Health Legislation Amendment Bill 2019 (Qld)

Submission to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

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Introduction

Thankyou for the opportunity to comment on this Bill. Although I am Dean of Law at UQ, I write in my personal capacity and drawing upon my expertise in issues concerning child protection, the rights of children and adolescents, and related issues.

This submission is concerned with the insertion of Chapter 5B, to do with so-called "conversion therapies". My focus is on the application of the law to young people under the age of 18. My particular concern is with the issue of gender identity. There are also issues, but to a much lesser extent, with the issue of sexual orientation, given how fluid this can be during the adolescent years.

Executive summary

I have serious concerns about this part of the Bill. I have no doubt that it is put forward with the best of intentions. There has been a real attempt by the drafters to distinguish between the kinds of counselling or therapy that the Government seeks to criminalise, and the kinds of counselling or therapy that the Government wants to support (and indeed which it should strongly encourage). The difficulty is that drawing these lines is almost impossible in situations where an experienced therapist has real concerns about a troubled young person's desire to go down the pathway towards gender transition.

There is now strong evidence to suggest that adolescent identification as being 'born in the wrong body" may in some cases be the result of peer influence. The issue of peer pressure is particularly significant in relation to teenage girls, who are now identifying as 'transgender' in numbers that depart sharply from historic patterns. This suggests a problem of social contagion. In addition, disproportionately, adolescents who adopt another gender identity suffer from other mental health issues or are on the autism spectrum. It is therefore absolutely imperative that they get the best possible counselling and support and do not embark down the pathway of irreversible medical interventions such as hormone treatment without:

a) a clear and unequivocal diagnosis that their mental health issues are due to discordance between gender identity and natal sex and do not arise from some other cause related to mental health;
b) assurance that medical interventions such as puberty blockers and lifelong hormone treatment represent the best possible treatment for the young person in the circumstances.

There cannot be an experienced lawyer in every counselling session, advising therapists on what is lawful and what is not. Furthermore, it is very likely that if the relationship between a client and a therapist turns sour, any subsequent prosecution will turn on the different perceptions of the therapist and the client as to what the intent of the therapy was.

Consequently, this legislation will have a severe chilling effect for psychologists and other therapists. Rather than try to walk the fine line between what is lawful and what is unlawful, they are more likely to stay away from counselling in the area of gender identity entirely. That could

lead to some many troubled young people not getting the mental health care that they need. The result, very possibly, will be greater suffering, including increased suicides.

Young people who have concerns about their sexual orientation also need to be able to access appropriate help and guidance to understand how their feelings and attractions may change during their adolescent years and in order to deal with distress about what they understand their sexual orientation to be. While the proposed legislation does attempt to draw clear lines between supportive counselling and 'conversion therapy', therapists are likely to have a strong disincentive to counsel in this area if they fear the threat of a prison sentence, should a judge or jury retrospectively determine that they have crossed the threshold of illegality.

Given the declining state of young people's mental health, particularly in terms of anxiety, it would be disastrous if well-intentioned laws have the effect of driving psychologists and other therapists away from providing certain kinds of counselling that are desperately needed and ought to be more, not less available.

The other issue is that I don't think it is possible for the Parliament to define the offence sufficiently clearly in relation to children and young people. When does a child or young person's gender confusion, for which they would benefit from counselling, become in law a 'gender identity' that it is a criminal offence to counsel them about? When can a young person be said to have a sexual orientation that it is a criminal offence to try to change, given the fluidity of sexual orientation in adolescence, and how common it is for adult heterosexuals, particularly females, to have had some same-sex attraction or sexual experience in the past?

The criminal law requires absolute clarity as to what the offence is and when it is committed. If either gender identity or sexual orientation are, at any stage of development, fluid, changing and, in the case of gender identity, prone to 'false positives', it is simply not possible to create a criminal offence that could justly be used to punish a therapist who acts in good faith to assist a child or young person in distress.

Finally, I note that there does not seem to be any pressing need for this legislation. The Government has not made a case for saying there is a problem in Queensland with "conversion therapy" which is so significant that it needs the heavy hand of the criminal law to deal with it. Although small groups of activists may offer examples, so often these examples appear unfounded when subjected to close scrutiny, or cannot be verified at all. The Bill, with respect, seems to be copycat legislation that represents the fruits of lobbying by very small and unrepresentative groups that do not even represent a significant proportion of the LGBT communities.

To explain these opinions, it is necessary to go in some depth into the research literature on gender identity and sexual orientation, so far as this concerns children and adolescents. It ought to become clear that good therapy to assist troubled adolescents is absolutely essential and nothing should be enacted which will drive away good therapists from providing excellent mental health support.

Criminalising counselling

It is a really serious matter to ban certain kinds of counselling and treatment, or counselling and treatment for certain kinds of problems. To criminalise it, making it an indictable offence, is even more serious. The Parliament would need to be 100% sure of its ground, and of the science on which such legislation rests. Legislation also can only be justified if there is a significant problem to be addressed.

To draw a parallel, Parliament could be confident of the science in taking legislative action concerning children's vaccinations. There is, and has been, for a long time, a uniform scientific consensus on the value and importance of children's vaccinations and their safety. The recent rise of the anti-vaccination movement is based on beliefs that have no scientific basis. If a Parliament uses the law to encourage vaccination in some way, or to penalise parents who refuse to vaccinate their children, this is entirely justifiable. Furthermore, it responds to a significant problem, since the incidence of childhood measles is likely to increase if the proportion of vaccinated children goes down, exposing to risk children too young to be vaccinated.

