From: [redacted]
Sent: Friday, 10 February 2023 2:22 PM
To: Legal Affairs and Safety Committee
Subject: Births, Deaths and Marriages Bill 2022

Dear Ministers,

I am late to the discussion and I hope my comments can be included and reviewed in the committee review.

I strongly disagree with the changes to the Births, Deaths and Marriages Bill 2022 with regard to gender self-identification. Women and girls will be put at risk by these changes.

Gender self-identification has huge ramifications for all aspects of society.

Current transgender trend
With regard to the current epidemic of transgender young people, I have serious concerns about the quality of the scientific evidence being used as reasons why transitioning young people is justified. I have a family member who was "treated" by the Queensland Children's Hospital Gender Clinic as a teen. The service does not abide by scientific evidence. Their processes are based on the AusPATH guidelines which in turn are based on the WPATH guidelines (which in its most recent update late last year recommended allowing young men to cut off their penises to help them align with their "eunuch" identity if they so desired.

At my family members' first appointment, as a 13 year old girl, she was given this fact sheet because she expressed discomfort with her (then new) period. What 13 year old doesn't have discomfort with periods? Why is this the first response without any kind of mental health support or assessment?

Children's Health Queensland Hospital and Health Service
Queensland Children's Hospital

Queensland Children's Gender Service

Menstrual Suppression

Information for General Practitioners treating young transgender, non-binary and gender diverse (trans) people

For some trans people who were assumed female at birth, menstruation can be a source of severe distress. Suppressing menstruation with medication can be initiated safely and effectively in primary care at any stage. This may be particularly useful when people are awaiting specialist assessment and does not interfere with the assessment process.

There are two main options for menstrual suppression in primary care:

1. Norethisterone (Primolut) 5mg twice daily
Norethisterone is a progestogen, and is the preferred method for menstrual suppression among young trans people. The starting dose is one tablet twice daily, but can be increased incrementally to a maximum of 30mg (two tablets three times per day). As these recommended doses exceed the amounts covered by the standard PBS schedule, an authority prescription for increased amounts is recommended. Taken consistently, norethisterone is contraceptive at the doses recommended for menstrual suppression

2. Combined Oral Contraceptive Pills eg. Levlen ED or similar
Combined oral contraceptives (COCs) safely and reliably suppress menstrual bleeding when active pills are taken 'back to back', omitting the inactive pills. Break-through bleeding is more likely with COCs than with the norethisterone regimen above. COCs containing 30 micrograms of ethinyl oestradiol provide more reliable menstrual suppression than lower dose pills. Trans people who are presumed female at birth may dislike taking an oestrogen-containing medication. Taken consistently, COCs provide reliable contraception

As with all medications, prescribers should review Prescribers' Information. Following gender clinic's multidisciplinary assessment, endocrine treatments to suppress puberty and/or affirm gender identity may commence, and medications for menstrual suppression can cease in most circumstances with the guidance of the treating paediatric endocrinologist or sexual health physician.

