Dr Cary Breakey

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Committee Secretary,
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Parliament House
George St
Brisbane Q4000.

Dear sir/madam,

Re: **Health Legislation Amendment Bill 2019**
Chapter 5B Conversion therapies

I have major concerns re proposed legislation limiting therapeutic approaches supporting gender distressed children and adolescents.

During over forty years of working in all areas of Child and Adolescent Psychiatry, including establishing and directing Barrett Adolescent Centre, Queensland's first inpatient adolescent unit, my experiences are consistent with those of Professor Kosky described in a 1987 paper - that in many of these (then relatively uncommon) cases, there were identifiable dynamic pressures in the child, family, or even culture, that explained the desire of the child to change gender.

Separately there are a very small number of children born with medical/genetic/hormonal problems leading to ambiguous genitalia and errors in identifying sex/gender. These are **not** the patients presenting with Gender Dysphoria that this act relates too, although their stories have been used inappropriately in the past to support gender transition issues.

For almost all of the Gender Identity Disorder/ Gender Dysphoria patients I have seen, there were clear (but different in each) family issues which made choice of the opposite gender an understandable response Problems ranged from relatively uncomplicated sibling "favouritism" to risks of sexual abuse, (real and perceived). In many, there was a strong history of inter-generational sexual abuse, domestic violence, and/or high occurrences of tragedy for either males or females in the family. Dealing with these issues with the patient and family members both resolved the gender issues, and improved family functioning.

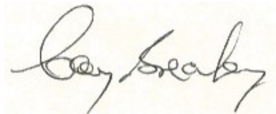
Current interventions are using hormone treatments (with potentially high risk side-effects and almost certain sterility), and subsequently surgery. Any new pharmacological treatment, especially for children, is subject to extensive research, and stringent regulation before clinical use. This has not happened here. Any psychological or emotional interventions with the child and family are focussed only on supporting the conversion of the child to their chosen gender (not addressing subtle but powerful family dynamlcs). The proposed legislation will functionally impose this as the automatic treatment pathway for all children reporting gender issues.

This legislation goes far beyond just supporting these current interventions. It effectively puts any psychotherapy and family therapy practitioners at risk of offending if not "affirming" the child's (or even adults) gender preference. Even Gender Clinics who do do comprehensive evaluations of family and dynamic drivers of the child's gender feelings could be vulnerable, especially if they identify powerful parental dynamics heavily influencing the child's expression.

The relevant descriptors as stated in the proposed act do not reassure me that practitioners. All of the approved therapeutic examples speak of assisting .. , facilitating.. transition; so helping children and families to look at the origin of these feelings, amongst other issues, would transgress. And Section (3) with the need to "prove innocence" is not the least reassuring.

I am gravely concerned and saddened to think of the future for many of these children and adolescents deprived of appropriate interventions, and processed down a medical/surgical path that unfortunately offers an apparent "easy" early resolution but with potentially catastrophic consequences.

I hope these insights help your committee with its deliberations and am very willing to provide further detail, answer queries, etc.



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Ref: Kosky RJ Gender-disordered children: does inpatient treatment help? MJA.1987:146;June 1:565-569