HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:
Mr AD Harper MP (Chair)
Mr MF McArdle MP
Mr MC Berkman MP
Mr BL O'Rourke MP
Ms JC Pugh MP

Staff present:
Mr R Hansen (Committee Secretary)
Mr Z Dadic (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE HEALTH LEGISLATION AMENDMENT BILL 2019

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 7 FEBRUARY 2020

Brisbane

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The committee met at 8.40 am.

CHAIR: I declare open this public hearing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. I would like to start by acknowledging the traditional owners of the land that we are meeting on today. I am Aaron Harper, chair of the committee and member for Thuringowa. The other members of the committee with me today are Mark McArdle, member for Caloundra and deputy chair; Michael Berkman, the member for Maiwar; Barry O'Rourke, member for Rockhampton; and Jess Pugh, member for Mt Ommaney, who is the substitute for the member for Lytton, Joan Pease, who cannot make it here today. We have an apology from Marty Hunt, the member for Nicklin.

Today's hearing is part of the committee's inquiry into the Health Legislation Amendment Bill 2019. The bill was introduced and referred to the committee on 28 November 2019. The reporting date for the bill is 21 February 2020. This public hearing of the committee is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I do remind all witnesses that potentially misleading the committee is a serious offence.

I remind members of the public that, under the standing orders, the public may be admitted to or excluded from the hearing at the discretion of the committee. The proceedings are being recorded by Hansard and broadcast live on the parliament's website. The program for today has been published on our committee's web page. There are hard copies available from committee staff.

DESPOTT, Mr Nathan, Brave Network, SOGICE Survivors and Equal Voices, Melbourne branch (via teleconference)

JOHNSON, Ms Roe, Brave Network, SOGICE Survivors and Equal Voices, Melbourne branch (via teleconference)

CHAIR: Appearing via teleconference this morning, I welcome from Brave Network, SOGICE, Survivors and Equal Voices, Melbourne branch, Nathan Despott and Roe Johnson. Thank you for joining us this morning, gentlemen, and thank you for your submission. I ask you to make an opening statement and then we will move to questions. Who would like to start?

Mr Despott: By way of introduction, Brave is the only survivor self-advocate organised support and advocacy group in Australia that meets regularly and takes referrals for survivors of conversion practices. We meet once a month in Melbourne. We have approximately 200 people in our online network. We have 15 to 20 people that meet regularly once a month. Our focus in our advocacy is about ending the harm caused by the conversion movement. We are not so much concerned about sending a symbolic message. We have seen legislation in other countries and jurisdictions where the aim of legislation has been to send a message to warn people not to provide conversion practices. Our focus is ending the harm which is why our recommendation is usually a lot deeper than just banning therapy. Indeed, we do not use that terminology anymore in Victoria.

Also I wanted to point out that at the moment we still see a large number of people who are survivors seeking support. Almost none of these people have just been through formal practices and certainly none of them have been through conversion practices with a psychologist or a psychiatrist or a doctor. It almost always happens in the forum of pastoral care in an informal setting, usually in places that are very hard to define. Some of the proposed legislation we have seen around the world we find very hard to reach. Our interest is basically in stopping the harm caused by the movement and in making sure that government understands what the main proposition of the conversion movement is and, by doing that, to then adequately confront that proposition and challenge it.

CHAIR: Thank you and thank you very much also because there are some very personal stories in your submission from, the best way to describe it as, lived experience.

Mr Despott: Yes.

CHAIR: Are you aware of conversion therapy occurring in Queensland?

Mr Despott: That is an interesting question. I am aware of a small number of programs and a lot of those I think you probably would have heard of already. There was a *60 Minutes* story. We are more interested in the large number of people in Queensland that we see through some of our closed online groups that we are part of—on Facebook, for example—who have been told systematically through their religious organisations and communities that the reason they are LGBTIQA+ is that they are broken or damaged or something happened to them in their childhood, and also people that have had had one-on-one pastoral care relationships with either a religious leader or a pastor who has helped imbed that ideology and messaging in their thinking. That is definitely a very, very common practice.

I have seen information and reports from other groups who have given evidence to you and also religious organisations that have arced up against your plans to intervene in the conversion movement in Queensland. The belief that queer people are broken as part of their theology is a proposition that we challenge and we say that it is actually an ideology, that it is widespread, and that it really has no place in a secular, pluralist democracy. It definitely has no place being promoted as it is based on thoroughly outdated pseudo-scientific principles. Are there formal therapeutic programs happening? Yes, a small number. Is the ideology rampant in faith communities? Absolutely.

CHAIR: Thank you. Roe, did you want to add anything to this particular topic of discussion?

Ms Johnson: Yes. What is really important is I am calling out that I am not a gentleman; I am a woman.

CHAIR: Sorry.

Ms Johnson: My pronouns are 'she' and 'her'. It is okay; you were not to know. I can talk a lot about my experience, but the salient point that needs to be made is that when this is talked about, it is talked about very much from a gay and lesbian perspective and not at all engaging in gender diversity, which is a huge issue. Indeed, my experience was that from the age of around 3, I was put through very difficult experiences that continually told me that I was broken, that I was wrong, that I was fundamentally flawed, that I needed to be fixed, and that it was not okay to be who I am. That came not only from internally within my family relentlessly, but also whilst it was not in a formal programmed therapy system, it was very much in the pastor's office, in the Sunday School teacher's office, in the youth pastors' offices, and so on and so on, the continual message of, 'You must not be who you are because who you are is fundamentally flawed, fundamentally broken and you are destined to hell because of who you are. The only way for you to fix that is to not be who you are, is to be changed and to become something that you are not.'

The salient point in all of that is that when we talk about the conversion movement in the media, we are constantly seeing gay conversion therapy, gay conversion therapy, gay conversion therapy. The reality is that the trans community has been subjected to conversion ideology and practices from a very young age, both from within their families and from external agencies and people. The pervasive nature of that experience is, in my view, a fundamental connection as to why we have such horrendous mental health and suicide outcomes for the trans and gender-diverse communities.

CHAIR: Thanks very much, Roe. It is timely to thank you for sharing parts of your lived experience. It is very important for members of the committee to hear that. I congratulate you for joining us today. I move to questions from the committee, firstly Michael Berkman, member for Maiwar.

Mr BERKMAN: Thanks, Chair. Thanks to both of you for being available to speak to us today. I want to touch on the terminology. You raised in your submission that there is a general preference for the use of the term 'conversion practices' rather than 'conversion therapies'. From what you have said, as I understand it that reflects that these are not generally practices that are undertaken in clinical settings or formal therapeutic settings. Do you want to elaborate on that? In the context of this bill are there any practical consequences for the use of the alternative term 'conversion practices' rather than 'therapies'?

Mr Despott: Fantastic. Yes, great question. There are a few things there. If we think about the word 'therapy' in terms of what it implies, 'therapy' is quite a vague term. I know 'practice' sounds more vague, but 'practice' is also broad, whereas 'therapy' is both a vague and a narrow term because it implies something therapeutic. It usually conjures up images of people who are psychologists or psychiatrists.

As to that, in Australia, because of AHPRA regulation and because of the declarations from the Psychological Society and psychiatric peak body, it is already not permitted for those licensed mental health practitioners to deliver conversion practices. It is already against the standards from those peak bodies. In addition to that, to deprive someone of liberty or to use any sort of violence

through that conversion practice, that is already illegal. That is already a criminal offence; you cannot do that to someone. Kidnapping a child—you might see in some of the movies that have come out around the world about conversion therapy. A lot of that is already covered and it is really a matter of making sure that it is better policed.

When we think of what happens today, like I said, 99 per cent of the conversion practices we see happen in this realm of pastoral care. There is a small number that happens through counselling. Counselling is not regulated in Australia. It is not government-regulated through AHPRA. 'Pastoral care' is a vague term that has almost no legislative definition around it. Consequently, one of the things we have argued for is for 'pastoral care' to be better defined.

The next thing is that one of the major protective shields that the conservative communities hold up—and I say this as someone with a Masters of Theology, who did a lot of ministry work and went through 10 years of conversion practices myself—is that the belief system that they have behind conversion practices is a theological religious belief system that is part of their religious freedom and religious right. Our opinion is that because it seems that Australian politics is quite hesitant to engage with anything to do with religious freedom, apart from the last 12 months, this idea of legislation and government delving into that theology is avoided. That is why we say it is not a theology; it is an ideology. It makes claims that are crossing the line and swimming out of their lane into claims that are actually psychological. They are pseudo-scientific.

As in the JONAH case in New Jersey, to claim that someone is broken due to psychological reasons is seen as making a false and misleading claim. That is something we would like to see in Queensland. It is a false claim to make the statement that someone is psychologically damaged or broken and that is what caused them to be queer. To then offer the opportunity to engage some kind of process that will help remove that damage would be a therapeutically fraudulent claim. That decision has been reached in Malta and JONAH. That is why we use the term 'conversion practices'. It is not about the specific setting of where the practice occurs; it is more about the claims that are being made. Any activity that is taken to act on that ideology would therefore be a conversion practice. That is why we have instead been focusing on specifically where it happens. The focus is on the ideology and the general activities, which usually involve prayer, talking through someone's childhood, talking through some of the abuse they might have gone through as a child, and then trying to link that abuse or neglect to the person's sexuality and gender. Again, most of that today happens in informal settings.

Mr O'ROURKE: Being conscious of the time, I just want to say thank you to Roe and Nathan for what you have provided. I really do appreciate it. I do not have any further questions, thank you.

Mr McARDLE: To Roe and Nathan, thank you for being online today and congratulations on your courage to come forward. Nathan made the comment that 99 per cent of conversion therapy takes place in a pastoral setting. Is that your statement?

Mr Despott: I said 99 per cent of conversion practices that we see with Brave have occurred in a pastoral care setting, yes.

Mr McARDLE: That would be an informal setting with a pastor or somebody with a religious background or religious concept about LGBTIQ community members?

Mr Despott: When I say 'pastoral care', I am just not referring to pastors but they would be included. I am talking about a situation where there is one person seeking support from another or being offered support from another, and that person has some kind of authority or there is a power differential or there is some understanding that they have some ability to help and care for that person.

Mr McARDLE: Okay. Would you agree that if a young person came to a psychologist or a psychiatrist and said that they have a gender identity position that it would be proper for that clinical expert to discuss and investigate with that person whether that sense of gender identity is correct or whether it is based upon other factors so that that clinical person can form an opinion in relation to the young person's statement about gender identity? Would that be clinically appropriate for a suitably qualified person?

Mr Despott: I think there are plenty of processes that psychologists and psychiatrists go through to ask questions about where a person is coming from. The question you are posing is a very common question. It is quite a loaded question, so I am not quite sure exactly where you are coming from.

Mr McARDLE: What I am trying to define is this-

Mr Despott: I argue that there would be several appropriate angles to take.

Mr McARDLE: Exactly. It would be appropriate for an expert to do their job, to ask questions, to satisfy themselves clinically that the young person has a belief not based on external factors?

Ms Johnson: I suggest, number one, that the premise of the question is saying that the psychologist, a professional mental health person, is looking at forming an opinion about this thing, whereas in fact that is not the psychologist's role there. The psychologist's role is to assist and affirm the person that is in front of them in discovering, journeying and investigating themselves, rather than coming to form an opinion, and to then extol that opinion towards that person. I think the premise of the question is a little bit out of kilter because that is not actually a role. I say it is absolutely wrong for a psychologist to sit there and form an opinion about that. It is absolutely right for a psychologist and psychiatrist to assist that person in coming to a genuine and true understanding of who they are.

Mr McARDLE: You used the word 'investigation'. That would be their role, an investigatory role, to begin with?

Ms Johnson: Yes.

Mr Despott: I argue as well that we are talking about this idea that a person's gender identity or sexual orientation, what they are self-describing, has been caused by or reached due to some kind of damage or issues in their life. It would be quite unbalanced and quite poor practice for a psychological professional to immediately come from that line of reasoning. That is why I thoroughly agree with what Roe has said in terms of their role is to help the person work out who they are and go on that journey. If they start immediately asking questions about causes and causation, that is not in line with psychology.

Mr McARDLE: No, I am not asking that. I am not asking that at all. I am simply saying that taking the word 'investigation' that was used by—I cannot recall which of you—that imposes an obligation for psychiatrists to do certain things, to work with the young person.

Mr Despott: Yes, among other things, including making sure how their mental health is going, seeing if they need some support to deal with the fact that they may have spent many years being closeted and living not as their true self and the harm that that may have caused, as well. There are many angles.

Mr McARDLE: Absolutely correct, thank you very much.

CHAIR: Thank you very much, Nathan and Roe. We have a very big day ahead of us, but you have started the day well by sharing your views. On behalf of the committee I thank you for joining us this morning. There are 30 seconds left. Do either of you have any closing comments?

Mr Despott: Roe?

Ms Johnson: No, I am good.

Mr Despott: Just to say thank you very much for hearing us. It has been really great that you have been able to speak to a group such as Brave and the SOGICE Survivors. I encourage you to make yourselves acquainted with the SOGICE Survivors statements, which contains more of our views.

CHAIR: Thank you very much for joining us to better inform us and for sharing that lived experience. It has been very beneficial to the committee this morning. Have a good day, both of you. I call our next witness: from the Royal Australian and New Zealand College of Psychiatrists, Dr Vikas Moudgil.

MOUDGIL, Dr Vikas, Member, Queensland Branch Committee, Royal Australian and New Zealand College of Psychiatrists

CHAIR: Good morning and thank you for joining us. We have a very tight time frame, so can we go straight to an opening statement before we move to questions?

Dr Moudgil: RANZCP stands for the Royal Australian and New Zealand College of Psychiatrists, which is a principal organisation representing the medical speciality of psychiatry in Australia and New Zealand. We have 6,700 members. Our summary statement is that we would like to commend the Queensland government for its commitment to prohibiting conversion therapies. That is No. 1. We also commend that it is trying to protect the work of clinicians engaged in evidence based practices to support the mental health needs of the LGBTI-plus community. Conversion therapies have been used previously. There have been statements made by other associations, such as the American Psychological Association, and our college has made a commitment that this has to be prohibited. We would like to condone the efforts of evidence based practices of clinicians who are working in this field, trying to support and protect people with sexual orientation issues. That is our summary statement.

CHAIR: In your submission, on page 2, you state that the proposed definition of conversion therapies is broad and that—

> The meaning of 'treatment' may need to be clarified, given it may include the clinical process of assessments, diagnosis and formulation leading to any appropriate treatment or interventions.

In reference to this bill, you also state that—

> Importantly, this could lead to unintended consequences whereby clinical practice may possibly be at risk of legal action despite there being no use of conversion practices.

Can you give the committee some examples of the sorts of clinical practices, treatment and interventions your members provide to their patients that may inadvertently be captured or prohibited by the definition of 'conversion therapy' that is proposed in clause 28 of the bill?

Dr Moudgil: That is a good question. When people with sexual orientation issues are going through it, they are going through the stigma of living in society—social stigma—and some of the challenges from their own confused state about what they are and what they are not. It is during that time that people go through treatment and practices that are evidence based practices that support people. It helps them to accept their identity and their orientation. It understands and then facilitates people to develop some skills for coping with their own identity and sexual orientation issues and social support, and helps them to go to the next stage of how they can fit into society without having any psychological issues. Those are the evidence based practices that are being done in this field.

However, they are not about converting them and we are not endorsing and condoning that. They are not about trying to change their sexual orientation. That has to be very clear. The sexual orientation change efforts practices—and conversion therapies is part of that—have been used to try to move people and change their sexual orientation. However, our evidence based practices are much more about assisting people in accepting their sexual orientation, supporting them and helping them to develop coping skills, so that they fit into society without having any undue psychological damage. We endorse those evidence based treatments.

CHAIR: In your opinion, is conversion therapy harmful or dangerous?

Dr Moudgil: Yes, it is harmful and dangerous.

Ms PUGH: Following on from the chair's question, I note on the last page of your submission that you say that people who have previously experienced conversion therapies need to be appropriately clinically supported. Obviously that would indicate some sort of trauma has been inflicted. Would you be able to provide some examples of the kinds of supports that they need? You have stated that it is harmful. Are you able to elaborate on what supports need to be provided and why?

Dr Moudgil: There are two different things we are talking about here. I just want to touch on the background. There is a sexual orientation issue where people may have a preference for same sex, the other sex or both. Then there are gender identity issues, which involve people who are born with some gender and they are uncomfortable and they have a desire to be a different gender. There are two different things that we are talking about.

Sexual orientation change efforts, like conversion therapies, have been focused on trying to change the way people are sexually oriented to others by using conversion therapies. I can give you a history on that. Briefly, from the late 19th century and even by the middle of the 20th century, people were using psychological means to convert people to change the way they oriented sexually. That caused enormous damage to people, without doing anything. Some of the therapies that have been

used include giving minor electric shocks when people are shown videos of the same sex. They are averted, so that they do not get any sexual arouse from seeing same-sex videos. Those are some of the therapies that have been done. There has been no evidence as to whether they have helped, but it has damaged people more.

In psychiatric practice, although we have come to an era where we do not see those patients now, some of the patients we had seen who were severely damaged had PTSD, post-traumatic stress disorder, and other psychological issues, such as alcohol dependence, self-harm and suicide, coming from when we were forcibly trying to make them change their orientation into something that they cannot do. There had been no evidence. Homosexuality, for example, was classified as a mental disorder. It was prohibited as a mental disorder in the DSM, which is the diagnostic and statistical manual used in psychiatric practice. The American Psychological Association banned it from being used and the DSM was taken off in the 1970s or something like that. From that time onwards, it has not been seen as an illness. We went through a period when sexual orientation issues were seen as sinful from a religious point of view or from an illness point of view. I think psychiatrists came to what society was wanting, so we have moved on from there.

What we are focusing much more on is the damage that has been caused by non-evidence based conversion therapies. The support is there for people who have been damaged and for people who are having sexual orientation issues, by trying to support them and help them to accept it. There are psychologists and psychiatrists who are available to assess them. They are helping them to accept their orientation and move on in their life, by trying to develop some skills for how they fit in to society without any stigma, such as they can face in schools and among family and friends.

Also, this is with the background of the government's policy on non-discrimination, which has helped people to fit in with society. It is not only treatment that helps. It is also about a government's policies on discrimination, plus the environment that is provided for people to develop and be part of the normal society, plus psychological interventions to try to counsel them and accept them. Emerging anxiety, depression, alcohol dependence, suicidal thoughts or self-harm are behaviours that are very common in people who are going through this and having this period of trying to accept their identity or orientation. Treatments are available in terms of medications and other alcohol-dependence treatments. There are a number of treatments that are available for people who are going through this stage, which are all evidence based.

Ms PUGH: Thank you, I really appreciate that.

Mr O'ROURKE: Dr Moudgil, thank you for your submission. Your college represents members in New Zealand, as well as Australia.

Dr Moudgil: Yes.

Mr O'ROURKE: Is conversion therapy banned in New Zealand?

Dr Moudgil: I am not sure. I do not think so. I have been told—

Mr O'ROURKE: What measures are in place to ensure that children and vulnerable adults are protected from the harmful effects of conversion therapy?

Dr Moudgil: I think one is the government's antidiscrimination bill on that, plus for children and adolescents we have psychiatrists who specialise in this field. When people are going through this challenging period of trying to go through orientation issues, they are being assessed. If part of their orientation issues relate to their gender identity, there are some evidence based treatments around assessing them through Queensland Health and the children's hospital paediatricians, and through child psychiatrists. They are assessed and they are correctly diagnosed—not diagnosed—but having a gender dysphoria. Gender dysphoria is a separate category. From there, if they have gender identity issues—not sexual orientation issues—then they have a separate path of hormonal treatments, gender reassignments and sometimes there are hormone suppression treatments to help people to move into the identity with which they are more comfortable. There are some separate evidence based practices for gender identity issues that I have highlighted. For orientation issues, people are rightfully identified and supported in terms of psychological and other complications that may emerge. That is the only thing that I can add, because once people are referred to us we have to assess them correctly. We are not bound by what is happening in society. Hopefully things have changed now.

Mr BERKMAN: Thank you very much for your time this morning and for your submission. In your submission you raised some concerns around the definition of 'conversion therapy' and particularly suggested the inclusion of the term 'evidence based' to ensure that evidence based practice is captured. The department's response to that—I am not sure if you have had a chance to

read it—makes the point that the definition does not apply to treatments or practices that are evidence based. Are you content with that response or do you still feel that there needs to be some more explicit recognition of evidence based practices in that definition?

Dr Moudgil: We are content with the response from the government, yes.

Mr BERKMAN: Obviously there is a new definition in the bill for 'gender identity'. We have heard the view expressed that gender identity in and of itself has been framed as an ideology or as something that is not based in reality or in fact, I suppose. I am interested in your view and the college's view on gender identity. Is there any kind of doubt in clinical circles about gender identity, as defined in the act, as a concept and a clinical lived reality for people?

Dr Moudgil: That is a good question. As I was trying to explain earlier, there is no confusion around gender identity. In fact, the college has developed a task force which is looking into what is gender dysphoria and what issues people face in terms of gender dysphoria. Gender identity is when people are not comfortable with their own sexual identity—what they are born with—and have a desire to be of opposite sex. Gender identity is separate from sexual orientation. There is no confusion around that. As I explained earlier, there are treatments available based on properly assessing people and rightfully diagnosing if there is a dysphoria, because not everyone who has a desire to be of a different gender identity may not have discontent with that. People who develop psychological, emotive and cognitive issues—cognitive is the way they think about themselves—about their identity that they are born with. Those people are labelled in psychiatric terms as having gender dysphoria, a DSM-5 term that has changed from DSM-4 previously used as gender identity disorder.

From a psychiatry perspective, we are trying not to label them as having an illness. I am talking about gender identity now. Gender dysphoria is people who have gender identity issues in terms of the opposite sex. If they develop gender dysphoria, they are supported, properly assessed and given treatments which may include hormonal treatment or surgical reassignment treatments that are evidence based and available. That work should carry on, because that is separate. If people are not properly assessed, the college will use best evidence practices because people end up developing anxiety and depression and there is alcohol and drug misuse. Further, there are an increased incidents of suicidal or self-harm behaviours in these people. There are evidence based practices in supporting people, especially around that. We are very clear. The RANZCP has developed a new task force to develop a pathway in terms of managing gender dysphoria. That is a separate pathway, but at this stage I do not want to muddy the water in relation to sexual orientation issues, because some of the sexual orientation change efforts, like conversion therapies, have been used to change people's sexual orientation. It has been very harmful and it should be prohibited. That is the college's stance.

Mr BERKMAN: We heard from the previous witness that the experience of survivor advocacy groups is that the vast majority of instances of conversion therapy occur in a pastoral care setting as opposed to a clinical therapeutic setting. Does that reflect your understanding, and is that the case in considering both conversion therapies around sexual orientation and gender identity? Do you have any reflections on that?

Dr Moudgil: There is some truth behind it, that most of those conversion therapies were based on religious background and used in a religious setting. There were some psychological interventions in trying to change the conflict and orientation in terms of coming from a religious background. People have their religious faiths and ways, so people develop their skills based on that. But that is a good point, because at this time we are a juncture of that. There is always going to be—I won't say a 'conflict'—between science and religion. Psychiatry is always trying to prohibit these conversion therapies.

What I was trying to understand from the previous witness is we also have to understand that, when people have a strong belief and go to their religious backing, they do have confusion and they go to places where they find comfort. Therapies that have been provided in religious settings—the same principles—have the same outcome. People are more comfortable with who they are but they may have ongoing damage. These therapies are not evidence based. We are saying that, if we provide a similar kind of support therapy in helping people accept what they are, we can achieve good outcomes; but in religious settings, which have been misused at times to try to forcibly convert, it has caused lots of damage.

From our perspective, rather than criticising it in terms of a religious background, we say that conversion therapies should be prohibited. Predominantly, it has been used in religious settings, which we all know, but we are not here in a state to criticise religious settings. All we are saying is that some of those methods which have been used have damaged people, and it has long-lasting effect on community and society. But we do not want to take a stance of criticising a religious setting or cultural background, because that is not a place for us to comment on.

CHAIR: Are you aware of any of members of your organisation currently practising conversion therapy in Queensland?

Dr Moudgil: Sorry, I am not aware of that. If that is the case, they will be reported immediately to AHPRA.

Mr McARDLE: That was going to be my first question.

Your medical body prohibits conversion therapy from being practised, and any practitioner who does will face severe sanctions from yourself and from AHPRA as well. To your knowledge, what evidence is there of professionals practising conversion therapy in Queensland, either within your college or in other settings outside of pastoral care? Does that happen?

Dr Moudgil: It should not happen. I do not know. I am not aware at this stage if it happens or not.

Mr McARDLE: As a professional body, you would certainly be conversing with other colleges, psychologists, physicians, et cetera. Has that been raised with you that it is an ongoing practice by professionals in Queensland outside of your own college?

Dr Moudgil: I am not aware of that.

Mr McARDLE: How many complaints has your college received in relation to conversion therapy, say, in the last five years against a practitioner?

Dr Moudgil: I am not aware of any, but I can get the answer for you.

Mr McARDLE: If you wouldn't mind, can you take that on notice?

Dr Moudgil: Yes.

Mr McARDLE: What is the sanction by the college if a complaint of that nature occurs?

Dr Moudgil: There is a complaint process where two different pathways are taken. In Queensland especially, one can report to the Health Ombudsman. The Health Ombudsman can pass the complaint to AHPRA. The college can also take a stand and report to the professional college in Melbourne, the central\federal. It can get the endorsement from the local state branch, the Queensland branch. We can do that and report to AHPRA and also report to college standards. If someone is practising outside the norm, their practice can be addressed and there can be some sanctions. People have been sanctioned before.

Mr McARDLE: For conversion therapy practices, or other practices?

Dr Moudgil: Other practices which are out of norm.

Mr McARDLE: You said in answer to a question that the role of the psychiatrist is to assist the person. If a person comes to see you and they say they have a sexual orientation question or a gender identity question, what do you do to satisfy yourself as to the correct course of action to take?

Dr Moudgil: This is what we call a proper assessment, a psychiatric assessment. I am talking from a psychiatrist's perspective. We do a thorough assessment. In Queensland in the public sector we also have the sexual clinics where people who specialise in this field are available to assess people. Assessment is based on the thorough assessment from the person and their families and on getting reports from schools and other behaviours about how people are behaving and how they are uncomfortable. There are also sometimes investigations done. With some people, we do not have to undermine the role of biological factors. People may have other congenital hormonal conditions which can also lead to those identity issues. I am not talking about sexual orientation issues. It is all based on thorough assessment. At times, we get referrals. Someone can be a referred to a psychiatrist directly. Someone else can be referred to a psychiatrist after approaching a plastic surgeon or their general practitioner. We get referrals not from patients or their families but from other practitioners when people approach them for hormonal therapy or when doing other surgical interventions; so they are referred for a proper psychiatric assessment. That is based on thorough assessment and having a second opinion, if that is required.

Mr McARDLE: Would you agree that part of the psychiatrist's assessment approach would be questioning the young person or the person to establish whether what they are saying is based upon reality—I do not mean that in a stark sense—as opposed to social mores or having pressure on that person to take a certain course of action. That is important, isn't it?

Dr Moudgil: Yes. I can give you some facts. For example, when families of children and adolescents are approached about some of their non-societal conforming behaviour and are assessed by a psychiatrist and a psychologist in that field, 80 per cent of the people as they grow have ambiguity and confusion around their own identity, who they are and what they want to be,

especially when they are children growing up. They have ambiguity and confusion around their identity. That is dealt with by asking them questions, properly assessing them and supporting them. Only about 20 per cent of these people—don't quote me on that—actually have some issues around their sexual identity or sexual orientation. The majority of the people have confusion, and when they are properly supported they go through that phase where they are accepted in the school and the family or in terms of some of the behaviours which could not lead to eventual different sexual orientation.

Mr McARDLE: If a young person is put on blockers and then goes through the relevant medical treatments, in time to come that young person, without having a proper assessment done in the early stages, could suffer irreparable psychological damage down the track?