By contrast, the case for criminalising counselling to help someone deal with issues of gender identity would seem to ignore a substantial body of evidence that some young people who express a gender identity different from their natal sex are not in fact transgender, as this quite rare phenomenon has previously been understood. Many subsequently deeply regret taking gender transition hormones and having other related medical treatment. Furthermore, there is no evidence of a social problem in Queensland to which this legislation is addressed.

Gender dysphoria

There have long been children, young people and adults who, while being genetically either male or female, have so strongly identified as being of the opposite sex that they have eventually taken steps to identify publicly as having a different first name and gender.

This used to be classified as a disorder – gender identity disorder. It ceased to be pathologised in version 5 of the *Diagnostic and Statistical Manual of Mental Disorders,* published by the American Psychiatric Association. There, the term 'gender dysphoria' is used. It describes a condition, causing a person psychological distress, in which they experience a disconnect between their unambiguous physical characteristics (male or female genitalia) and their feelings about what gender they are or how they want to identify**.**

For some this is a very distressing and enduring condition, which may be alleviated by engaging in hormonal and surgical treatments that have the effect of bringing a person's external appearance and genitalia more into concordance with their subjective gender identity.[1] Such treatment is not without risks and deficits however. For example, to maintain the appearance of the preferred gender, people need to take cross-sex hormones for the rest of their lives and this carries significant

[1] See e.g. E. Castellano and others, 'Quality of Life and Hormones after Sex Reassignment Surgery'. (2015) 38(12) *Journal of Endocrinological Investigation* 1373–1381.

health risks.[2] The medical treatment may also render a patient sterile, depending on what treatments are provided.[3]

Given the extreme seriousness of the decisions involved, there is properly a concern that people who undergo processes of transition from one gender to another do so only when this represents the optimal treatment plan for a medically diagnosed problem.

Gender identity confusion among children

The evidence is clear that gender dysphoria in prepubertal children is very likely to be transitory, with the right therapeutic support.[4] There have been a number of studies of childhood gender dysphoria in which researchers and clinicians have followed up these children over time.[5] The great majority resolve their gender identity issues during puberty. Ristori and Steensma, in a review article, summarise the research evidence as follows:[6]

> The conclusion from these studies is that childhood GD is strongly associated with a lesbian, gay, or bisexual outcome and that for the majority of the children (85.2%; 270 out of 317) the gender dysphoric feelings remitted around or after puberty.

Ristori and Steensma identify three different approaches to the management and treatment of childhood gender dysphoria. One is therapy to assist the child to accept his or her natal gender. Another is to support the child and alleviate social risks while keeping options open. This is known as "watchful waiting". The third is to encourage and assist the child to transition. Ristori and Steensma explain that:[7]

> The rationale for supporting social transition before puberty is that children can revert to their originally assigned gender if necessary since the transition is solely at a social level and without medical intervention. Critics of this approach believe that …a child may 'forget' how to live in the original gender role and therefore will no longer be able to feel the desire to change back; or that transitioned children may repress doubts about the transition out of fear that they have to go through the process of making their desire to socially (re)transition public for a second time.

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[2] See e.g. Darios Getahun and others, 'Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study' (2018) 169(4) *Annals of Internal Medicine* 205–213 (effects of estrogen treatment in natal males).

[3] See generally, M. Telfer and others, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* Version 1.1. Melbourne: The Royal Children's Hospital; 2018 p.14.

[4] M. Wallien, & P. Cohen-Kettenis, 'Psychosexual Outcome of Gender-dysphoric Children' (2008) 47 *Journal of the American Academy of Child and Adolescent Psychiatry* 1413–1423.

[5] This research is contested. See Julia Temple Newhook and others, 'A critical Commentary on Follow-Up Studies and "Desistance" Theories About Transgender and Gender-Nonconforming Children' (2018) 19 *International Journal of Transgenderism* 212; and the responses to that critique from Kenneth Zucker, Thomas Steensma & Peggy Cohen-Kettenis in the same issue.

[6] J. Ristori and T. Steensma, 'Gender Dysphoria in Childhood' (2016) 28 *International Review of Psychiatry* 13 at 15.

[7] Ibid at 17.

It may not be at all helpful to many children with gender dysphoria issues to encourage them to embrace an identity of being 'transgender' when for so many, it may be a transitory stage on their journey towards a sexually and mentally healthy – or at least more healthy – adulthood. What this Bill does is to allow and perhaps encourage gender identity affirming therapy while potentially criminalising counselling that may help a child to live with their natal sex – as most eventually can do with the right support. To criminalise counselling and expert therapeutic support of children experiencing gender confusion would be extraordinarily reckless and irresponsible. While those promoting this Bill may not intend to do so, it is quite likely that this would be the legislation's effect in practice.

Gender dysphoria that is not resolved once the child or young person goes through puberty may be much more enduring;[8] but what is clear from all the literature is that gender dysphoria in adolescence requires careful and expert clinical management involving thorough assessment of the child or young person's mental health. The therapist needs to be open to assisting the young person to an understanding of their difficulties other than that they were 'born into the wrong body'. This Bill makes an attempt to distinguish between different therapeutic interventions that are lawful and unlawful, but the lines are very difficult to draw, and this is likely to result in many therapists believing that they are at risk of jail sentences if they offer any such therapy.

