on medical consensus about gender identity disorders and the need for surgical interventions. The surgeries did not alleviate their distress. Some tried to commit suicide while struggling to live as the opposite sex after the irreversible operations. The director of the clinic was forced to resign (Stark, 2009).

The treatment protocols then, like now, were not founded on evidence-based medicine but medical consensus and ideological beliefs about the nature of gender expression and behaviour.

Individuals and organisations ought to be liable for both physical and psychological harms suffered by minors and non -consenting adults, when it can be demonstrated that informed consent was compromised by the level of cognitive development or the experimental nature of the treatments or practices or lack of scientific evidence to support the practice.

Therefore, detransitioners, like Keira Bell and many others, ought to be financially compensated for the physical hams done by their misdiagnosis and the experimental approaches to care. These included the off label (ie the unapproved) use of puberty blocking drugs, known to reduce bone density, atrophy sex organs and increase in suicide ideation (Turban et al 2020).

The amount of compensation for physical and psychological harms is well established by the accident, worker's compensation and medical indemnity insurance industries. For instance, girls who are misdiagnosed as having gender dysphoria, treated with puberty blockers, cross sex hormones and radical surgery, as in the case of Keira Bell and other detransitioned young women, can gain very considerable amounts in damages (some case studies of Marsdens Law Group and phone conversation

1. Lifelong loss of fertility, a side effect of male hormones $180,000 - $300,000

2. Loss of both breasts $200,000 +
3. Loss of ovaries and uterus- $260,000 +
4. Loss of sexual sensation, loss of a female voice, permanent change of skin and permanent growth of unwanted beard etc, etc
5. Psychiatric injuries – $120,000 +

COAL suggests that the time limits for claims be extended to at least 20 years, as children are being set on a gender affirming treatment pathway from around 10 years old, and may well not grow into an understanding of what has happened to them until their mid-twenties.

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QUESTION 7

Should any existing Tasmanian laws (besides criminal laws or the Civil Liability Act 2002 (Tas)) be amended to cover SOGI conversion practices? If so, which ones and in what way?

As discussed in Q2 and Q4, the results and outcomes of the gender affirmation model when applied to same sex attracted teenagers, particularly girls, need to be addressed urgently as a civil matter. It is urgent because there are no Federal initiatives for a national approach to the treatment of very vulnerable children with very complex needs and to protect them from treatments that can lead to the suppression of their sexual orientation as homosexual.

COAL is uncertain which laws would be the most appropriate to cover these issues and which need additions to uphold key aspects of the rights of the child.

We urge that the widely used definition of sexual orientation as same sex attracted, should not be altered in any Tasmanian laws eg anti-discrimination. The change in definition to **same gender** attracted, is simply untrue and excludes same sex attracted lesbians. (See Background) Any change is likely to have the effect of altering or removing protections for lesbians under the provisions of the law.

COAL is concerned that the Issues Paper, by excluding and avoiding any material critical of the affirmative model implemented by gender clinics in Australia, has taken no account of the growing evidence of the level of false positives of gender dysphoria among teenage girls. This "gender blindness" echoes that of LGBTQA+ lobby groups, legal institutions and governments, which illustrates how lobby groups are so focused on "gender" issues primarily related to the rights of adult men who want to be women. Full consideration of the judgment in the Keira Bell case *(Bell and Ors v Tavistock and Portman* 2020), would clearly highlight areas of law that need to be amended in Tasmania.

Advertising

There needs to be a ban on the advertising and publishing materials which contain false claims about sexual orientation, sexuality and gender identity and any treatment related to these. Banning advertising sends a very strong symbolic message and may in fact be more useful in alerting the public that conversion of lesbian and gays is not acceptable. This forms part of the German model and it is noted as a useful strategy by the ILGA 2020.

All States need a mechanism to ensure that governmental agencies and bodies, at any of their levels, are not providing support to groups or organisations engaging in "conversion practices". Governments at the State level ought to prohibit the advertising or use of false information in their health, antidiscrimination, education and child welfare services, resources and materials. We believe this would be a powerful and cost effective tool to curb the incidence of conversion practices.

A mechanism of reporting and determination needs to be established – to determine if government funding of programs such as disabilities services, aged care, education is used by any group or organisation that engages in conversion practices.

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QUESTION 8

Are there any other models or approaches that are preferable to, or should complement changing the law?

Coal would urge the TLRI to examine the approach of Intersex organisations to medical interventions on minors for psychosocial reasons, in conjunction with the UK judicial review and its evidence. Intersex organisations have long dealt with issues of intervention and sterilisation in children based on parental consent, which has not proved in the interests of the child.

Intersex model

To provide greater assurance that parents will not inappropriately agree to surgery under pressure to assign a sex to the child, consideration should be given to regulating surgical intervention aimed at modification of the sex characteristics of infants and children (and adults without capacity) primarily for psychosocial reasons.

IHRA recommends that all medical treatment of intersex people take place under guidelines that ensure treatment is managed by multidisciplinary teams within a human rights framework. The guidelines should favour deferral of normalising treatment until the person can give fully informed consent, and seek to minimise surgical intervention on infants undertaken for primarily psychosocial reasons

To give effect to its recommended approach, the Committee proposed all medical interventions relating to intersex children aimed at modifications of sex characteristics for psychosocial reasons be authorised by a civil and administrative tribunal in each state or territory or the Family Court with child welfare jurisdiction under the Family Law Act.

A model that is rejected

COAL notes that the TLRI has already adopted a position in relation to the gender identity and minors in the Final report on Legal Recognition of Sex and Gender. (TLRI 2020). TLRI Final Report 2020) says children under 16 should be entitled to proceed with surgery that involves the removal of healthy tissues and sex organs, if a medical practitioner is satisfied they are competent to consent. The report also rejects any mandatory pre-operative counselling as “an unnecessary imposition” for these teenagers.

Unfortunately, the TLRI has already framed medical treatment as a higher priority human right than safeguarding of the long term health and wellbeing of children by claiming counselling is “medical gatekeeping”.

It is also noted that in **Recommendation 7** (Page 112)

The Criminal Code should be reformed to criminalise nonconsensual medical interventions in the following terms: 178F Unnecessary medical intervention to change the sex characteristics of children,

1) Any person who performs a surgical, hormonal, or other medical intervention to alter or modify the sex characteristics of a child is guilty of a crime, unless:

(a) it is performed to address a clear danger to the life or health of the child and it cannot be deferred until the child is able to give informed consent; or

*(b**) it takes place with the informed consent of the child.***

(2) Nothing in this Section is intended to apply to interventions involving a consenting transgender child seeking treatment to delay puberty or secondary sexual differentiation.