Dr Moudgil: Yes.

Mr McARDLE: That assessment is absolutely pivotal and, if we remove the right of a psychologist or psychiatrist to do that, the outcome down the track could be quite devastating?

Dr Moudgil: Yes, I agree with you.

Mr McARDLE: Okay, that is fine. I understand that the federal government is also looking at transiting children. I think the health minister wrote to the college of physicians seeking their advice. Are you aware of any federal inquiry by way of correspondence seeking input into this question in relation to children?

Dr Moudgil: Sorry, I am not aware of that.

Mr McARDLE: Thank you. Thank you, chair.

CHAIR: Thank you. I think we might end this session. You did take a question on notice. If we can have that back by Wednesday 12 February, that would be appreciated. We will move on to our next witnesses.

GILLOTT, Ms Debbie, Ambulance Lead Organiser, United Voice, Industrial Union of Employees, Queensland

NELSON, Mr Torrin, QAS Paramedic, United Workers Union

PEVERILL, Mr Dermott, Industrial Officer, United Voice, Industrial Union of Employees, Queensland

CHAIR: Thank you for being here today. There are many parts to this particular bill. There are five health portfolio acts. Your submission talks around the strengthened governance network between Queensland Ambulance Service and Queensland Health. I declare that I am also a member of the union, a proud member of nearly 30 years, and I am a former ambulance paramedic. I am absolutely interested in this particular part of the bill. I might ask for an opening statement and then we will move to some questions. Who would like to begin?

Mr Peverill: Thank you, Chair, for the invitation to appear before the committee this morning. United Voice is a proud union, representing employees employed by both Queensland Health and the Queensland Ambulance Service. No doubt the committee has a copy of our submissions. Our opening comments are brief. There are a number of points that we wish to expand on. Our starting point is we commend the bill to the committee. The bill, as far as it affects our members in Queensland Ambulance Service and Queensland Health, reinforces what we see as an initiative and some policy objectives which deliver good public health outcomes, not just for Queenslanders but for employees in both Queensland Health and the Queensland Ambulance Service.

The two other separate points that sit outside our submission but which are ones that we want to put in front of the committee this morning are these: firstly, we want to reinforce that the objectives of the bill are based on statewide initiatives. We want to share with the committee that these are responsibilities not only with Queensland Health but also with each of the 16 hospital and health services. United Voice anecdotally has feedback from members like Torrin and others across the state where, if the objectives of this bill are enacted, it will help deliver better outcomes. We want to see not only those responsibilities at a state level but also across each of the 16 HHSs. That is an issue that we often see. We have given the committee an example. In the Metro South HHS where the two entities, Queensland Ambulance Service and Queensland Health, have come together at a senior level and tried to work through some issues around patient care and especially when the service delivery is under intense pressure as it is.

The second issue we wanted to draw the committee’s attention to that sits beyond our submission is: what comes next? The bill has some policy initiatives and objectives which will serve not only Queensland Health but also the Queensland Ambulance Service which is often seen as a bit of a bolt-on to the public system since the Ambulance Service has fallen under Queensland Health. We want to see what happens next with the bill and, in the form of the implementation plan, how the HHSs will meet their legislative obligations under this act should it pass through the bill stage.

For the purposes of the committee meeting this morning, they are the two issues beyond our submissions that we want to leave with you. We think they are two very important ones. Anecdotally they are two issues that our members are telling us about that, firstly, this is not just the responsibility of statewide health but that of each HHS which can often, from what we understand, work independently sometimes. What you might see in Metro South may be different to some of the initiatives you see in Metro North and throughout the state. The second issue is the implementation plan. We think there are good initiatives in this, but we want to see how that hits the road in terms of possibly a plan that could involve a review in two years’ time where we revisit to see if those initiatives and objectives have been met. Committee, unless there are any other questions of myself, we are more than happy to assist with questions for Mr Nelson or Ms Gillott.

CHAIR: Thanks very much, Dermott. In a practical sense, I think you have nailed it. Maybe that is a good question for the department this afternoon: in a practical sense, how has the implementation affected the strengthened governance between both organisations, Queensland Health and Queensland Ambulance Service, in each HHS? I think the example you have given about the coming together in Metro South is good.

In looking back at the work that was done with the MEDAI initiative in 2012, certainly in my time as a delegate there, we provided quite a bit of work to government to alleviate some of the pressures on the Ambulance Service, including, in a real practical sense, getting ambulances back out on the roads and not locked up at hospitals. The Metropolitan Emergency Department Access Initiative was quite a significant body of work. It is good to see the organisation of United Voice is still very much in

current discussions with government and Queensland Health of how one can better unpack the issues around POST—patient on stretcher times—throughout Queensland. I want to commend the work the organisation does.

We could put that question this afternoon of what it looks like from an implementation point of view to the department and ask them for their views. No doubt, like any bill, there will be a review in a couple of years' time, but for people who are watching, it is all about making sure that ambulances can unload and turn around and go out and treat people in the community. I do not have any other questions apart from that opening statement. I will move to questions, starting with the member for Maiwar.

Mr BERKMAN: Can you provide some practical examples of how well this improved coordination between Ambulance Service and HHSs actually benefit people in everyday settings?

Mr Nelson: By improving communication. We have a state-based ambulance service. We respond to anywhere in the state, but we are still siloed in the way we operate. By bringing the HHSs together and cooperating with the Ambulance Service, we can improve our spread across our areas. For example, at Metro South we respond regularly to Gold Coast, West Moreton and Metro North. We take patients into those different areas and we see different ways of operating. A lot of the time we are not sure how they operate. So we would like to see a breakdown of those silos, especially around the ideas of the PATCH system and what happens with POST times. Whilst we might be looking after a potentially unstable patient in the hospital, our most unstable patient is the one out in the community that has not yet had the opportunity to be assessed.

Mr BERKMAN: You referred in your answer to the PATCH system. We have almost unpacked what POST means. For the ill-acquainted, what is the PATCH system?

Mr Nelson: PATCH is a system that is in place to look at access to hospitals and the facilities in the hospitals. It is a collaboration between the Ambulance Service and the HHSs where they look at what beds and resources are available in the hospital and direct ambulances with their patients to the right hospital to get them the fastest access to care.

Mr O'ROURKE: I have a similar question. Thank you very much for your submission. What improvements or outcomes would you expect to see for your members who work in the health system and the QAS from the increased collaboration and cooperation?

Mr Nelson: We would like to see faster access into the hospital system for our patients so that they are off-loaded more quickly and we are able to get our ambulances back out either into the community or back to their respective stations to undergo the routine infection-control cleaning and also to allow for break times for our paramedics.

Mr Peverill: If I can just add to that. As an industrial officer with the union, we obviously see a lot of our issues come through from our members. One of the other issues that inevitably comes up is the sharing of patient information from first responders who are often ambulance officers. We think there is a huge opportunity for Queensland Health and Queensland Ambulance Service to improve first responders' ability to access patient information. There are obviously confinements to that, but we think there are some initiatives under way already which will help first responders with access to the information, whether it is radiology or pathology information. We are aware of some circumstances where, as first responders in a vehicle, they have some communications. That access would be well-facilitated where HHSs and the health system and QAS can work to improve it. That is what we are looking for. In regards to the question about the practicalities of it, we think that is one example of them.

CHAIR: That is a very good example. In our broader inquiry of aged care, palliative care and end-of-life care, QAS and Queensland Health are talking about paramedics having access to the Viewer which provides information, particularly for someone with an advance healthcare directive or a palliative care treatment plan. That is a really good example of early information-sharing; when you are out at scene without having to go through the unpacking of the patient's care plan, you can access that information. We are looking forward to seeing the development of that. That is a very good example of accessing information.

Ms Gillott: Can I just add, that another initiative that we have welcomed is the mental health nurse co-responder which has been piloted in West Moreton and is now being rolled out in areas of Metro South and the Gold Coast. That has shown in less presentations to hospital. The mental health nurse can give information on a patient to the paramedic and then quite often it is decided that they do not have to take that person to the hospital, which not only helps with less presentations and our paramedics back out on the road, but also to the patient in that they are not suffering the trauma or

the anxiety of being put in a hospital and/or the possibility of waiting several hours for someone to come to see them. It is all about getting access to resources or their support at home. The data we have seen to date has shown significantly less presentations to hospitals, so we welcome that initiative.

CHAIR: I have seen that. I am aware of it being used in Townsville, too. The co-responder model is another good example, thank you very much. I think they use police and a mental health nurse, again freeing up ambulances to go out and do the acute work in the community. It is an excellent initiative.

Ms Gillott: Yes. We have not forgotten our regional comrades either. A mental health clinician can give advice or consultation to our paramedics out in the more remote areas as well. That has been welcomed and has had some really good positive outcomes.

CHAIR: They are two very good examples. Thank you very much for that.

Mr O'ROURKE: Debbie, in regards to the mental health client, the co-visit, how does that actually work in a practical sense? Is the mental health worker in the ambulance?

Mr Nelson: We have two models. One is the consult line that the paramedic can call to get details if the patient is on the system. They can ask for details about that patient, their medication, et cetera. The frontline model is an ambulance with an extended care paramedic and a mental health clinician. The patient will undergo a full mental health assessment in the field in their home and a care plan can be made from there.

Mr O'ROURKE: That is great. Thank you.

Mr McARDLE: Thank you for being here today and for your submission as well. Clearly this is a very important issue for the union. The collaboration between the HHSs and the LASNs is very important for medical outcomes. I am a bit curious. There are 16 HHSs. Only one made a submission. That HHS is not here listed for hearing today. Not one LASN made a submission. The commissioner did not make a submission. The union made a submission. If we have the major players not even bothering to submit to this committee, my concern is they do not see a problem. I am stunned that the commissioner has not made a submission to this body. The peak individual should have made a submission if there are issues because he would be across all the LASNs. Would you agree that it would have been prudent for that to occur?

Mr Peverill: I am not here to speak for the commissioner. I appreciate the question. It raises some valid points. But I am not here to speak for the commissioner.

Mr McARDLE: I agree. I think you are right, they are valid points; so you would agree with that.

CHAIR: Perhaps it might be a question for the department this afternoon.

Mr McARDLE: I also ask the personnel, the union rep—I do not know the lady's occupation, I do apologise for that—but certainly the paramedic at the end there. I am just stunned that that is, in fact, the case. In any event, we will move on. You made comment that there were in place now programs that were delivering outcomes. I will not go back into those. We have one director-general. We have one department. But have things gotten so bad that we need law to make you work together?

Mr Peverill: I think there is a clear need. This all comes back to the devolution of the centralised model. You will be aware in the past decade we have seen Queensland Health shift entirely in terms of model. It was originally a centralised Department of Health responsible for statewide delivery of public services. The whole hospital and health service model has devolved that.

The model itself, and the requirement for the governance that this bill is a vehicle for, is to remind those HHSs and in our view other departments that interact with Queensland Health and the Queensland Ambulance Service, there are other public sector government agencies that interact with QAS and Queensland Health but I think this particular bill, given the devolution of the centralised model and the fact that it is now 16 HHSs is a stark reminder of some of the pitfalls of the decision to devolve it. With HHSs, there are 16 boards, there are effectively 16 potential service delivery outcomes. Is it avoidable that the bill has to do the work it does?

Mr McARDLE: Yes.

Mr Peverill: Potentially, yes, and we agree with that, but for the delivery outcomes in terms of patient care it is a requirement because we do want to see an integrated governance model between QAS and the public health system, which right now is 16 HHSs, deliver good patient outcomes. That is why we support the bill.

Mr McARDLE: Go back a bit. What you are saying to me is this, as I take your words—if I am taking you incorrectly I am certain you will pull me up. It worries me that we had the Hunter review a few years ago into Queensland Health that went through a lot of these issues with the HHSs. That

was an extensive review. That did not work, obviously, with the QAS. What I am worried about is this: if legislation is required to get a governance model in place as opposed to negotiation, as opposed to sitting down with the commissioner and the HHSs and the union, there must be something fairly rotten at the core because I have never struck legislation that says two organisations under the one structure have got to work together. This is probably a comment not a question: you are being forced to work together. That is simply ludicrous. Are you telling me that the union cannot sit down with the commissioner and the director-general and the minister and come to a solution, the law has to be imposed as an answer, because you support the bill. There is no other way for that to happen.

CHAIR: I think we will take that as a comment.

Mr McARDLE: No, sorry, the union have supported the bill.

CHAIR: This is about strengthened governance networks.

Mr McARDLE: They have supported the bill and I accept that statement as being actual. Is there no other way but for law to be imposed?

Mr Peverill: I think it is one of a number of mechanisms that can be imposed. I thank the member for the question. It is one mechanism to do it. I think keeping in mind we come from a period of history. QAS has often operated independently of Queensland Health. It is a public service provider. We want to see any improvements and any mechanisms that will facilitate better outcomes. This is one of a suite of outcomes. Is there better communication? Possibly, but we think this is a good step in terms of ensuring good public sector health outcomes.

Mr McARDLE: Are you sure that this is not more about the union power in HHSs or with the QAS? Are you sure it is not about union power? I mean devolving to the union greater power: EBAs and the like. Is that what it is all about, really, at the end of the day?

CHAIR: Deputy Chair, I am probably going to rule that out of order.

Mr McARDLE: I have posed the question and they are entitled to respond.

CHAIR: It absolutely has imputations.

Mr McARDLE: It is a legitimate question to a union who is supporting a bill. I am posing a question which is perfectly legitimate given the content of the bill.

CHAIR: I would ask you to rephrase it.

Mr McARDLE: I am not putting you on-the-spot. It must have crossed your mind that someone was going to ask that question here today. Is it a matter of a union grabbing more power down the track?

CHAIR: Deputy Chair, I think that has imputations.

Mr McARDLE: Of course it does.

CHAIR: I am probably going to rule that one completely out of order.

Mr McARDLE: This is a hearing. You can refuse to answer or the chair can overrule me. One or the other.

Mr Peverill: We will respect the chair's call on that one.

CHAIR: Thank you. We thank United Voice and Queensland Ambulance Service represented here today by yourself, Torrin, for the work that you do out there, particularly looking after the paramedics. I know through this particular bill it is about strengthening the relationship through that particular clause of the bill. Thank you for your submission. Thank you for being here today. We will move on to the next witnesses.

BREAKEY, Dr Cary, Child and Adolescent Psychiatrist, AMA Queensland

DHUPELIA, Dr Dilip, President, AMA Queensland

PARRY, Dr Peter, Child and Adolescent Psychiatrist, AMA Queensland

CHAIR: Thank you for your attendance today and for your submission. It is very helpful to the committee. I might ask that we start with an opening statement before we move on to questions.

Dr Dhupelia: I thank the committee for the invitation to AMA Queensland to present at this public briefing. My name is Dilip Dhupelia and I am the president of AMA Queensland. I am here with two other doctors, Dr Peter Parry and Dr Cary Breakey who are both child and adolescent psychiatrists and also AMA Queensland members. Drs Parry and Breakey have significant clinical experience in assisting children and adolescents who present with gender dysphoria.

At the outset I would like to clarify that we are providing evidence as members of the Australian Medical Association and as members of such an organisation we would like to place on record that any such evidence presented by us today is not in any way associated with nor reflects our employment at Queensland Health or by any hospital and health service but is made by each of us in our personal, professional capacities as representatives of AMA Queensland.

We wish to concentrate on chapter 5B, conversion therapies, in the Health Legislation Amendment Bill 2019. From the outset we wish you to note that AMA Queensland does not support conversion therapy. These therapies have been shown to be detrimental and with no benefit and have been denounced by numerous medical associations and colleges. We concur that conversion therapies should not be part of any behavioural health treatment of children and adolescents. Whilst our position on conversion therapy is clear, it is worth noting that we are not aware of any significant evidence or data supporting the need for the decision by the Queensland government to draft the proposed legislation which we are discussing today. I reiterate that the data is scarce and non-existent. We consider that the proposed amendments we seek should this legislation proceed are set out clearly in our submission to this parliamentary committee.

Our proposed amendments will mitigate the real risk that these sections as currently drafted could lead to the inadvertent prosecution of health professionals who provide established and evidence based practices. Whilst the AMA Queensland does not support conversion therapy, a health practitioner who, acting reasonably, in good faith and in accordance with relevant professional standards, treats a patient in a manner that could be subjectively perceived as not affirming or supporting their sexual orientation or gender identity is liable for criminal prosecution under the proposed legislation as it currently stands. We consider that the practice of conversion therapy is already capable of being targeted by the relevant health regulators and referred to the Health Ombudsman.

Where outdated and harmful therapeutic practices are used in medicine these are almost always best dealt with by the health practitioner regulation to eliminate the practice and not by criminal offences. A summary of our recommendation amendments are as follows: proposed amendment to section 213F—our members find the definition of conversion therapy in section 213F to be ambiguous. As a result we are concerned and hope that you will rightly see it this way: that doctors working in this area, which are psychiatrists, endocrinologists, paediatricians, surgeons and general practitioners, may inadvertently fall foul of the legislation.

AMA Queensland strongly recommends the following amendments to ensure clarity and certainty for our members: firstly to section 213F(1), we consider the need for precision in the definition sections of legislation is critical. Precision allows for persons who are interpreting legislation, whether health practitioners or not, to have absolute certainty about what they can do and what they cannot do. Therefore, we call on the definition to be changed to, 'conversion therapy is a treatment for which the only intent is to attempt to change or suppress a person's sexual orientation or gender identity.' Secondly, to section 213F(2), we recommend that for clarity we support the position of NAPP and seek the following additional examples to be added: treatments and practices that provide empathetic acknowledgement and evidence based support and understanding for the facilitation of an individual's coping, social support, identity exploration and development, and, importantly, treatment of any identified psychiatric co-morbidity.

Let me explain why we are recommending these additional examples. Whilst examples of what is not conversion therapy found in subsection 213F(2) are useful, they are potentially subject to change in the future to stay in line with medically appropriate treatments. Further, whilst the

amendment we seek does not alter the intent of the legislation to prohibit conversion therapy, what it does provide is certainty and clarity for health practitioners and non-health practitioners about what conversion therapy is.

Thirdly, we recommend that the following wording, which is currently in the explanatory notes, be incorporated into clause 213F(3)—

The exclusion will protect practitioners who, acting reasonably, in good faith and in accordance with relevant professional standards, treat a patient in a manner that could be subjectively perceived as not affirming or supporting their sexual orientation or gender identity. For example, a doctor may advise against surgery because a patient has a pre-existing condition that means the surgery is not safe. A doctor may also be required to advise a patient about potential side effects of drugs. In cases such as these, health service providers will be able to rely on the reasonable professional judgment exception to ensure that the health services provided are delivered in a safe and clinically appropriate manner.

The question that our members and our counsel have asked is as follows: if it is in the explanatory notes why is it not in the legislation?

Finally, we recommend in sections 213H and 213I the removal of the indictable nature of the offences for health professionals. AMA Queensland believes there are insufficient grounds, nor evidence supporting data, for offences contained within the bill to be prosecuted under the Criminal Code and believes these offences should be managed by health regulators as previously outlined.

There is one final clarification that AMA Queensland needs to make to the committee. On 9 December 2019 this committee met with Queensland Health, attended by Dr John Wakefield and Karson Mahler. It has been recorded in *Hansard*, in an exchange with the deputy chair of this inquiry Mark McArdle MP and Karson Mahler, that AMA Queensland attended the health minister's conversion therapy round table which was held in November 2018 and which helped determine the definition of conversion therapies. I request that this record of *Hansard* be changed to clarify that AMA Queensland has no record of receiving an invitation nor attending this event, nor having any responsibility in its deliberations and outcomes.

AMA Queensland submits to you that one option the committee may consider is what AMAQ suggested in its submission and that is wider consultation is necessary and could be possible by postponing part 5, clause 28 of the bill, which would not hold up the whole bill as a result. I encourage you now to draw on the expertise of my fellow members, Dr Parry and Dr Breakey, to further understand the thinking behind the position that AMAQ is seeking.

CHAIR: Thank you for your opening statement. I will go to the other gentleman. From a practical point of view can you comment on what harms conversion therapy or practices have on an individual?

Dr Parry: There is clear evidence that conversion therapies, as historically practised to convert people away from their sexual orientation, are extremely harmful. In my practice of psychiatry over the last 30 years since I started in the specialty I have never come across any cases of that happening. That is not to say of course that it does not happen, but I have not actually heard of any or witnessed any happening. Conversion therapy is different to the treatment of gender dysphoria cases and that is something we would like to get on to.

CHAIR: If it is happening—and you say you are not aware of it—why should those practices be left unregulated?

Dr Parry: I am not saying that they should be left unregulated. I think the AMA position, as read by Dr Dhupelia, is clear that we condemn conversion therapy. The issue with chapter 5 is the definition. It is not sufficiently clear enough that it would exclude best practice, evidence based, respectful, thoughtful assessment and therapy that looks at all biopsychosocial factors. That is our model in psychiatry, the biopsychosocial model. When somebody presents to us with a collection of symptoms, concerns and suffering, we have to think, 'What could be the causes of this?' You can have the same collection of symptoms with different causes for a different individual. It is very important to find out for that individual why they are presenting—if I may just give an analogy.

An adolescent girl might come and see Cary or me. She would say she is morbidly obese, she desperately needs to lose weight, she wants some appetite suppressants and she would not mind some bariatric surgery. She gets weighed and she is well over 100 kilograms. Even though she is a teenager, she has already got early onset type 2 diabetes, so you refer her to the obesity clinic and it is life saving.

The next girl might come in and say she is morbidly obese and wants appetite suppressants and bariatric surgery. She has a BMI of 13, she is critically ill, she is amenorrheic and she has anorexia nervosa. She is Mental Health Act perhaps—or you persuade her voluntarily, which is

always best practice, that she needs to be in hospital for lifesaving treatment. That is an example of somebody who comes in with the same set of symptoms but a very different underlying diagnosis or set of problems.

Our concern is that if somebody comes to us saying that they are in the wrong body and they want a sex change and they would like it pretty soon, best practice and evidence based—there is a clinic in the Netherlands that has been doing this for decades—is that you take things slowly, you thoroughly assess and you look at other potential causes. They could be family dynamic, child sexual abuse in the past—not wanting to be a woman because being a man might be safer after a history of sexual abuse. This is probably only a very recent concern and it needs more research and understanding. There was a paper, if I may digress, in *Public Library of Science One*, which is a very reputable international journal by Dr Lisa Littman in the United States, in which she interviewed parents of 256 adolescents to find that there does seem to be a trend now towards peer and social contagion of young people wanting to be transgender. That needs further research. There could be a social factor driving it. We certainly know that that can happen with anorexia nervosa, that peer and social pressures can exacerbate it. You can go on websites, which will encourage you in your anorexic behaviour and path.

The best practice is to take time; do thorough psychiatric assessments; if other factors come up, respectfully help the young person reflect on these; and maybe do some family therapy if indicated. Over time quite a number of cases do what is called 'desist' in their transgender pathway. In other cases it is very much their core sense of being that they are transgender and they 'persist'. The outcome research, such as it is, shows that many of these people are happier when they make the transition. It is really important to stick to the middle ground that we do need good, thorough assessments, but there also is a pathway for young people to transgender. If you do transgender during your adolescence, then the physical changes will look more genuine in your adulthood. In the past it was people in their 30s, 40 or 50s who were transgendering and sometimes it became quite obvious. That was then a secondary cause of suffering for them.

It is a very complex area. In terms of the bill as we read—and I have feedback from colleagues—we are concerned that it is all a bit ambiguous. To take another analogy, parents bring a young person to me who say he has ADHD and they want Ritalin to help him at school. However, if you do a thorough assessment you find out from the teachers that, in fact, he can concentrate quite well and that there are other things going on; or you might find he does not seem to concentrate well, but then further investigations show that dyslexia is a cause and when his subjects are maths or technical, he concentrates perfectly, so it is not a problem of attention. You have to actually get the understanding. The etymology of the word 'understanding' is to get beneath the surface and to understand what is underneath, what is presenting. We certainly do have occasional parents who would say, 'Doctor, I'm not very happy with you. You haven't diagnosed the ADHD.' You can explain very politely and respectfully why you do not think it is ADHD, that it is dyslexia, anxiety or depression or something else or complex traumatic stress. Some parents occasionally might still take umbrage with that, but so what? They can go off and see another practitioner, another paediatrician or a child and adolescent psychiatrist and go through the same process, and I would not be at risk of any criminal charges if they decided to go to court. That is our concern.

CHAIR: Dr Breakey, do you want to make any comment on that?

Dr Breakey: I would like to reinforce Dr Parry's and Dr Dhupelia's comments because I do perceive a significant risk. I think that the question that was dealt with by Dr Parry was, 'Don't we need the regulation?' I do not think that any of us would disagree that there is need for regulation of conversion therapies. Whether or not it needs to be under the Criminal Code is where we see major issues.

There are existing processes to manage cases where people—children, adults—are being treated inappropriately and that is very powerful. It becoming an indictable offence, for instance, does make a quite significant difference. My concern is that the definition of gender dysphoria or the diagnosis is being seen as simplistic when, as Dr Parry has pointed out, it actually is very complicated. I would move it a step further in that it is quite possible—quite likely—that a child may be diagnosed with gender dysphoria with a certain set of presentations in the same way as if I suddenly rose to my feet, grabbed my chest and collapsed and the ambos came in and said, 'He's had a heart attack or a coronary occlusion or the diagnosis would be myocardial infarction.' Even while they are working on me and looking at the ECG, Dr Parry and Dr Dhupelia are thinking, 'Is Carey reacting to the stress or running up from the car park? Does he have a long family history of coronary problems and atherosclerosis? Should that have been dealt with? He does not have look like he has a diabetic angiopathy.' Even though the diagnosis of myocardial infarction would be a perfectly accurate description, the pathways for treatment would be very different.

Similarly, with adults with a diagnosis of—I will speak predominantly about kids and adolescents—gender dysphoria, we need to understand what is happening for that child and within the family. I am not sure how many years Dr Parry said that he had been practising but I was initially a GP and then a psychiatrist over the last 50 years. I was seeing gender dysphoric kids back in the seventies and eighties, which predates the availability of Lupron and the use of testosterones, oestrogens et cetera. In fact, it was an era when we were looking closely at the use of hormones as contraceptives and trying to match that to the particular patient lady in front of us.

If we look at what the process was then—and at one stage in the early eighties I happened to change jobs and inherit a clinic that had five gender dysphoric kids—or kids with gender identity disorder, as it was called. My way of working is undertaking a lot of interviewing, a lot of work with families to understand what was happening. By the end of six months—actually I did very little, I have to admit, about the gender dysphoria in those days; there was very little literature. However, by understanding what was happening within the family—and each of the families had different issues happening. I shouldn’t say a couple were easy or simple, but in the case of one, the boy who was wanting to be a girl had actually been born as a replacement for a baby girl that the family had lost; she had died in early infancy. He unconsciously—and the family I am sure quite unconsciously related to this boy—related as the replacement for this girl. I should be able to remember his name. What I remember of it was that the name of the girl who had died could easily be masculinised. I cannot remember what it was. It might have been Antonio or something like that.

CHAIR: We might move to questions. That is a good example and you have just unpacked that.

Ms PUGH: Dr Parry, you were relating some of the issues back to anorexia nervosa in terms of presentation. I recall reading about body dysmorphia, which is slightly different to the concept of gender dysphoria. Could you explain the difference between gender dysphoria and what we are talking about with transgender children so we can better understand the differences in the potential pathways there? That question goes to any of the panel. It is just that you specifically mentioned anorexia nervosa, Dr Parry.

Dr Parry: I mentioned anorexia nervosa as an analogy. No analogy is ever perfectly exact, but it is certainly very useful.

Ms PUGH: Yes.