Gender identity confusion among adolescents

Until a few years ago, cases of gender identity disorder were quite rare. In the DSM 5, the most authoritative source of information on mental health, rates for natal adult males are estimated at 0.005% to 0.014% of the population, and for natal females, from 0.002% to 0.003%.[9] However, there has, in recent years, been an explosion in the number of young people now identifying as transgender and seeking assistance from gender identity clinics.

For example, at a specialist clinic in the Royal Children's Hospital, Melbourne, referrals have increased from one child or adolescent patient every 2 years after the clinic was established in 2003, to 104 new patients being in 2014.[10] By 2017 the number had increased to 253. Exponential growth in the number of children and young people with referrals to such clinics has been reported elsewhere. For example, at the Gender Identity Development Service of the Tavistock Centre in London, there were 2,016 referrals for children and young people under 18 in 2016, more than six times more than the 314 referrals five years previously.[11] The Service, like others in the UK, is

[8] S. Leibowitz and A. de Vries, 'Gender Dysphoria in Adolescence' (2016) 28 *International Review of Psychiatry* 21.

[9] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, (5th ed, 2013) p. 454.

[10] M. Telfer, M. Tollit, & D. Feldman, 'Transformation of Health-care and Legal Systems for the Transgender Population: The need for Change' (2015) 51 *Journal of Paediatrics and Child Health* 1051.

[11] https://www.telegraph.co.uk/news/2017/07/08/number-children-referred-gender-identity-clinics-has-quadrupled/.

experiencing unprecedented demand, and now has a two year waiting list for a first appointment.[12] The numbers continue to rise everywhere.

This reflects trends among adolescents over the last ten or fifteen years to identify as transgender or 'gender fluid' at rates hundreds of times higher than the incidence that has previously been observed in the adult population. A study of 9th-12th grade students in Boston schools conducted in 2006 found that 17 out of 1032 students reported being transgender (1.6%).[13] A survey of 2730 Californian students in years 6-8 conducted in 2011 found 1.3% identified as transgender when given the choice of male, female or transgender.[14] A larger-scale study of 8,166 high school students in New Zealand in 2012 found that 96 (1.2%) identified themselves as transgender, in response to a question: "Do you think you are transgender? This is a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl."[15] An even larger percentage was found in a survey of nearly 82,000 students in Minnesota in 2016. The study found that 2.68% of students answered affirmatively to the question: "Do you consider yourself transgender, genderqueer, genderfluid, or unsure about your gender identity?"[16] This was more than double the number who identified as gay or lesbian.[17]

Adolescent girls and gender confusion

Most of the child and adolescent clients who attend gender identity clinics now are natal females. A study in Finland of all the young people presenting at one of two clinics in the country over a two year period reported that 41 were natal girls and 6 were natal boys. In the other clinic in Finland the gender ratio was similar.[18] An inversion in the gender ratio in adolescent clinics since

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12 https://www.telegraph.co.uk/news/2019/08/23/two-year-waiting-times-nhs-gender-identity-clinics-amid-unprecented/.

13 Joanna Almeida and others, 'Emotional Distress Among LGBT Youth: The Influence of Perceived Discrimination Based on Sexual Orientation' (2009) 38 *Journal of Youth and Adolescence* 1001.

14 JP Shields and others, 'Estimating Population Size and Demographic Characteristics of Lesbian, Gay, Bisexual, and Transgender Youth in Middle School' (2013) 52 *Journal of Adolescent Health* 248–50.

15 Terryann Clark and others, 'The Health and Well-being of Transgender High School Students: Results from the New Zealand Adolescent Health Survey (Youth'12)'. (2014) 55 *Journal of Adolescent Health* 93–99.

16 Laura Baams, 'Disparities for LGBTQ and Gender Nonconforming Adolescents' (2018) 141(5) *Pediatrics* e20173004. For another analysis of the same dataset, see Nicole Rider and others, 'Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study' (2018) 141(3) *Pediatrics* e20171683.

17 Baams, ibid, Table 1 (1.27% identified as gay or lesbian and 4.98% as bisexual).

18 Riittakerttu Kaltiala-Heino and others, "Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development" (2015) 9 *Child and Adolescent Psychiatry and Mental Health* 9.

2006 has also been observed in clinics in Toronto and Amsterdam,[19] and at the Tavistock Centre in London.[20]

The historic pattern is that most of those who were diagnosed with a gender identity disorder were natal males.[21] Studies in the past suggest that at least three times as many men identified as transgender as did females,[22] and, the ratio has been as high as 6-1,[23] although there appear to be variations between countries.[24] There is thus a disconnect between the proportion of female adolescents self-identifying as transgender, and the established patterns in the adult population in terms of male-female ratios.

The cause of transgender identification is far from clear. Indeed, it remains poorly understood.[25] A recent review of studies of the brain found that: "Despite intensive searching, no clear neurobiological marker or "cause" of being transgender has been identified".[26] If the condition has a physiological origin, or if biological factors have a major influence on transgender identification, then one might expect the number of those with such problems to remain relatively stable over time, as a proportion of the population. An exponential increase in the apparent prevalence of any illness, disease or disorder requires explanation. In the case of communicable diseases, analysis would likely include the pathways by which it is spread. In the case of other illnesses, reasons may be sought to determine whether there has been a real increase in the population-wide incidence, or whether the illness has previously been under-diagnosed.