The explicit exclusion of children undergoing gender affirmation from the provision of this law, stands in disturbing and stark contradiction to the evidence presented in this submission as well as the judgment of the UK High Court Case. Contradictions in relation to consent to practices deemed experimental.

Recommendation 9 (p125) of the same report says:

> *The Tasmanian Government enact a Consent to Medical Treatment Act that covers the field with respect to children's consent to medical care.*
>
> *The TLRI recommends that this Act should enable a child of 16 years or older to obtain medical treatment and undergo surgical procedures when they consent to treatment and surgical procedures*.
>
> *For children under 16, the TLRI recommends that Gillick competence be enshrined in this Act.*
>
> *The TLRI does not recommend that counselling be a mandatory precondition to children receiving medical treatment or undergoing surgical procedures*

As discussed throughout this submission the complexity of psychological factors such as internalised lesbophobia, autism, parental homophobia, and trying to anticipate lifestyle choices in adulthood, means Gillick competence needs much greater, and critical scrutiny. The High Court case makes it clear that in the case of children wanting to transition to a trans identity, they are unlikely to be Gillick competent at 16.

COAL supports the concept of a Consent to Medical Care Act in Tasmania which **includes** gender affirmation and transition treatments AND includes mandatory counselling. The evidence from detransistioners about their pre-existing mental health status, makes such a clause essential to safeguard minors of all ages.

Disability

There are also principles from the area of disability and consent to medical procedures that can help inform a better model in relation to a claimed trans identity in children. Many in the disabilities area express concerns about informed consent generally as well as in the specific context of sterilisation practices. Women with Disabilities Australia argue the 'best interest' approach to the sterilisation of women and girls has been used in a discriminatory way and the lack of education and accessible services can prevent women from making choices regarding their fertility and conception. *Children with Disability Australia* argue that the criminalisation of forced sterilisation would be justified, as existing requirements for court authorisation have failed to protect the rights of people with disability, under the CRPD, to be free from violence and to retain their physical integrity. (ALRC 2014). As sterilisation can be an outcome of cross sex hormones, the issue intersects with disability.

In its General Comment No 1, the United Nations CRPD Committee has stated that States Parties have an obligation to require mental health practitioners to obtain the free and informed consent of persons with disabilities prior to any treatment. However, there is a large gap between what the CRPD Committee requires and the 'weak' protection that continues to be afforded in relation to informed consent to medical treatment. (McSherry and Waddinton 2017) Developmental disorders impact on *development* of a gender identity in children, as well as other facets of their identity such as personal and sexual identity. The impact of this will however vary considerably and may lead to misdiagnosis of a stable trans identity. Note a fixed innate gender identity is not assumed in this framework.

Research looking at intellectual disabilities and gender dysphoria is limited to case studies and case series, mostly involving young people with Autism Spectrum Disorders. Cognitive ability also appears to influence how gender dysphoria presents. Developmental delay influences views of gender, gender role and sexuality with perhaps more rigidity in these ideas. Low self-esteem and lack of self-concept is an important and under-acknowledged issue which is arguably worse in those with an intellectual disability. It is proposed that this may lead some to want to make changes to their identity. (Bevan and Laws 2019).

Any new laws must also ensure the safeguarding of people with disabilities in relation to medical interventions associated with gender affirmation, to ensure they retain their physical integrity and are protected from misdiagnosis.

Advertising

The survivor of conversion practices in a faith- based setting, commented on the passing of the ACT Bill saying:

> "*I've advocated for the Government to implement strategies for quite a few years now. We do feel that the ACT's legislation* ***excludes*** *some pretty important definitional things that survivors have been advocating for,* ***and it excludes things like the***

advertising of false and misleading claims, which we have been advocating for*. But we're cautiously optimistic*." (Doherty and Roy, 2020)

As discussed elsewhere, clauses about advertising prohibitions need to be part of new laws, along with clauses about false and misleading claims.

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Question 9 OTHER ISSUES.

9.1 FURTHER CONTEXT AND DIFFERENT ASSUMPTIONS

The way we as a society perceive and understand sexuality and gender, profoundly affects the way we select, develop and implement law making. Law making as presented in the Issues paper, makes assumptions about the general social consensus about the very nature of sexuality orientation and gender identity. These in turn determine what does and does not count as a conversion practice in the working definition that is offered. We note TLRI has already made assumptions about the nature of gender identity in children and medical interventions in the Issues Paper, as well some of recommendations in the final TLRI report on Sex and Gender (2020).

However, these assumptions are highly contested and disputed by COAL and many others (Brunskell-Evans 2017, 2020, Schrier 2020, Hawthorne 2020). Who has the power to define sexual orientation, gender identity and what does the word woman or lesbian mean exactly in law. There are 2 views which are fundamentally incompatible, so we urge the TLRI to make the safeguarding of children from lifelong harms and irreversible procedures central to definitions of conversion practices and base their recommendations on evidence based medical care.