Dr Parry: Body dysmorphia is where somebody feels that a part of their body is misshapen, ugly, unwanted, they would like to have surgery, they would like to have it removed. They may pursue cosmetic surgery and often the dysmorphophobia persists in some way—nothing can ever be good enough—and so there could be some psychopathology with things about feeling unworthy and perfectionism underlying that. There may be similar dynamics in some cases of gender dysphoria, but there are certainly cases of gender dysphoria where what does seem to work is going down the transgender journey, which is a very courageous journey to go all the way, and people do feel better according to some of the outcome research. That is usually after there has been very thorough assessments—thorough assessments and watchful waiting that may be perceived by some families and young people as seeking to change their identity and then they could, under the wording of the current bill, start to claim, ‘You’re using conversion therapy.’ No, we are just trying to understand and use our evidence based, best practice biopsychosocial way of doing assessments and therapy and looking for factors, like Dr Breakey has just mentioned, that can occasionally come up when you take very detailed family histories. Some will desist and some will persist with gender dysphoria. Of those who do persist, some will benefit greatly from having good, quality gender clinic services with all the endocrine and surgical and psychiatric support that is inherent in that.

There are some cases of what is contained in one of the submissions by a Cathryn Warburton, although personally I would disagree with some of what was written in that submission. In that submission there were certainly some links to what is now a growing phenomenon of detransitioners, and their stories need to be listened to because some people who have persisted all the way to a full sex change later come to regret it. There have been reports in the media by a Serbian American surgeon who does a lot of this surgery in the United States and in Belgrade who said that there is a new phenomenon of people coming back wanting to have revisions and to revert to their cisgender, their birth sex. That could be for different reasons. It could be that they still feel transgender, but they are just finding that living amongst discrimination is too hard. Everything is always complex. Everything has to be individualised. I do not know if I have answered your question, but I have conveyed some information.

Dr Breakey: I would just add an extra comment there because it relates to your question about regulation. One of the issues that AHPRA regularly deals with is men particularly who are strong into body building with perhaps a dysmorphic not necessarily diagnosis but are getting testosterone or anabolic steroids to build muscle and we regularly through AHPRA see reports of doctors being reported and having penalties for inappropriately prescribing. I guess what I am saying is that we do have strong regulation for circumstances that are not appropriate.

Mr BERKMAN: Thanks very much for being with us. I have a few questions, if I am able to get through them. I wanted to start with the concern that you have expressed that the legislation could lead to prosecution of evidence based practices, and this issue came up before with the representative of the Australian and New Zealand College of Psychiatrists who expressed the same concern. They were content with the departmental response that the definition does not apply to evidence based treatments. The material that you have referred to that is in the explanatory notes reinforces that. I suppose I am just eager to understand whether that material allays your concerns at all or if you are unwavering in that view that the definition is inadequate.

Dr Parry: As the bill is currently worded—this is my personal reading of it, but I have also had comments from colleagues who feel the same—it is somewhat reassuring. However, when there are serious criminal penalties like 18 months in jail and $20,000 or $30,000 in penalties, it might make clinicians and therapists think twice about how far to push proper evidence based inquiry into biopsychosocial factors and so you may become somewhat shy in doing your job. That can lead to not enough slowing down or not enough consideration, and that is the complaint of the detransitioners. You can look them up online and they talk about how they just wished that things had been slowed down and they had been able to think that in fact it was something like the sexual abuse that they were hoping never to suffer again by becoming a man and things like that.

Mr BERKMAN: Exploration of those issues, as I understand it as you have explained in your evidence now, is a very well recognised and accepted part of clinical treatment and engagement with patients dealing with gender dysphoria.

Dr Parry: If you read the wording carefully, you could say that, yes, that is somewhat reassuring, but you want it to be explicit and clearly reassuring so that practitioners do not think, 'I'm going to cause umbrage to this young person, this young adult, this family and they're going to take me to court and I don't want to go there and so I'm not going to do my job. I'll refer on. I'll just go with the flow,' kind of thing. Our patients deserve us to be doing the job for them to help them whether they eventually become transgender or whether they eventually find that that is not quite the pathway for them. Perhaps same-sex orientation or something else was underneath their gender dysphoria.

Dr Dhupelia: If I may take that on as well in the sense that you asked about the clarity. It comes down to make it clear up-front what the intent is, and they are the words we use in our submission. There are three things I need to say. First of all, if a practitioner inadvertently is prosecuted, whilst the wording or the way the department is intending the legislation to operate by protecting practitioners, it still comes down to the interpretation at that particular hearing or at that particular prosecution and there is no certainty that there will be consistency in the way that legislation has been interpreted. That is the first thing. The second thing is that the Queensland Law Society in their submission has also outlined the reason why the clarity needs to be defined. Finally, I wish to make the point that the Office of the Health Ombudsman, an appointee of the minister, has also raised some concerns about the clarity. It comes down to what a judge or jury would interpret. Is it the intention of interpreting what is actually written in the legislation? Make it clear so that it is not subject to different interpretations. That is our point.

Mr BERKMAN: This is a related point, but you have made the point in your submission that the evidence is far from clear that conversion therapy is occurring, and we have heard evidence from survivor advocacy groups that it is not so much happening. In fact, the great preponderance of conversion theory, or practices as they refer to it, is happening in non-clinical, non-therapeutic but pastoral care settings, which I suppose leads me back to this definition and the consequence of amending in the way you have suggested so that it deals with treatment for which the only intent is conversion. My concern—and my question is whether you share this concern—with an amendment like that is we might exclude the kind of conversion practices that occur in a pastoral setting, which is, I suppose, maybe the main body of practice that we are trying to deal with here given that those pastoral care settings can be framed as very broad support. I hope the question makes sense, but I do not know.

Dr Dhupelia: I guess I could say that if the intention of the government is actually to capture that practice, then why are the health practitioners being captured under the same practice when we have a regulation that looks after these unacceptable behaviours? When we came to you for the

abortion law, we supported the abortion law to change from the Criminal Code to the health code so that if anybody with an unwanted pregnancy went to a practitioner and the practitioner did not behave appropriately they were referred immediately to the regulators, not to the Criminal Code. What we are doing here is completely the reverse.

Mr McARDLE: Thank you for coming here today. This particular part 5 deals with health service providers. It does not deal with people outside that, so it is targeted very clearly at the AHPRA 14 or 16 categories of health service providers. What I am trying to establish though is this: to put in place a regime that targets a negative outcome and to impose a criminal sanction, what is the evidence that health service providers are actually practising conversion therapy in Queensland?

Dr Breakey: Yes, there is not.

Dr Parry: We would not know. You would have to direct that question to AHPRA itself—

Mr McARDLE: Exactly.

Dr Parry:—because much of it would be confidential. In terms of just general discourse amongst health practitioners, we do not know of any.

Mr McARDLE: Have you in your conversations with your colleagues come across people raising conversion therapy being undertaken by a health service provider in Queensland?

Dr Dhupelia: I have not.

Dr Parry: No.

Dr Breakey: No.

Mr McARDLE: Okay. If we cannot establish the basis for making a law, the question I pose—and it might be rhetorical—is why are we penalising or putting a penalty on something that does not occur in the health service provision environment? Would you agree with that?

Dr Dhupelia: Yes, I totally agree with you because there is, as we have said, very strong regulation for health practitioners. It is really rigid.

Mr McARDLE: We have been referred to a paper called preventing harm, promoting justice published by the Human Rights Law Centre at La Trobe University. It says at page 53—

While the National Law does not expressly prohibit conversion practices, such practices are effectively prohibited by the broader obligations under it to provide competent, professional, evidence-based and nondiscriminatory health services.

Is this not a matter that should sit with the regulatory bodies, including the national body, to deal with this matter as opposed to imposing a criminal sanction on practitioners who are simply investigating and assisting a young person or a person to understand why, what should happen and what the outcome is going to be?

Dr Dhupelia: As I said in our submission, under the same paper, which I have a copy of here, in the recommendations section of that document under the section titled 'Appropriate sanctions and penalties', the recommendations do not request that conversion practices be criminal offences. The recommendation suggests that regulatory bodies enforce the provisions in that very paper that you are quoting from.

Mr McARDLE: Okay; all right. Going back to part 5, what you are saying to the committee is this: the wording is insufficient to protect a professional person undertaking the investigatory assessment required to come to a conclusion to assist a treatment regime, as you outlined, Dr Parry, and that person could then face up to 18 months in jail and, I suspect, potentially a loss of their licence. Would that be correct?

Dr Parry: Yes. You might be well defended in court and get off—

Mr McARDLE: They are wonderful people, lawyers.

Dr Parry:—but just the thought of it is the problem—impinging on one's practice in one's clinic.

Mr McARDLE: Unless we can establish the basis for a law, particularly when it imposes draconian penalties, am I right in saying we should not be doing it?

Dr Breakey: Yes.

Dr Dhupelia: We do not support conversion therapy but, as I said, there are two options. The answer is 'Yes'. If the law is to continue, we want the changes done. While the consultation is required, the committee does have the power to make a recommendation that clause 5 not hold up the rest of the bill—which is important—and that that be struck off for further discussion later on.

Mr McARDLE: In fact, part five could be carved out because it is a stand-alone part of the bill. It has no impact on the balance of the bill.

Dr Dhupelia: With a recommendation that that wider consultation does occur.

CHAIR: Thank you, deputy chair. I know we have gone over time, but I would like a response from AMAQ in regard to the Queensland Human Rights Commission submission which states—

Regardless of the prevalence of conversion therapy practices, the extent of the harm alone justifies a strong legislative response.

Would you agree?

Dr Breakey: If that were our approach to legal issues, we would have an even more vast number of offences on books. Creating an offence functionally that we have very little evidence, if any, is actually happening, where we already have legislation through the regulatory bodies to deal with it, seems to be, if you like, an unusual use of the creation of an indictable offence.

CHAIR: Any other views before we close?

Dr Parry: If chapter five remains, the reassurance could just be made more explicit and clear. The definition of the term 'conversion therapy' would be clarified by stating, as our submission says, that the only intent of the therapist or clinician were to suppress or change a person's sexual orientation or gender identity. That would mean that the intent was to turn all clients into 'desistors' rather than help the person discover for themselves whether desisting or persisting is in line with their truest sense of self, mental health and happiness. It is clarifying the wording, or perhaps removing the section for further consultation.

CHAIR: Speaking of consultation, this will be my final question to Dr Dhupelia. In your opening statement you corrected the record in regard to consultation—to the roundtable that you say you did not attend. Were you invited to get a further briefing as a result of the roundtable, the framework?

Dr Dhupelia: We spoke to the department officers. We do not have any record of it. Obviously when a situation like this arises, we start querying whether there was an administrative error on our part or on the department's part. When we spoke to the DG's department, we were able to ascertain that, no, we probably did not receive an invitation. We just cannot find a record. I do put a disclaimer in that, if there has been an administrative error, that is fine, but we just cannot see any evidence that we were actually invited. We have asked the department, if there is some evidence that we have missed or any record that we have missed, to make it available to us.

CHAIR: Thank you very much for clarifying that. I thank you to AMAQ and its representatives for their time today. We will ask the next witness to come to the table.

YOUNG, Ms Angela, General Manager, Policy and Research, Queensland Aboriginal and Islander Health Council

CHAIR: Welcome, Angela. Thank you for being here today. Would you like to make an opening statement before we move to questions?

Ms Young: Thank you, chair. Firstly, good morning. I would like to begin by acknowledging the Turrbal people, the Traditional Custodians of the land on which we meet today. I pay my respects to their elders past and present. My name is Angela Young. I am a Kulilli\Koa woman of the Conlon family of south and south-west Queensland, and I grew up in Townsville. I am the general manager of policy and research for the Queensland Aboriginal and Islander Health Council, commonly known as QAIHC. QAIHC is the peak body in Queensland that represents 26 Aboriginal and Torres Strait Islander community controlled services in Queensland, two representative regional peak bodies and a handful of associate members that provide health support services to Aboriginal and Torres Strait Islander people.

Our member services deliver comprehensive primary health care to their Aboriginal and Torres Strait Islander communities and are run by community elected boards. Our members operate in direct response to the needs of their communities. QAIHC was pleased to offer a short submission to the inquiry into the Health Legislation Amendment Bill. Our response was appropriately confined to part three of the bill, amendments to the Hospital and Health Boards Act 2011 and the commitment to achieving health equity for Aboriginal and Torres Strait Islander people. QAIHC is encouraged by the commitment of the Queensland government to support systems change in an effort to address institutional racism in its health service delivery structures.

I understand that the committee has been provided with and has discussed the QAIHC commissioned report addressing institutional barriers to health equity for Aboriginal and Torres Strait Islander people in public hospital and health services and the institutional racism matrix developed by Adrian Marrie at Bukal Consulting. Since the report was released, QAIHC has collaborated with Queensland Health to develop solutions to some of the concerns contained in the report. For instance, we know there has been positive increase in representation of Aboriginal and Torres Strait Islander people on hospital and health boards. Dr John Wakefield presented that, before the report, there were only three of the 16 hospital and health boards that had Aboriginal and Torres Strait Islander representation. Now we are pleased to say that nine of the 16 HHS boards have Aboriginal and Torres Strait Islander representation. We also know that there has been an encouraging increase in expenditure for Aboriginal and Torres Strait Islander service delivery that correlates with that increased representation.

QAIHC recognises that institutional racism is a confronting and complex concept. It is different essentially to personal, direct racism. Institutional racism is covert and can be passive, almost invisible, as the beliefs and misconceptions are embedded in policies, structure, attitudes, hierarchies, practices and perspectives of some of our health institutions. It entrenches attitudes and perspectives in organisational culture. It is difficult to detect, monitor and report on. Due to the complexity of its existence, institutional racism is extremely hard to dismantle because it is so entrenched in organisational culture it is often occurring with the absence of any malicious intent. Often the perpetrators of it are rarely aware of how damaging their casual reactions to particular service delivery can be.

In attempting to eliminate institutional racism, governments have a propensity to rely on two basic strategies—one, to increase Aboriginal and Torres Strait Islander workforce programs. We have seen some positive movement on that front in terms of board representation and increase of senior executives within Queensland Health and in HHSs and a general increase in clinical workforce. The other most commonly relied upon strategy is increasing cultural education and Aboriginal and Torres Strait Islander immersion. However, these strategies are not enough to dismantle the systemic barriers that exist. What is required in our view is that Aboriginal and Torres Strait Islander people are legally supported to be included in decision-making roles that have influence over policy and program delivery, service design, workforce structure and, importantly, expenditure. When this happens, hopefully we can start to unpack some of the systems that have, essentially to date, excluded Aboriginal and Torres Strait Islander input.

One may assume that, given we have recently experienced improvement, the proposed amendments that we are talking about today may be unnecessary. Our view is that those improvements have been the result of current stakeholder relationships, innovation, keen advocacy and organisational and political goodwill. We all know that these are heavily dependent on the opinions and views of individuals. Systemic change will require legal protection of these strategies to ensure that the commitment can be sustained in the long run.

The other vitally important strategy in breaking down systemic barriers is transparency and accountability. The proposed implementation of mandatory health equity strategies will ensure that HHS boards make Aboriginal and Torres Strait Islander health equity a priority, will encourage engagement and consultation with Aboriginal and Torres Strait Islander communities, and will ensure greater transparency of financial investment in health outcomes for that investment. It is QAIHC's view that these legislative changes, as we have seen with native title and human rights legislation, will enforce the dismantling of systemic barriers that currently exclude the perspectives of Aboriginal and Torres Strait Islander people and will go a long way to supporting our people to exercise their right of self-determination as designers of the health services that are there to protect and support their advancement.

We take this opportunity to share our appreciation for the support and encouragement of other peak health bodies, both local, state and national indigenous and mainstream organisations who also wholly believe in the benefit of these proposed amendments. The collaboration of the whole health system and the broader Queensland community is required to achieve health equity. QAIHC congratulates the Queensland government on its leadership and commitment to this important step in supporting the human rights of Aboriginal and Torres Strait Islander people.

CHAIR: Thank you very much, Ms Young, for your opening statement. It is good to see another good product from Townsville; well-articulated on this.

Ms Young: Well, there is two—and Jonathan Thurston!

CHAIR: Yes, thank you for clarifying that! I think this is a great step going forward in terms of the inclusion of Aboriginal and Torres Strait Islander representatives on boards. You have touched on that. What positive outcomes do you see at a practical level in terms of having those people on the HHS boards? What do you hope to see?

Ms Young: Absolutely; thank you for the question. What I can share with you is what we have already seen in representation and its impact on health service delivery. A number of the representatives currently on HHS boards are either current or former chief executives of our community controlled health services. What that naturally brings is integration of perspectives between the primary health care sector and the tertiary sector. That supports a seamless journey of health care for Aboriginal and Torres Strait Islander people. It allows Aboriginal and Torres Strait Islander people to embed their lived experience and perspectives in governance in delivery and design and also share a real natural cultural appreciation for our First Nations culture that currently does not exist in a lot of government boards.

We are encouraged by a number of really innovative health service projects on the ground in a number of the regions in Queensland, because of this shared integration that has happened because of the increase of HHS representation. We also hope that the embedding of perspectives within the systems will encourage Aboriginal and Torres Strait Islander people to better present at public hospital and health services, because we know at the moment the statistics. In particular, with one example—cancer morbidity rates—Aboriginal and Torres Strait Islander people are choosing not to present at publicly available health treatment services. That is directly attributed to the extremely high morbidity rates in cancer. Our hope is that better representation and embedding of perspectives will support a seamless health journey for our communities and will encourage more Aboriginal and Torres Strait Islander people to feel safe in accessing vital services.

CHAIR: Thank you very much for the response. The committee might recall travelling to Palm Island and seeing the new health clinic opened up there. The governance model is actually to have the Palm Island community council run that, a significant step in going forward.

Ms Young: Thank you for that comment. It is great and we often say amongst the sector that the way that our member services are governed by being directly responsible to community elected boards is the ultimate consumer feedback, because the services are delivered for the people who live and access those services and then are part of the governance.

CHAIR: Exciting times ahead, I think.

Ms Young: Yes, thank you.

Mr BERKMAN: Thanks very much for being here, Angela. This may not be an easy question to answer, given what you have already said about how widespread and sometimes subtle or hidden institutional racism can be. Are you able to provide the committee with some examples of how this actually plays out in practical terms and what you would hope to see addressed in terms of health care, if the bill passes?

Ms Young: Yes, absolutely. In a general sense, the most apparent institutional racism in public health services, hospital and health services, is where the statistics demonstrate a complete reluctance of our community to access those services. Did-not-attend rates are extremely high in most hospital and health services. Discharge-against-medical-advice rates in a number of the HHSs are extremely high, which means that the Aboriginal and Torres Strait Islander patients are choosing to no longer be serviced there. Actually, to the detriment of their health, they choose to leave and not access those services.

More direct examples are, for instance, some feedback we have recently received about maternal and antenatal care. Aboriginal and Torres Strait Islander women with high-risk pregnancies are being transported to hospital and health services very early in their pregnancy, sometimes as early as 32 weeks. The policies, which are at the discretion of the hospital and health service organisations, generally will fund the woman to travel and be accommodated on her own, without support people. We have heard all sorts of stories about the assumptions about partners or families that might travel with those women. Women are taken away from their homelands and their communities really early, at a really traumatic time of their life. The policies that exist are preventing them from bringing people who would generally be caring for them during that time.

A quite distressing extension of that is that sometimes those women are accommodated in substandard accommodation, which means that there are assumptions being made about their level of comfort and the quality of their comfort during that time in their life. That is a very direct example.

An extension of that is some patient specialist schemes, which again are at the discretion of the hospital and health services for how they fund, when they fund and the extent of what they fund. We are consistently receiving stories of Aboriginal and Torres Strait Islander patients being asked to travel at extreme times, also without support people and family members, and to accommodation that is probably not safe or comfortable for the types of specialist services that they are seeking. Those are two direct examples.

Mr BERKMAN: Thanks very much.

Mr O'ROURKE: This is just a comment. Angela, thank you for your submission and your opening statements, which were really very good and insightful. I want to thank you for that.

Ms Young: I appreciate that.

Mr McARDLE: Congratulations, Angela, on your oral submission here today. A few years ago, there was speculation about an Indigenous health service being established in Queensland as a separate entity. Are you aware of that? Are you aware of a discussion around that topic?

Ms Young: To provide specialist services as opposed to the pretty sophisticated infrastructure we have in terms of primary health care?

Mr McARDLE: Yes.

Ms Young: I think that is a very common speculation in the community. I know there are a number of Aboriginal and Torres Strait Islander specialists that do operate in their own right or operate in conjunction with our community controlled services. However, it is certainly not a story I have heard recently.

Mr McARDLE: I want to touch upon Indigenous medicine, which has also been discussed over a number of years. It may not be purely on topic, but I am keen to understand a bit more about that, because our first nations people have been here for 60,000-odd years and they have survived through droughts, et cetera. Is that an issue that 'QUACK' would like to take on board?

Ms Young: 'QUACK' is not one we have ever been called before, but I like that. I will have to take that one back to the office.

Mr McARDLE: Why not? We are all 'quackers' here, Angela.

Ms Young: It is very fitting, as a health body. Yes, traditional medicine is something that is still practised very widely in our community. In more recent times, things such as the Ngangkari and traditional healers in Aboriginal and Torres Strait Islander community controlled primary health care is a topic that is probably more widely discussed now than actual medicinal value. We know that in South Australia—I can take this on notice if the committee prefers—the Ngangkari movement, which is the word for traditional healers, has provided significant health results. I think they have advocated for significant amounts of funding and possibly even Medicare to support the use of traditional healers in primary health care.

Also, the practices of social and emotional wellbeing, which is about the strengths based value of community supporting community in ways that are culturally appropriate and supporting the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander people. Absolutely, traditional medicines and practices are still a very vibrant part of our contemporary practice.

Mr McARDLE: They are an important component.

Ms Young: Absolutely, yes.

Mr McARDLE: If the bill becomes an act, how do you see it playing out? Do you have a structure in mind? We are going to have at least one person of first nations background on each of the 16 HHSs. Do you have a concept of what, in four to five years, that might look like as we devolve down through the structures?

Ms Young: Absolutely. I am enthused at what the next five to 10 years looks like with Aboriginal and Torres Strait Islander people being central to the design of a future health system. We know that in New South Wales public hospital systems, they have moved beyond representation and workforce and are now creating infrastructure in hospitals that is more culturally appropriate for Aboriginal and Torres Strait Islander people. They are also operating under my personal advocacy ethos that if you design policy, program and infrastructure for the most marginalised of the community it will suit the whole community. We are starting to see that policies and programs and the way that health services are actually being set up for the support of Aboriginal and Torres Strait Islander people are having wide-reaching effects for the whole community in how they access health care.

I am extremely excited to see the increase in the general health workforce in hospital and health services and the Queensland government that will naturally flow from seeing people who look like them, talk like them and have similar backgrounds in their most significant governing bodies, absolutely. Being where I am, in the peak body for the community controlled sector, we are also really keen to continue to integrate with the hospital and health systems and build on some of the significant partnerships. We have already started in terms of delivering a life course that is safe for Aboriginal and Torres Strait Islander people, from primary health care through to tertiary services.

Mr McARDLE: Do you see the systems running in parallel or as one?

Ms Young: As one, at being better at different parts of the journey.

Mr McARDLE: I take it back: you are not 'quackers'. Thank you very much.

Ms Young: That is okay. The people in the office will like that one. It is good Friday afternoon banter.

Mr McARDLE: Indeed.

CHAIR: Angela, thank you for your enthusiasm and the strong advocacy you bring for Aboriginal and Torres Strait Islander people, obviously under the guise of the organisation QAIHC.

Mr McARDLE: That is the word!

CHAIR: I wish we could have 10 of you.

Ms Young: There are. There are many.

CHAIR: Parking Johnathan Thurston aside for a moment—

Ms Young: Yes. He is not as articulate as I am, but definitely much more athletic.

CHAIR: Angela, thank you very much for your contribution today. We will move to the next witnesses.

Ms Young: Thank you, I appreciate your time.

COSTELLO, Mr Sean, Principal Lawyer, Queensland Human Rights Commission

HOLMES, Ms Neroli, Deputy Commissioner, Queensland Human Rights Commission

CHAIR: I welcome the Queensland Human Rights Commission. Thank you for being here today. I invite you to make an opening statement before we move to questions.

Ms Holmes: Before I start, I also acknowledge the traditional owners of the land on which we meet today and pay my respects to elders past, present and emerging. I thank the committee very much for the opportunity to speak today. We have made submissions on two portions of the amendment bill: part 3, which proposes to amend the Hospital and Health Boards Act 2011 in order to strengthen the commitment to health equity for Aboriginal and Torres Strait Islander people; and part 5, which proposes to insert new chapter 5B into the Public Health Act, prohibiting conversion therapies.

As you know, the Human Rights Act 2019 commenced on 1 January with regards to the requirement for a member who proposes to introduce a bill into the legislative assembly to prepare a statement of compatibility. No statement of compatibility was required for this bill when it was introduced in 2019. Nonetheless, we note the detailed human rights discussion in the explanatory notes to the bill and compliment the department for putting that material together.

First of all, the amendments to the Hospital and Health Boards Act 2011: the commission strongly supports part 3 of the bill. For some considerable time now, there has been recognition and public attention to the poorer health of Aboriginal and Torres Strait Islander people compared to the non-Indigenous population. The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 identified the need to address systemic racism within the health system, to improve health outcomes. Our previous speaker very eloquently outlined what systemic racism is. It is the observance of an administration of policies, rules and procedures that purport to treat everybody equally, but are unfairly or inequitably administered or applied in dealings with people belonging to a particular racial, ethnic, religious or cultural group.

In March 2017, Adrian Marrie provided the report titled *Addressing institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland's public hospital and health services* to the then Anti-Discrimination Commission. That report was commissioned by the then ADCQ in partnership with QAIHC. The recommendations of that report are the genesis of the proposed amendments to the Health and Hospital Boards Act. The amendments are consistent with and affirm human rights of Aboriginal and Torres Strait Islander people to recognition and equality before the law, the right to receive health services without discrimination and the cultural rights of Aboriginal and Torres Strait Islander peoples. We recommend that the committee supports the passage of part 3 of the bill through the parliament.

I turn now to the other submission we made in relation to this bill, which is the amendment to the Public Health Act prohibiting conversion therapies. We appreciate the strong community interest in this part of the bill demonstrated by the many submissions to this inquiry, including the submissions of a number of important peak bodies. They demonstrate that public policy in this area requires the balancing of competing rights protected in the Human Rights Act—rights such as the freedom of expression; the right to freedom of thought, conscience, religion and belief; and the right to liberty and security for those who may be subject to criminal penalties arising from these new proposed offences.

Section 13 of the Human Rights Act requires that any limitation of human rights is the most proportionate, least restrictive way of achieving a legitimate purpose. In this case, through its explanatory notes and information provided to the commission, the government has sought to demonstrate that these limitations are proportionate. The introduction of new criminal penalties will always require a very strong justification.

Based on the evidence we have seen, it seems that a ban on conversion therapy is needed to protect the rights of lesbian, gay, bi-sexual, transgender, intersex and queer people. Those rights include the rights to freedom of expression, the right to privacy and reputation and the right to receive health services without discrimination.

The legislation, in our view, is consistent with the positive obligation on governments under international human rights law to respect the rights of all individuals. Where not already provided for by existing legislation, there is a positive obligation on governments to take steps to amend laws to recognise rights. The United Nations Human Rights Committee has commented that this obligation includes ensuring individuals are protected not only by the state but against violations of their rights by private persons. This includes taking appropriate measures to exercise due diligence or prevent, punish, investigate or address harm caused by acts of private persons and entities. We are seeing

this is happening in relation to the royal commission into child sex offences. Offences that previously went under the carpet and were buried are now being recognised and very strong and proportionate legislation is now being brought before parliaments to address that sort of harm. Again, that sort of obligation is on governments. When previously unrecognised damage comes to the forelight and people are revealing that level of damage it is appropriate for governments to then start addressing it.