It may be that gender dysphoria has been under-diagnosed in the past; but even acknowledging this possibility, consideration needs also to be given to the role of other factors. Gender identity

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[19] M. Aitken and others, 'Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria' (2015) 12(3) *Journal of Sexual Medicine* 756.

[20] N.M. de Graaf and others, 'Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009–2016)' 2018) 47(5) *Archives of Sexual Behavior* 1301.

[21] H. Wood and others, 'Patterns of referral to a Gender Identity Service for Children and Adolescents (1976–2011): Age, Sex Ratio, and Sexual Orientation' (2013) 39 *Journal of Sex & Marital Therapy* 1–6; Kenneth Zucker, 'Epidemiology of Gender Dysphoria and Transgender Identity' (2017) 14 *Sexual Health* 404.

[22] International statistics are found in G. De Cuypere and others, 'Prevalence and Demography of Transsexualism in Belgium' (2007) 22 *European Psychiatry* 137.

[23] See e.g. J. Veale, 'Prevalence of Transsexualism among New Zealand Passport Holders' (2008) 42 *Australia and NZ Journal of Psychiatry* 887; M. Ross and others, 'Cross-cultural Approaches to Transsexualism: a Comparison between Sweden and Australia'. (1981) 63 *Acta Psychiatrica Scandinavica* 75.

[24] De Cuypere and others, above n.22.

[25] The research evidence is reviewed in S.C. Mueller, G. De Cuypere, & G. T'Sjoen, 'Transgender Research in the 21st Century: A Selective Critical Review from a Neurocognitive Perspective' (2017) 174 *American Journal of Psychiatry* 1155–1162; Jack Turban & Diane Ehrensaft, Research Review: Gender Identity in Youth: Treatment Paradigms and Controversies' (2018) 59 *Journal of Child Psychology and Psychiatry* 1228–1243; Lawrence Mayer and Paul McHugh, 'Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences: Part Three' 50 *New Atlantis* (2016) available at https://www.thenewatlantis.com/publications/part-three-gender-identity-sexuality-and-gender.

[26] Mueller and others, ibid, at 1158.

issues are being widely talked about, and normalised in the media and entertainment industries. Transgender is the "T" in the popular acronym LGBTI, and in recent years a high profile has been given to transgender issues.

The evidence for social contagion

At least some of the adolescents who identify themselves as transgender appear to be influenced by peers and the internet.[27] Lisa Littman, in a landmark study,[28] provided a 90 question survey to parents who reported that their child had a sudden or rapid onset of gender dysphoria, occurring during or after puberty. This would seem to be a new phenomenon, for hitherto, children and young people with gender identity issues seen at clinics have all had symptoms of gender dysphoria since early childhood. Particularly new is the phenomenon of adolescent onset gender dysphoria in young women.[29]

There were responses from 256 parents. Nearly 83% of the young people concerned were female and on average were 15 years old at the time they announced a new gender identification. The majority had been diagnosed with at least one mental health disorder or neuro-developmental disability prior to the onset of their gender dysphoria. None of them, based on parents' reports, would have met diagnostic criteria for gender dysphoria in childhood. Nearly half had been formally assessed as academically gifted. Over 40% expressed a non-heterosexual sexual orientation prior to identifying as transgender. Nearly half had experienced a traumatic or stressful life event prior to the onset of their gender dysphoria such as parental divorce, sexual assault or hospitalisation for a psychiatric condition.

For 45% of these young people, parents reported that at least one of the members of their friendship group came to identify as transgender. The average number of individuals who became transgender-identified was 3.5 per group; for 37% of the young people, the majority of friends in the group had come to identify as transgender. Parents reported that about 60% of the young people experienced increased popularity within their friendship group when they announced that they now identified as transgender. A similar proportion of the parents reported that the friendship groups were known to mock people who did not identify as lesbian, gay, bisexual, transgender, intersex, or asexual.

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[27] Lisa Marchiano, 'Outbreak: On Transgender Teens and Psychic Epidemics', (2017) 60(3) *Psychological Perspective*, 345–366.

[28] Lisa Littman, 'Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria' (2018) 13(8) *Plos One* e0202330. The article was heavily amended post-publication following complaints that she was spreading misconceptions about transgender people and employing biased methods. This is despite having gone through a conventional peer-review process prior to initial publication. The amendments were required by the editor following reviews by senior members of the journal's editorial team, two Academic Editors, a statistics reviewer, and an external expert reviewer. This illustrates how difficult it is to publish research which challenges favoured ideological positions within academia. See further: https://quillette.com/2019/03/19/an-interview-with-lisa-littman-who-coined-the-term-rapid-onset-gender-dysphoria/

[29] Littman, ibid at p.3.

The majority of parents reported that when the young person disclosed the belief that he or she was transgender, the language came word for word from online sites. Two-thirds indicated, at the time of disclosing an identification as transgender, that they wanted to take hormones and over 50% wanted gender reassignment surgery. Again, more than half had very high expectations that transitioning would solve their social, academic, occupational or mental health problems.

Sudden, post-pubertal identification as transgender helps to explain the very high rates at which adolescents identify as transgender compared to the adult population. In a New Zealand study, 54% of the respondents first wondered about being transgender when they were at least 12 years old.[30] 65% had not disclosed to someone else their belief in being transgender.