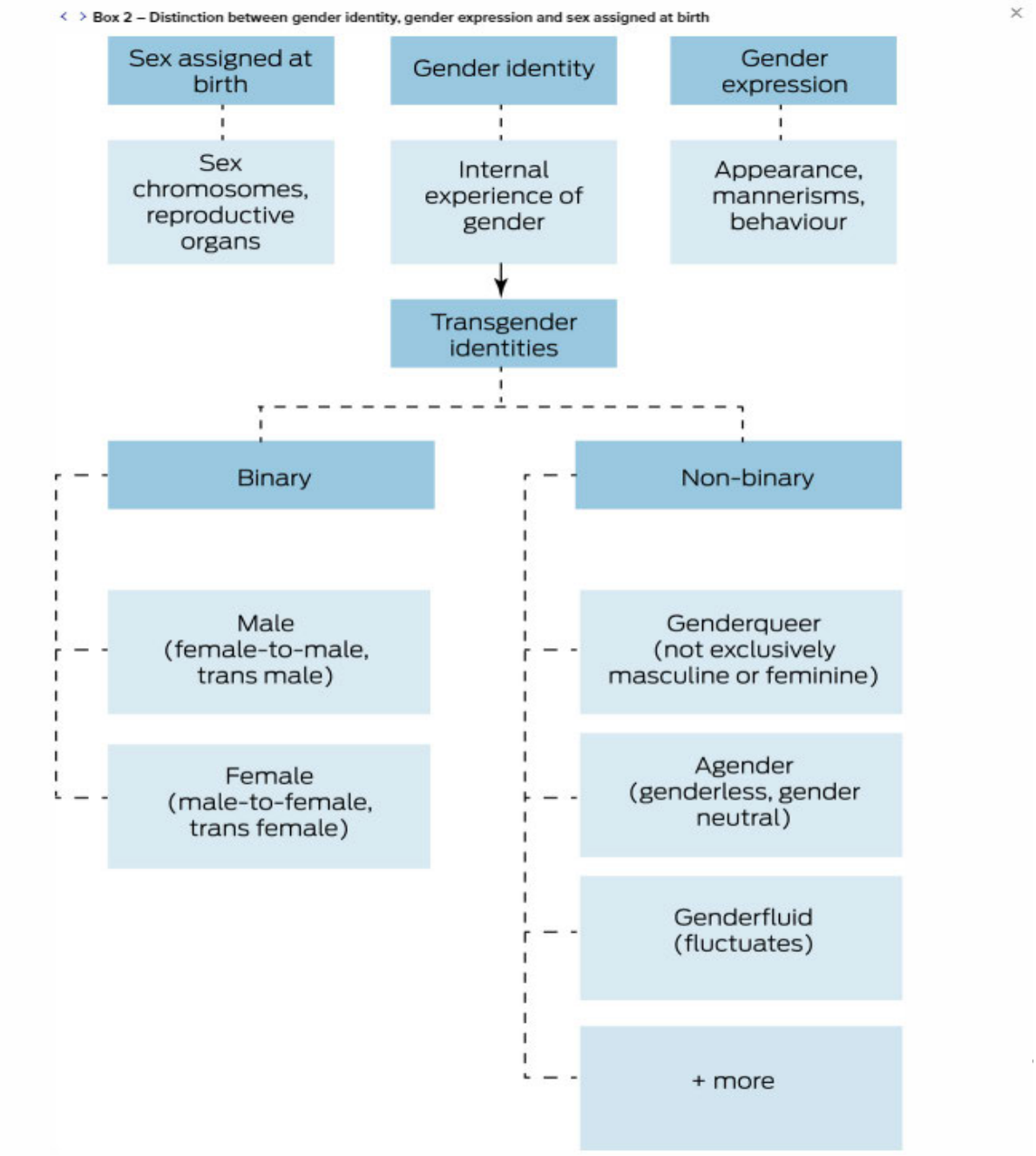
The first view is a scientific one that a woman is a biological female and that humans are a dimorphic species. This view provides the basis of much legislation in Australia, designed to provide equal opportunities for women, protect women from violence and discrimination on the grounds of their biological sex, for example the *Sex Discrimination Act 1984* and *Paid Parental Leave Act 2010)* covering maternity leave for the birth mother.

This verifiable biological view is opposed, primarily by LGBT peak organisations and transgender advocacy groups who assert that a woman, is any person, male or female who identifies themselves as a woman. This internal feeling based belief then creates contradictions when it comes to defining conversion practices in relation to sexual orientation and gender identity, and lesbians in particular.

In 2020, the second view was been given political priority over the first view in laws about conversion practices in QLD, ACT and Victoria. Worryingly, it already appears to be the view of the TLRI. The Final Report on Sex and Gender (TLRI 2020) gives the impression that the TLRI, which we would expect to critically examine all views and the evidence, has already adopted the second set of assumptions. The TLRI appear to support lowering the age from 18-16, for trans identified children to have both breasts or their penis removed without parental consent or mandatory counselling (TLRI, 2020 Part 3). A view consistent with trans ideology but one opposed by numerous submissions and around the world. The extreme harms of which were highlighted in the Bell case.

This preference for the second view by the TLRI also highlights the extent to which the legal process is both a social and politicised one: whose beliefs and values are dominant, why are they dominant and whose rights are secondary? The chosen stakeholders in the consultation leading to the present issues paper were predominantly LGBTQAP+ organisations and individuals, while other important voices were absent.
The experiences of detransitioners and desisters were missing, as were the voices of autonomous lesbians, women's rights groups, clinicians who have resigned from children's gender clinics, and the parents distrustful of the necessity of cross sex hormones for their teens.

The distinctions between basic concepts



9.2 THE IMPORTANCE OF LANGUAGE

The AIFS, a Federal government agency provides a glossary of LGBTQA+ approved definitions with the following:

> *Further, it is acknowledged that some terminology is contested and language in this area is evolving Therefore, practitioners and service providers are encouraged to use this resource sheet in conjunction with other sources of information. (e.g. see the Further reading and Resources and organisations listed at the end of this resource sheet).*
>
> *There is a great deal of diversity within the LGBTIQA+ communities and a wide range of terms and language related to: Sex, bodies, gender, sexuality, sexual attraction,* experiences*.*
>
> *Having an understanding of LGBTIQA+ terminology and using language that is inclusive demonstrates respect and* ***recognition for how people describe their own genders, bodies and relationships****. It is worth noting that considerable debate around language and terminology can exist within and outside LGBTIQA+ communities (GLHV, 2016).* (AIFS, 2019)

Whilst, the issue of contested language is acknowledged by the Federal government, the glossary does not include the alternatives to this contested language in the resources. Instead, this guide opts to present only definitions and resources consistent with the non-biological view of women and sexual orientation.

9.3. GENDER DYSPHORIA – CLINICAL INDICATORS

The DSM-5 defines gender dysphoria in children as a marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least 6 months, as manifested by at least six of the following (one of which must be the first criterion) (APA 2021):

1. A strong desire to be of the other gender or an insistence that one is the other gender
2. A strong preference for wearing clothes *typical of the opposite gender*. In boys a strong preference for wearing or simulating female attire, and/or a resistance to wearing *traditional masculine clothing.* In girls, a strong preference for wearing *typical masculine clothing*, and/or a resistance to wearing *traditional feminine clothing*
3. A strong preference for *cross-gender roles* in make-believe play or fantasy play
4. A strong preference for the toys, games or activities *stereotypically used* or engaged in by the other gender
5. A strong preference for playmates of the other gender
6. A strong rejection of toys, games and activities *stereotypical of one's assigned gender*
7. A strong dislike of one's sexual anatomy
8. A strong desire for the physical sex characteristics that match one's experienced gender

Five of the eight “diagnostic’’ criteria, are based on the child not conforming to outdated and traditional feminine or masculine stereotyped behaviour, appearance or activities. Note you only need 6 to be diagnosed as a gender dysphoric child. This is one of the reasons girls who are “tomboys” can easily be misdiagnosed as transgender. The emphasis on non-conformity in these criteria, would have seen many of us who were children in the 1950 and 60s diagnosed with gender dysphoria, and denied the possibility to grow into our lesbian selves.

This philosophical and clinical position of pathologizing children who reject stereotypes, is definitely at odds with Federal and State Governments, allocating resources for STEM programs across the country. The aim of these initiatives? To break down and challenge traditional stereotypes that activities involving science, technology, engineering, and maths are masculine, so that more girls and women explore and take up careers in these less traditional areas.