We at the Human Rights Commission are not medical experts. We largely defer to the expert opinions of the respected peak bodies of the various medical groups on the evidence of the impact of conversion therapy and we note that those peak bodies are coming before this committee and talking about that. We note that the peak health bodies in Australia, the Australian Psychological Society, the Royal Australasian and New Zealand College of Psychiatrists and the Australian Association of Social Workers have made strong statements about the lack of scientific evidence and significant harms caused by conversion therapy. The Queensland branch of the AMA, which you heard from previously, has also acknowledged the harm that the practice of conversion therapy has on LGBITQ people and states it supports the prohibition of conversion therapy.

It seems to us that the long-lasting, harmful effects of such therapy are well documented and probably not contested. The bill also sends a strong message that being a LGBITQ+ person is not a disorder that requires treatment or correction. Such a statement seems particularly critical for LGBITQ young people to emphasise that there is nothing wrong with them, they are not broken or disordered. Therefore, while perhaps refinements and improvements could be made to the bill, we provide in-principle support to this bill which seeks to protect the rights and health, equality, privacy and expression of the lesbian, gay, bi-sexual, transgender, intersex and queer community and protect them from harm caused by conversion therapy. Thank you.

CHAIR: I do not know if you were in the room when AMAQ were here.

Ms Holmes: We were sitting in the room next door which was broadcasting this committee's hearing.

CHAIR: There was some discussion around the lack of evidence. I think I quoted your submission that what the bill is trying to do is needed to send a strong message and I think you have articulated that quite well. The other discussion they had was should AHPRA or the OHO deal with this. What are your thoughts on that?

Ms Holmes: We always think that it needs to be thought through very carefully where the appropriate remedies for this sort of behaviour, if it occurs, should be. What we understand is AHPRA rarely receives complaints about this sort of therapy. I note when we looked at the Queensland Medical Association's submission they said there was not actually a comprehensive set of guidelines yet developed and they were proposing that those guidelines be developed.

Even if it is dealt with by AHPRA I think this bill is dealing with other practitioners that AHPRA may not necessarily have control over—the unregistered health practitioners. They are a very important body. From anecdotal evidence around Queensland, there is evidence that non-registered health practitioners may be involved in conversion therapy. AHPRA does not deal with that group. Also sometimes for complaints to come forward before AHPRA, we know from our antidiscrimination experience that complaint making is actually sometimes a very challenging and difficult thing to do, particularly for children. Children do not generally complain. They usually have to have their parents complain for them. Often people do not complain until a very, very long time after the event about sometimes things that have happened to them that have been very destructive.

The difficulty with the AHPRA model I think is that children have challenges making complaints to AHPRA. AHPRA does not cover all the people who might hold themselves out as health practitioners. Also there is the length of time. Sometimes that person who may have been doing the conversion therapy may be well and a long time out of practice. The only consequence, I suppose, is a period of deregistration. That is a very serious sanction, but if you are not even registered, you are not a registered person, the threat of deregistration is no remedy for anyone at all.

There is the problem with the patients and their ability to complain with the AHPRA model and I think the other difficulty is the remedies model with the complaint being sometimes so slow to be made and such a long time after the event of their therapy occurring. That is one of the reasons why we probably think AHPRA is not necessarily the best course to deal with this sort of behaviour which is not a proper health treatment. I suppose that is the other issue. If you are going before AHPRA it is for a series of medical treatment that is seen as evidence based and a proper health treatment.

AHPRA does not look after matters that are not proper health treatments. I think all the professional bodies are saying conversion therapy is not a proper health treatment. There is no way of really regulating something that is improper. Unless there is the gradation that the AMA talked about, which we think the bill does cover, where you are doing an exploration of someone's situation and taking a slow and steady course, we think the bill already probably covers that fairly adequately, maybe it could be refined, but that is not what this conversion therapy is about. This conversion therapy is about practices that are not medically recognised, are not evidence based and are destructive and damaging and that is not the role of AHPRA to look after. It does not look after other areas where something is not within the medical framework at all. This is outside the medical framework and we feel that AHPRA is not the appropriate body.

CHAIR: Thank you very much. Well articulated.

Mr BERKMAN: Thank you very much for your time today. You have touched on this just now but I guess I just wanted to flesh out the way the bill deals with the full breadth of evidence based therapies. I think you did say you heard AMA's concerns. They remain concerned notwithstanding the content of the explanatory notes that it is not adequately clear in the bill that evidence based treatments are covered. You bring a really useful legal perspective to this as well as human rights. For the committee can you touch on how that material in the explanatory notes informs the application of the act?

Ms Holmes: The explanatory notes will always assist any court in understanding what the intent of the legislation was. They would be very pivotal in how the court deals with a matter that comes before it. There is always the very important role of the police and prosecution in deciding whether to bring a court matter. Even if there is a complaint, there is a long process before it gets to a court. If it does get to the court the explanatory notes are influential to a large degree on how the legislation is interpreted. What is in the explanatory notes is a very important element of the court understanding what the intent of the legislation is. I do not know if Sean wants to add anything further to that.

Mr Costello: Only that one of the features of the Human Rights Act recently commenced, as Neroli mentioned, is that all legislation has to be interpreted consistently with human rights. It may be that in interpreting that definition the court would look to a human rights consistent approach in terms of interpreting it broadly based on the explanatory notes.

Mr BERKMAN: This morning we heard from survivor advocacy groups and they made the point that the vast majority of concerning therapies or practices happen outside of a clinical setting in pastoral care type settings which are not covered by this bill. You have noted that in your submission and also pointed out that this avoids any incursion into the right to freedom of thought, conscience, religion and belief. What scope do you think there is to deal with those non-clinical settings and balance that against those rights?

Ms Holmes: I do not know if we have turned our mind greatly to that in the consideration of this bill. There is always the obligation, as we said, in relation to the child sexual offences royal commission where they actually did impose on the rights of people in the confessional in the Catholic religion, which is a very strong invasion into the rights of people to practise their religion. I think the royal commission justified that and had some strong evidence as to why that was appropriate and we in the end, having a look at the proportionality and the damage again to children, supported that approach.

I do not think we have necessarily turned our mind to it here in Queensland with regard to pastoral care and those other issues. Of course, if there is evidence that extreme harm is being perpetrated on children it is always the obligation of the state to look into that and to consider if there is the need to look further to protect people who may not be receiving the protection the state ought to afford them for very destructive conduct.

Ms PUGH: Thank you very much for appearing before us today. I am a ring-in on the committee. It is my first time on the health committee and I am very excited to be here. You have in your submission that conversion therapy can occur in both clinical settings and in a pastoral care setting as well. We have heard from AMA Queensland earlier this morning. I am wondering if you can elaborate on where it may have occurred in Queensland or anywhere else in a clinical setting—conversion therapy specifically.

Ms Holmes: We are reliant on the evidence of what we hear and what we have heard through our staff member who has attended at the health forum where this legislation has been developed. She is also a member of the LGBTI community and has had experience with her colleagues and friends having had experienced this in the past. At this stage we are relying on the material from

Queensland Health where in its material to the committee it said there is evidence that suggests health service providers, including registered health practitioners, continue to provide conversion therapy in Queensland.

A general practitioner who attended the health briefing stated he was aware of registered psychologists who are providing conversion therapy in Queensland. I think we have other anecdotal evidence. At the commission we have not had any complaints about this sort of conduct ourselves and it actually is not, again for the reasons that I talked about earlier about the difficulty in making complaints, an easy thing to complain about it and it is not necessarily even covered by the Anti-Discrimination Act. It is really not the sort of conduct that readily falls within our personal experience as being something that could come to us and be dealt with as a complaint. We are reliant on the evidence of what this committee has received from the Department of Health about anecdotal evidence in Queensland.

Mr McARDLE: Thank you for being here today and congratulations on your appointment to your position.

Ms Holmes: I have been in it for some considerable time. I am actually the Deputy Commissioner. I have been in that role for quite a long time.

Mr McARDLE: I want to explore a couple of points. Let us accept that conversion therapy is a practice that leads to disastrous outcomes. I am not questioning that point, I am questioning the bill in relation to conversion therapy and how it is tackled within the bill. You mentioned earlier that you also hold a very strong view that conversion therapy is very bad and you said that statement was based on ‘evidence we have seen’. You made the comment, ‘evidence we have seen’. What evidence are you referring to?

Ms Holmes: I guess the evidence that we have read about. The evidence that we are relying on is some of the material that has come out not only from the 2018 Latrobe University study, which I know people are questioning on some level, but the American Psychological Association Task Force has done some studies and a recent study in America that has been published in *JAMA Psychiatry*, one of the respected psychological journals, which surveyed 27,715 transgender adults about exposure to gender identity conversion efforts at some point in their lifetime was associated with severe psychological distress during the previous month and had a 2.2 higher odds of lifetime suicide attempts. If the conversion therapy occurred in childhood under 10 years of age this was associated with a 2.4-fold increased odds of lifetime suicide attempts. They are fairly serious figures. America is a community that is not that dissimilar from Australia. What has happened in America often happens in Australia. In the absence of more studies in Australia that is the evidence that we can see: that it is causing quite severe impacts on particularly young people but other people over their lifetime.

Mr McARDLE: Let’s look at those stats. Do the reports break down how many of the people who had an adverse outcome—and a significant outcome—were based upon pastoral care or healthcare providers such as psychologists, psychiatrists and the like? Do the reports or information that you have there make that distinction? I ask for the simple reason we had two men speak to us today and one made the point that 99 per cent actually occur by way of pastoral relationships. This is not a pastoral relationship. This is a healthcare provider—quite distinct. Do the studies break down those figures into those categories?

Ms Holmes: I am sorry I cannot give that answer to you.

Mr McARDLE: You also mentioned the La Trobe University study—and I have a copy of that here—which was referred to by Queensland Health as well. I have quoted already from that study. You may have heard me make the comment that in essence the national law ‘effectively prohibits conversion therapy’. You have also heard the AMAQ make comment that really it is a matter that is now regulated by AHPRA and other organisations. Is that not sufficient in your mind?

Ms Holmes: I would be surprised if there are very many health practitioners working under the auspices of AHPRA who are doing that work, but there may be a couple. We just do not know. It is usually not wildly proclaimed by people who might be doing it. I do not know that. Obviously there are other people who hold themselves out as health practitioners who are governed by the AHPRA model but who are not registered. The consequences for them being taken before AHPRA for some work in this area, if they are performing work in this area—and we understand from anecdotal evidence sometimes that may be. That model is not a great model to regulate the behaviour of people who have no regulatory body and no way they can be disassociated from the problem.

Mr McARDLE: What I am having difficulty understanding—and I take your point—is that no-one can give me the evidence. Sean, you are a lawyer; you understand evidence. No-one can point to evidence either in Queensland or Australia where conversion therapy is practised outside of

pastoral care, which I think is a horrendous situation—I accept that—if it leads to a criminal sanction being imposed on a problem that has not been shown to exist when you can consider the terms of the bill. If the bill had covered pastoral care—and how it will do that I do not really know; it is a valid argument. However, it seems to be a narrow set of individuals, given 99 per cent occur in the pastoral care setting, without evidence. Human rights has to cut both ways. The doctors also make it very clear; they are quite concerned that the terms in part 5 could eliminate their capacity to investigate, which is every practitioner's obligation. To say that then it depends upon the court or the prosecution is too late; they are charged and their name appears in the paper and it goes to OHO or the like. They are doomed. The rights cut both ways I would have thought.

Ms Holmes: Absolutely, they do.

Mr McARDLE: I think we need to be very cautious about this. The AMAQ have a fairly valid point in that if we refine it to say the only purpose is conversion therapy—and I have not thought that through properly yet—that seems to clarify to a point the issue you are raising and may deal with the issue of evidence as well.

Mr Costello: You are right to make the point that particularly human rights justification as required by the Human Rights Act does rely on evidence and a justification for why rights are omitted. I think one of the reasons why the pastoral care setting has been excluded is to try to limit the limitation on the freedom of religion in the Human Rights Act. I also know that some of the material the government has provided back to the committee notes in some situations, given this bill covers both registered and unregistered health professionals, someone in a non-government setting or a non-registered health setting may move into the realm of providing or seeking to provide a health service that may be covered by this bill. I guess it will depend on exactly the setting we are talking about when we are talking about a pastoral care setting and what exactly the circumstances of it are.

The other point to note is that the La Trobe study did note that there is at least one Brisbane based organisation arguably that may have been offering this service. We are not sure—I do not know and perhaps it is a question for government—exactly what the context of that service provision is and whether it falls more into the pastoral care setting or whether it would fall under the definition of a health service under this bill.

I absolutely take your point and the point of the AMA that we need to be really clear about what we are talking about and that intent we would expect should be part of the prosecution's burden in proving this offence. Whether that needs to be made clear in the offence itself rather than the definition—and, like you, I have not really thought through the consequences of putting 'intent' into the definition of conversion therapy; that may lead to some unintended consequences. Absolutely, there should be a fault element of intent for the prosecution to prove in the provision of this sort of service.

Mr McARDLE: My final question goes to the role of the specialist, and I am talking about a psychiatrist or psychologist—those qualified people. Does the person coming to see them not have the human right to have their concerns assessed?

Ms Holmes: Absolutely.

Mr McARDLE: If a bill removes that obligation on the part of the practitioner, does that violate the human right of the individual to get proper medical advice, and that would be wrong?

Ms Holmes: If a bill did do that, yes, it would be.

Mr BERKMAN: On that point, do you think this bill does that?

Ms Holmes: We think the definition is very broad. The exception covers appropriate medical treatment, so if a practitioner is doing the sort of medical treatment that we heard the AMA and the previous experts before this panel speak about, in our view that is a very broad—if they are doing an evidence based approach and appropriately conducting themselves as medical practitioners, we would think they would not be caught by this bill.

Mr McARDLE: One final point: until we go to court and the court rules otherwise?

Mr Costello: Correct.

CHAIR: I thank the Human Rights Commission for being here today and for your contribution. I invite the next witness.

PARKINSON, Professor Patrick AM, private capacity (via teleconference)

CHAIR: Welcome. Thank you very much for your submission. I ask if you could perhaps make an opening statement before we go to questions.

Prof. Parkinson: First of all, thank you for the invitation. I am sorry I cannot be there in person. As many of you may know, I am Dean of Law at the University of Queensland. I am speaking in my personal capacity, not on behalf of the law school or the university.

To give some background, I have more than 30 years experience in child protection, mostly child sexual abuse. I chaired the legislation review in New South Wales. I helped the Carmody inquiry in Queensland. I work very closely with medics, psychologists and psychiatrists in this sort of work, so I believe I have some relevant expertise.

Queensland Health currently has its hands full with an epidemic, the new coronavirus, which I am sure is causing them enormous pressures and understandably has had widespread publicity. This bill engages with another epidemic in Queensland, an epidemic which is not only in Queensland but in other parts of Australia, North America, Britain and many countries of Europe. So far it has escaped public attention, but this hearing is a good time in my view to focus in on this and to ask Queensland Health what it is doing to address it.

The epidemic to which I refer is one of ever larger numbers of teenage girls who are now identifying as transgender and seeking very invasive medical treatments to transform their bodies irreversibly to take on a male appearance and voice and often later regretting it. There is quite a large number, a growing number, of young adults, of woman, who have gone through this process and have reverted to their original gender.

I focus on teenage girls because this is the real concern; it is a reversal, as you may have heard, of historic trends. We have long known transgender people have a very painful and difficult experience for those who have gone down the journey of feeling they needed to go through sexual transition surgery, or gender reassignment surgery. Most of those were born male—typically three to five times as many males as females. What we are seeing in Queensland Children's Hospital, what we are seeing in other parts of Australian clinics all around the world is the majority of patients are now female. Sometimes this gender dysphoria can be quite sudden. Over 600 children and young people are now being seen by the Queensland Children's Hospital. Over 200 are on puberty blockers. Over 80 are on cross-sex hormones, mostly testosterone. This is a growing epidemic of cases of children and young people identifying as transgender.

I do not want to generalise the cause. No doubt among them are very clear cases of children who from an early age identified in some way as being born in the wrong body, as sometimes people talk about. The evidence from every recent study around the world is that the teenage girls who are now going to these clinics in such large numbers are very troubled young people. In one study they were 10 times as likely to be on the autism spectrum and there or four times as likely to have experienced sexual abuse. They disproportionately come from highly dysfunctional families—parents with mental health issues. They have other mental health disorders: anxiety, depression, eating disorders, conduct disorders or ADD. There is an awful lot of evidence now that they are getting the idea of self-diagnosis from YouTube and from social media. There can be great status and great kudos from being associated with being trans; it can make them very popular in some circles. These young people may be absolutely convinced (a), that they are trans and (b), that they need and want medical intervention and they may be highly resistant to anyone saying otherwise.

These young people desperately need therapy. They need good, expert mental health care. Part of that may be to help them understand that they are not actually trans or that their problems will not be resolved by lifelong medical treatment of the kind which is available to some. The problem with this bill—and I say this with all sincerity; I am sure it is well intentioned—is that it will drive away the expert therapists that these young people so desperately need, people with great expertise, great experience. They will consider it just too risky to continue working with these troubled teenagers. I would have to give that advice if I was asked. I would have to advise them that continuing this work of helping young people to understand where their problems may be coming from other than being born in the wrong body risks prosecution.

Queensland Health properly referred to the various defences in the bill. They are well drafted defences and they will protect health practitioners who make reasonable clinical judgements and assessments—I do not dispute that—but it does not solve the problem. The bill will have a severe chilling effect. If someone tells you the cliff edge is dangerous, the ground may crumble beneath your feet and you could fall to your death, you will not go as close to the cliff edge as you think is reasonably safe. You will avoid the cliff entirely, and this is the risk. If a therapist tries to help a young person

understand that their mental health problems may have different causes, different ideologies and different solutions to the ones the young person has identified, they risk the young person running off to the police and claiming that the psychiatrist or psychologist has engaged in conversion therapy and then that health professional will have to go through all of the stress of police interviews, the long wait to see if they will be prosecuted, possibly the stress of being charged and having to mount a defence.

Yes, those defences may be good, but why would anybody do it? Why would they take that risk? This is the real concern. I feel that, with great respect, this bill is profoundly dangerous. It could deprive young people of the mental health care they so desperately need, it could increase youth suicides and it could lead young people who do not get the right help down the path of lifelong medical interventions which they later deeply regret as they transition as young adults. There is, as many of us believe, a medical legal time bomb in the waiting here which Queensland Health needs to explain to the parliament how it is going to address. Thank you. That is my opening statement.

CHAIR: Thank you very much, Professor. I want to start by getting a view off you on conversion therapy. Is it harmful and dangerous?

Prof. Parkinson: One of the big issues if you look at gay conversion—which is where this has all come from, gender identity being so new—it has been harmful in the past. There is no doubt that there are many people or at least some people in midlife or the later years of their lives who had traumatic and difficult experiences when they were younger of people, genuine and well intentioned, who wanted to cure them of a same-sex attraction. What Queensland Health, with respect, and the government have not done is to demonstrate that there is any problem now. I do not think they can rely properly on the La Trobe report because the La Trobe report basically said there was no evidence of issues now. If there are, then I think it would probably be not with health practitioners as defined in the act. It might be quite remote and conservative religious groups of one type or another that are not well connected to the mainstream Queensland community. I do not think the case for this bill has been demonstrated as representing a current need.

CHAIR: I am not sure if you have read the Queensland Human Rights Commission submission, but they go on to say—

> Regardless of the prevalence of conversion therapy practices, the extent of the harm alone justifies a strong legislative response.

What is your view on that?

Prof. Parkinson: Lawyers are always seeing legal solutions to problems, and human rights lawyers certainly are. There are a range of ways in which you can deal with a problem—once you have identified what it is. One of them is through improved education of health professions. Another is through (inaudible) the existing accreditation system. There are various ways of dealing with a problem, but the first thing that any doctor must do, and what Queensland Health must do, is do no harm. If the legislation, as I hope I have demonstrated, does harm, then you need to back off a criminal justice solution to that problem.

CHAIR: We heard from the Human Rights Commission just before you and we talked about those other ways—those range of other ways—that you have touched on by regulation with, say, AHPRA or the OHO. Their response was that those particular bodies are for registered health practitioners and there was evidence of non-registered health practitioners doing the conversion therapy or practising it in Queensland. I think that goes some way as to answering why the regulatory body would not have any effect on those particular practitioners.

Prof. Parkinson: I do understand the issue of unregistered health practitioners, but Queensland Health has also said that it does not want to exclude prayer and spiritual counselling and spiritual advice which may be part of that. The Human Rights Commission is a pretty small organisation. I would respectfully ask them to adduce the evidence. I hear so much anecdote in my work—so many claims—but let them produce the evidence of a current problem for which a criminal justice solution is the only one. If they can and if Queensland Health can, then consider this, but moving into the area of gender identity is an absolute disaster, and that is why I am so strongly urging you at least to reconsider that part of the bill.

CHAIR: Thank you, Professor.

Mr O'ROURKE: Professor, your submission refers to social contagion and transgender. Would you explain social contagion in the context of conversion therapy provisions of the bill and what you mean by that?

Prof. Parkinson: Social contagion is a technical term much used in the scientific literature. It refers to an epidemic, if you like, which has emerged through social interactions, and here we are talking particularly about some of the YouTube, Reddit and some of these other social media programs. The research findings by Lisa Littman on this are quite revealing. She is an American scholar. She found whole groups of friends—three, four, five friends—all coming out as transgender with no history in their past and peer pressure coming from other friends to identify as trans as well. That is what we mean by social contagion—not the spread through germs but the spread through peer influence and YouTube videos, some of which greatly glamorise the life of a transgender person.

Mr O'ROURKE: Thank you.

Mr BERKMAN: Thank you very much for being with us online, Professor. I do not know if you heard the earlier evidence. The first witnesses we heard from today were survivors and an advocacy group and they made the point that the vast majority of conversion therapies happen in a non-clinical setting that are not covered by this bill. Do you have a view on whether, given the harms of conversion therapy, those settings should be dealt with and perhaps even, given what you have said about the potentially chilling effects on the availability of therapies, that that should be a priority?

Prof. Parkinson: I did not hear the earlier submissions, I am sorry; I have been busy in Melbourne. All the focus has been on gay conversion at its core dealing with same sex attraction, and this is a very different issue from transgender, so I really must ask that we differentiate them. What I would like to propose with this issue is rather than rushing a bill through parliament with all the criticism you have had of doing so over the summer to actually conduct an investigation of what are the problems now in Queensland, not the problems 20 years ago. What are the problems now and what can we best do with them? Get people who do not have a vested interest and are not part of activist groups to have a calm, measured, evidence based look at the problem and then come back in a few months or a year's time and ask, 'How are we going to deal with today's issue?'

Mr BERKMAN: I am not sure whether you have seen the department's response on concerns that have been raised about the overdiagnosis of gender dysphoria in children, but if you have do you have any comment you might like to make on that?

Prof. Parkinson: I do not wish to be critical, but I was deeply disappointed by the response of Queensland Health. I got the impression that it was digging in its heels. It was resisting any criticisms of the bill or policy behind the bill. It did not engage with my legal arguments at all. It did not engage with the medical evidence at all. There is enormous concern about what is going on now. In many parts of the world there are inquiries in Britain, there are inquiries in Sweden and in other countries. There is a huge debate in the medical and scientific literature on the proper treatment and support of children and young people with gender dysphoria. Queensland Health does not appear to be aware of that extraordinary level of concern and the extent of those debates in the medical community. If they are, then whoever wrote the Queensland Health response did not seem to be aware of that. With great respect, I think they owe the committee and they owe the people of this state a much more open willingness to consider different options and explore different understandings of this very grave problem.

Mr BERKMAN: Thank you.

Ms PUGH: Thank you for being with us today, Professor. My question is about your submission. Under the heading 'Gender identity confusion among children', your first sentence reads—

> The evidence is clear that gender dysphoria in prepubertal children is very likely to be transitory, with the right therapeutic support.

Can you expand on what you mean by that?

Prof. Parkinson: Yes. The approach over the last 20 or 30 years has been one of great caution, understandably, with children who may appear to identify very strongly with the other gender at some stage of their lives. It is called watchful waiting where you help the parents help the child to deal with those feelings but without taking any serious steps to alter the status quo. With that watchful waiting the research evidence from around the world is that some 75 per cent to 85 per cent of children will resolve those issues by the time of puberty when they go through puberty. It is why puberty blockers are such a controversial issue. Some will not. Some will go on to continue through their teenage and early adult years strongly experiencing with gender dysphoria and very often they will identify as gay or lesbian so they will grow up as adults with a gay or lesbian orientation, but some will continue to have these deep feelings and may well go on to gender reassignment surgery. For most of these young people, they resolve this often into a gay or lesbian same-sex orientation.

Ms PUGH: You are not the first submitter today to refer to the idea of watchful waiting, and I note in your submission you have the three options in terms of the treatment of childhood gender dysphoria. Can you elaborate a little bit on watchful waiting? You have talked about it a little bit. I just want to be sure that I am understanding this correctly. It is really, I suppose, continuing to check in with that child and that family without the clinician making any suggestions either way. Would that be correct or am I misinterpreting it?

Prof. Parkinson: I must say that I am a lawyer and not a medic, so I would leave others who have expertise to that, but that is my understanding—that is, it is a cautious approach and a gradual approach and seeing what happens. I think your question leads to the really big issue for Queensland Health and for the government. There is huge controversy about this. There needs to be a public inquiry, not around this bill—this bill needs, with respect, to be shelved—but to the way in which we are dealing with this problem, this growing epidemic, and what is the best way of dealing with children and young people and supporting them and is there a medical legal time bomb here of young adults who detransition and then sue Queensland Health—sue the government—for serious medical negligence? I fear there is and I think that is where the inquiry needs to go.

Mr McARDLE: Thank you, Professor. You have made the comment on several occasions that there should be an open inquiry into this before we rush to judgement. The Andrews government, as I understand, is undertaking this issue and a discussion paper has been published to the broader community and they are now looking at some legislation coming into play after a full and frank discussion by the public before the bill is put together. Are you looking at that style of inquiry or something wider?

Prof. Parkinson: I am saying as a lawyer that the legal approach to this is seriously misguided. The Andrews government legislation will also lead to increased suicides. It will deprive children and young people of the mental help they definitely need. The same arguments I would make in this forum I would make to the Andrews government. This is not the way to help children and young people.

The only inquiry I would like to see is a medical one—one in which non-investigative psychologists and psychiatrists—great experts—and paediatricians can look together collaboratively and as far as possible build a consensus around the proper treatment of children and young people, explore the dangers of puberty blockers, the dangers across cross-sex hormones and the risks to children and young people of a wrong diagnosis of being transgender. This is the sort of inquiry I would like to see. It is not a legal issue.

Mr McARDLE: Professor, are you aware of a letter having been forwarded by Minister Hunt to the Royal Australasian College of Physicians seeking their advice on clinical best practice and the treatment of gender dysphoria?

Prof. Parkinson: Yes, I am. The concern about that is that that body is not seen to be the sort of body which could conduct the kind of inquiry that is needed. I would see a public inquiry led by an expert panel of clinicians with various backgrounds—psychiatry, psychology, paediatrics, endocrinology and so on—would be the appropriate way to investigate this. Leave all the gay conversion therapy issues on the side until we have evidence that there is a real need for this bill even in relation to the same-sex attraction issues. The real argument here is about gender dysphoria.

Mr McARDLE: What you would say to this committee is that this bill potentially is dangerous. There is so much research being undertaken across the globe at the moment that we do not know enough about what we are talking about. We need to get a thorough investigation underway given the massive increase particularly with young teenage girls claiming a transgender status to move—

Prof. Parkinson: That is precisely what I am saying. Thank you for summarising it. My point about the bill is that however good the defences may be, however well drafted they are—and they are—the effect of the bill as cast will be to drive wonderful, expert, experienced clinicians with the best interests of children and young people at heart away from this field, depriving young people of the help they desperately need. That is why it is dangerous.