Socio-economic background, family situation and abuse history

The importance of expert therapeutic support to determine whether a teenager's asserted gender identity is masking other problems is particularly important given the family histories of some of these young people.

Many of the adolescents who identify in surveys as transgender, or who are seen at gender clinics, come from troubled family backgrounds and have histories of abuse. This is so for a much greater proportion of adolescents identifying as transgender, than in the general population.

In a New Zealand study, adolescents identifying as transgender were substantially more likely to come from households that had experienced high levels of deprivation (43% compared with 30% of those who did not identify as transgender).[31] They were also less likely to report that their family got along (64% compared with 81.5% of those who did not identify as transgender).[32]

In the Minnesota study, those who identified as transgender, "genderqueer" or similar were about 75% more likely to have a parent or guardian in prison, nearly twice as likely to live with a problem drinker, over twice as likely to live with a drug abuser, and also reported much higher levels of physical abuse, psychological abuse and of witnessing domestic violence. They were about four times as likely as those who did not identify as transgender to have experienced childhood sexual abuse.[33]

This raises important issues for understanding both the aetiology of gender dysphoria and its treatment. If the explanation for gender dysphoria is primarily or entirely physiological ("being born into the wrong body", as it is colloquially understood) then one would expect a demographic profile and range of family histories for transgender-identifying young people to be similar to the population as a whole.

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[30] Clark above n.15 at p.96.

[31] Ibid.

[32] Ibid at 97.

[33] Baams, above n.16.

Autism and mental health issues

Another reason for expert therapeutic support is that many children and young people who identify themselves as transgender have other mental health issues or disorders. Numerous studies have found that children and young people who identify as transgender are many times more likely than the general population to be diagnosed as on the autism spectrum.[34] A leading study of 204 children or adolescents seen at the Gender Identity Clinic in Amsterdam indicated that the rate of autism diagnoses among those with gender dysphoria were about ten times as high as the general population.[35] A study in Finland of children and young people presenting at a gender identity clinic found that over 25% were diagnosed as being on the autism spectrum.

These children and young people are also much more likely to have depression and anxiety disorders. They are also more likely to experience suicidal ideation – in some cases leading to suicide attempts.[36] This is often explained in terms of the struggle they experience with the discordance between natal sex and gender identity, because of discrimination and parental disapproval or rejection on account of their gender identity. While these may be factors, other causes of depression, anxiety and suicidal ideation need to be considered – including a history of sexual abuse[37] and family dysfunction, as so many of them have.

Anxiety and depression are not the only mental health issues for children with gender identity issues. In one study of children aged 3-9 years old identified as gender non-conforming, there was a much higher rate of attention deficit disorders than the control group.[38] Gender dysphoria may also co-exist with eating disorders.[39]

For some expert clinicians at least, the presence of other psychiatric disorders leads to caution about offering hormonal treatments and other interventions to children and adolescents that lead them on the pathway to full transition. One German team, that includes experts in adolescent

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[34] The data is summarized in John Whitehall, 'Gender Dysphoria and the Fashion in Child Surgical Abuse' (2016) 60(12) *Quadrant* 23.

[35] A. de Vries and others, 'Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents' (2010) 40(8) *Journal of Autism and Developmental Disorders* 930-6. See also A. van der Miesen and others, 'Autistic Symptoms in Children and Adolescents with Gender Dysphoria' (2018) 48(5) *Journal of Autism and Developmental Disorders* 1537–1548.

[36] TA Becerra-Culqui and others, 'Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers' (2018) 141(5) *Pediatrics* e20173845; Johanna Olson and others, 'Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria' (2015) 57(4) *Journal of Adolescent Health*, 374–380.

[37] A. Plunkett and others, 'Suicide Risk Following Child Sexual Abuse' (2001) 1 *Ambulatory Pediatrics* 262–266; M. Cutajar and others, 'Suicide and Fatal Drug Overdose in Child Sexual Abuse Victims: A Historical Cohort Study' (2010) 192(4) *Medical Journal of Australia* 184–187.

[38] Becerra-Culqui and others, above n. 36.

[39] G.L. Witcomb and others, 'Body Image Dissatisfaction and Eating-Related Psychopathology in Trans Individuals: A Matched Control Study. (2015) 23(4) *European Eating Disorders Review* 287–293.

psychiatry, sexual medicine, and paediatric endocrinology described its research findings as follows:[40]

> All of the 21 patients who received a new diagnosis of GID in our clinic up to mid-2008 (aged 5 to 17; 12 boys, 9 girls) had psychopathological abnormalities that, in many cases, led to the diagnosis of additional psychiatric disorders. As a rule, there were also major psychopathological abnormalities in their parents. The "motive for switching" among the 15 adolescents in the group was mainly a rejected (egodystonic) homosexual orientation, the development of which would have been arrested by puberty-blocking treatments.

The importance of counselling for gender confused children and adolescents

The consensus amongst most medical professionals seems to be that it is essential for these children and young people to have counselling and careful therapeutic exploration of the reasons why they are expressing a gender identity different from their natal sex.[41] The young person may well experience this as an attempt to change his or her gender identity, leading perhaps to complaints to police if this legislation is passed.

Earlier research on gender identity issues identified problems in the family of origin as important in understanding the aetiology of gender confusion,[42] and therapeutic support is necessary to identify these influences.