Telling a child that she was born in the wrong body pathologizes “gender non-conforming” behaviour and makes gender dysphoria less likely to resolve during maturation. It is our position no child is born in the wrong body. Rather, all adults need to expand their understanding of what male and female behaviour and preferences look like in a pluralist and secular society. In our society being female comes with a huge range of personalities, preferences, and possibilities.

The DSM-5 defines gender dysphoria in adolescents and adults as a marked incongruence between one’s experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least two of the following:

- A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong *desire to be rid of one’s primary* and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender)

In order to meet criteria for the diagnosis, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA 2021). The evidence of desisters and detransitioners, indicate the extent to

which such clinical criteria can lead to misdiagnosis, the harms that follow from irreversible biomedical interventions and distress that goes unresolved.

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APA 2020. American Psychological Association https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf

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WHO 2021. Leave no-one behind. https://www.who.int/gender-equity-rights/news/sexual-gender-diversity-faq.pdf

Appendix A – COAL Submissions and Consultations

Year	Organisation	Submission Title
16 Jun 2006	COAL	*Submission to the National Inquiry into Discrimination Against People in Same-Sex Relationships- Financial and Work-Related Entitlements and Benefits* (Human Rights and Equal Opportunity Commission)
10 Mar 2008	COAL	*Convention on the Elimination of All Forms of Discrimination Against Women - Melbourne Consultation* (Commonwealth Dept of Families, Housing, Community Services and Indigenous Affairs FaHCSIA)
2008	COAL	*Submissions on Same-Sex Relationships (Equal Treatment in Commonwealth Laws – General Law Reform) Act 2008* and *Same-Sex Relationships (Equal Treatment in Commonwealth Laws – Superannuation) Act 2008*
12 Jun 2009	COAL	*National Human Rights Consultation* (Commonwealth Attorney-General's Department)
1 Jul 2009	COAL	*National Women's Health Policy* (Commonwealth Department of Health and Ageing)
16 Jul 2009	COAL & Matrix Guild Vic Inc	*Review of the Accreditation Process for Residential Aged Care Homes* (Commonwealth Department of Health and Ageing)
28 Aug 2009	COAL & Matrix Guild Vic Inc	*Review of Aged Care Complaints Investigation Scheme* (Commonwealth Department of Health and Ageing)
25 Sep 2009	COAL	*Beijing+15 Consultation,* JERA International
23 Oct 2009	COAL	*Inquiry into the Impact of Violence on Young Australians* (House of Representatives Standing Committee on Family, Community, Housing and Youth)
19 Nov 2009	COAL and Matrix Guild Vic Inc	*Inquiry into Suicide in Australia* (Senate Community Affairs References Committee)
30 Apr 2010	COAL and Matrix Guild Vic Inc	*Eames Hate Crime Review* (Victorian Department of Justice)
June 2010	COAL	*Update to the Australian NGO Report on the Implementation of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* (YWCA Australia, Women's Legal Services NSW & Kingsford Legal Centre). Sat on National CEDAW Advisory Group 2010-2011.
31 Jul 2010	COAL and Matrix Guild Vic Inc	*Caring for Older Australians* (Productivity Commission)

23 Oct 2010	COAL	*Break the Cycle – Social Inclusion Board Consultation, Melbourne* (Aust Govt Social Inclusion Board)
27 Oct 2010	COAL	*Senate Inquiry Into Human Rights (Parliamentary Scrutiny) Bill 2010 And The Human Rights (Parliamentary Scrutiny) (Consequential Provisions) Bill 2010*
29 Nov 2010	COAL	*Inquiry into Protection from Discrimination on the Basis of Sexual Orientation and Sex and/or Gender Identity in Australia* (Australian Human Rights Commission)
22 Mar 2011	COAL	*Response to Draft Revised Standards for Residential Aged Care* (Commonwealth Department of Health and Ageing)
29 Jun 2011	COAL	*Review of the Victorian Charter of Human Rights and Responsibilities Act 2006* (Scrutiny of Acts and Regulations Committee)
31 Aug 2011	COAL	*National Human Rights Action Plan - Baseline Study* (Commonwealth Attorney-General's Department)
1 Feb 2012	COAL	*Consolidation of Commonwealth Anti-Discrimination Laws - Discussion Paper* (Commonwealth Attorney-General's Department)
3 Apr 2012	COAL	*Action Plan Consultation Framework - Addressing Violence Against Women and their Children* (Office of Women's Policy, Dept of Human Services, Victoria)
20 Dec 2012	COAL	*Response to the Exposure Draft of the Human Rights and Anti-Discrimination Bill 2012* (Commonwealth Senate Standing Committee on Legal and Constitutional Affairs)
29 Jan 2013	COAL	*Workplace Gender Equality Act 2012 Consultation on Reporting Matters* (Australian Government – FAHCSIA)
30 Jul 2013	COAL	*Communications Procedure on Challenges and Achievements in the Implementation of the Millennium Development Goals for Women and Girls* (UN Commission on the Status of Women)
14 Aug 2013	COAL	*Victoria Police Community Consultation* (Victoria Police)
25 Mar 2014	COAL	*Community engagement – Gay, lesbian, bisexual, transgender and intersex (GLBTI) health and wellbeing 2014* (Victorian Department of Health)
30 Apr 2014	COAL	*Response to Exposure Draft on Amendments to Part IIA, Racial Discrimination Act*
30 Jun 2014	COAL	*Equality, Capacity and Disability in Commonwealth Laws* (DP 81) (The Australian Law Reform Commission (ALRC))

12/13 Aug 2014	COAL	*Presentations on Being a Lesbian Senior/Elder; Participatory Action Research with Older Lesbians; End-of-Life Decision Making* (2nd National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Roundtable with Australian Government)
10 Oct 2014	COAL	*Beijing +20 Review of the Beijing Platform for Action.*
19 Aug 2016	COAL	*Victorian Law Reform Commission's consultation on Funeral & Burial Instructions*
7 Feb 2018	COAL and Matrix Guild Vic Inc	*Lesbian-Specific Consultation on LGBTI Action Plan as Part of the Diversity Framework,* Women's Health In The North
17 Jan 2019	COAL	*Review into University Freedom of Speech* University of Melbourne
14 Feb 2019	COAL	*Disability Advocacy Sector Conversation run by the Disability Advocacy Research Unit*
Sep 2019	COAL	*Submission to the Royal Commission into Safety and Quality in Aged Care*
7 Jun 2020	COAL	*Joint NGO Submission on Behalf of the Women's Human Rights Campaign – Australia's Third UN Universal Periodic Review* (COAL input)
6 Jan 2020	COAL	*Submission to Qld Govt Health Legislation Amendment Bill* (Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee)
9 Dec 2020	COAL	*Submission to Change or Suppression (Conversion) Practices Prohibition Bill 202 (Vic)* (Letter sent to all Victorian MPs)

Appendix B

Detransitioners' Stories: Videos and Links

There are many, many more stories of detransitioners' lived experiences being added to the internet every day. Although they have often not published their stories in peer-reviewed journals, they are, perhaps, *the most authoritative sources* on SOGI Conversion Practices.