Mr McARDLE: Professional bodies—the AMAQ and the Royal College of Psychiatrists—have argued that the bill is so wide that anything that hints in the mind of the young person of conversion therapy could lead to a criminal charge being laid against them. Do you share that concern?

Prof. Parkinson: Yes, I do. It is not so much about whether charges will be laid, but I can see there will be complaints to the police and the police then having a need to investigate with all the stress that that would involve. I suspect that most of these cases were they to happen would be resolved two months later with the police informing the person that they did not intend to press charges. That itself is extraordinarily stressful for a clinician. We owe such a debt of gratitude to these wonderful professionals. To put them through that, to threaten them with that, is frankly an abomination.

Mr McARDLE: What would be the professional damage to a person investigated but not charged? Would that be fairly damaging to their professional status?

Prof. Parkinson: I think it would depend on whether it was publicly known that the police were pursuing the matter. Inevitably if that were public knowledge it would harm their reputations because people do not grasp the detail or the nuance. They get the headlines and that is where the damage would be.

Mr McARDLE: The AMAQ have made a suggestion that the clause could be amended in relation to conversion therapy to say that it becomes an offence where the sole intent is to provide conversion therapy. That constitutes the offence. Maybe you need more time to think about that.

Prof. Parkinson: No, I do not. I respectfully would say to the committee that it does not matter how you change the bill. It does not matter how carefully you draft it, how narrowly you define conversion therapy, how good the defences are. The problem lies in the message out there to the professional community: if you engage in this sort of therapy, particularly when a young people is convinced that they are transgender, you risk the police knocking on your door. You risk all the consequences. It is not a badly drafted bill. I think it is too wide. You could have a prosecution only with the consent of the Attorney-General. You could limit it in those ways, but I do not think you can limit the damage of the message it will send through better drafting. The other risk, of course, is that insurers say, 'We will not insure you if you work in this area.' That is another possible unintended consequence of this bill.

Mr McARDLE: If the bill is interpreted in the worst case scenario that a professional cannot undertake what they believe the bill says they cannot do, the only path open is to agree with the young person and provide the blockers and they start on a path that could be quite devastating because, on your own testimony, many of these young people resolve their own issues, but in the case where the treatment has start and the blockers are employed it is too late.

Prof. Parkinson: This is where we need the intense debate in the medical community. We need paediatricians and others to look at this. From what I understand of the medical literature—I am a lawyer, not a medic—puberty blockers are not harmless. They are not necessarily fully reversible. They will make changes including to bone density. They will have other effects. This is not a neutral treatment. We need a medical debate about the suitability of this novel treatment, this experimental treatment, for very vulnerable and mentally troubled children and young people—at least mentally troubled in many cases.

CHAIR: Professor, in your response to the deputy chair you mentioned the Andrews government. You talked about the fact that this will lead to increased suicides. If you read the brave submission of people who spoke about their lived experience—and we have heard a couple this morning—

Prof. Parkinson: I have not had a chance to read as much as I would like. I have also seen many videos now of young adults who have deeply regretted the treatment that they received.

CHAIR: For the record, that was a confidential submission. However, what we can take out of that is the increased rate of—and we heard it from the Human Rights Commission—people who had been subjected to it. What I read was that the increased rate of attempted suicides is quite high in that cohort. I drew issue with your comments in regard to this will lead to increasing suicides.

Prof. Parkinson: If the bill is passed and young people who have significant mental health issues do not get the help they need, all of us can see what the consequences will be. It is obvious. If you agree that is going to be the effect of the bill in relation to gender identity issues, you cannot ethically and responsibly vote in favour of this bill. It needs to be withdrawn and reconsidered with the benefit of much more research and evaluation of how we are dealing with these issues within Queensland and across Australia as a whole.

CHAIR: Could you give us your thoughts on conversion therapy? Is it harmful?

Prof. Parkinson: There has been a history of same-sex attracted people who have gone through practices which are no longer regarded as either efficacious or ethical. This is a very different issue from gender identity. I know of nobody who has been harmed by therapy which has helped them to deal with their gender identity issues. Indeed the evidence even from the Tavistock Centre in London, which is one of the gender-affirming clinics, in a recent article is that they had 12 young people who were dissuaded from thinking themselves as transgender through good therapy and support. Under this bill those therapies would risk prosecution.

CHAIR: Thank you very much for your time today and for your contribution. We will adjourn the hearing until 12.30 pm. Thank you, Professor.

Prof. Parkinson: Thank you for your time.

Proceedings suspended from 11.55 am to 12.29 pm.

ALEXANDER, Ms Matilda, President, LGBTI Legal Service Inc.

MCPHEE, Mr Emilie, Vice President, LGBTI Legal Service Inc.

CHAIR: We will recommence the public hearing. Welcome. Would you like to make an opening statement before we move to questions?

Ms Alexander: Thank you. Before we start, we would like to acknowledge the traditional owners of the land upon which we walk and pay our respects to the Turrbal, Jagera, Yuggera and Ugarapul peoples and pay our particular respects to the LGBTI Aboriginal and Torres Strait Islander leaders in our community from Tekwabi Giz, Gar'ban'djee'lum and IndigiLez.

Conversion therapy seeks to suppress or change characteristics of sexuality or gender identity, sometimes using shaming or emotionally or physically traumatic stimuli to suppress desires and sense of self. This premise is abhorrent. The label 'therapy' is a distracting misnomer. We are not broken in need of fixing. We are not disordered or ill in need of care and treatment. We cannot be tinkered with to make us more cis or heteronormative, nor can we be changed to take away the gay or trans identities that reside within us. We are sometimes in need of health supports which should be based on our wellbeing and affirm our choices. The journey to self-identity is an intensely personal one. Whether a person's sexuality or gender identity is static or fluid, affirming and supporting us can only do good, while seeking to change and deny us such an integral part of life can only do harm.

Conversion therapy, like other outdated medical practices that only cause harm, has no place in a free, equal and democratic society. If a patient requested a healer to engage in bloodletting to treat a fever, as was previously acceptable medical practice, that healer would be criminally liable, especially where such an act was performed on a child. A UK study found 19 per cent of conversion therapies are undertaken in a health context. This bill thus addresses a significant proportion of this abhorrent practice and focuses on where a person is in a position of stature and authority with a significant power imbalance such as the carer/patient relationship.

Conversion therapy neither converts nor produces therapeutic outcomes. Instead, it is an aggression, an attack on integral identity. Let's stop calling it 'conversion' and let's stop calling it 'therapy' and call it what it is: criminal abuse and harm perpetrated against vulnerable members of our community. Where so-called therapies cause harm and have no evidence base, they do not deserve the label of 'health' nor 'therapy'. Thank you.

CHAIR: Thank you very much, Matilda. According to your submission on page 2, you say, 'Conversion therapy practices continue to exist in Australia today.' You might have heard from earlier submitters and people who appeared this morning questioning the science or the evidence behind that, which will be the premise of my question. You also say that such practices are offered by unregulated health practitioners. We heard that as well from the Human Rights Commission. On what data are those statements based? Are you able to provide the committee with any identifying organisations in Queensland that practice conversion therapy?

Ms Alexander: There was one identified in the La Trobe report. Looking at its website, it talks about offering counselling to those struggling with their gender and sexuality. The first resource provided on that website advises people to 'accept the reality of your attractions, then start on the indirect process of change. This can be done by dealing with those same three factors that make attraction so powerful. No. 1: break the habit.' So stop engaging in homosexual behaviour. 'No. 2: identify the real needs behind the attraction and seek to meet them in legitimate ways.' In other words, it is not legitimate to be homosexual. 'No. 3: seek out the deeper sins and repent of them.' The resource goes on to say that for some 'the way to discover the deeper sin may involve Christian counselling'. There you have it right there, the link to the counselling service. So we have that level of evidence.

We also have the evidence that we draw on through our legal service. We are not a health service, but I think people who have been through this experience do not often know where to turn so they come to us in crisis. I was speaking with some of our staff. We do not have a lot of staff and we do not have any social work staff, but to have such would enhance our service delivery. We do not have a whole picture, but one staff member reported that in the last six months calls were taken from three people who had experienced conversion therapy and were calling us for advice. One of those callers was acutely suicidal and, at the end of the call, there was immediate referral made to the emergency department of a hospital. Two of those three were very, very distressed while making their calls. Certainly we are seeing it coming through the doors of our service. We are seeing on the ground that conversion therapy is alive in Queensland and is having a strong impact on our clients.

Mr McPhee: I am sure the committee has read it, but the evidence submitted in the Department of Health's response to questions included anecdotal evidence of conversion therapy happening, as reported by a practitioner in Queensland. That has been corroborated. While we are certainly not suggesting it is mainstream, it is certainly happening here in Queensland.

CHAIR: You might have heard from AMAQ's submission this morning. They thought that it is best for the bodies that regulate, being AHPRA and/or the Health Ombudsman, to deal with the matters in relation to conversion therapy. What is the view of the legal service on that?

Mr McPhee: We support a broader approach, primarily because it is not necessarily just registered practitioners who are undertaking conversion therapy, to use that term. We recognise that not a majority, or even a minority really, of registered practitioners are doing this practice. I think it is important for it to have a broader application than just those.

Ms Alexander: Yes. We support the Human Rights Commission's statement in regards to that and in regards to the complaints process and the difficulty of children bringing complaints and the time difference as well between when people are experiencing conversion therapy and able to make a complaint. Looking at where health practitioners are being regulated, in cases such as re Craddock which is a 2012 case of a doctor who prescribed Cyprostat to cure an 18-year-old of his homosexuality, that was considered to be unsatisfactory professional conduct.

On reading the case, it is revealed that that was not the first time that he had been reported and held up for that behaviour. Imagine the number of times he has done that and it has not been reported and it has caused harm, as you can imagine. It takes a lot to bring these kind of complaints through to a successful hearing against a doctor. That was the second time. The result was that his practice was restricted to a particular area, which you can apply to change, and he was strongly reprimanded. However, what is in that for that 18-year-old whose life has potentially been ruined? He is four times more likely to attempt suicide because he is unfortunately one of the people who has experienced conversion therapy. He was 18, but children could be subjected to the same experience with that doctor as well.

CHAIR: Thank you very much. I will open up to questions from the committee. I will start with the member for Rockhampton.

Mr O'ROURKE: Thank you for being here this afternoon. Matilda, I am not sure if you have answered the question, but through your legal service, are you aware of the number of people who have undergone gender conversion therapy by a Queensland Health practitioner in recent times? We heard this morning that 99.9 per cent of the time it is undertaken through faith groups and not so much through Queensland Health practitioners.

Ms Alexander: The research internationally shows that it is about 20 per cent, so one-fifth, would be coming through the health providers. I do not have data on the three in the six months that that one staff member had dealt with or how many of our other staff members have had similar queries or through our evening advice sessions. I do not have specific data on Health, but if the numbers are about the same, I would say that it is a problem here.

Mr O'ROURKE: Would you be able to find those numbers and provide it to the committee?

Ms Alexander: I can have a look. It would depend on what details were recorded in the nature of those advices. I can definitely have a look and let you know whether or not that has been recorded.

Mr O'ROURKE: It would be great to see a snapshot over the last two years.

Ms Alexander: I do not think we would have data on the last two years because we have only recently been up and running as a funded legal service. I will give you what we can.

Mr O'ROURKE: Thank you very much.

Mr BERKMAN: I really appreciate your time and thank you for being here. Have you heard the earlier evidence from this morning from listening in next door?

Ms Alexander: Yes, bits and pieces of it.

Mr BERKMAN: I want to refer back to the last witness we heard from, Professor Parkinson from UQ. He thinks the bill is well drafted, the exemptions are good, in his view, but he remains concerned that it could have a chilling effect on the availability of good impartial evidence-based therapies and services, particularly for young people dealing with gender identity issues and gender dysphoria. Bearing that in mind, we have heard suggestions from the AMA and the Royal Australian and New Zealand Society of Psychiatrists that there be explicit mention in the bill of evidence-based practices being acceptable. Is that something you support? Do you have a view on that suggestion or the issues raised by Professor Parkinson?

Ms Alexander: I would say it is not about stopping kids from get the help they need; it is about ensuring that they are not harmed. It comes down to why are we calling it therapy? If it is therapy, it is helping them and it is not going to be excluded from the act. Evidence-based and good clinical practice is not going to fall under 'conversion therapy'. That buys into this idea that there is something therapeutic about conversion therapy. There is nothing therapeutic about conversion therapy. It only causes harm, otherwise it is not conversion therapy. That is what is reflected in the definition.

Mr McPhee: I would add that the exemption particularly in subsection 3 is really quite broad. From what I understand of the hearing this morning, I think the Royal Australian and New Zealand—

Mr BERKMAN: Yes, the college certainly seems satisfied.

Mr McPhee: Yes. I do not have any objection with the proposal that there perhaps be more explanation around it. Our submission certainly called for greater collaboration and resources afterwards to make sure that this reform was made aware to people throughout Queensland and exactly what it meant. The Australian Medical Association Queensland also suggested that there be a committee that meet and decide best-practice standards. That would be a wonderful opportunity and something that would really benefit the community. Their suggestion went on to say that that would cure the issue overnight which I respectfully do not agree with, but certainly it would be for everyone's benefit to fully understand what the best medical practice is.

Ms Alexander: In that respect there are already some quite strong international and national standards. Looking at standards from entities such as the Professional Association for Transgender Health and the Australian and New Zealand Professional Association for Transgender Health, there is already a body of work that says affirming somebody's sexuality or gender identity and working with them to affirm that is helpful and does not cause harm. That should be the way medical practice goes. The other thing to think about is we are talking about a criminal standard of proof. You would need to show that beyond a reasonable doubt there was no evidence basis for this; there was no reasonable professional judgment that could justify this intervention. I do not think that doctors will be put off engaging in this kind of therapy because to reach that standard is very high.

Mr BERKMAN: Thank you. I will quickly follow up by asking about the limited application of this law and the fact that it does not go anywhere near faith-based practices or pastoral care. I am interested to hear your view on how we should approach that in the future.

Ms Alexander: This is a start to address conversion therapy and these laws that we are looking at introducing are unique in Australia. They will not stop conversion therapy. They will stop about 20 per cent of conversion therapy, which is important and is vital, too. Even if it addresses such a huge level of harm for a small number of people, it is still important to do. In regards to laws that outlaw slavery, you could say, 'Oh, why do we need that? We don't really have slaves anymore,' yet we are introducing modern slavery laws. We need to keep introducing laws that will prevent harm and will keep making this world a better place for all, particularly the most vulnerable people.

Ms PUGH: We have heard some concerns around current clinical practices that are considered mainstream potentially being captured by these laws. I am interested to know whether you have spoken to anybody who has been treated in a mainstream clinical setting using mainstream clinical practices complaining about gender conversion practices?

Ms Alexander: Maybe we could include that in the information that Mr O'Rourke requested we provide. I cannot say off the top of my head specifically what our clients have detailed to us.

Mr McARDLE: You are going to provide the committee with information from your own database, as I understand it. To make that relevant to the inquiry, we would need to know a few things. I do not want to know the name of the person. The age of the person would be fairly important, I would have thought. Also important would be the reason for the call, in as much detail as you can provide without breaching confidences, statements that you can report to us that deal with the conversion therapy practice under which they were put and not the name of the person who conducted the conversion therapy practice but whether it was pastoral or done by a psychiatrist—that sort of professional detail. That would make it relevant so that we can look at the data and say that it is broken into age groups, type of conversion therapy and who performed it. Otherwise it becomes a little bit hard to dissect and understand the source.

The bill before the House does not deal with the pastoral conversion therapy—and I apologise for the use of that phrase; that is the one we have to use when referring to the bill. It deals with health service providers which is quite a distinct class. This morning we heard from two men from Melbourne who had a lived experience. One of them said that for the group that he organises 99 per cent of the conversion therapy issues derive from pastoral conversion therapy. Is that something that you could agree with?

Ms Alexander: I would not agree with that based on the research that shows that 20 per cent is based on health care. Within the limits of our client confidentiality, I will provide you with as many details as I can relating to those case studies.

Mr McARDLE: You talk about research that you are relying upon. Is that the research of your own organisation?

Ms Alexander: No, that is a 2019 study. In the UK a national LGBT survey by the government found that seven per cent of respondents had received or were offered conversion therapy with 13 per cent of trans and gender diverse respondents being offered conversion therapy. It is the largest study of LGBTI people in the world.

Mr McARDLE: Could you provide a citation for that study to the committee because I would not mind reading that myself. It would be intriguing to do so. You mentioned the La Trobe authority publication which I have read as well. You referred to an organisation that I think is based in Melbourne. Is that the Exodus organisation or a name like that that practises in Melbourne in relation to people who have been through the process?

Mr McPhee: I believe the one in Brisbane that is mentioned in the La Trobe report is from the Exodus people.

Ms Alexander: It has another name up here.

Mr McARDLE: You also mentioned that there were three issues. Then you mentioned that it came down to Christian counselling as being one of the platforms to move forward?

Ms Alexander: I was just quoting from their website.

Mr McARDLE: Would that imply that that is a pastoral care organisation not a health service provider organisation?

Ms Alexander: It is my understanding that counselling would fall under the realm of a health practitioner under the definition in the law. There is a grey area there—that is, whether that counselling is provided by a registered counsellor who is a Christian all the way down to the other end of the spectrum to counselling provided by a pastoral carer who has no qualifications. The website did not specify. Given there is that grey area we need to ensure that protections extend beyond simply the registered practitioners.

Mr McARDLE: Both the college and the AMAQ raised the point today that they were concerned about the terms of the bill capturing what they need to do medically or clinically to make an assessment. If you are seeking advice—that is, if you are not taken to a practitioner but you go there of your own free will—their concern is around their assessment process to determine in their mind whether the young person is—and I do not mean to be offensive here at all—in reality a transgender or whether it is something else in society that is impacting upon them. That is their concern. If that is the case, they could be facing 18 months jail. Their concern is that the loose terminology could create a problem for them and could push qualified people away from assisting younger people, particularly younger girls whom I understand from Professor Parkinson's submission are increasingly more likely in today's society to raise questions about their sexuality. Do you get a sense that it is an important process to make certain that the medical advice and clinical advice is undertaken correctly and that an opinion be formed?

Ms Alexander: Absolutely, and I do not think this bill stops that from happening. It talks about the reasonable professional judgement and it puts it at a criminal standard which is beyond a reasonable doubt. Talking to a young person who is questioning their gender identity about all of the aspects of why they are doing so is a reasonable professional judgement and is accepted practice. I do not think that a criminal court would be able to find such a person criminally liable.

Mr McARDLE: The issue of the criminal standard of proof comes at the trial and not in a consultancy room. What happens of course is that if a young person feels that there is a conversion therapy they may then go to the police and make a report. The report will then generate an inquiry and then the process starts. The fact of guilt or innocence beyond a reasonable doubt is down here somewhere. They are concerned that the trouble that they will find themselves in will impact upon their professional standing and their professional obligations and, more importantly, the profession as a whole. At the end of the day, the standard of proof, which you and I may understanding, is not really going to help a psychologist in a consultancy room.

Ms Alexander: I guess I would disagree that the question of guilt or innocence comes at the end of the process. The way the criminal law works is that you are innocent until you are proven guilty. That has been reinforced by our Human Rights Act in Queensland. The charges are not just brought

on nothing. A report is made to the police and the police would do an investigation. If there is nothing there to support charges or if there is enough to support a civil standard of proof but not a criminal standard then the matter would not proceed. The matter could be over after one phone call if there is no substance to the matter. How far it goes depends on how much substance there is to the complaint.

Mr McARDLE: I accept the fact that you are innocent until proven guilty. My concern is though, and this was raised by the college and the AMAQ, that the person suffers professionally because of the complaint made. They are concerned that that will be the outcome. Do you accept that from a subjective perspective that is a real concern for them? Objectively the result might be as you say, but subjectively they have a problem in their own mind.

Ms Alexander: The same argument could be used against any complaints mechanism against any health practitioner. We need to have complaints mechanisms.

Mr McARDLE: Agreed, and they do have that through OHO and AHPRA.

Ms Alexander: And they do already through the criminal process. If they are accused of, say, sexually assaulting their client it would be the same thing. It is not that we then do not criminalise sexually assaulting your clients in a doctor-patient relationship just because somebody might make a false complaint.

Mr McARDLE: Sexual assault is sexual assault. It does not really matter whether it is in this room or a doctor's surgery. This is a particular matter. OHO and AHPRA already deal with this matter and the college's and AMAQ's point is that that is where it should rest. They make the point that we remove the criminal essence in relation to termination but we are putting the criminal essence into this argument.

Ms Alexander: I support the earlier submissions and our submission that AHPRA and OHO do not regulate all practitioners in this area. Even looking at the federal religious discrimination bill there are threats to the ability of professional bodies to regulate their profession where it is not a criminal matter and just a disciplinary matter.

Mr McARDLE: My understanding is that OHO regulates non-medical practitioners. All healthcare providers are regulated by OHO.

Ms Alexander: They would go through a conciliation process where there is no binding recommendation at the end of it. There are no means to enforce it. There is no remedy available for that victim who has had to bring this complaint off their own back and had to do the research in order to prove that what was done to them was not accepted medical practice.

OHO has a 12-month limitation. To do that within that time frame is difficult. That is particularly so for children. There are too many gaps in the current system. I agree that criminalising something is very serious and we do not want to do that if there is an alternative. We also need to recognise that the current system has too many gaps. We are tossing up between these two mechanisms at the moment. At the moment criminalisation has more merit, in my opinion.

Mr McPhee: In case it assists, I think Matilda and I both broadly agree in relation to that point with the Department of Health's comments in the summary of submissions.

CHAIR: That brings this part of the hearing to a close. Thank you very much for your contribution.

DAINTREE, Ms Helen, Member, International Women's Day (IWD) Association, Brisbane Meanjin

MCCORMACK, Ms Anna, Convenor, International Women's Day (IWD) Association, Brisbane Meanjin

CHAIR: Welcome ladies. Thank you for being here today. I ask that you make an opening statement before we move to questions.

Ms McCormack: Thank you. My name is Anna McCormack. I am the convenor of the International Women's Day Association, Brisbane Meanjin. I also acknowledge on behalf of both of us that we meet on Aboriginal land, land of the Turrbal people, land that was taken violently and that has never been ceded. I acknowledge the leaders and elders of the women's liberation movement in addition upon whose shoulders many of us now stand. We are a volunteer group of left-wing feminists, contrary to the claims that are sometimes made about the people who are expressing concerns about this bill. It is not just conservative people or Christians. We are left-wing; we are not religious. We came together three years ago because we were concerned that feminists had been replaced in the preparations for the annual IWD rally and march by trans activists, many of whom were not even transgender. Women's concerns around safety, dignity, privacy and fairness were dismissed by the mantra 'transwomen are women'.

Issues of historical importance to women, in particular men's violence against women, were also dismissed. I present as a person coming up to 70 years of lived experience as a woman, an adult human female, of knowing from very early in my life that I am secondary, that I am lesser than and that my appearance is far more important than it should be. I have experienced sexual harassment, including in the workplace. I have been aware because I am a woman of the dangers of rape and sexual assault and have had to take precautions to protect myself. I have also been close to domestic violence, because I am a woman. As a woman, in the '70s I was denied a lawful termination of pregnancy in my own state and I had to go to another state. What followed was 40 years of activism, advocacy, campaigns, rallies and marches until, with great joy, I was able to sit in parliament in October 2018 and see the decriminalisation of abortion.

Our written submission to the bill focuses on several objections to the linking of opposition to lesbian and gay conversion therapy on the one hand and affirmation of conversion therapy being the only model for those with gender dysphoria on the other hand. The affirmation model is conversion therapy. Gender conversion is actually the major form of lesbian and gay conversion therapy today. We cannot at the same time and in the same sentence outlaw conversion therapy and then affirm it.

I will elaborate on the planned haste and accompanying lack of consultation and scrutiny with which gender ideology is being steered through the parliamentary process. I will address the attack on women's rights that this ideology represents. Recognising that there is gender ideology is not to say that people do not exist who suffer from gender dysphoria; of course there are. I know a couple. Helen Daintree, my comrade sister, will elaborate on the outcomes for children and lesbians in particular. It is one thing for adults to think they can change sex and quite another for children to embark on puberty blockers, a lifetime of cross-sex hormones and unnecessary surgery. A 400 per cent increase over five years to 2020 in referrals to London's Tavistock Institute Gender Clinic for young people is astounding, especially when three-quarters of those referrals are girls. This should be of concern to all but the most cavalier among us. Why do so many girls today hate their female bodies? It is not an individual issue; it is political.

Why do so many girls hate the thought that they are lesbians and they grab on to the prospect of becoming boys as a lifeline? It is far more acceptable for a heterosexual couple to walk around holding hands than it is for two women, and it is less acceptable today than it was when I was a young woman. It is time that the accusation that lesbians are transphobic because they do not have sex with penis were challenged by anyone who claims to support same sex orientation. Trans the gay away? No way.

The biggest losers from gender ideology are women. The Department of Health advises in its correspondence of 3 February to the parliamentary committee that it is comfortable excluding women and other interested organisations from its consultation. This bill is hugely important in the imposition of an ideology that harms women and girls in particular. We are probably the only groups speaking today from the political perspective of the defence of women's and girl's sex based rights. It is not a very sexy topic but it is an important one. Governments are establishing identity ideology with no input from women's organisations to which feminists say, 'Nothing about us without us.'

We are one of the few groups giving evidence today who are not professionals. We are not medical doctors, lawyers or psychiatrists. We have no paid staff. We are grassroots activists and we focus on the rights of women, but we have a lot of lived experience and knowledge and understanding of what it is like to be a woman in our society. Because of our focus on women's rights, we have been shunned, vilified, threatened, excluded from other movements and refused solidarity by former allies. We are the women who set up safe spaces for women, the DV shelters, the rape crisis centres and 100 or so years before that female-only public toilets. All of those things are now under threat because of gender ideology which this bill upholds. I would like to hand over now to my comrade sister Helen.

Ms Daintree: We would like to provide additional information about two issues, that is detransitioners, which has already been mentioned a few times, and the chemical sterilisation of children which happens through the use of puberty blockers and cross-sex hormones. We want to give a voice to the young women who have been harmed by the model of treatment being endorsed by this bill. They were all diagnosed in their teens with no prior symptoms. They are known as 'detransitioners' because they transition to be trans boys or men, reconciled with their birth sex and returned to being women. No detransitioners were consulted in the framing of this legislation, because this bill was supposed to be about sexual orientation and not gender identity. These young women are definitely not represented by any LGBTIQA+ organisation. Yet these young women are the very ones who needed to be consulted in relation to the gender identity clauses. Without their input into the process, it is a biased, narrow exploration of issues and has ignored the potential for harmful consequences of the bill.

I would like to introduce some young women to the committee. We want to redress their exclusion from the roundtable. I present Max, Cari and Kira. Max—

I was misdiagnosed. I went on cross-sex hormones when I was 16 and had a double mastectomy when I was 17. I am now 22 and have detransitioned. I questioned my teachers about why I had to make an angel instead of Santa as a Christmas craft or why the girls bathroom pass had ribbons on it instead of soccer balls when I played soccer and I knew a lot of other girls in the class who loved soccer too. I grew up a happy tomboy until puberty. People expected me to grow out of it at that age and people starting getting uncomfortable when you don't. The way people treated me started getting increasingly sexualised. I remember one boy when I was 12 kept asking me to pick up his pencil so he could look down my shirt. The endocrinologist I saw wasn't sure. I think what she was seeing was a lesbian teenager—not a trans one. At the time I thought my doctor's reluctance was her being ignorant and her trying to hurt me. I had a referral from a therapist and I got the endocrinologist to prescribe me the hormones I wanted. I went into the surgery convinced it would solve a lot of my problems, but I hadn't named a lot of those problems yet. I wasn't able to pass fully as a male. After surgery, I had my new masculine chest and facial hair. I had left behind my assigned sex. It felt like an accomplishment to be seen the way I wanted to be seen. But the feeling didn't last. My discomfort did not go away. I identify as a woman now. I think I misinterpreted my same-sex attraction as well as the effects of misogyny and my traumas when I was younger as being about gender identity. But no health professional posed that question. With maturity, I realised it was not about gender identity at all. I was encouraged to rush into physical transition by clinicians who thought it was the only way someone like me could experience relief.