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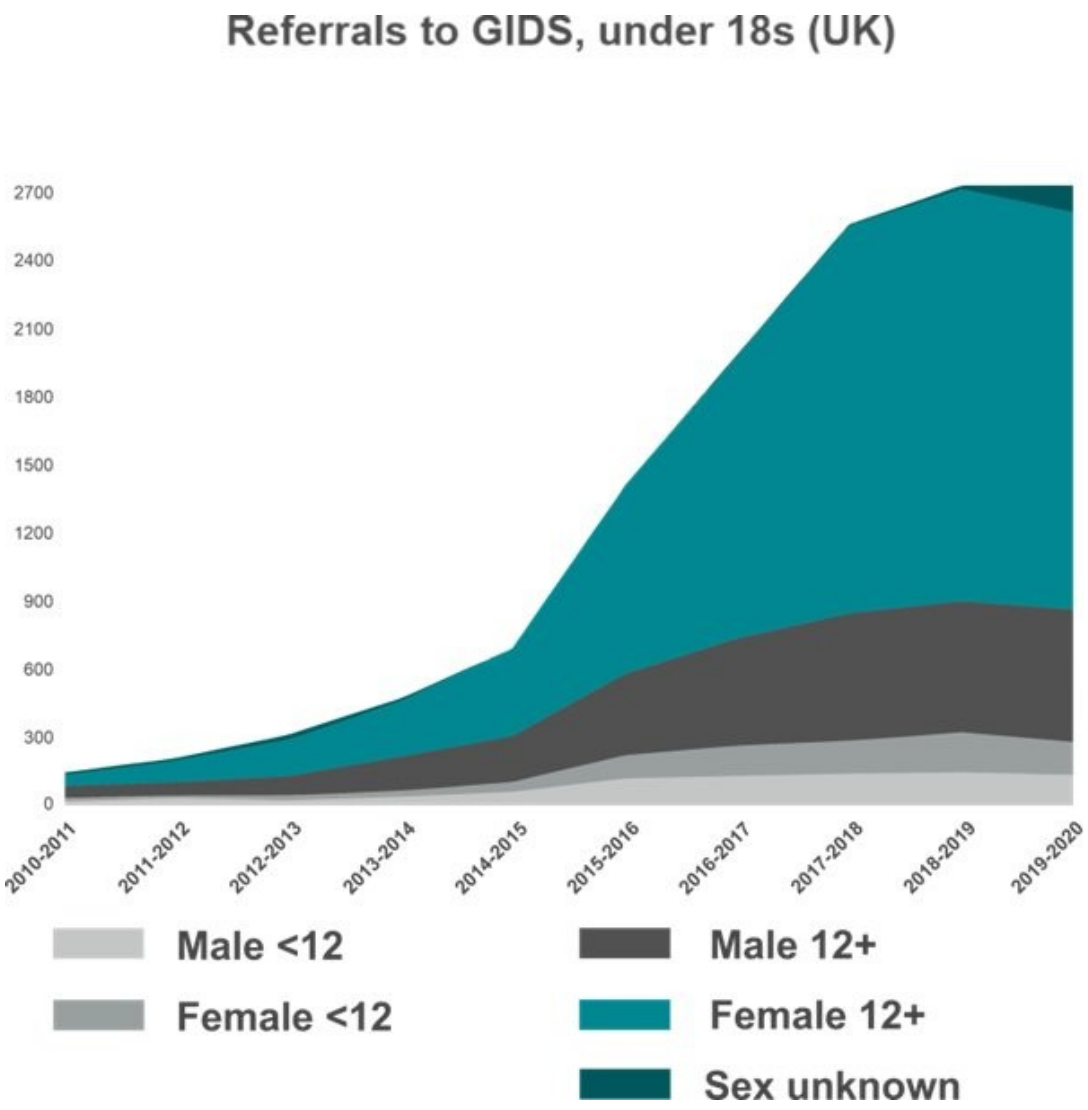
Queensland Government

Last Review 2 October 2020

Binders were also offered - to try on with a "assigned male at birth" but female-identifying staff member. What kind of organisation suggests a male fit a girl with any kind of intimate clothing?

Social contagion

Australia doesn't have good public data, but our trends are similar to the UK. If this doesn't expressly demonstrate social contagion I don't know what would.



This is a new article out today from someone who worked at a US Gender Clinic and tried to raise the alarm (she is also married to a trans man so she can not be called a transphobe):
https://www.thefp.com/p/i-thought-i-was-saving-trans-kids

I am a 42-year-old St. Louis native, a queer woman, and politically to the left of Bernie Sanders. My worldview has deeply shaped my career. I have spent my professional life providing counseling to vulnerable populations: children in foster care, sexual minorities, the poor.

For almost four years, I worked at The Washington University School of Medicine Division of Infectious Diseases with teens and young adults who were HIV positive. Many of them were trans or otherwise gender nonconforming, and I could relate: Through childhood and adolescence, I did a lot of gender questioning myself. I'm now married to a transman, and together we are raising my two biological children from a previous marriage and three foster children we hope to adopt.

...

The girls who came to us had many comorbidities: depression, anxiety, ADHD, eating disorders, obesity. Many were diagnosed with autism, or had autism-

like symptoms. A report last year on a British pediatric transgender center found that about one-third of the patients referred there were on the autism spectrum.

Frequently, our patients declared they had disorders that no one believed they had. We had patients who said they had Tourette syndrome (but they didn't); that they had tic disorders (but they didn't); that they had multiple personalities (but they didn't).

The doctors privately recognized these false self-diagnoses as a manifestation of social contagion. They even acknowledged that suicide has an element of social contagion. But when I said the clusters of girls streaming into our service looked as if their gender issues might be a manifestation of social contagion, the doctors said gender identity reflected something innate.

To begin transitioning, the girls needed a letter of support from a therapist—usually one we recommended—who they had to see only once or twice for the green light. To make it more efficient for the therapists, we offered them a template for how to write a letter in support of transition. The next stop was a single visit to the endocrinologist for a testosterone prescription.

That's all it took.

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When a female takes testosterone, the profound and permanent effects of the hormone can be seen in a matter of months. Voices drop, beards sprout, body fat is redistributed. Sexual interest explodes, aggression increases, and mood can be unpredictable. Our patients were told about some side effects, including sterility. But after working at the center, I came to believe that teenagers are simply not capable of fully grasping what it means to make the decision to become infertile while still a minor.