1. Post Trans. Stories of detransitioners. https://post-trans.com/

2. What the Homones Didn't Change – a Detrans Story, with Watson 15 Jan 2020 https://www.youtube.com/watch?v=M0zWaNdkp7Y This covers many of the sues faced by all detransitioners

3. Pique Resistance Project
   - Detransition Q and A https://www.youtube.com/watch?v=kxVmSGTgNxI
   - What do detransitioned women think of social media https://www.youtube.com/watch?v=o5A2n-EAli0

4. Thousands Of "Trans" Teens Want To DETRANSITION... (Women, Lesbians, Homophobia) Arielle Scarcella https://www.youtube.com/watch?v=bHOASkcG-zY

5. NHS child gender clinic: Staff welfare concerns 'shut down' - BBC Newsnight 18 JUN 2020 https://www.youtube.com/watch?v=zTRnrp9pXHY

6. Detransitioning - Reversing a Gender Transition 18 Jun 2018 https://www.youtube.com/watch?v=V6V0p3_bd6w

7. 'I Wanted to Take My Body Off' Detransitioned, Jun 18, 2018 - Carey Callahan https://www.theatlantic.com/video/index/562988/detransitioned-film/

8. Dagny on social media, gender dysphoria, ‘trans youth,’ and detransitioning 4 JUN 2019 https://www.feministcurrent.com/2019/06/04/dagny-on-social-media-gender-dysphoria-trans-youth-and-detransitioning/

9. I hated her guts at the time – A transdesister and hr mom tell their story 18 Jan 2018 https://4thwavenow.com/2018/01/18/i-hated-her-guts-at-the-time-a-trans-desister-and-her-mom-tell-their-story/

APPENDIX C

Keira Bell Interview

Raquel Rosario Sánchez *There was nothing wrong with my body*

30 November 2020

Interview with Keira Bell

Raquel Rosario Sánchez: You are an ex-patient of the Tavistock's Gender Identity Development Service (GIDS) for under 18-year-olds. What led you to walk through the doors of the Tavistock as a 16-year-old?

Keira Bell: The couple of years leading up to that point, I was stuck in severe depression and anxiety. I felt extremely out of place in the world. I was really struggling with puberty and my sexuality and I had no one to talk these things through with. I identified most with butch lesbians and I initially felt like I had found my tribe.

However, the women that I saw through the internet still seemed to be comfortable with their bodies and having sexual relationships. So, I think that I began to doubt myself and I began to think that there must be more to it. When I stumbled upon transsexualism, that was me – I was meant to be a boy. It made absolute sense to me and I related so strongly to those women [online] that had started to undergo medical transition. I felt that I needed to start with medical transition as soon as possible in order to achieve my happiness.

RRS: Do you think the internet, particularly social media and online forums, are fuelling the rise of teen girls seeking gender transitioning treatments? How do you think adults can challenge the messages spread on these websites?

KB: Absolutely, and this rise has been increasing exponentially in the past decade. From what I have seen, social media is more often than not really harmful to girls and young women. When I was a teenager, I was virtually using social media and online forums as a way of discovering myself and learning about the world.

I know that must only be getting more and more common, and the messages more extreme as time goes on. It is extremely unhealthy. The messages being given can be challenged by raising awareness. I would say to adults to spread the word, speak out, resist the propaganda that is being pushed.

RRS: A 16-year-old is not legally old enough to drive a car or get a tattoo. According to the Children Act 1989, a minor is considered someone who is under eighteen years old. Yet we are witnessing a worldwide push to consider children and teenagers "adult enough" to consent to life-altering treatments. What do you think lies behind this global push?

KB: Follow the money!

RRS: What was your initial experience and reaction to puberty blockers as 16-year-old, and to cross-sex hormones and surgery, later on?

KB: Hormone blockers were viewed as a means to an end and I did not like being on them at all. I was very happy and excited to start cross-sex hormones, as I thought that I could finally start to live my life how I was supposed to.

When surgery came around, I thought of it as more of a practicality situation. I was sick of wearing my binder. It was painful and an annoyance. I was unhappy with how my breasts looked, even more so at that point than before.

RRS: Looking back now, how do you reflect on those years of your life?

KB: I look back with a lot of sadness. There was nothing wrong with my body, I was just lost and without proper support. Transition gave me the facility to hide from myself even more than before. It was a temporary fix, if that.

RRS: How can society address gender dysphoria in children and teenagers, without resorting to experimental, and oftentimes unnecessary, medical practices?

KB: It has to start with how we look at gender non-conformity, and non-conformity in general. Almost every girl (if not all) that wants to or has transitioned has felt like they are wrong because they do not conform to something that this society deems as important or necessary.

Gender nonconformity needs to be accepted. Role models are really important. Young lesbians or bisexual women, especially those of us who are black or brown, don't have many role models. We need better mental health support, and I think that speaks for most countries. Mental health support is a great preventative measure.

RRS: Over the years, a lot of adults, particularly medical professionals, were involved in your treatment. Did any of them express doubts or challenge you against making these life-altering decisions?

KB: In my experience, when professionals outside of the gender identity clinic saw me, they were hesitant about dealing with me much, because (at least back then) gender dysphoria or the desire to change sex was a rare occurrence in patients. They would direct you to the Gender Identity Development Service as they were under the impression that the GIDS gave specialist support and therapy in a neutral environment. This of course wasn't the case. Once I arrived there, I was not challenged in any sense and I was affirmed [as a boy] from the beginning.

RRS: After realising that medical transition would not help alleviate your dysphoria, you took the brave step of taking legal action against the Tavistock. What galvanised you to take legal action?

KB: I was and am so desperate to see positive change. I felt that I was in the perfect position to do so – it is my story and I have come out the other side. I clearly see how damaging this issue is, especially because now it has turned into a movement. There are so many girls out

there who are just like I was and their true needs for support and care are being ignored. I want justice.

RRS: What would you say to a girl or young woman who is questioning her sex and feels that going down a path of medicalisation might be the only solution to her dysphoria?

KB: I would feel wrong to do anything but discourage it. The environment over the past 10 years has changed so drastically. Nowadays, everyone is being asked left, right and centre "what are your pronouns?" or "what's your gender?".

I would encourage that girl or that young woman to really limit her time on social media, to go out into nature and most importantly: think for yourself! In my opinion, the further you can get away from self-centredness, the better.

RRS: Today, you are an inspiration to many people, particularly to young women who also struggle with the imposition of femininity. Where do you see your advocacy taking you next?