CHAIR: Just in the interests of time—I would love to hear all three—but I think we might move to questions. The other thing we could do is ask you to table those so we can read them. Is leave granted to table them?

Ms Daintree: Could I make one further point?

CHAIR: Absolutely.

Ms Daintree: Kira Bell is currently mounting a case in the United Kingdom against the Tavistock Institute for her treatment, which started at 14, involving puberty blockers and cross-sex hormones. She is taking a case against the gender clinic for her treatment, because she argues as a child she was unable to give proper, informed consent which is the case for most of the young teenagers whose stories we have.

CHAIR: Thank you both very much for your opening statements. Your association's submission states that clause 28 of the bill, which inserts proposed new chapter 5B 'conversion therapies' in the Public Health Act, establishes a controversial ideology gender identity ideology in law. Can you explain your association's views on what gender identity ideology is in a practical sense—I think you have started to unpack that for us today—and the basis for those concerns?

Ms McCormack: We can. Gender identity ideology focuses largely on trans identified men but it does give some consideration to trans identified women. The slogan that is used mainly and quite often very aggressively at us feminists is transwomen are women—no discussion, no debate. In terms of the practical consequences, we have experienced them. The first International Women's Day rally and march that we organised in 2018 was taken over by the trans activists. Most of them were not transgender people; they were mostly men who hate women. Our march was also taken over. Last October, we held a meeting in defence of women's sex based rights. We were so fearful of violence, because it has happened in other places in this country, in the UK, in the US, in Canada, that we had to make the meeting secret; it had a secret venue. Why should we? This year, this March we are

having a women's liberation conference and we have decided that we are not going to be skulking in secrecy anymore. It will be at a public venue but that means we have to spend a great deal of money, which we do not yet have, to pay for security guards. This has never happened before. Last Saturday, at a meeting in Seattle public library for women to discuss the threats that gender identity ideology present to our safety, privacy, dignity and rights, the women were abused both entering and leaving the building.

This is not acceptable when it has become so intolerable for women to meet peacefully and safely to discuss an ideology that is a big threat to us and to girls. The ideology insists that transgender women are exactly the same as women; that they are literal women. It insists that feeling overrides biological sex. It does not. We are much more ambitious in terms of the changes we want in our society. We do not want to pretend that we can change sex. What we want to do is break down the gender restrictions that are imposed on women and men—mostly on women—and that create subordinate/superior relationships. We are much more ambitious. That is what transgender ideology is doing to women. It is also opening up domestic violence shelters, so that men who identify as women can enter them. That has resulted not only in women feeling uncomfortable but also being traumatised. It has resulted in some women having to leave those shelters because they are so traumatised—leave the shelters that were built for their safety.

The same thing is happening in sport. You would have read about the moves currently in this country and a whole lot of other countries, at community and elite level, for men and boys who identify as women and girls to compete in women's sport. The girls are losing, predictably. They are also losing scholarships. There is a young woman in the US who has taken a case to court because she did not make it to the first eight in the running races and so she missed out. She is a young African American woman who was relying on a scholarship to get to college. She missed out on her scholarship, because two transidentified boys beat her. This is the sort of thing that transgender ideology supports and it is happening.

Ms Daintree: In relation to this legislation, we can see how the importance of biological sex has been erased in the definition of 'sexual orientation', where sexual orientation talks about same-gender attracted not same-sex attracted. As a lesbian, I can say I am same-sex attracted; I am definitely not same-gender attracted if that person still has a male body. Sex really matters when it comes to sexual attraction. We have an objection to the definition of 'sexual orientation', which has removed sex altogether from the definition.

CHAIR: Going back to the bill on conversion therapy, what are your views on it? Is it harmful? Do you have particular views on what the bill is attempting to do?

Ms McCormack: We are both old enough to have been involved in activism opposing conversion therapy of lesbians and gays. I know no-one—I cannot imagine people supporting conversion therapy of lesbians and gays, but to put in the same sentence affirmation of conversion therapy for people with gender dysphoria is just wrong. These two elements need to be separated out. We need to stop. We need to consider better what is happening with the gender identity section of this act. What you are doing in putting them together is following the legal advice provided by Dentons, the largest law firm in the world, to transgender activists. Part of their legal advice is, when you are getting through legislation supporting gender identity ideology, put it through with something that is popular or uncontroversial. That is what is happening here.

Mr McARDLE: Ladies, thank you for being here today. I read your paper and it is very interesting. I am trying to get an overview of your argument, if I can. You started with transactivists. Did you make the comment, or am I reading you wrong, that conversion therapy is in fact transgender or transgender is conversion therapy?

Ms McCormack: No. What I said was that, in the second part of that sentence—

Mr McARDLE: Gender identity.

Ms McCormack: Yes—it outlaws conversion therapy when applied to lesbians and gays, but it actually affirms conversion therapy for people who have gender dysphoria. It is a contradiction. Do you want to explain?

Ms Daintree: Yes.

Mr McARDLE: Just a moment: with all due to respect to my colleagues, this is where I am a bit confused. The distinction between the two would help me understand your point.

Ms Daintree: On the two ideas of sexual orientation and gender identity being similar, we do not accept that they are at all. On the whole area of gender identity with children and girls, which is our main focus, it is really only about 10 years ago when puberty blockers and cross sex hormone

protocols were introduced. The evidence is that around 40 to 50 per cent of young girls who have rapid onset gender dysphoria in their teens in fact, before they had that, are non-heterosexual. With the affirmation of them and the stories of all the desisters—of which there are many, now—many of them were same-sex attracted, but with gender affirmation were transitioned to being masculine. We know the frontal cortex does not fully develop until you are 25, so in their early 20s they have realised how profound was and can reflect on that experience and realise that a lot of their issues were not about gender identity, but about not wanting to grow up female and certainly not wanting to grow up lesbian, because there is such abuse and vilification these days around lesbians.

Mr McARDLE: Professor Parkinson would argue that you are quite right: a lot of young people have an idea in their mind, but as they mature they then come to their own self-realisation that what they thought was correct at 14 years of age is not at 25. That is your point, too, isn't it? It is very clear.

Ms Daintree: Yes. Certainly because of the use of puberty blockers, which stop the development of sperm and ova, followed immediately by cross sex hormones, which also stop the maturation of sperm and ova, a 12-year-old in a gender clinic is agreeing to become sterile. That regime of puberty blockers plus cross sex hormones means that their reproductive future has been taken from them. The state is not protecting those young people from chemical sterilisation. I think that is one of the big issues and why I would support a public inquiry that opens up the treatment options for gender dysphoric children and adolescents, rather than what this bill appears to do, which is to say affirmation and support, otherwise you are a criminal.

Mr McARDLE: Once you start that process of blockers, et cetera, it is irreversible. You cannot take it back.

Ms Daintree: No.

Mr McARDLE: With maturity, at a certain age, if that young person realises, 'I've made a mistake', it is too late.

Ms Daintree: There are huge irreversible harms and those young women in their early 20s are the concrete evidence of the harms being done by the misdiagnosis of gender dysphoria in teenage girls. They are telling us their story about how the model was that your best treatment is a medical treatment, not a psychological one.

Ms McCormack: There are now numbers of young women who are forming detransitioner groups, particularly in the UK where hundreds of women have started coming together—young women who transitioned in their teens and who, in their early 20s, have realised what a terrible mistake they made and do not want to transition any more. There have also been two very recently formed groups in Sydney, a group of detransitioners, and a group of parents of some detransitioners and some who have not yet detransitioned. It is too early to be making legal changes when these things are just starting to happen now and the message we should be taking is to exercise caution; do not overturn women's and girls' rights.

Mr McARDLE: Professor Parkinson is the YouTube professor of law. He said that this is a very early stage. Research across the globe is ongoing. We do not know enough about what we are talking about—these are my words, not his. What we should be doing is exactly that: shelve that portion of the bill, do some medical research, get a uniform outcome across Australia—again, my words—and then move forward with that. He raised a real concern about this bill, because we could be treading into areas when we have nothing really to back it up with.

Ms McCormack: Many, many women in particular are raising concerns about what is happening, but mostly we are closed down. We try and organise meetings at universities. They take our booking and then they get threats from transactivists and they cancel. That is what is happening. We are not being allowed to meet and to publicly express our concerns.

Mr McARDLE: Thank you very much, ladies.

Ms PUGH: This is more a question for clarification. I have read your submission. I note that you are very concerned that in some countries that would traditionally be seen as quite conservative they are recommending transtherapy as a form of dealing with—

Ms McCormack: Homosexuality.

Ms PUGH: Yes, I want to be really clear about that. I had not seen that before. To be clear, your concern is that in countries right around the world, including Australia, young women in particular can transition so that they do not have to identify as being same-sex attracted, but they find it easier to identify as transgender than as being same-sex attracted?

Ms Daintree: That is certainly one of the examples from some of the women if you read their stories and there are lots of stories from young women aged 14, 15 and 16. We know that sexual orientation identity does not really stabilise much before 19 or 20. We know adolescence is a time of change. To affirm at 14 or 12, I think we need a lot more caution. Young women who get abused for holding hands with their partner, they have transitioned so that they can walk around like everyone else holding hands. They are still attracted sexually to the same sex, but their gender is different. We need a definition of sexual orientation that respects that.

CHAIR: Thank you both very much for your contribution today. It has been insightful. I call to the table Dr Philip Morris.

MORRIS, Dr Philip, President, National Association of Practising Psychiatrists

CHAIR: Welcome, Dr Morris. This is the not the first time that you have been before us. I am reminded that you were at our aged-care inquiry at Southport. It is good to see you again. We will start with an opening statement and then move to questions.

Dr Morris: Thank you very much, Chairman. It is the second time that I have been before your committee. The other time we were talking about euthanasia.

CHAIR: Yes.

Dr Morris: I would like to acknowledge our Indigenous brothers and sisters who are the traditional custodians of this land. My sisters, in a sense, who just preceded me have made a pretty good case for making sure that we are clear about the fact that sex is observed at birth and determined by genetic endowment, and gender is defined as the stereotypes and behavioural traits typically associated with one's sex. They were very clear about that.

They were also clear about this: the banning of conversion therapies covers its use both in same-sex attraction and gender identity situations. These are very different entities and they have talked about it, as did the Coalition of Activist Lesbians' submission which was I think submission 120, and the previous witnesses, their submission was No. 95, but unfortunately this legislation does not distinguish between these two very different phenomena. I think that is a real problem for this legislation.

Just a brief background. I am a psychiatrist and in a sense I want to provide you a little bit of history very briefly. In psychiatry homosexual attraction or homosexuality went from being a disorder, an illness, in the 1950s. It gradually became not an illness but people who were homosexual in sexual attraction who were distressed became homosexual dysphoria and now, of course, homosexuality is completely taken out of all the medical textbooks and the nomenclature and the classification system as it is regarded as not being an issue.

The distinction between that and the gender identity issues is that homosexuality and the expression of that does not require a doctor to prescribe medication or to do surgery or anything of that nature. It is purely a personal choice and has no medical interventions. The problem that we have from the psychiatric point of view and the medical point of view with the movement towards gender dysphoria and the conversion therapy related to that is that while the same thing is happening in both society and within the medical profession, gender identity problems used to be called a disorder, it was called a gender identity disorder. It has now moved on to gender identity dysphoria or gender dysphoria which is you can have the view that you are the sex of the opposite sex, but if you have distress then that is gender dysphoria.

I suspect that in the future we will probably be taking this out of the psychiatric nomenclature completely, but to be able to transition from the girl that you have been born as, to the man that you believe you are medical interventions are necessary. You can do this socially by just saying just behave like a man, but that is usually never sufficient for either the person who wants to move into the man's role or to the people who support them. They want to have same-sex hormones or they want to have hormones of the opposite sex. Ultimately they want to have sexual surgery transition and this involves doctors. Doctors have to be involved in this, unlike with sexual orientation differences.

For doctors to be involved we must be convinced that the interventions are necessary, that they are applied to the correct patients and the benefits outweigh the risks where sex change treatments, and we are talking about puberty blocking drugs, and you have heard something about this today, opposite sex hormones and sexual reassignment surgery, have permanent adverse effects and that is why we are so concerned that this is done in an appropriate way and we do not jump too far ahead of where the science is. This is particularly relevant where children are concerned.

I know that a lot of people are putting great weight on this report from the Latrobe University 2018, *Preventing harm, promoting justice: Responding to LGBT conversion therapy in Australia*. This is being used I think to support some of the changes that are being proposed in part 5 of this legislation. I have read that report and I am sure that many of you have read that report as well but if you read it you will find that there are four things that that report says. No. 1, it says that there are no studies of the prevalence of conversion practices in Australia. There is absolutely no data that we have that is of any scientific validity about what is happening in Australia with conversion practices. In other words, we are completely blind at the moment as to what the problem is. Is there a problem? Anecdotally people might say there is, but there are no scientific reports.

Secondly, this report says it is highly unlikely that health service providers perform conversion practices in Australia. Now, this legislation is designed to actually target health service providers, yet that report says that it is highly unlikely that health service providers undertake conversion practices.

The third thing it says is that the only data that is presented in that report is 15 case reports. It was not a properly conducted scientific survey. It is 15 reports. Of those 15 case reports only two relate to gender identity concerns. One is a young Jewish woman who was sent by her rabbi to a Christian counsellor and once she identified that the counselling was of a Christian background she said, 'No, I don't want to go any further', so it was a very brief exposure. The only other case was a man of Asian background who was told by his parents, 'If you continue to have this idea that you are a girl when you are really a boy'—from their perspective—'we will send you back to the home country and you can say hello to uncle such-and-such who will convince you that you are not.' That is the only evidence we have at the moment that backs up any of these changes that are being put forward.

The fourth thing that comes out of that report is this: while recommending that state governments prohibit conversion practices, the report does not recommend this to be a criminal offence, rather that report recommends the enforcement of the provisions be through regulation under an appropriate officer, office holder or statutory authority like a health complaints commissioner. I think when you are looking at that report you can just see that the legislation here in section 5 has gone way beyond even where that report was coming from.

There is clearly insufficient evidence of a problem in Queensland with conversion therapies among registered health practitioners to justify part 5 clause 28 of the legislation. Legislative best practice, and I would say this applies to all Australian parliaments, requires robust research and evidence to support the changes, especially when the legislation proposes criminalising a practice that will have a penalty up to 18 months imprisonment. Placing violations of the prohibition of conversion therapies in the Criminal Code is both draconian and unnecessary.

The definition of conversion therapies in the legislation is too broad. In its application to gender identity matters it captures medical and health practices that are not conversion therapies but are necessary for the assessment, diagnosis and treatment of individuals with identity concerns. I just want to give you an example. A man who says, 'A month ago I saw someone look at me and their eyes suggested that they knew that I was a woman. I am now hearing voices telling me that I am a woman.', goes and sees the doctor. Explains this background. The doctor says, 'My gosh. I am going to prescribing some antipsychotic medication and we are going to get you into some counselling because you have schizophrenia.' 'No, no, no, no, I want to be a woman.' The man is accompanied by a gender advocate. 'What did the doctor say? Did he say that you should be a woman? He is going to help you do that?' 'No. He is going to treat me with antipsychotics', 'Oh, those antipsychotics, they cause problems. He didn't affirm your gender change?' 'No.' 'Well, let us report him to the police.'

The next thing the poor doctor gets is a policeman coming to his practice wanting to know why he is doing this practice. No. 2: a young girl who has become depressed, for whatever reason. She starts, because of her depression, to believe that she is not attractive to boys and she will never be attractive to men so therefore she is now saying, 'I want to be a man because I don't want to go through this position where I am going to have no hope as a girl.' She is depressed. She goes to the doctor. The doctor says, 'You are depressed. This is the problem. Let us put aside talking about becoming a man until we get you over this depression.' The gender advocate who goes with the young girl, 'What did the doctor say?' 'The doctor says I'm depressed. I'm put on antidepressants and we are having counselling and they are not talking about me changing to be a boy.' 'Oh, we better go and see the police because this doctor is not doing the right thing.' The doctor gets visited by the police. I think Professor Parkinson made the same point. This way of criminalising what is regular medical practice will lead to a disaster in terms of the practice of care in this particular field.

I find it surprising that the Queensland government is proposing a piece of legislation that favours a particular medical clinical condition because when you look at it, the only thing in the legislation that says that it is not conversion is helping a person change to the other gender which basically says if you don't do that then everything else could be seen as conversion therapy. The doctors will say, 'I could have the risk of being taken to court and prosecuted for what I am doing, which is basically normal clinical practice'. It seems to me crazy that the Queensland government is favouring a particular form of therapy for a clinical problem that still needs to be regarded by the profession as an area that needs further development. This therapy can lead to infertility and permanent adverse effects and it is being put into legislation. Why don't we leave it up to the professions and the clinicians to make those decisions.

I respectfully submit that the committee recommends that part 5 clause 28 be deleted from this bill. Certainly the rest of the bill can go ahead. Consideration of part 5 clause 28 should be postponed pending a separate inquiry and report addressing the intended and unintended consequences of this part of the proposed legislation. That is my basic introduction. Thanks very much.

CHAIR: Thank you very much, Dr Morris. I think you are starting to unpack the evidence side of it and that is certainly what AMAQ raised as well. If you heard the Queensland Human Rights Commission speak—I think you might have been here—they say regardless of the prevalence of conversion therapy practices the extent of the harm alone justifies a strong legislative response. What do you say to that?

Dr Morris: I think if they were concerned about that then the way to do it would be under the current arrangements which we have. In relation to doctors' behaviour—I am talking mainly about doctors because that is my professional area, but it can affect psychologists and others—people can make a complaint to the health regulators—it could be the Health Ombudsman, the medical boards—and they can get satisfaction through that.

CHAIR: I think the response to that is that AHPRA is the regulator for health practitioners but that a lot of this conversion therapy is actually being done by non-registered health professionals. Their response was that it is not capturing the people who are doing it.

Dr Morris: That is important, because what you are proposing in your legislation relates to health practitioners primarily and if you wanted to take the view that, look, most of this, if it is happening and it may be happening I don't know, I have not done surveys on this, outside the health practitioners, if it is happening in religious cults or whatever else—I don't at a personal level have knowledge about what is happening in the mainstream churches and the Jewish community and the Muslim community—then surely legislation should be proposed that would deal with that because I don't think this is a problem within the health community.

Mr BERKMAN: Thank you for being here, Dr Morris. The two examples that you gave, would you agree that they would quite clearly fall under subclause (3) of the definition of conversion therapy in that their practice that, in the provider's reasonable professional judgment, is necessary to, et cetera, et cetera?

Dr Morris: They do fall under that category, but the problem is that all these things should be clearly outlined so that doctors know clearly that if they are doing certain things that they will not be ever approached by the police. It is unclear because anybody can go to the police and say well they have not affirmed my gender change and they are not giving me anything to do with that and they have been talking to me about my sexual orientation or my gender orientation and I believe that they are practising conversion therapy. Then it is up to the doctor to ultimately prove that they are not doing it.

I think this is wrong to make it like exceptions. There should be a much tighter definition of conversion therapy. It should not be for the doctors to have to defend themselves. The way that it happens in the medical board, and it has happened to me because there have been one or two complaints, the person has made the complaint, the board looks at it, if there is enough there for them to think that it has some legs they send the complaint back to me for my response. My response, with due advice from my medical defence organisation, goes back to the medical board or the Health Ombudsman and then they determine whether this needs to go further. In all those cases they have said, 'No, you have explained yourself, it doesn't need to go further.' That to me is where this should reside.

Mr BERKMAN: Wouldn't we expect the same outcome though where a health practitioner is providing a health service in a manner that is safe and appropriate and complies with professional obligations. We would expect the same outcome, would we not?

Dr Morris: I do not understand your question.

Mr BERKMAN: You agree that both of those examples that you have given clearly fall within the definition.

Dr Morris: They may do, but that will be up to the court to decide surely because if the complaint has been taken to the police and the police then charge the person—

Mr BERKMAN: But the police need to be satisfied that the evidence exists to meet that standard of proof to take it to a prosecution.

Dr Morris: I am not a lawyer. I don't know what sort of guidance and advice the police would need to be able to do this.

Mr BERKMAN: Some of the assertions you are making, though, about the consequences of this definition actually carry with them certain assumptions about how charges would be laid and a prosecution would proceed.

Dr Morris: Yes, sure.

Mr BERKMAN: I would suggest that they are not perhaps completely on point. Anyway, I will move on. I think you made the comment earlier that treatments for transition have permanent, adverse effects. Would you also agree that in some instances for some people—and we heard evidence to this effect earlier today—transition is in fact the best outcome?

Dr Morris: It could be. At the moment we are not being told—and we know that there is literature on this which I can provide you with on notice—whether these puberty-blocking drugs and hormones of the opposite sex cause lasting damage.

As I said in my introduction, doctors always have to weigh the pros and cons of treatments. If you have a patient with cancer, you are looking at the chemotherapies available, at what you would do if you did not do anything for this person, at what the changes are in terms of lifestyle and at their opportunity to recover or maybe go into remission. We have to make these judgements, but that is where it should lie—with the doctor, not with the legislation that says you have to do it this way or the other way.

Mr BERKMAN: Indeed. I suppose this brings me to the final issue that I wanted to raise. We heard evidence this morning from other medical practitioners around the simple fact that there are good evidence based approaches to providing health services to people dealing with gender dysphoria. Do you accept that that is the case?

Dr Morris: There are different approaches. My concern with the legislation is that you have basically identified one approach that seems to be the preferred approach.

Mr BERKMAN: Okay. That is what I really was ultimately getting to. Subsection (2) in this definition of 'conversion therapy' is I assume to what you are referring. If we look down that list of the five subsections there, so if we look at (d) and (e) particularly, it does not include practice that—

(d) provides acceptance, support and understanding of a person; or

(e) facilitates a person's coping skills, social support and identity exploration and development.

Those certainly do not imply or exclusively allow affirmation of a transition approach.

Dr Morris: Depends on how you interpret that, sir. I could interpret that by saying, 'Well, as long as I am affirming the person wanting to go on to become a girl or a boy and I provide them with acceptance of that support, that might be the case.' Let us just say that I think that they are way wrong in their assumptions about their sex because they are severely depressed or psychotic? I would not be going down that path. I would be saying—

Mr BERKMAN: Then we move on to subsection (3), do we not, and the provision of appropriate clinical care based on your professional judgement?

Dr Morris: But this legislation is pointing out that there is one sort of preferred model. It would be better off saying that any approach as determined by a medical practitioner for the care of their patient as long as it was within the bounds of their professional area and acceptable practice should be excluded.

Mr BERKMAN: Some witnesses today and submissions have suggested that there should be an express reference to ensure that there is an exclusion of evidence based approaches to the provision of care. Would that appease your concerns?

Dr Morris: I am not quite sure what you mean there. Exclusion of what?

Mr BERKMAN: Exclusions in this definition. To be clear, conversion therapy does not include practice that is evidence based.

Dr Morris: Well, my proposal was that this section should be removed entirely. However, at the bottom of my introduction that I did not get to, I said that if the legislation goes ahead it is essential that the definition of conversion therapies be constrained to the following: firstly, that any therapy or practice deemed to be conversion therapies must be therapies that only and solely have as their purpose the change of sexual orientation or gender identity, and, secondly, That the definition of conversion practices must exclude treatments and practices that explore and understand the underlying clinical influences or causes on sexual orientation and gender identity, and provide empathic acknowledgment and evidence-based treatment, support, and understanding for the facilitation of an individual's coping, social support, and gender identity exploration and development, and the treatment of any identified psychiatric comorbidity.

That was the fall-back position, and I think that addresses some of the issues that you were asking me about. That was an initial response, but then we see so many problems with this section 5 that it really should be taken out of the legislation. That is our recommendation.

Mr BERKMAN: Do you accept that your position is at odds with that of the Royal Australian and New Zealand College of Psychiatrists?

Dr Morris: I do not know whether it is at odds. I was not here this morning to hear the nuances of their submission, so I do not know. What I do know about that organisation—and I am a member—is that its submission was put in under the signature of the president-elect, Dr Vinay Lakra, and the chairman of the local branch, Dr Brett Emmerson. Normally a college submission would go in under the signature of the president of the college. The president of the college is Dr John Allan who is also the director of mental health for the state of Queensland. He will be coming here this afternoon to justify this legislation. I have a problem. I am not making any allegations. I am just saying that there is a potential conflict of interest between the proposals and the submission you were given this morning by a college that does not want to do anything to harm the reputation of its president. It is a bit difficult for me. I was not here this morning to hear it, so whatever you say—

Mr BERKMAN: That is a mildly spurious assertion, but I leave my observation at that.

Dr Morris: It is a problem.

Mr O'ROURKE: Thank you for being here this afternoon. Page two of your submission states that children and adolescents may temporarily have thoughts of being of a different gender, et cetera. Can you explain the role of psychotic therapy in assessing and treating children and adolescents who have thoughts of being a different gender?

Dr Morris: This was addressed earlier, but puberty—depending on when you start menstruation, et cetera—from age 10 sometimes to age 18 is a time where people have different thoughts about themselves. Our identity is being formed and individuals can have views about themselves which they feel are very strong where they can change. It is a fluid period.

Maybe I am again simplifying, but there is a difference between those who are strongly in the affirmative model of treatment of children with gender dysphoria and those who say, 'Let's treat this without going into medical interventions immediately', is in this area where if it is a child—if it is a girl—at the age of, say, 10 or 11 says, 'I want to be a boy'? The people who advocate the more conservative approach say that the child can dress as a boy and play as a boy but they will not put them on any medical interventions. They will support the child and their parents and see what happens over a period of time with that sort of support; it is treatment. This versus those who have a much more strong and aggressive approach to this who say, 'We do not want this child to have to put up with any of the changes of puberty, so we are going to put them on puberty blockers'? That is the crucial area where there is a difference between those who say, 'We have a conservative approach to treatment,' or 'a more aggressive approach to treatment.'

The evidence is not in as to which is the best way of doing this at the moment but, if you put children on these puberty blockers, at the end of three, four or five years most of them will go on to cross-sex hormones and then you run into all the complications of these medications for people later in life.

Mr McARDLE: Thank you for being here today. I was keen to hear my colleague's commentary in relation to subclause (2) where they define conversion therapy does not include certain practices and in relation to subclause (3). I can understand your interpretation of subclause (2), that it may require an acceptance of the statement by the young person, then you move forward. I also find that subclause (3) however seems to be more general in that it does tend to provide the health service provider with an opportunity to do more than comply with subclause (2). To me, they are at odds. To me, it is confusing as to how those two subclauses fit together. Am I right in assuming that the profession is concerned that that confusion could lead to a criminal investigation of some sort and could also lead to psychiatrists and other professionals removing themselves from that sector of the industry?

Dr Morris: That is the practical consequence, that people are going to be so worried that they may get caught up in this that they will leave the area, which will be of no benefit to the patients we are wanting to help unfortunately.

Mr McARDLE: The other point that has been raised a few times is that at the end of the day it is a criminal standard of proof required. That is taking the super view way up in the air. To a psychiatrist who gets a knock on the door from a police officer who says, 'We are here to investigate you for conversion therapy' that is simply a startling revelation. It impacts upon your profession and

your business. People who run the argument that the criminal standard of proof really is a safe haven are looking at it from an objective perspective. Subjectively, you are the doctor in the gun and the doctor facing a criminal charge; and that is the worry, isn't it, the fact of a threat?

Dr Morris: Yes, the threat, and the effect on your practice by having police officers coming in and talking about this, that and the other thing. I am not saying that this sort of therapy particularly related to people of same sex attraction should not be prohibited. It is just that the method of doing this is draconian.