Side Effects

Many encounters with patients emphasized to me how little these young people understood the profound impacts changing gender would have on their bodies and minds. But the center downplayed the negative consequences, and emphasized the need for transition. As the center's website said, "Left untreated, gender dysphoria has any number of consequences, from self-harm to suicide. But when you take away the gender dysphoria by allowing a child to be who he or she is, we're noticing that goes away. The studies we have show these kids often wind up functioning psychosocially as well as or better than their peers."

There are no reliable studies showing this. Indeed, the experiences of many of the center's patients prove how false these assertions are.

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How little patients understood what they were getting into was illustrated by a call we received at the center in 2020 from a 17-year-old biological female patient who was on testosterone. She said she was bleeding from the vagina. In less than an hour she had soaked through an extra heavy pad, her jeans, and a towel she had wrapped around her waist. The nurse at the center told her to go to the emergency room right away.

We found out later this girl had had intercourse, and because testosterone thins the vaginal tissues, her vaginal canal had ripped open. She had to be sedated and given surgery to repair the damage. She wasn't the only vaginal laceration case we heard about.

...

Being put on powerful doses of testosterone or estrogen—enough to try to trick your body into mimicking the opposite sex—-affects the rest of the body. I doubt that any parent who's ever consented to give their kid testosterone (a lifelong treatment) knows that they're also possibly signing their kid up for blood pressure medication, cholesterol medication, and perhaps sleep apnea and diabetes.

...

One of the saddest cases of detransition I witnessed was a teenage girl, who, like so many of our patients, came from an unstable family, was in an uncertain living situation, and had a history of drug use. The overwhelming majority of our patients are white, but this girl was black. She was put on hormones at the center when she was around 16. When she was 18, she went in for a double mastectomy, what's known as "top surgery."

Three months later she called the surgeon's office to say she was going back to her birth name and that her pronouns were "she" and "her." Heartbreakingly, she told the nurse, "I want my breasts back." The surgeon's office contacted our office because they didn't know what to say to this girl.

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Then I came across comments from Dr. Rachel Levine, a transgender woman who is a high official at the federal Department of Health and Human Services. The article read: "Levine, the U.S. assistant secretary for health, said that clinics are proceeding carefully and that no American children are receiving drugs or hormones for gender dysphoria who shouldn't."

I felt stunned and sickened. It wasn't true. And I know that from deep first-hand experience.

So I started writing down everything I could about my experience at the Transgender Center. Two weeks ago, I brought my concerns and documents to the attention of Missouri's attorney general. He is a Republican. I am a progressive. But the safety of children should not be a matter for our culture wars.

Given the secrecy and lack of rigorous standards that characterize youth gender transition across the country, I believe that to ensure the safety of American children, we need a moratorium on the hormonal and surgical treatment of young people with gender dysphoria.

In the past 15 years, according to Reuters, the U.S. has gone from having no pediatric gender clinics to more than 100. A thorough analysis should be undertaken to find out what has been done to their patients and why—and what the long-term consequences are.

There is a clear path for us to follow. Just last year England shut down the Tavistock Centre, the only youth gender clinic in the country, after an investigation revealed shoddy practices and poor patient treatment. Sweden and Finland, too, have investigated pediatric transition and greatly curbed the practice, finding there is insufficient evidence of help, and danger of great harm.

Some critics describe the kind of treatment offered at places like the Transgender Center where I worked as a kind of national experiment. But that's wrong.

Experiments are supposed to be carefully designed. Hypotheses are supposed to be tested ethically. The doctors I worked alongside at the Transgender Center said frequently about the treatment of our patients: "We are building the plane while we are flying it." No one should be a passenger on that kind of aircraft.

The full whistleblower article can be found here: https://www.thefp.com/p/i-thought-i-was-saving-trans-kids

Puberty Blockers

Puberty blockers supposedly help young people buy time to think about how their mind and body relate, but they chemically castrate young people and lower sexual desire, and seem to affect brain maturation, in addition to harming bone development. They haven't been shown to be reversible though it is often claimed they are. And most (61%-98% of) kids who weren't socially transitioned in the past outgrew their gender dysphoria, while those on puberty blockers in studies have been seen to mostly (over 95% of the time in one study) go on to hormones. Not exactly the same samples but a big difference in outcomes!

Cross-sex Hormones

Hormones are taken for life. They lead to atrophy and histological changes to the gonads and impair sexual function, increase cardiovascular risks (VTE, strokes, heart attacks), alter the brain and confer increased risks to the immune system. The vaginal and uterine atrophy from testosterone can lead to pain. Chronic conditions and shortened life are also associated with being trans-identified.