KB: I haven't made any solid plans as I like to move freely. But for now, I want to continue raising awareness and help some way in getting better mental health support for gender dysphoria.

Thanks to Keira for granting me this interview. I am grateful for her courageous campaigning for the rights of girls to stereotype-free lives and for better protection for children with gender dysphoria. I look forward to Keira's continuous leadership and advocacy on this matter in the years ahead. *https://womansplaceuk.org/2020/11/30/keira-bell-there-was-nothing-wrong-with-my-body/*

APPENDIX D
Thomasin's Story

THOMASIN age 20 © LAURA DODSWORTH

The Detransitioners Laura Dodsworth Aug 19, 2020·24 min read

I was a trans man for 2½ years.

When I think of growing up, everything was pink or blue. I played with Barbie and pink stuff because that's what I was given. I probably would have played with my brother's Hot Wheels toy cars if I'd felt there was a choice. Overnight, when I was 13, all the girls started wearing

make-up. I tried to fit in, but I didn't really want to. I felt like I had gone wrong compared with all the other girls.

I knew I didn't feel attracted to boys sexually and it was obvious I felt different to other girls. I went online and found the term "asexual" on Tumblr. At school we'd been taught about being gay, but I don't remember the term lesbian ever coming up. I thought that if I didn't fancy boys then I must be asexual.

I recently found one of my first Tumblr posts, which went along the lines of: "I don't like wearing dresses like other girls, I don't want to put make-up on, could I be agender?" I applied how I felt about sexuality to gender: I don't fancy boys so I must be asexual; I don't feel like girls so I must be agender.

I soon felt confused by agender and non-binary, and I thought it would be easier to say I was a boy and decided I was transgender. I joined some transgender groups on Facebook. Some older trans people started messaging with me, which, in hindsight, was pretty ropey. I had just turned 16 and one person I was talking to was a man who identified as a trans woman in his forties. I don't think it was OK that he talked to a 16-year-old girl the way he did. If I'd tell him I had doubts about being trans, he'd say doubts are normal and I should ignore them.

When I was 16 I decided to come out publicly as trans. I gave my parents a letter one morning on my way to school, basically saying you know me as your daughter but I am your son, Percey, and I need this to survive. Don't get the wrong idea about them, but they went off the handle. My dad took it quite badly because he felt like he was losing his daughter. He asked why I thought I was a man. I think it's interesting now that I couldn't give him an answer.

They did some research online and read that it was best to let me transition and support me. So they helped me to get referred to a gender identity clinic in the UK.

Online there is a lot of advice about how to behave in your meeting at the gender identity clinic so you'll get what you want. With a lot of pushing I got referred to an adult gender clinic because I wanted hormones and a mastectomy. However, by my second appointment I decided I didn't want hormones at all. At the time I was saying I didn't need hormones to be a man, but I think I was scared. I always had doubts about being a trans man. But either someone would say it's normal to have doubts, or I would tell myself that.

I still wanted a mastectomy — wanting not to have breasts never changed — but I went back to being non-binary. I also still wanted a hysterectomy. I have really bad cycles, on-the-floor-in-pain kind of stuff. I need time off every month. Honestly, I think the fact that I hate my periods is part of why I felt I was trans.

I was told I could be waiting for months. I'm grateful now that I didn't have the mastectomy, but at the time I was self-harming and felt terrible.

I can't explain why I changed my mind about being trans, but kind of overnight when I was 18 I realised I may want kids. I don't know what to put it down to — except maybe age and maturity. I started seeing holes in me being trans. I started questioning everything again.

Then some unexpected words came out of my mouth: "I need to accept womanhood." It was so strange because I couldn't say the word woman before — it used to make me feel ill, but it just changed.

A lot of people have said to me I was never trans. Well, I was. I was seen by my GP, the gender identity clinic — people accepted it, I changed my passport, all my documentation.

I feel better about my body as a woman than I used to. But I can't turn around a lifetime of feelings in one year. I accept my breasts now. I used to only be able to shower or bath once a month when I was trans because I hated my body so much. I do it every day now and that's an improvement!

I've accepted that I like women. I get that there are people with serious gender dysphoria, but I think the biggest reason that women are transitioning is because they can't accept they are lesbians.

I got the "Valid" tattoo when I was non-binary to say I know myself best, I'm valid. I know other detransitioned women regret surgery choices and they have all my respect for everything they have gone through, but I'm glad the tattoo is the worst thing I came out of this with. I'd like to think it's technically still applicable: I've accepted I am "valid" as a woman.

APPENDIX E

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APPENDIX E – Health Risks and Harms of Transition Acts, or Treatments

Act, or Treatment	*Risks of Act, or Treatment*	*Reference/s*
Sexual orientation – Conversion Practices Gay conversion therapy is an umbrella term given to any attempt to change someone's sexual orientation. Sexual orientation conversion practices have gone underground. They can now take the shape of online courses on "self improvement" or "spiritual healing"; pastoral care; counselling, either privately or in 'support' groups; mentoring; religious instruction in schools; medical consultations, exorcisms; or prayer groups.	There is plentiful evidence of past practices of "health professionals'" and religious organisations' "conversion practices" in trying to change same-sex oriented people into heterosexuals (See also Question 1, sub-question 1). In 2018, there were still at least ten ex-gay organisations operating in Australia. In Sep 2018 the AMA unequivocally condemned sexual orientation conversion therapy: *There is no place for [sexual orientation] conversion therapy in our society in the twenty-first century. We know that it's associated with negative outcomes. It's not based on any*	SOGICE Survivors 2020, SOGICE Survivor Statement, http://socesurvivors.com.au/wp-content/uploads/2020/12/Survivor-Statement-A4-Doc-v1-2-Digital.pdf Jones et. al., **(**2018**).** *Preventing Harm, Promoting Justice. Responding to LGBT conversion therapy in Australia,* Bundoora: La Trobe University and Melbourne: Human Rights Law Centre. AMA President Dr Tony Bartone on SKY News - Conversion therapy - 4 Sep 2018 (Updated 11 Mar 2020). *https://ama.com.au/node/6844*

	research. It's archaic. And it's only associated with long-term harm to the patients involved. Dr Tony Bartone, President, Australian Medical Association *I'm logged into a "support group" run by Living Hope Ministries, one of the most prolific proponents of gay conversion in the world. And, for a moment, they've gotten under my skin."Affirmation. Attention. And affection. And she needs to receive them from both parents to be gender healthy."Fleetingly, unexpectedly, I am profoundly unsettled. This is how it feels to be "ministered" to by Living Hope, an organisation I have covertly joined as part of a Fairfax Media investigation. Gay conversion has been discredited as ineffective, damaging, even dangerous. But across Australia, organisations who believe that LGBTI people can or should change are hard at work.*	Tomazin, F (2018), "'I am profoundly unsettled': inside the hidden world of gay conversion therapy," *Sydney Morning Herald,* 9 March**,** https://www.smh.com.au/national/i-am-profoundly-unsettled-inside-the-hidden-world-of-gay-conversion-therapy-20180227-p4z1xn.html