Mr McARDLE: You would say to remove the part from the bill. Professor Parkinson said that we need a medical discussion about what we are talking about here. It is new ground, it is evolving ground and we are really at day one. When the medical practitioners get together and come to a consensus, then we can look at what laws are required at that point in time. Do not put the laws in place and block the experts from undertaking the investigation required.

Dr Morris: I agree; it is premature. The other thing that is happening is of course the Minister for Health, Mr Hunt, has asked the Royal Australian College of Physicians to provide him with a report about the treatment of gender dysphoria in children, because he and others know that this is a very controversial and, at the moment, unexplored area. As the national association of practising psychiatrists, we have called for a national organisation or committee to look at this area with the national health and medical research council, the medical boards, the AMA and the professional organisations that treat children in this area to come up with a set of guidelines that can guide the country, because it is a very controversial area—the difference between the affirmation model of treatment and the more conservative model of treatment. It has not been resolved. It is way too premature to put up legislation before there is any resolution in the field about what is the best way forward.

Mr McARDLE: Given the impact of getting this wrong, isn't it better for a COAG initiative to do legislation that is required nation-wide so that we have uniformity? Victoria is doing an inquiry now. They may come up with a different set of guidelines and legislation going forward. Given the nature of what we are talking about, if we are going to legislate shouldn't it be national and not on a state-by-state basis?

Dr Morris: If it is going to come not under the criminal codes but under the code of professional regulation, there would be more chance for this to be a national model, because the COAG people all agree that the health laws and the medical boards are actually a national model rather than a state-by-state model. The state groups have acceded to a national approach.

Mr McARDLE: Thank you doctor.

CHAIR: Thank you for your contribution today, Dr Morris. I will now call up the next witness.

KENNY, Professor Dianna, Private capacity

CHAIR: I welcome Professor Dianna Kenny to the table. Thank you for your submission and thank you for being here today. I invite you to make an opening statement before we move to questions.

Prof. Kenny: Thank you very much for the opportunity to present today. Just by way of introduction, I have been an academic at the University of Sydney but I am speaking completely on my own behalf today. I do not represent any institution. I am an expert in developmental psychology and developmental psychopathology and I am an active clinician in treating children with gender dysphoria.

Section 5 of the bill lacks a scientific basis; has not established the need; overrides the basic human rights of parents, children and adolescents; deprives practitioners of ethical, autonomous clinical judgement; and has the potential to inflict severe and irreversible harm on those receiving so-called gender-affirming therapy during childhood and adolescence given that most children will desist if not treated with gender-affirming therapy. The bill is fatally flawed by virtue of its illogical and ill-founded ideological base, its factual errors and its failure to address issues in its implementation. It cannot be improved by amendments and should be abandoned. In short, the bill deceitfully conflates LGB issues with transgender issues. It has not defined the term 'conversion therapy' with any rigour or accuracy.

The proposed Public Health Act 2005 amendments define 'conversion therapy' as 'treatments and practices that attempt to change or suppress a person's sexual orientation or gender identity'. The proposed chapter 5B 'Conversion therapies', if passed into law, will have a highly detrimental impact on health service providers caring for and advising individuals on matters related to their gender identity. It will provide gender dysphoric young people with no options other than gender-affirming therapy. If passed, it will create an important precedent for other Australian jurisdictions.

No legislation founded on false premises can be justified or implemented. This legislation is fatally flawed because it is underpinned by a gender identity ideology that conflates gender, which is a social construct, with sex, which is an unalterable biological fact. It asserts that gender identity is fixed and immutable during the early part of the life span. It supports those attempting to establish a fixed transgender identity in young people who are in the exploratory phase of their sexual and gender identity development. We know that the majority with gender dysphoria in early adolescence will desist by young adulthood.

The conversion therapy clauses are very poorly conceived and worded. They contain many inconsistencies and anomalies. They are founded on incorrect assumptions and they are not evidence based and have no scientific merit. The now discarded conversion therapies attempted to change an individual's sexual orientation from homosexual to heterosexual. Specifically, these therapies included lobotomies, a surgery involving incision into the prefrontal lobe of the brain; chemical castration using hormonal treatments; aversion therapy using emetic medications to induce nausea and vomiting in response to sexual arousal to a same-sex stimulus; electroconvulsive therapy involving application of electric shock to the hands and/or genitals of individuals who had arousal to same-sex stimuli; religiously based pastoral care, intensive group therapies, ex-gay camps, prayer and exorcisms.

These have not been specified in the bill to define conversion therapies. However, the bill specifies psychoanalysis, hypnotherapy, 'counselling' and 'group activities'—the precise nature of which have not been specified as forms of conversion therapy. Religiously based conversion therapy emerged in the 1970s independently of mainstream medical psychiatric and psychological practice. Prima facie, the universal call from the trans lobby for the sole practice of gender affirmation therapy to the exclusion of all other therapy meets the definition of a conversion therapy because we know that once children commence social transition and puberty blockers 100 per cent will proceed to cross-sex hormones. Hence, according to the bill, gender affirmation therapy is a conversion therapy and should be outlawed with severe penalties for those continuing to practice it.

I had a lot of other things to say, but some of the points have been covered. I do want to spend just a couple of moments looking at the neglected concept of social contagion. Social contagion is mentioned in passing by a number of people saying, 'Look, it's due to social contagion and we have to take it into consideration,' but I want to just flesh out what we mean by social contagion and its importance in the current debate. The trans lobby has vehemently denied the role of social contagion in the spread of gender dysphoria in young people because it flies in the face of their flawed ideology

that children are the experts regarding their own gender identity—that is, their internal experience that cannot be altered by social factors. That is why social contagion is ignored or even criticised by the transgender lobby.

A very large body of research that I will make available to the inquiry shows unequivocally that social contagion is a powerful force that influences the behaviour of individuals. Social contagion describes the spread of behaviours, beliefs and attitudes across network ties. Networks with high centrality are the most effective in disseminating information. A key example is the trans activist lobby that has achieved spectacular success in a short time in changing health care, educational practices, legislation related to transgender individuals, and sport and social behaviour, among many.

Social contagion is a major factor in the disquieting upsurge in the number of children and young people presenting to gender clinics around the world despite our collective failure to date to fully understand the phenomenon of gender dysphoria and its rapid epidemic-like spread in the Western world. We know that peer contagion has a powerful socialising effect on children beginning in the preschool years. There is very strong evidence to show that social contagion among adolescents has been robustly demonstrated in eating disorders, marijuana use and suicide, among many others. The question is: is gender dysphoria socially contagious? Indeed, it meets all the criteria for a psychic epidemic. This network is highly centralised with only one voice—the trans activist lobby—being heard above the desperate cries of terrified parents and horrified academics, doctors, psychologists and psychotherapists.

I also want to bring to the committee's attention that social contagion is not limited to children and adolescents. Indeed, we see social contagion in medical and other treating practitioners, in legislators and in educators. Contagion in the prescribing patterns of doctors has been found after controlling for marketing outreach and systemic changes such as the advent of new drugs and changes in the prevalence of diseases. Shared geographical proximity, shared group membership and self-identified ties between doctors are all factors in behavioural contagion, with self-identified ties the most compelling factor. We see such influences in the gender clinics where one voice dominates and dissenters are silenced or expelled. We see it in law and legislation. Transgender activists have persuaded gender clinics to lower the barrier age groups to social transition, puberty blockers, cross-sex hormones and even mutilating surgery—many without requiring parental consent. Other changes include change of sex on birth certificates and change of names and pronouns.

The bill does not specify the population to which it is directed. It does not differentiate between adults and children and it does not divide children into subgroups or discuss the issue as to whether the child has the competence to make a decision. There is no need—and this has been discussed repeatedly today, so I do not want to labour the point. We have heard from other submissions that conversion therapy is practised, if it is indeed being practised, primarily in religious settings and not in mainstream health care where it has been prohibited by the regulating health bodies. However, the bill does not mention the practice of conversion therapy in pastoral settings and this is a major oversight.

The bill does not specify how the proposed changes to clinical practice in transgender therapy will be administered. There are many professional bodies overseeing the work of health practitioners. The bill does not specify how these bodies will interact with those administering the proposed legislation. There are many human rights violations implied in the proposed bill both for patients and for therapists. This bill is being proposed at a time when a major aspect of it—that is, the transgendering of children—is under consideration by the federal health minister and should therefore wait until a full review is completed. In conclusion, the ideal outcome would be that the committee recommend that part 5 clause 28 be completely deleted from the bill in order not to hold up the rest of the bill pending a separate inquiry and report that is fully constituted with experts to assist that inquiry.

CHAIR: Thank you very much for your opening statement. You mentioned your concern about some human rights violations implied in the bill both for patients and for therapists. What are those human rights violations? Can you talk to that?

Prof. Kenny: Yes. The primary human rights violation is the mutilation of children. This begins with social transition. The research shows that as soon as a child embarks on that very first stage of social transition—that means that the child chooses a name of the opposite sex, starts to use the opposite pronouns of 'she' and 'her' or 'he' and 'him' and dresses in clothing opposite to their natal sex—even before following through with the rest of this untested experimental treatment—and that is the second human rights violation—the chances are that the child will complete the process.

They will go on to puberty blockers. If they go on to puberty blockers, there is a 100 per cent chance they will go on to cross-sex hormones, and then a number of them will undergo mutilating surgery, which has a 35 per cent serious complication rate—infections, having to have resurgery and so forth. Young people undergoing mutilating surgery lose their sexual function in most cases so they cannot enjoy a normal sexual relationship. They suffer significant lifelong disability in the form of osteoporosis. They require lifelong hormones. We are now getting information that they have elevated risk of thromboembolism, cardiovascular accidents, stroke and so forth.

The human rights violation to children is subjecting them to torture. In any other jurisdiction, if we said that we were going to do these kinds of things to children it would be considered torture. That is the human rights violation on children.

Parents are being denied their parental authority. There have been many cases, for which I have provided expert evidence, in the United States and Canada where parental rights are completely disregarded and parents are being charged with child abuse for refusing to call their seven-year-old son by his male name and using ‘he’ and ‘him’ pronouns. The father is charged with child abuse, but the mother is not charged with child abuse for transitioning a boy who has reportedly stated that he is happy to be a boy like his twin brother. That family will be destroyed. We know that the siblings of children who were transitioned end up with significant emotional disability.

Finally, to the practitioners, they will be dictated to in a way that robs them of their many years of study and expertise to make autonomous clinical judgement with due consideration and peer supervision. They are going to be mandated to inflict a mutilating treatment on young children.

CHAIR: In your opening statement, you mentioned now-discarded therapies, and you went on to talk about lobotomies and ECT therapy. Are you aware of current conversion therapy practices in Queensland or anywhere else?

Prof. Kenny: I searched the literature in preparation for the presentation today. There are no documented papers, evidence, articles from the past 10 years that indicate that any of those original conversion therapies are currently being practised. They have been prohibited by every health regulation authority in the country. They are just severely frowned upon, as you have heard throughout the day. They are the conversion therapies from an original definition and, by sleight of hand, the translobby has slipped in psychoanalysis, hypnotherapy, counselling and group activities. What is a ‘group activity’? It could be a book club. It could be cooperative games. The wording in this legislation is completely unacceptable.

CHAIR: What harms do you think occur to someone when they do have conversion therapy?

Prof. Kenny: My definition of ‘conversion therapy’ is gender affirmation treatment. That is the current conversion therapy that is being perpetrated on young children and adolescents, and I have outlined some of the damaging effects that this has on young people. Just one website called reddit now has a membership of 5,000 young people who are detransitioning. There is very little work in the literature on detransitioning, because the translobby appears to have hijacked all sorts of agendas, including the acceptance of papers that talk about desistance among young people who were gender dysphoric and no longer are gender dysphoric, but accept that they may be gay, lesbian or bisexual. There is still a proportion of young gender dysphoric children who become heterosexual, but the majority, as late adolescents and young adults, are homosexual or bisexual if left or if managed conservatively or if they receive treatment to work through their emotional distress.

The only conversion therapy that I am aware is being practised is gender affirmation therapy and this is the issue that should be central to this debate, not some nebulous definition of ‘conversion therapy’ that attempts to change or suppress a person’s sexual orientation. It is an absolute nonsense to talk about ‘broken’ and ‘if it’s not broken don’t fix it’. We know definitely that the majority of young people presenting with gender dysphoria have a range of serious comorbid psychological and psychiatric problems. There are often problems in the family constellation that need to be addressed and treated. If a child says, ‘I’m not a girl; I’m a boy’, the transgender lobby will have us believe that that child knows 100 per cent that he is not a boy, he is a girl, and that directs the medical and psychological treatment of that child. It is an absolute nonsense.

In this country, a child under the age of 18 years cannot have a tonsillectomy without parental consent, yet we are moving and have moved and there are cases where young children have been permitted at the age of 14, 15 and 16 to undergo double mastectomies of healthy breast tissue on the say-so of obsessed gender therapists and children who have been sucked into this vortex of translobby and transactivist ideology.

Ms PUGH: In your submission you have said that by adulthood some 61 to 98 per cent of children desist from a transgender identity. We have heard about the two pathways, which are persist or desist. Obviously that is a significant statistical difference. Can you elaborate on how you have come to form that data and the pathways from there, if they do desist?

Prof. Kenny: Yes. I have brought all the data for you. I have a number of studies that I have summarised in a written submission today that show you all of the available studies, the numbers of young people in each of those studies and the proportion who were followed up, often for periods of 10 years, and the outcome for those young people.

CHAIR: Do you want to table those?

Prof. Kenny: Yes, I am tabling those.

CHAIR: Is leave granted? Leave is granted.

Prof. Kenny: On the issue about the big gap, some studies have said 68, some have said 61 and some have said 98. That is to do with the number of young people in the study; it is to do with the length of the follow-up period; it is to do with where the study was conducted and how it was conducted. It would be nice to have a much more narrowed down figure. What that figure shows, what that range shows, is that treating young children with gender affirmation means that we are going to definitely harm more than 60 per cent of the young people who, in childhood and adolescence, state that they are transgender, because 60 to 98 per cent of those will no longer be transgender if they are allowed to receive appropriate medical and psychological assistance and they are not put on the path of the conversion therapy that is gender affirmation therapy.

Mr BERKMAN: Professor Kenny, you heard the questions before to Dr Morris. Are you familiar with subsection (3) of the definition of 'conversion therapy'?

Prof. Kenny: Can you remind me what subsection (3) is?

Mr BERKMAN: It states—

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.

Prof. Kenny: I am not persuaded by these get-out clauses. This is a very sinister bill. It is an extremely sinister attempt to sneak in gender affirmation therapy.

Mr BERKMAN: I want to ask about this section. You are familiar with the section as I have read it to you?

Prof. Kenny: Yes.

Mr BERKMAN: I am interested in putting some of your submission through that filter. You have said that this bill will legislate and criminalise all other forms of therapy. Are you saying that those forms of therapy are not health services that, in the provider's reasonable professional judgment—et cetera?

Prof. Kenny: That is all very well, but why have certain therapies like psychoanalysis, hypnotherapy, counselling and group activities been specifically stated in the bill to be conversion therapies?

Mr BERKMAN: I think you are referring again to subsection (2), which sets out that conversion therapy does not include practices such as those set out, and examples of those are 'support for persons with social adjustments related to gender dysphoria'—sorry; no, I see. You are talking about subsection (1).

Prof. Kenny: There has been a complete—

Mr BERKMAN: I am sorry, the point I want to get to is that if those examples, if they are under subsections (2) and (3)—or (3) in particular—are reasonably required in a health service provider's judgement then they are not part of conversion therapy as defined in the act.

Prof. Kenny: I think it is far too difficult to interpret what exactly that means. It does not apply to those kinds of things. We heard examples from the AMA Queensland and from Dr Morris just now that working clinically with very disturbed young people is a very subtle affair. The judgement about whether a clinician who refuses to immediately refer a young person to a gender clinic, where we know almost for certain that they are going to be led down the path of gender affirmation therapy, is a very fine line. I am wondering who is going to be able to determine which side that practitioner is on.

Mr BERKMAN: Isn't it the case that there are already well accepted evidence based practices that are conducted in this space?

Prof. Kenny: No, there is not. Not at all.

Unidentified Speaker: That is the problem.

CHAIR: We will have a bit of order. We can have only the person at the table speaking. In the interests of time, we will need to crack on with questions.

Mr McARDLE: Professor Kenny, how long have you been practising as a psychologist?

Prof. Kenny: Thirty years.

CHAIR: Thank you, Professor Kenny. We will now move to the next witnesses.

FORBES, Mr Andrew, Deputy Chair, Occupational Discipline Law Committee, Queensland Law Society

MACKENZIE, Mr Ken, Deputy Chair, Criminal Law Committee, Queensland Law Society

MURPHY, Mr Luke, President, Queensland Law Society

CHAIR: I welcome representatives from the Queensland Law Society. Gentlemen, welcome and thank you for your submission. We always like to get the Queensland Law Society's view on things and you have made a number of recommendations. Would one of you like to start with an opening statement and then we will move to questions?

Mr Murphy: Thank you very much, Chair, and thank you to the committee for having us here to address questions. Chair, with your approval, what I was proposing to do was just make a very general statement and then hand over to Mr Mackenzie and Mr Forbes in their areas of expertise. Before I commence, I would like to acknowledge the First Nations of Australia, the Aboriginal and Torres Strait Islander people, as the original owners of the land upon which this hearing is taking place today. We recognise the country we stand upon, the home of both the Turrbal and Jagera nations, and pay our respects to their elders past, present and emerging.

As the peak legal body for Queensland, we stand by our commitment towards reducing the high rates of Aboriginal and Torres Strait Islander men, women and children in jails and strive towards increasing the number of legal professionals represented across the legal industry and the judiciary.

As the committee is aware, the society's submission on the bill was limited to the proposed insertion of chapter 5B which seeks to prohibit the practice of conversion therapy. The society agrees that conversion therapy is a reprehensible practice. We refer in particular to the submissions made by the Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society which submit that conversion therapies are harmful and not evidence based. Whilst we are therefore supportive of the policy intent behind the provisions, we have some specific reservations about the creation of the new criminal offence. As mentioned, I might now ask both Mr Mackenzie and Mr Forbes to address those concerns specifically.

CHAIR: Thank you, Mr Murphy.

Mr Mackenzie: As Mr Murphy said, we support reasonable measures to prevent harmful, non-evidence based practices that seek to change or suppress a person's gender identity or sexual orientation. We have concerns about the lack of any cogent data to support treating this conduct as a criminal law issue and we would echo the concerns in that respect which were made by the Australian Medical Association Queensland branch in their submission.

As a general policy, it is the society's view that law reform and particularly the creation of criminal offences should be based upon evidence informing policy and there appears to be a scant amount of evidence as to the extent to which health service providers in Queensland are practising conversion therapy and why the existing laws, whether the existing criminal law or professional disciplinary offences, do not currently address the conduct that the bill contemplates. Usually, where outdated and harmful therapeutic practices are used in medicine, these are almost always dealt with by way of health practitioner regulation and not by criminal offences.

Perhaps our most significant concerns relate to the gap between the intent of the bill and the policy behind it and the expression that that has found in the words of the bill. Perhaps to start with, it appears that the offence will apply to a health service provider, whether that is a registered regulated one or not, when that person is participating in religious activities. There has been some evidence about that to this committee from Dr Wakefield and from the department in its response to the submissions. The effect of that evidence has been that whether a person is acting as a health service provider or is acting in another capacity will depend upon the factual context of their actions, so if the dentist goes down to church on Sunday then he is not acting as a dentist. The suggestion has been in the evidence that this offence will not apply to them, but that is not set out in the wording of the offence. The wording of the offence applies to a person who is a health service provider. It does not say a person who is a health service provider in the course of providing health services; it just applies to a person who is a health service provider. We would suggest that that reassurance which has been given to this committee about whether the offence will apply to people when they are acting in another capacity is perhaps misconceived.

The bill defines its terms in very broad scope and that the gender identity of a person includes such things as other expressions of the person's gender, including their name, dress, speech and behaviour. The definition of 'sexual orientation' is defined to mean—

... 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.

One reading of that is that it is a person's capacity for sexual and emotional and affectional attraction to anyone, regardless of their gender. When you come to the definition of conversion therapy being a change to that, it is at least arguable that any intervention or attempts to change a person's sexual behaviour or who they are attracted to is captured by this bill rather than simply therapy which is designed to change the gender to which they are attracted or to suppress an attraction. It could even be arguable that that definition is so broad as to capture the work that is done in prisons with sex offenders and with sex offenders who have attraction to people who are under the legal age of consent. That is not the intention of the bill, but the wording is not sufficient to make it clear. In the Australian Medical Association's submission they suggest adopting the definition of 'sexual orientation' from the Sex Discrimination Act. That seems to be a better and clearer definition which fits the intention of what this legislation is trying to achieve.

Then the bill attempts to approach the prohibition of conversion therapy in a three-step process. The first step is to define as 'conversion therapy' any treatment or other practice that attempts to change or suppress a person's sexual orientation or gender identity, as those terms are very broadly defined. Given that there is then a provision creating an offence for performing conversion therapy, the structure of the bill is such that it at first prohibits and makes criminal any conversion therapy. It then goes on to try to limit the scope of that offence by saying that other things are not conversion therapy, and paragraph (2) does that but it does it in very general terms. Conversion therapy is not something which 'assists a person who is undergoing a gender transition' or which 'provides acceptance, support and understanding of a person'. It may very well be that the examples given in paragraph (1) come into conflict with the statements of what is not conversion therapy in paragraph (2), and that would create a problem for the courts to attempt to resolve.

Paragraph (3) provides some reassurance to practitioners for work that they have performed in their reasonable professional judgement. We have some concerns about the structure of paragraph (3) because, firstly, the offence will apply to many people beyond the regulated health professions. It applies to anybody within the very broad definition of 'health service provider' which is anybody who is holding themselves out as providing a service which assists with somebody's health and wellbeing. Outside the scope of the regulated professions, how does one assess the reasonable professional judgement of a yoga instructor or a massage therapist? It is unlikely to provide much assistance to those sorts of people. Also, the reasonable professional judgement is not a reasonable professional judgement about what is in the best interests of the patient, but it is a reasonable professional judgement as to what is necessary to provide a health service in a manner that is safe and appropriate. That test of necessity, rather than what might be desirable or what might be best practice, may raise the bar higher for a defendant than the draftsman actually intended it to do.

With all of those problems of construction, from the point of view of a prosecutor, this would be an offence that would be very difficult to prosecute because the scope of the—they are not defences—exceptions to what is prohibited conversion therapy is so broad. From a defence lawyer's point of view, there is enormous scope to bring the very practices that the bill seeks to prohibit within the scope of the exceptions. From the point of view of a lawyer advising a health practitioner as to whether or not what they propose to do might breach this provision, that will be very difficult, at least until the courts have provided some interpretation around the bill. The prudent advice to avoid any risk of being prosecuted would be to cease providing any services which might arguably result in a breach of paragraph (1). It is more a matter of construction and drafting that raises our concerns. As a piece of criminal legislation, if it is going to be enforced and followed, it is unworkable—almost hopelessly unworkable in our view.

CHAIR: Thank you, Mr Mackenzie. Before we move to Mr Forbes, I want to touch on a point you raised. You might be aware of the Human Rights Commission submission, and they were here this morning. We put to them and other bodies such as AMAQ questions in terms of trying to regulate this, and I note that you say that it should be dealt with by one of the health regulation bodies as well in your submission. It was the view of some of the submitters that that did not capture—because they are regulated health practitioners—the unregulated health practitioners out there who are practising conversion therapy. I do not know what your view is on that, but we have had two different views.

Mr Mackenzie: I might pass that on to Mr Forbes because we were having an interesting discussion about that very point before we came in.

Mr Forbes: Just by way of introduction, I will simply speak from a health regulator's perspective in terms of the mechanics. We were talking about some of the definitions which fall within the Health Ombudsman Act, of course the key being 'health service' and 'health service provider'. Some—and I confess I fall into this category a little bit—would say that the definitions within that act do appear to be very broad, but if you are the regulator and take a conservative approach and maybe take a conservative approach to that definition then you may not capture everybody. I do not profess to have any expertise in the area that the bill is trying to tackle, but I understand that, for example, in other countries like the United States counsellors, priests, religious people and so on do find themselves in this area of offering these services.

It would be arguable that providing pure counselling or services of that nature may not fall within the definition of a health service provider. That to my knowledge has not been, in terms of the Health Ombudsman Act, challenged just yet or to what extent, but they do by nature—that is, the Health Ombudsman and AHPRA operate within the regulated space, as you say. There is certainly scope to extend it. As to how far and whether it covers all of the practices, I think that is at least a grey area.

CHAIR: In the interests of time, do you want to go any further?

Mr Forbes: Just very quickly. I will keep it in summary in the context of the time. This clearly falls within a health regulator's ambit. As the committee no doubt knows, there are really two broad tools that they have. One is to take disciplinary action against a regulated practitioner or someone who falls within the definition and, as the committee well knows, that can take time. The member for Maiwar touched upon subclause (3) before. I suspect from a regulator's perspective a practitioner will be pointing to that subclause (3) to say it was necessary in their mind at the time. If the intention is to regulate this, if I crudely say the long way, there is the disciplinary action and it can take time.

The other tool, of course, is taking what is called immediate action—an injunctive power. That can be more difficult in some respects because there is a certain barrier to entry for taking action in that regard. I will come back to that in a second. In the context of just generally taking action, it is easier for a regulator to point to certain things to say this is not prohibited. One is, for example, a criminal law or a criminal conviction to say this conduct is not acceptable. The other is a regulation, and we gave an example within the Law Society's submission, a regulation that says you cannot do these in certain circumstances. The third, of course, is the colleges say that this type of therapy is not acceptable.

Outside of that you are in the hands of establishing as a regulator that this does not meet professional standards and so on. There are only two colleges that I know of, psychiatrists and psychologists, who have stated that in their view for their professionals, for their registrants, it is not acceptable. The point we want to make was it would be far clearer for a regulator, especially in the context of immediate action, to be able to point to something to say this is not acceptable in the eyes of parliament. The easy example we thought of was our drugs regulation. The health drugs regulation allows certain people to provide drugs, but they can only provide it in certain circumstances. If they stray outside that it allows the regulator to move quickly. In that context the suggestion on behalf of the society was either that there be a regulation that the therapy is not to be provided or, in the context if parliament wants the health regulator to be in a better position to move quickly rather than waiting years to just regulate through the tribunal, section 58 has a provision where a notation gives an example where the Health Ombudsman, for example, might move.

The concept of public interest is still a relatively novel concept in Queensland. If, for example, there was a notation saying that this type of therapy was not in the public interest that would empower a regulator, in my view, to move a little quickly.

Mr McARDLE: Thank you for being here today, gentlemen. You started by saying that there was scant evidence in Queensland for the need for this particular part of the bill to exist and you made the comment, Mr Mackenzie, that if we are going to put in place a criminal sanction it needs to be buttressed against an issue and the outcome is commensurate with the nature of the issue. Do you see anything here at all that justifies that?

Mr Mackenzie: I might defer in this respect to the submission of the Australian Medical Association which said that there was scant evidence of these practices occurring in Queensland at all and referred to a study, I think, done at Latrobe University with about 15 participants in Victoria. The society's usual position in relation to the creation of criminal offences is that they should be measured and tailored to meet an existing problem.

Mr McARDLE: If you accept the AMA's evidence, there seems to be little rationale for a criminal offence to be created which really imposes an 18-month jail sentence.

Mr Mackenzie: That leads us to another limb of our submission which is that if there is a need to regulate this conduct we have not seen the argument for doing that through the criminal law rather than through the ordinary regulatory systems that manage health service providers and regulated health providers.

Mr McARDLE: The member for Maiwar raised the point of subclause (3) at 213F and that does alleviate some of the concerns, I suspect, with the rider and the caveat that you put on the word 'necessary'. Does that particular subclause create confusion when you consider subclause (1) and subclause (2)? Subclause (2) is couched in the negative.

Mr Mackenzie: Yes.