Given these dangers, and unclear benefit, it is worth noting that one set of criteria to start these treatments is based on "standards of care" written by a special interest group, WPATH, which are neither "standards of care" nor evidence based. They are just practice guidelines. "Unlike standards of care, which should be authoritative, unbiased consensus positions designed to produce optimal outcomes, practice guidelines are suggestions or recommendations to improve care that, depending on their sponsor, may be biased." In a rigorous guideline review, 5/6 reviewers did not recommend the 2012 WPATH guidelines, while the last reviewer recommended them only if modified (they were found to have no list of key recommendations or auditable quality standards, and some "extracted statements might have been intended as recommendations or standards, but many were flexible, disconnected from evidence and could not be used by individuals or services to benchmark practice."). Although the "W" in WPATH is for "world," these are not being followed all over the world. For example, a more cautious approach is being taken by countries responding to rigorous reviews of the limited evidence available (e.g., Finland and others below).

Another set of similar guidelines from the Endocrine Society found that all the evidence behind their own treatment recommendations was low quality, very low quality, or ungraded quality (except for confirm diagnosis, counsel for fertility preservation, and treat medical conditions that might interfere with hormones). Low and very low quality mean "the true effect may be substantially different from the estimate of the effect" and "the true effect is likely to be substantially different from the estimate of effect" respectively. In other words, you can't estimate very well what the outcomes might be if you do these treatments.

BUT SURELY the doctors and nurses and therapists that treat gender dysphoric patients know what the science and evidence says. Do they? No, they don't. They assume the science is sound. It's not. The Whole Transgender Industry Is Founded On Two Faulty Studies. What if the "Gold Standard" of Youth Gender Medicine is More Like Tarnished Brass?

With regard to prisons

In this paper, titled Rights and wrongs: How gender self-identification policy places women at risk in prison, Jo Phoenix examines the effects of the Canadian government in 2017 that allowed prisoners to self-ID their gender and thus for fully functional men to be housed in women's prisons, arguing that it actively places women at risk, undermines their rights, and disproportionately disadvantages minority women. By all means add a third type of prison - a transgender prison, but do not allow changes that will let males into women's prisons.

Dr Michael Biggs submitted the following to the UK Women and Equalities Committee: Reform of the Gender Recognition Act in November 2020:

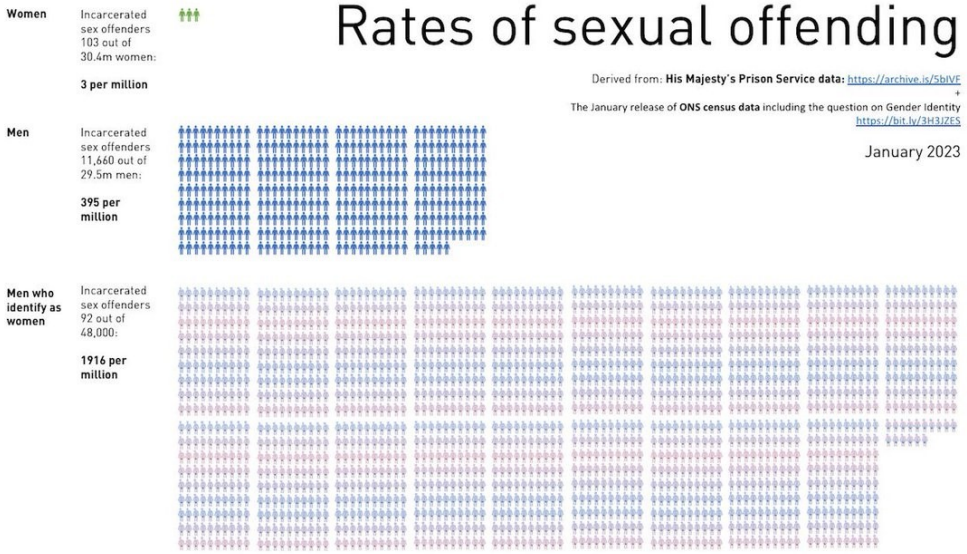
3. Patterns of offending among transgender males

3.1 There is no evidence that transgender males are less violent or sexually predatory than males overall.

3.2. Males are more likely to commit murder than be murdered, while females are more often victims than perpetrators. In Britain since 2010, 13 transgender males have committed murder, while 7 have been the victims of murder. This replicates the overall male pattern.

3.2 There is evidence than transgender male prisoners are more likely to be sexually predatory than male prisoners overall. Of the 125 transgender prisoners counted by the prison service in 2017, 60 had been convicted of sexual offenses, including 27 convicted of rape (BBC News 2018). In the overall prison population, by comparison, 19% of males had been convicted of sexual crimes (Ministry of Justice 2018b). In other words, those male prisoners who identified as transgender were more than twice as likely to have committed a sexual offence.

Rates of sexual offending for women, men and then trans women - derived from UK prison data:



Please say no to self-ID in Queensland and set up an investigation into the unethical and unscientific basis for transitioning our children.