There are compelling reasons not to accept an adolescent's self-diagnosis of being transgender as the basis for affirming a new gender identity. As Finnish experts have advised:[43]

> [F]or the majority of adolescent-onset cases, [gender dysphoria] presented in the context of severe mental disorders and general identity confusion. In such situations, appropriate treatment for psychiatric comorbidities may be warranted before conclusions regarding gender identity can be drawn. Gender-referred adolescents actually display psychopathology to the same extent as mental health–referred youth.

The wisdom of this approach is illustrated by a study conducted by two clinicians from the Tavistock Gender Identity Development Service in London. They reported on 12 cases of adolescents seen at the clinic who initially sought medical transition, and who met the criteria for a diagnosis of gender dysphoria, but who did not proceed to hormonal treatment. They arrived

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[40] A. Korte and others, 'Gender Identity Disorders in Childhood and Adolescence: Currently Debated Concepts and Treatment Strategies', (2008) 105 *Deutsches Ärzteblatt International,* 834 at 838.

[41] There seems to be just a minority of clinicians, albeit some prominent and vocal ones, who say that the adolescent's self-identification as transgender is a sufficient basis for life-altering hormonal and medical treatment programs.

[42] John Whitehall, 'Conversion Therapy and Gender Dysphoric Children' (2019) 63(3) *Quadrant* 26–32.

[43] R. Kaltiala-Heino and others, 'Gender Dysphoria in Adolescence: Current Perspectives' (2018) 9 *Adolescent Health, Medicine and Therapeutics*, 31 at 38.

at a different understanding of their distress through counselling.[44] Such counselling could well be determined to be illegal, under Queensland's proposed legislation. I will turn to the legal analysis later.

A growing number of young people are now deeply regretting their decision to transition with hormonal or medical interventions. What is not known is the percentage this represents of all the adolescents and young adults who have received hormonal treatment or surgery in the last ten or fifteen years. It may still be the case that the majority of patients treated in Australia and other countries with well-resourced and affordable health care have made the optimal decision for their health and wellbeing, and a few years later do not regret their decision. There is a paucity of research on this area. A Swedish study from 1960–2010 found 2.2% had sought to reverse the process surgically.[45] However, the research team found high rates of suicide among post-operative transsexuals compared with a general population control group, even after controlling for prior psychiatric morbidity.[46] The authors concluded that: "Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons."[47]

What we know about regrets among modern adolescents and young adults comes mainly from social media. This evidence, while anecdotal, is sufficiently voluminous to warrant attention. One study was conducted through Tumblr, Facebook groups, and on the Wordpress blog 4thWaveNow. The author of the survey invited responses from females who had formerly identified as transgender. The survey was posted for a two-week period and received 203 responses that met the criteria. On average they had transitioned for four years before detransitioning. Over 75% reported that detransitioning had helped them to cope better with their gender dysphoria – indeed 11% reported that it had completely gone. Disturbingly, of the 117 individuals who had medically transitioned, only 41 had received counselling beforehand. That is, 65% had received no therapy prior to receiving medical support to transition. The two most common reasons for detransition were shifting political/ideological beliefs (63%), and finding alternative coping mechanisms for dysphoria (59%). Over two-thirds indicated that they had been given inadequate counselling and information about transition.[48]

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[44] Anna Churcher Clarke & Anastassis Spiliadis, "Taking the Lid Off the Box': The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties'. (2019) 24(2) *Clinical Child Psychology and Psychiatry* 338–352.

[45] Cecilia Dhejne and others, 'An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010: Prevalence, Incidence, and Regrets' (2014) 43(8) *Archives of Sexual Behavior* 1535. For results of a follow-up on satisfaction with the effects of the surgery, see Dmitry Zavlin and others, 'Male-to-Female Sex Reassignment Surgery using the Combined Vaginoplasty Technique: Satisfaction of Transgender Patients with Aesthetic, Functional, and Sexual Outcomes' (2018) 42(1) *Aesthetic Plastic Surgery* 178.

[46] Cecilia Dhejne and others, 'Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden'. (2011) 6(2) *Plos One*, e16885.

[47] Ibid at 7.

[48] Cari Stella, 'Female Detransition and Reidentification: Survey Results and interpretation' (September 2016). Retrieved from http://guideonragingstars.tumblr.com/post/149877706175/female-detransitionand-reidentification-survey.

A detransitioning site on Reddit makes painful and sobering reading.[49] New posts on the site seem to be very frequent. Writers report a great deal of confusion about who they "really" are; profound regrets at having had irreversible medical treatments; suicidal ideation as a consequence of medically transitioning, issues with the effects of cross-sex hormones, especially natal females taking testosterone; views that the trans community are like a cult, regrets at the loss of sexual desire, and many other effects.[50]

Issues concerning adolescent sexual orientation

The Parliament also needs to think long and hard before enacting criminal offences which may have a chilling effect on the provision of therapeutic support for adolescents uncertain about their sexual orientation or distressed that they might be attracted to members of the same sex.

The legislation seems to be premised on the assumption that same-sex attraction is something fixed, and defines a young adolescent's identity, rather than being, for some, a transitory phase in psycho-sexual development.

While adults who are same-sex attracted will identify becoming aware of their sexual orientation in their teenage years, the reverse position is not at all the case. That is, a great many same-sex attracted adolescents do not go on to have a same-sex orientation as adults. There is a major difference between having feelings of romantic attraction towards someone of the same gender as an adolescent, and going on to enter into a continuing same-sex relationship. There is also a gulf between ever having had a same-sex experience and identifying as an adult who is either exclusively, or predominantly, gay or lesbian in orientation.