Lack of evidence on gender identity Conversion Practices	According to Kenny (2020) there is no evidence that lobotomies (a surgery involving incision into the prefrontal lobe of the brain), chemical castration (with hormonal treatment), aversion therapy (emetic medications to induce nausea and vomiting), and electroconvulsive therapy (application of electric shock to the hands and/or genitals), religiously-based intensive group therapy, 'ex-gay' camps, and exorcisms, have ever been systematically practised on those who are transgender.	Kenny, D. (2020). Submission to the Queensland Inquiry into Outlawing Conversion Therapy. Available at *https://www.diannakenny.com.au/*
Social transition – Breast binding (flattening of the chest using items such as bandages, sports bras, or commercial chest binders)	Negative health outcomes reported by 97.2% of respondents included: Rib fractures [2.8%]; rib or spine changes; back pain; overheating; chest pain; shortness of breath; itching; bad	No peer-reviewed studies directly assessing health impacts of chest binding have been reported. Peitzmeier, S., Gardner, I., Weinand, J., Corbet, J., & Acevedo, K. (2017). Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study. *Culture, Health, and Sexuality: An International Journal for Research, Intervention, and Care*. Available at: https://pubmed.ncbi.nlm.nih.gov/27300085 Research institution: The Binding Health Project at Boston University.

	posture; shoulder pain; shoulder joint “popping”; muscle wasting; numbness; headache; fatigue; weakness; respiratory infections; lightheadedness/ dizziness; cough; heartburn; abdominal pain; digestive issues; breast changes; breast tenderness; scarring; swelling; acne; skin changes; skin infections. Reviews the above study. Notes that “97.2% of respondents reported at least one negative outcome from binding”. Four main themes: (1) diversity of experiences; (2) negotiating (dis)comfort: participants negotiated between physical, emotional and social comforts and discomforts; (3) perceptions of safety: in the absence of formal research, participants mediate public narratives of fear; and (4) interactions with health care: insensitivity and incomprehension present barriers to care.	Apr-May 2014. Method: Self-report, online survey, 1,800 female and intersex participants aged 18-66, from 38 countries. 70 different gender IDs. Janitorqueer. (21 Jun 2016). 28 risks of chest binding. Available at: https://janitorqueer.com/2016/06/21/28-risks-of-chest-binding/ Method: Blog review Lee, A., Simpson,P., & Haire, B. (7 Jan 2019). The binding practices of transgender and gender-diverse adults in Sydney, Australia. *Culture, Health, and Sexuality: An International Journal for Research, Intervention, and Care*, *21*(9): 969-984. doi:10.1080/13691058.2016.1191675 Ten in-depth, semi-structured interviews with trans or gender-diverse participants, recruited from social media and community, who were born female. Method: Thematic analysis Minus18. (18 DEC 2017). How to bind your chest safely and healthily. Available at: *https://www.minus18.org.au/articles/how-to-bind-your-chest-safely-and-healthily* Partner of Safe Schools project,

	Fact sheet describing Different Binding Methods, including bandages, layering shirts, sports bra method, neoprene, sports compression wear, pantyhose, professional binders**.** ***"****Some use binding methods to help alleviate body dysphoria, but there's a level of risk attached to it. Because you are compressing tissue, it can cause damage and potentially even breakages to your ribs if done improperly. If things go wrong with your ribs, it has the potential to be really damaging. If you are having any difficulty breathing or are experiencing pain, take your binder off straight away. And be sure to get yourself to a doctor or hospital as soon as possible if that doesn't make it go away."*	which has adopted 'trans language' i.e. uses the term "chest binding", not "breast binding".
Puberty blockers Stop secondary sex characteristics from developing e.g. block development of oestrogen in females, breasts, ovaries, menses	Three main concerns: 1) young people are left in a state of 'developmental limbo' without secondary sexual characteristics that might consolidate gender identity; 2) use is likely to threaten the maturation of the adolescent mind, and 3) puberty blockers are	Heneghan and Jefferson (2019) https://adc.bmj.com/content/104/6/611#ref-1 cited an *Archive of Diseases in Childhood* letter by Richards et. al., that referred to GnRHa treatment as a momentous step in the dark. Richards, C., Maxwell, J., & McCune, N. (2018). *Use of puberty blockers for gender dysphoria: a momentous step in the dark. http://dx.doi.org/10.1136/archdischild-2018-315881*

	being used in the context of profound scientific ignorance. Puberty blockers (PBs) are medically approved for treating prostate cancer; precocious puberty in 7-year-old girls; chemical castration of sex offenders; endometriosis/ uterine fibroids in women ***(for less than six months, due to serious side-effects)***. But *not* licensed for gender dysphoria or for transitioning girls. Youngest girl given PBs at Tavistock was 10 years old, despite Ethics Approval only having been given for children 12 years or older.. The Dutch Protocol had strong eligibility criteria before children could tranistion: Dysphoria began early in childhood; dysphoria was worse at onset of puberty; child was psychologically stable, with no other mental health problems; the child had the support and approval of her parents. If those conditions were met, there was an automatic progression from PBs at 12 years, to cross-sex hormones at 16, to surgery e.g. mastectomy, from 18 years.	Biggs, M. (Dec 2020). Puberty blockers for gender dysphoria: The Dutch protocol. *https://www.transgendertrend.com/puberty-blockers/*

	According to Biggs (2020) these were not adhered to in countries other than Holland. At first Gooren & Van de Waal (1996) claimed that PBs were fully reversible after 3-18 months. However, in 2006 Delemarre and van de Waal (2006) were not quite as confident: *"It is not yet clear how pubertal suppression will influence brain development"*	
Cross-sex hormones (CSHs) Suppresses ovarian function; increase in clitoral size (to 4-5 cms i.e. not enough for penetrative sex); cessation of menses; growth of male pattern facial and body hair; male pattern baldness; coarsening of skin texture to face; increase in lean body mass; increase in upper body strength; decrease in body fat; increased aggression and general drive; increase in libido; patients feel more masculine; improved visio-spatial ability; vocal cords lengthen and thicken, deepening the voice;	Polycystic ovarian syndrome (PCOS); lower myocardial infarction; increased red blood cells leading to polycythaemia; increase in strokes; liver dysfunction/ fulminant hepatic failure; endometrial cancer; endometrial atrophy; ovarian cancer; occasional breast cancer; pro-atherogenic changes to cholesterol; C**ognitive and brain-related effects -**Neuroimaging studies suggest CSHs affect brain structure and circuitries,	Seal, L.J. (2016). A review of the physical and metabolic effects of cross-sex hormonal therapy in the treatment of gender dysphoria. *Annals of Clinical Biochemistry*, 53(1): 10-20 Burke et. al., (2016). Prospective case-control study (n=62). Girls with gender dysphoria (GD) (n=21, mean age 16.1) underwent functional MRI scanning while performing a mental rotation task twice: when receiving medication to suppress their endogenous sex hormones before testosterone treatment, and 10 months later during testosterone treatment.