This may be illustrated by perhaps the largest and most representative study of adolescent same-sex attraction ever conducted, which has the great advantage of being a longitudinal study. Wave 1 of the National Longitudinal Study of Adolescent Health was conducted in the United States in the mid-1990s, and this cohort of young people has now been followed up into adulthood for many years. The latest wave is wave 4, 13-15 years later. This was a nationally representative sample.

In Wave 1, over 12,000 young people from years 7-12 answered questions about romantic attractions and relationships. Respondents were asked: Have you ever had a romantic attraction to a female?" and "Have you ever had a romantic attraction to a male?". They were also asked questions about their three most recent romantic relationships. 7.3% of boys and 5% of girls

[49] https://www.reddit.com/r/detrans/. See also https://sexchangeregret.com/; Walt Heyer, *Trans Life Survivors* (2018); Jesse Singal, 'When Children Say They are Trans', *The Atlantic* July/August 2018 at https://www.theatlantic.com/magazine/archive/2018/07/when-a-child-says-shes-trans/561749/.

[50] These are based upon reading just one week's posts on this site: August 17th 2019.

reported romantic attractions. Same-sex romantic relationships were reported by 1.1% of boys and 2.0% of girls.[51]

However, the students who identified as same-sex attracted in wave 1 were not the same as in later waves. In Wave 2, only a year later than the first wave, 4.5 % of boys and girls reported having any same-sex romantic attraction – a substantial decrease for the boys.[52] Most striking was the change for boys, just one year older. In the first wave, 69 boys reported romantic attraction only to boys and never to girls; but a year later, nearly half of these boys reported that during the past year they had only been attracted to girls while 35% reported that they were not attracted to anyone; only one in ten reported attraction only to boys.[53]

The evidence from this study is that most young people who identified as same-sex attracted at school were not so 13-15 years later. Of Wave 1 boys who indicated they had any same-sex romantic attraction, over 80% identified at Wave 4 as exclusively heterosexual.[54] Of Wave 1 girls who indicated they had any same-sex romantic attraction, 60% identified as exclusively heterosexual at wave 4 and 30% were mostly heterosexual.

Even in early adulthood there were changes. Between waves 3 and 4 (a 6 year period when respondents were in their 20s), 18% of women exhibited change in their sexual orientation, as did 6% of men.[55] For both sexes, mixed-sex attraction was especially volatile over time, with more people who had previously identified as attracted to both sexes changing to identify as having an exclusively heterosexual orientation than to gravitate towards a homosexual orientation. This was especially the case for women.[56] Conversely, those who identified at wave 3 as 100% homosexual typically remained so at wave 4.[57]

Further analysis of the four waves of data has been conducted by Hu and colleagues.[58] They reported that across the four waves of the study from the mid-1990s to 2008, 19% of respondents indicated that they had had at least one experience of attraction to their own gender or both genders. However, only 0.03% of the population consistently indicated being attracted to the

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[51] S. Russell & K. Joyner, 'Adolescent sexual orientation and suicide risk: evidence from a national study'. (2001) 91 *American Journal of Public Health* 1276.

[52] R. Savin-Williams & G. Ream, 'Prevalence and stability of sexual orientation components during adolescence and young adulthood'. (2007) 36 *Archives of Sexual Behavior,* 385.

[53] J. Udry, & K. Chantala, 'Risk factors differ according to same-sex and opposite-sex interest'. (2005) 37 *Journal of Biosocial Science,* 481.

[54] R. Savin-Williams, & K. Joyner, 'The dubious assessment of gay, lesbian, and bisexual adolescents of Add Health'. (2014) 43 *Archives of Sexual Behavior* 413.

[55] R. Savin-Williams, K. Joyner, & G. Rieger, 'Prevalence and stability of self-reported sexual orientation identity during young adulthood' (2012) 41 *Archives of Sexual Behavior* 103.

[56] Ibid.

[57] Ibid.

[58] Y. Hu, Y. Xu, & S. Tornello, 'Stability of self-reported same-sex and both-sex attraction from adolescence to young adulthood' (2016) 45 *Archives of Sexual Behavior* 651.

same-sex and 0.16% consistently reported being attracted to both genders. In other words, for the great majority of young people who at any stage reported some form of same-sex attraction, their sexual orientation did not remain stable over time. The researchers reported that individuals became significantly more consistent in their same-sex attraction around age 20.[59] However, there is some evidence that for women, the volatility continues into the adult years. Figures from a New Zealand study show quite high levels of same-sex attraction among women in the first two decades of adulthood, but for many that was changeable over time. Furthermore, attraction was much more common than same-sex experiences or a same-sex identity.[60]

What follows from this is that it is important for teenagers to have access to expert therapeutic support in working through their distress about same-sex attraction. A same-sex attraction in one's teenage years, or even some sexual experience with another person of the same gender, does not mean that a young person has a fixed and unchangeable orientation only to others of the same gender, or even to continuing bisexuality. The evidence on fluidity in sexual orientation among high-schoolers would suggest that the chances are that only some of the young people who experience a same-sex attraction in adolescence will go on to have an exclusively or even mainly same-sex orientation as adults. Many young people who experience same-sex attractions in adolescence go on to become adults who identify as having an exclusively or mainly heterosexual orientation, and enter into stable long-term heterosexual relationships.

The problems with the legislation

I turn now to the problems with the Bill, so far as it concerns children and young people. In my view, it cannot be fixed by amendment.

Section 213H makes it a criminal offence, punishable by up to 18 months' imprisonment, for a health service provider to provide conversion therapy, so defined in the Bill, to a child under 18.

The definition of conversion therapy

The actus reus of the offence, that is the deed or action which constitutes the offence, is to provide "conversion therapy". This is a treatment or other practice that attempts to change or suppress a person's sexual orientation or gender identity. Examples are given, and these include other clinical interventions, including counselling, that encourage a person to change the person's sexual orientation or gender identity. This is very broadly expressed. Even encouraging a young person to change their sexual orientation or gender identity is to be unlawful, even if no therapy is provided to endeavour to assist them to change.

[59] For other evidence of instability in sexual orientation as self-described by young people, see M. Ott et al. 'Stability and change in self-reported sexual orientation identity in young people: application of mobility metrics' (2011) 40 *Archives of Sexual Behavior* 519.

[60] N. Dickson, et al., 'Stability and change in same-sex attraction, experience, and identity by sex and age in a New Zealand birth cohort' (2013) 42 *Archives of Sexual Behavior* 753.

The legislation is silent as to when a child or young person has a definite sexual orientation or gender identity that it is unlawful to change. By definition, the adolescent years are a time of psychosexual development and change – a sometimes confusing and difficult time for many young people.

If sexual orientation and gender identity are fluid in these years, then there is no definitive point before which it will be lawful to provide counselling on these issues and beyond which it becomes unlawful.

Defences to a charge of conversion therapy

It is true that the proposed s.213F(2)(f) provides that conversion therapy does not include a practice that "facilitates a person's coping skills, social support and identity exploration and development." That defence may be of some assistance in relation to a charge that a therapist was seeking to change a young person's sexual orientation. The therapist may respond that he or she was only working with them to explore their identity and sexual development and to deal with anxiety or distress about unwanted sexual feelings.

Another example given is of therapy involving diagnosis and assessment of persons with gender dysphoria or gender non-conforming behaviour or identity. The difficulty is that where a therapist becomes convinced that the presenting problem of gender dysphoria arises from other mental health issues or a trauma history, and begins to provide therapeutic interventions to address those issues and to suggest to the young person another way of understanding their gender dysphoria, a line may be crossed.

It is almost impossible to draw the line between counselling to encourage a young person to change their gender identity and counselling to explore the reasons why a young person might be mistaken in seeing their problems as being because their 'real' gender is different to their natal sex. The therapist may have one motivation in mind – to test the durability of the assertion of a gender identity that is different to natal sex and to help the young person to a different understanding of their difficulties. The young person may testify that the therapist was trying to change his or her gender identity. For these reasons, the kind of therapy provided successfully by clinicians at the Gender Identity Development Service of the Tavistock Clinic in London, might lead to a criminal prosecution in Queensland if this legislation is passed.[61] Frankly, that would be a shocking outcome, even if the statutory defences were ultimately to succeed.

Another defence is contained in subsection (3).

> Also, conversion therapy does not include a practice by a health service provider that, in the provider's reasonable professional judgment, is necessary to— (a) provide a health service in a manner that is safe and appropriate; or (b) comply with the provider's legal or professional obligations.

[61] Above, n.44.

It is simply unclear what this means. If a psychologist is providing a health service which she reasonably considers, in her professional judgment, to be safe and appropriate, is it then lawful notwithstanding that it may be perceived as attempting to change or suppress a person's sexual orientation or gender identity? If she considers she has a professional obligation to act in the best interests of the child or young person, does this make it lawful to try to help a young person understand that there may be causes for his or her gender dysphoria that are grounded in other mental health issues or a history of trauma? Does the defence negate the offence completely? If not, where is the line to be drawn?

What health providers is the Government concerned about? If the issue is that there are in fact health providers in Queensland, providing counselling or therapy in this area, who would be unable to rely on the defence of acting on their own reasonable professional judgment, is not the solution to refer them for disciplinary action by their accrediting authority?

With such fine lines to be drawn between lawful and unlawful therapy, and the risk that the criminality of the therapy will turn upon perceptions of intentions, it is very likely that many outstanding psychologists will stay away from this kind of counselling completely. That would leave a lot of vulnerable young people without help and support for their problems – a disastrous outcome of this proposed legislation.

Conclusion

This legislation is well-intentioned; but it is also wholly unnecessary. From a legal point of view, it is not well-considered. Because both sexual orientation and gender identity can be quite fluid and changeable in the adolescent years, there is no clear point at which it can be said that a line in the sand has been crossed, making it unlawful, from that point onwards, to engage in any therapeutic intervention that might be interpreted, if only by the adolescent, as encouraging a change in a fixed and immutable sexual orientation or gender identity. The defences and the provision of examples help, but in truth the line between lawful and unlawful counselling in this proposed legislation is so unclear that the only safe way of avoiding criminal prosecution may be to stay away from any counselling that proceeds from treating sexual orientation or gender identity as not being as innate or immutable as this legislation presupposes.

This may lead to tragic unintended consequences, scaring highly qualified and experienced therapists away from providing the kind of mental health support that many troubled young people so desperately need.