increase in bone size and thickness.	ventricular volume and thickness, hypothalamic neuroplasticity, and functional connectivity. Testosterone therapy was associated with altered cognitive processes	Two age-matched control groups participated, twice, as well: 20 male controls and 21 female controls. Klink et. al., (2015) longitudinal observational study at a tertiary referral center. In 34 subjects bone mineral density development until the age of 22 years was analyzed. Klink et. al., (2015). In transmen there was a trend for decrease from 0.2 to -0.3. This suggests that the bone mineral density was below their pretreatment potential and either attainment of peak bone mass has been delayed or is attenuated.
	Bone development - lumbar spine bone mineral density scores fell during puberty suppression with GnRHa. Risk of osteoporosis. **Blood pressure.** Elevations in systolic and diastolic blood pressure with testosterone treatment after two years.	Obedin-Maliver, J. (2016) Pelvic pain and persistent menses in transgender menhttps://transcare.ucsf.edu/guidelines/pain-transmen
Effects of long-term testosterone use	The interaction between a genotypic female skeleton and increased muscle mass as a result of testosterone therapy may result in changes in postural carriage.	Braw, E., (06/08/14). East Germany's Steroid Shame**.** *https://www.newsweek.com/east-germanys-steroid-shame-253840*

	The use of testosterone has a dose dependent effect on vaginal tissue by inducing a hypoestrogenic state which promotes atrophy, increases vaginal pH and thus increases the risk of atrophic vaginal tissues represent a decline in tissue resilience, skin barrier function, and increased susceptibility to altered microbial environment and resistance which may result in atrophic or infectious vaginitis, cervicitis and cystitis. Among the ex-athletes' other common ailments: heart attacks, heart enlargements, malfunction of lungs and kidneys, deformed ovaries and skeletal illnesses. A generation of East German athletes form a unique case study on the life-long effects of doping….Severe depression and anorexia, also suffers from worn-out joints and a permanently damaged spine. Women who have high levels of both testosterone and estrogen in midlife may face a greater risk of	Wong, J.Y.Y., Johnson, W.O., & Gold, E.B. (2015). Elevated Testosterone Levels May Raise Risk of Uterine Fibroids. *Journal of Clinical Endocrinology & Metabolism.* 13-year longitudinal study of hormone levels, in 3,240 women, and the incidence of uterine fibroids in women participating in the Study of Women's Health around the Nation (SWAN). *Circulating Sex Hormones and Risk of Uterine Fibroids: Study of Women's Health Across the Nation (SWAN),"* was published online at *http://press.endocrine.org/doi/10.1210/jc.2015-2935* ahead of print

	developing benign tumors on the uterus called uterine fibroids…Fibroids can contribute to irregular bleeding, infertility, pelvic pain, recurrent pregnancy loss and other reproductive complications. The first-line treatment is undergoing a hysterectomy, and there are few other treatment options currently available.	Aykroyd, L. (7 Nov 7, 2019). Health consequences of PEDs continue to plague ex-East German athletes *https://globalsportmatters.com/health/2019/11/07/ex-east-german-athletes-struggle-with-health-problems-due-to-the-consequences-of-ped-taking/*
	Hepatitis, heart disease, liver tumors, and liver cancer…Women who received injections or ingested synthetic testosterone also had physical side effects such as acne, deepened voices, excess growth of leg hair and pubic hair, sterility,and enlarged clitorises. Some female athletes gave birth to children with club feet or other defects.	Curve magazine staff contributor (25 Jul 2020). Transgender Urinary Health - How Hormone Therapy Affects the Urinary Tract *https://www.curvemag.com/sexuality/transgender/transgender-urinary-health-how-hormone-therapy-affects-the-urinary-tract/*
	Vaginal dryness, increased frequency of urinary tract infections (UTIs), urinary urgency, dysfunctional voiding (over or under urination)	

Top surgery	Practice Setting: The Center for Transyouth Health and Development at Children's Hospital Los Angeles Among the nonsurgical cohort, 64 (94%) perceived chest surgery as very important, and chest dysphoria increased by 0.33 points each month that passed between a youth initiating testosterone therapy and undergoing surgery. Among the postsurgical cohort, the most common complication of surgery was loss of nipple sensation, whether temporary (59%) or permanent (41%). Harms included postoperative hematoma (10%) and complications of anesthesia (7%). Self-reported regret was near 0. Clinical practice should consider patients for chest surgery based on individual need rather than chronologic age. In the United States, the age of medical consent for major medical procedures without	Olsson-Kennedy et. al., (2018). Cohort study, survey. Of 136 completed surveys, 68 (50.0%) were from postsurgical participants, and 68 (50.0%) were from nonsurgical participants. At the time of the survey, the mean (SD) age was 19 (2.5) years for postsurgical participants and 17 (2.5) years for nonsurgical participants. In the interests of balance a gender-critical blogger offers another perspective. 4thWaveNow. (19 AUG 2015). Coming soon to a state near you? Double mastectomy for your 15-year-old, without parental consent. *https://4thwavenow.com/2015/08/19/coming-soon-to-a-state-*

	parental involvement is typically 18 years [but medical majority is at 15 in Oregon].. But…trans activists [aim] to lower the age of consent for trans-identified teens to undergo general anesthesia and major surgeries (both “top” and “bottom”), and to force both private insurance policies and taxpayer-funded state health plans to cover the procedures as a medical necessity. Apart from the questionable wisdom of colluding with a pubescent girl’s notion that she is “really a boy,” mastectomy and general anesthesia carry risks of complications. (Interestingly, “gender dysphoria” is no longer considered a mental disorder in the DSM-5, but a normal variant in the human condition – which somehow still requires extreme medical intervention)…They are doing their best–and succeeding–at further eroding the involvement of a child’s most trusted adults in permanent medical decisions. In 2014, TransActive Gender Center successfully lobbied the	*near-you-double-mastectomy-for-your-15-year-old-without-parental-consent/*

	state legislature to include transgender hormones and surgeries for children on the tax-payer funded Oregon Health Plan (OHP).	
Bottom surgery		There is little high-quality evidence on bottom surgery.