Mr McARDLE: Subclause (3) seems to be a method whereby a practitioner can undertake a normal course of conduct but subclause (1) and (2) seems to remove that capacity. I am just concerned about it in terms of confusion between subclause (1), (2), and then (3).

Mr Mackenzie: I am not sure that I would agree with the construction. I agree that subclause (2) creates a negative, as you have phrased it, because it creates exceptions to the general rule about what is prohibited. Paragraph (3) in its terms actually creates an additional exemption which is that conversion therapy does not include a practice by a health service provider that in the provider's reasonable professional judgement is necessary to provide a health service in a manner that is safe and appropriate or to comply with a legal or professional obligation. Where the confusion arises in that structure of the offence provision is where something which is specifically mentioned as an example in paragraph (1)— in the examples listed to paragraph (1) is argued to be something that, in the provider's reasonable professional judgement, is necessary.

Mr McARDLE: In subclause (3).

Mr Mackenzie: So you have one part of the section saying this is conversion therapy and another part of the section saying conversion therapy does not include this. That is a conceptual problem that a court would have to wrestle with, but probably more importantly that health service providers and their legal advisers will have to wrestle with in trying to determine what is and is not allowed under these very generally drawn provisions.

Mr McARDLE: That is my concern too: the confusion that exists between the subclauses create an issue for yourself as a legal adviser and a psychiatrist or psychologist and I think your advice would be I cannot guarantee what may happen, do not do it or, if you do it, this is the risk you face if a court comes to a conclusion.

Mr Mackenzie: I do not profess at all to be an expert in the area, but the impression that I have gained from the other submissions to this committee is that there is some area of disagreement within the professions as to what is reasonable and for a practitioner to rely upon subclause (3) they would have to be confident that their professional judgement is going to be regarded by some other tribunal as a reasonable professional judgement, and that appears to be something over which occasionally people in the professions disagree.

Mr McARDLE: I think that goes to the point that this is a criminal sanction we are talking about, not to the OHO or AHPRA, which is serious do not get me wrong, but 18 months in jail you are saying needs much greater certainty in relation to the terminology used if it is to go forward.

Mr Mackenzie: That goes to the tribunal which has to determine the issue of what is reasonable professional judgement because it will not be a professional regulatory body. This is an indictable offence which will be prosecuted and heard either before a magistrate or before a judge and jury at the prosecution's election. It potentially leaves the jury left to decide, on the basis of expert evidence that is led before it, whether the provider's professional judgement has been reasonable or necessary for those purposes.

Mr Forbes: Can I add to that? Even for the health regulators prosecuting these offences, which is my job, that is why I made the reference to the member for Maiwar's reference to subclause (3). The debate is going to be almost inevitably about this section meaning that it introduces a subjective analysis of whether in the practitioner's mind they were doing something reasonable and necessary. It is going to be a difficult prosecution.

Mr McARDLE: Linking subclause (1) and subclause (3) is confusing in its own right. The examples given in subclause (1) of what conversion therapy is could well be what you do in subclause (3).

Mr Forbes: Precisely.

Mr Mackenzie: That reminds me of a point that I forgot to mention, and I have not checked this thoroughly by reading the whole of the Public Health Act, but I am not sure who has authority to prosecute this offence. By that I mean it is often assumed that offences will be prosecuted by the authority which is responsible for the act, but there is scope within Queensland's law for people to

bring private prosecutions. It is mentioned in our submission that it has not been made clear whether this is an offence which requires the consent of the Director of Public Prosecutions to be brought, whether it will be prosecuted by another regulatory authority such as AHPRA or whether it will be prosecuted by ordinary police prosecutors or potentially people bringing their own prosecutions against practitioners that they are unhappy with.

CHAIR: Thank you to the Queensland Law Society for being here today. Your contribution is much appreciated. Until we see you before us for the next one, thank you.

BLACK, Prof. Peter, President, Queensland Council for LGBTI Health

CHAIR: Thank you very much for being here today. If you would like to start with an opening statement. We will then move to questions.

Prof. Black: Thank you to the committee for the opportunity to give evidence this afternoon. I would like to begin by acknowledging the Turrbal and Jagera people as the First Nations owners of the lands on which we stand and I pay my respects to their elders past, present and emerging. I am representing this afternoon the Queensland Council for LGBTI Health which was previously known for some 30 years as the Queensland Aids Council. We have been working extensively in the area of LGBTI health since our inception in 1984. I will also note for the record that I am also a lawyer by training and I am currently the Associate Dean, learning and teaching, for the faculty of law next door at the Queensland University of Technology and I was also a participant in the round table that the health minister convened on this issue at the end of 2018.

The Queensland Council for LGBTI Health supports this legislation as it appears before the committee today. The evidence that conversion therapy is harmful and unethical for LGBT people is clear and overwhelming. It is recognised around the world and it is why all Australian health authorities, including the Christian Counsellors Association of Australia strongly oppose any form of mental health practice that treats homosexuality as a disorder or seeks to change a person's sexual orientation. We are also increasingly concerned by the reports of conversion therapy taking place not just in the context of sexual orientation but with a person's gender and gender identity as well. That is why the Queensland Council for LGBTI Health supports this bill as a first step in the government's response to conversion therapy.

I must admit that I have not listened to all of the evidence that has been presented today, I have just heard parts of it throughout the day, but there has been quite a bit of discussion today around whether there is enough of an evidence base for this legislation to be necessary. I would make a few points in relation to that first of all.

There was clear evidence presented at the roundtable that the health minister convened that conversion therapy was taking place in Queensland, primarily in religious settings. What was alarming at that roundtable was the evidence from a number of the psychiatrists and psychologists in the room that they were aware of this practice also taking place within the medical setting as well which was, to be honest, something that I had not necessarily anticipated before that roundtable had taken place. That is why I think it is a very appropriate first step to focus on the area of health practitioners and those who provide these health services in that broad definition that has already been noted before this committee today.

The second thing I would note is that I do not claim for a moment that this practice is widespread in the state of Queensland, but there is evidence that it is taking place in some limited circumstances. There is also, as I said, clear evidence that this practice is harmful and unethical. Thirdly, the criminal law of Queensland is also a moral statement from the parliament and our elected representatives about what is and what is not acceptable in modern Queensland society. The medical evidence is overwhelming that this practice is harmful and unethical. This parliament should be commended for recognising that and taking this positive, proactive step to send a clear legislative symbol reflecting that fact. We believe that will be very powerful and important for a number of our members of the LGBTI community, whether they are survivors of conversion therapy or not. It is a recognition from the government of this state that that practice is wrong and that there is nothing wrong with being lesbian, gay, bisexual, transgender or intersex.

With respect, I suggest the focus on the data is somewhat misplaced in this unique set of circumstances that we are focusing on here today. I would also note that there has been concern expressed by some medical practitioners around whether this will interfere with their ability to provide adequate health care to their patients. I note again the discussion that I just heard with the representatives from the Queensland Law Society around the definition of conversion therapy in this bill. The inclusion of subsections (2) and (3) in that section do make it quite clear that decisions that medical practitioners or health care service providers are choosing to make if they are in accordance with the evidence base and are in accordance with their ethical and professional standards will not be captured by this definition. I think that is abundantly clear given the inclusion of subsections (2) and (3). I am happy to take any questions.

CHAIR: Thank you Peter. You touched on a point that there has been a number of submitters who have asked the question about evidence. At that roundtable, you said that you were surprised that you heard from psychologists or psychiatrists that it was happening. I do not know if you can share any of the detail in a public hearing, but the committee would possibly be better informed of

what is occurring out there. Perhaps if you wanted to do it in a confidential manner or if you could table anything that can assist us to get a clearer picture of what is happening out there? I do not know if you can answer that question?

Prof. Black: It was noted that two of the medical practitioners who attended that roundtable confirmed that there were cases in Queensland of people subjected to a type of conversion when presenting to psychologists, GPs and counsellors. It was also noted that there were several instances that these doctors were aware of whereby patients has been referred by a doctor to a faith based group for treatment rather than providing sort of gender-affirming treatment in that place. It would really be up to the doctors who participated in that roundtable to give any more details if they were willing to do so.

CHAIR: That is fine. You said in the opening statement that there was overwhelming medical evidence of harm. I ask that that evidence to which you are referring either be tabled or that you speak to some of that.

Prof. Black: I am certainly happy to table that, but the fact is that—and you heard this from the various medical groups that made submissions and gave evidence today—there is no medical support for the practice of conversion therapy. It is condemned by these professional associations as being unethical and harmful to LGBTI people. I am happy to provide the specific instances of that.

CHAIR: Thank you very much. I will open up to other questions.

Mr O'ROURKE: Thank you for being here this afternoon. In your experience, is there general support in the community for proposed bans on conversion therapies? How important is legislating a ban on these therapies in protecting the rights of the LGBTIQ+?

Prof. Black: I can say quite confidently that overwhelmingly within the LGBTI community there is support for these bans. Members of the LGBTI community know how difficult it is to live their life openly and freely as a member of that community in a number of instances. Most members of the LGBTI community would be friends with or know someone who has been subject to these practices. For a variety of reasons, which I am sure you can understand given how deeply personal both a person's faith as well as their sexuality and gender identity can be, a lot of these people are simply not willing to speak about that experience publicly or openly. To be frank, this is also not an uncommon problem when we are dealing with legislation aimed at supporting or improving the experiences of LGBTI people. I appeared before a different parliamentary committee when this parliament was considering the issue of expunging historic gay sex convictions and there was a similar challenge in that particular case of finding the data and finding the people, because a number of members of the LGBTI community who had had those experiences had lived with the shame and the trauma of that for a considerable period of time.

For quite understandable reasons, they do not particularly want to come forward and relive it, nor do they want to come forward and potentially see themselves exposed to further criticism, vilification or discrimination. But there is overwhelming support within the LGBTI community for these bans. To be honest, irrespective as to how many prosecutions ultimately arise from it, what is important to our communities is that it is a clear, definitive, unequivocal statement that there is nothing wrong with being lesbian, gay, bisexual, transgender or intersex and that these sorts of practices that try to change who people are cannot be tolerated or accepted in a modern Queensland society.

Mr BERKMAN: Thank you for being here Peter. There has been a lot of discussion and commentary around particularly subsection (3), the definition and some concerns expressed that it is too ambiguous and that health service providers will not be able to have faith in that as an exemption that applies to them. The QLS then said that it is such a broad exemption with such a subjective test that it will be difficult to prosecute. Is the possibility that the exemption is possibly too broad to allow effective prosecution under this section a concern for you?

Prof. Black: My view and the view of the Queensland Council for LGBTI Health is that that exemption is appropriate and in the language that it is written it is not a purely subjective test, either. It is within the provider's reasonable professional judgement. The inclusion in clause 3(b) around complying with the provider's legal or professional obligations also leaves scope for any professional bodies that are concerned about how their members may comply with this can set very clear guidelines around those professional obligations to ensure that beneficial, affirming treatment will not be captured by this definition.

Mr BERKMAN: The yoga instructor's college can get together and decide what is or is not appropriate. Sorry, I do not mean to make light of it. That was an interesting touchstone for the Queensland Law Society when they gave their evidence.

Prof. Black: I thought that was unusual as well. The reality is I also noted the two examples given around massage therapy and yoga. There are professional bodies that deal with that anyway, even in the unlikely event that it was going to arise in either of those particular contexts. If the professional bodies were so concerned, I could make very clear what the professional obligations are to protect both their members and also the broader community.

Mr BERKMAN: That is very helpful. Thank you.

Ms PUGH: Thank you very much for appearing today. We have had lots of great witnesses with very diverse views. We heard earlier from some medical and psychiatric practitioners around different clinical methods, I suppose, of dealing with things. A particular method that has come up a few times is watchful waiting. What is your view of watchful waiting as a method or a clinical approach to a child or an adolescent who is questioning their gender specifically as separate to questioning their sexual orientation?

Prof. Black: There are a number of circumstances that you would need to look at depending upon the fact pattern of any particular case, but as a general proposition when talking about watchful waiting for adolescents or young people in the right context and for a reasonable period of time, that is not necessarily an improper treatment or an improper approach. In some instances it may be, but I would not be prepared to issue a blanket statement on that.

Mr McARDLE: Thank you for coming in today Peter—a good submission as well. I want to return to the issue of data collection. You raised a point about your appearing before an inquiry regarding expunging criminal records of gay sex. I accept that that was a very difficult thing that many people had to go through. You used that to say that the data could not be located, but in that case we still did it. Here we are creating a criminal offence and that matter we are expunging is a record. Isn't it different when you are creating an offence that carries 18-months jail that really you need to bring something forward to substantiate the necessity for that?

Prof. Black: If anything, I would have thought the evidentiary burden was more difficult in the instance of expungement than it is in this particular instance. The reason why I say that again goes back to the fact that our criminal law is meant to be this moral statement around what is not and what is acceptable in modern society. If the people of Queensland, the medical community and the parliament all share the view that this practice is harmful, which is what the evidence suggests, the parliament should be prepared to legislate whether they suspect there is one instance or 1,000 instances of it taking place. I do not really see why the quantity is so relevant to this discussion.

Mr McARDLE: You just used the phrase 'what the evidence suggests'. I am simply asking you what is the evidence that makes this a necessity? No-one here today has been able to give me that evidence. We heard of comments made by people in meetings; that is not evidence. So I am stuck with that first question. How do we substantiate the creation of a criminal offence, particularly 18-months imprisonment, when no-one can show me that the evidence exists that it is occurring? That is my first hurdle.

Prof. Black: Can you present me evidence that it is not occurring?

Mr McARDLE: I do not have to do that. That is the point, you see. The bill exists. You are an expert who has come forward supporting the bill. Our role is to examine the bill. If you support the bill I have the right to say to you, in an objective assessment, 'Where is your evidence?' We will make up our mind as the committee when all the evidence is before us.

Prof. Black: The evidence has been referred to in the research that has been prepared by La Trobe University, which is the leading Australian study on this. You heard evidence earlier from the LGBTI Legal Service around a number of their clients presenting to them with stories. I can also again tell you that at the Queensland Council for LGBTI Health we have had clients and community members talk to us about their traumatic experiences with conversion therapy taking place in Queensland.

For the reasons I articulated earlier, it is very, very difficult for people to come forward to speak about these instances in any sort of public setting. I think that is why you do not see a great deal of firsthand reports of this coming forward. There is I think evidence in the research, which has already been referred to. I think the fact also that all of these medical associations have felt the need in even recent years to come out and condemn this practice suggests that they also believe it is happening or else they would not feel the need to do that.

Mr McARDLE: They believe the consequences of it happening are dangerous.

Prof. Black: I would suggest—

Mr McARDLE: That is the second alternative perspective: they believe that if it does happen it is dangerous. It need not be the fact that it is happening.

Prof. Black: I would suggest that that same approach, even if you are persuaded that there is not enough evidence of it happening—

Mr McARDLE: No, I am not saying that.

Prof. Black: That is why I said 'even if'.

Mr McARDLE: I made it very clear.

Prof. Black: Even if you were of that view that there was not enough evidence of it happening, you should be concerned by the evidence around the harm that that practice can cause to individuals, which is widely accepted within the medical community, and you should be wanting this parliament to take a very strong stance against that practice.

Mr McARDLE: The national laws in relation to health providers already effectively do that. OHO does it, AHPRA does it, the colleges do it. Why not remove the imprisonment and simply ban the practice? My concern is why do you criminalise something? Why not just ban it?

Prof. Black: You criminalise it because of the lives that are destroyed as a result of the practice. There should be a sanction attached to that.

Mr McARDLE: AHPRA would do that, OHO would do that, the colleges would do that. Abortion was removed from the Criminal Code just for that purpose: to take it out. Now we are putting this into the Criminal Code. I am not arguing with you in the sense that you are right and I am wrong; it is just clarification of a point. I just do not see the rationale. We removed termination from the Criminal Code and put it into the health basket, and now we are putting this into the Criminal Code.

CHAIR: They are two different things.

Mr McARDLE: I accept the point, but the action is very similar.

Prof. Black: If you accept the anecdotal evidence and the reports that we hear in the community sector, there is also evidence that where this practice is taking place is not purely and strictly within those areas of the medical profession that are subject to those same ethical and professional standards. Indeed, at the very beginning of this process one of the first things the health minister did was to ask the Health Ombudsman whether they had felt they had adequate scope to address this issue. The response came back: no. That is why we are now in this situation. We are trying to respond to this problem. We are trying to empower and support LGBTI people.

Mr McARDLE: When you look at the Health Ombudsman Act, 'health service provider' is defined and so is a 'health service'. It states—

A ***health service*** is a service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing.

There are not many people out there who would not fall under that umbrella. A masseuse would fall under that umbrella. It is difficult to accept the argument that there are organisations or bodies that will not fall under the OHO jurisdiction. It is a very wide definition.

Prof. Black: It is not so much that the bodies themselves will not fit under the definition; it is the way in which OHO operates and that the standards which they enforce are unlikely to cover these scenarios. I am not suggesting that that definition is not going to cover it, because that is the very same definition that is used in these amendments; it is drawn from the Health Ombudsman Act.

Mr McARDLE: Exactly right. Is it a lack of power in the OHO you are concerned about?

Prof. Black: That would have been one option open to the government to address this issue.

Mr McARDLE: A better option do you think?

Prof. Black: No, I do not think it would have been a better option.

Mr McARDLE: The Criminal Code is the only option?

Prof. Black: It is not the only option but I think it is the best option.

CHAIR: Thank you very much. We did receive some confidential submissions that talked to people's lived experience. That would be difficult to articulate in the public arena, but it is noted that the harmful effects of conversion therapy are blatantly obvious from those people who provided that. That is all we can rely on at this stage. You have heard it today; people want to ask for evidence. I think you have articulated the reasons why, much like we saw with the work done in the child abuse space, people only come forward years later. We do appreciate your time and your contribution here today.

Prof. Black: Thank you very much for the opportunity.

WHITEHALL, Professor John, Christian Medical and Dental Fellowship of Australia

CHAIR: Thank you very much for being here. I will start with your most recent engagement and again congratulate you on becoming admitted as a consultant meritus in Townsville last week—or whenever it was—it seems like last week that you were there. I know Professor Whitehall and the work he has done in the neonatal intensive care space. He is well regarded and I thought that was terrific recognition of your years of work in that space. However, you are here today to talk about this particular bill. I would ask before we start if you can clarify whether you are appearing today as a representative of the Christian Medical and Dental Fellowship of Australia or in a private capacity? I say that because your submission is on behalf of the CMDFA. Can we just get clarification?

Prof. Whitehall: I was a bit confused, but technically yes, I am representing them. I am not representing my employer; I need to make that very clear. Thank you for your kind words of introduction. That is nice.

CHAIR: You are well regarded in that space. I think we have all been a fan of the work you have done there. Would you like to start with an opening statement on this particular bill and your concerns around this?

Prof. Whitehall: I will be pedantic about that statement. I share the committee's concern for gender confused children. I acknowledge their increasing numbers and sympathise with the children and their families. I am not here to dispute their suffering, merely to point to local and international research that would warn there is little, if any, scientific basis for the experimental affirmative approach of hormones and surgery, which may well be mandated by your parliament, on the pain of jail sentences for dissenters of up to 18 months.

Worse, I would like to point out there is evidence of harm from this treatment by puberty blockers, for example, whose effect is not confined to a vertical access from the midbrain to the gonads. This effect that you are blocking extends broadly to other areas of the brain. Indeed, the blocked hormone may have a widespread role in the health of all nerve cells—recent research suggests—beyond the brain and even to nerve cells in the bowel. This is not a simple thing that is going to be blocked by the blockers.

Are there side effects that have been shown? Yes. Experiments on sheep in Glasgow, for example, in association with universities in Oslo, have demonstrated a lasting effect on the limbic system of the brain of sheep on blockers. The limbic system integrates emotions, experience, cognition and reward into an inner world view of identity. What happens if you put the sheep on blockers? They perform badly in the mazes and their emotions are disturbed; the males are more gung-ho and the females are more labile, a lasting effect.

Children as young as 10, however, have had puberty blocked by the blockers under the claim it will provide time—I am quoting—to consider gender identity and procreative future. Is that likely to work? My argument is that this is biologically and psychologically implausible. How is this child at 10 or 11 years of age granted more sensible time to work out whether he is a boy or a girl and how many children he is going to have? That is what we are going to work on, and is that helped by the blockers?

First, the limbic system is damaged; that is the integrating system of all these things. Second, the sexualising effect of a midbrain centre, which is dependent on the blocked hormone, is neutered. We have known about the existence of that centre since the seventies, for example. Third, the sexualising effect of gonadal hormones, testosterone and oestrogen, is neutered because you are suppressing the gonads, and we all know about the secondary sexualising effect of those things. We are expecting this neutered child to be able to better work out whether he is actually a boy or a girl when we have neutered all the hormones and yet he is under the sustained influence of all the authority figures who support an identity incongruent with his chromosomes.

Therefore, it is little wonder that the children started on blockers continue to the next phase, which is administration of cross-sex hormones, and there are side effects here. Metabolic effects are well publicised but not so the effects on the brain. Time is limited, but it has been shown in Hulshoff Pol's research, for example, that male brains on oestrogen may shrink at a rate 10 times faster than ageing after only four months of administration, presumably because of cell death. No-one can actually do the biopsies. The female brain hypertrophies; this is an MRI based study. It does not mean that she has more nerve cells, but it means they are pathologically enlarged somehow. Does that effect the way they are thinking? Yes, but a lot of the studies are in association with prostate cancer or endometriosis, and there are other factors. It is difficult to actually apportion the degree of blame.

It should be reported at this stage that blockers themselves, if given to a male child—this is a report from about a year ago. A male child had an MRI before he went on the blockers and an MRI after being on the blockers, and it showed there was a structural interference with the development of the brain and that was associated with reduced cognitive awareness. That is a bit hard to measure, I agree.

These are some of the side effects. How long does it take to recover? Everyone says that the blockers are safe—not me—and entirely reversible. I am saying it is not safe according to established research on sheep. Is it reversible? Nobody knows whether or how long it would take for that brain that you have blocked to come back to the normal structure. However, the development of the brain—and this is what I was studying in Townsville—is organised from about six weeks post conception. There is a development after birth and then it lies in an organised fashion awaiting activation by the sex hormones, which is time to receive according to a biological clock. If you mess with that biological clock no-one knows the answer. People say that this intervention is evidence based. It is not evidence based; we do not know what is going to happen to that brain. The next state after this stage of affirmation may be surgical intervention to create facsimiles of the opposite sex. Mastectomies on adolescent girls are claimed to be reversible as if the human breast can be reduced to a cosmetic appendage replaceable by silicon sacks.

It should be emphasised that chemical castration is involved in the earlier hormonal treatment and it is now corroborated with surgical castration. We are not only talking about reduced fertility and all these euphemisms; we are talking about chemical and surgical castration. Little appears to be shared, if you look at the information given out by these gender clinics, about the long-term complications of any of this, including the surgery, including castration, incontinence, infections, reduced sexual performance and so forth. Even less appears to be shared about the 20 to 30 times higher suicide rate in transgendered adults and about the growing number of disillusioned detransitioners complaining about the experimental therapy to which they were led to submit.

There is, indeed, no evidence—everyone is talking about evidence based, but there is in fact no evidence. There were authors from the Royal Children's Hospital in Melbourne who wrote a paper published in *[Pediatrics*, one of the top three journals of paediatrics in the world. They lamented in that, they confessed, having looked at all the literature, that there was a dearth of supporting literature for this affirmation process. You look at all of the things, even the proponent things, and people are saying there is a dearth of experimental evidence to support this. There is widespread acknowledgement by both protagonists and antagonists about that, and I will get to that at the end.

To the contrary, there is evidence that most confused children will revert to an identity congruent with natal sex through puberty without intrusive medical care, supported—and we have mentioned this several times—by a watchful waiting approach with individual and family therapy. What does that mean? It means watchful. These kids are vulnerable. All of the studies show that they have a much higher incidence of depression and anxiety—20 per cent in some people—a study of autism for goodness sake, and among other things children have even been diagnosed with psychosis and even schizophrenia. Everyone knows that these children have a high incidence of comorbidity and they need to be watched and cared for because of each one of those things, not to mention the fact that most of them come from broken homes and psychological difficulties with their parents. They need to be watched and each one of those things, even autism, is associated with a higher rate of self-harm. They have to be watched.

The argument is, and this is a manipulative tool, if you do not affirm them they will commit suicide. I quote—and I can give you references from the *Journal of Homosexuality*, for example, no less—that there is no evidence, none whatsoever, that the symptom of gender dysphoria by itself is associated with a higher rate of suicide. To the contrary, studies coming out, as we mentioned before, from the most accepting countries such as Sweden, Belgium and so forth, show a 20 to 30 times higher rate of suicide in adults who have transgendered.

Therefore, what is watchful waiting? You are watching and you are waiting in expectation of the statistics coming on your side and the statistics, even in the *Diagnostic and Statistical Manual of Mental Disorders*, the DSM, the bible—even the statistics are showing that the majority of those children will revert to an identity congruent with their natal sex if you support them along the way. You have defined that. You are legislators. You are going to define that as conversion therapy. You are going to ban that and if I practise that you are going to put me in jail for 18 months.

I will move quickly to the end and then you can ask me questions. I think it is regrettable that the trend of this litigation is likely to weigh heavily on departments of health. Why? Because human rights legislation after World War II should protect children from experimentation. Even by definition the Royal Children's Hospital in Melbourne is practising experimentation, because they have just

been in the process of completing research that is experimenting on children. They have accrued into their affirmative care 200 children a year, so 600 children in there are undergoing it. Now they are trying to work out what will happen to them. This is experimentation after the event and it contravenes all of the World War II legislation. Why? Somebody mentioned that before. Because it is not biologically plausible. You cannot give a pill to reverse the effect of chromosomes in every cell of the body. It is not reasonable. This is a huge intervention. We mentioned castration effects on the brain. This is a massive intrusion, a lifelong intrusion, into the child. This is an unreasonable experiment.

Is there need? No, because it has been shown in the past that with watchful waiting, counselling and this sort of stuff they will come through by themselves. Is there informed consent? No. How can a child give informed consent to the shrinking of his brain? Is there a right to withdraw? No. Stay on this stuff for four months and your brain is already shrunk. Can you withdraw? No. Is there an appropriate structure of the experimentation taking part in Melbourne and likely to be undertaken here in Brisbane, the same 'after-the-event, gee, we'd better have a look at what has happened'? No.

This should be a disinterested blinded appraisal. It should not be the person whose job depends on giving the medicines who then sits back and tries to work out whether it was helpful or not, because this is called confounded bias. There should be controls in the Melbourne thing. There are 600 children, but there are no controls. It would be logical to say, 'Okay, we're going to give them the therapy, but let's give another blinded lot over here watchful waiting and see what happens.' That is not it. There are no controls in this therapy, there is no blinded review and there is no defined end to it. They are going to measure it. There are questionnaires that you can give to children: 'Are you happy?' Yes, fine: he is happy after one year; he is happy after five years; he is happy after 10 years—but most of the detransitioners are appearing in later adulthood.

There is no defined end to this experiment in Melbourne as to what is going to happen to those people whose brains have been altered and who have been castrated, blah, blah blah. What happens in the cold and lonely years of adulthood, which is where the detransitioners are emerging? That is where your Queensland government is going to be liable, because these people are going to come medico legally. I was speaking just a week ago with Jeremy Hyam, who is leading the prosecution by two of these people who are detransitioning. They are suing the Tavistock Centre, the big centre in London that does this. Why? For leading them into an uncontrolled unregulated experiment, 'And look what happened to me.' That is to be regretted.

What else? We were talking about legal things. We should be mentioning Rogers v Whitaker. Rogers was an ophthalmologic surgeon. He operated on a lady's eye and forgot to tell her that, with the good eye, one in 12,000 to 14,000 may well go blind. He did not tell her that. It went all the way to the High Court. The High Court decided that you must tell people of these possible complications lest that interfere with their decision-making. I challenge you to look at all the affirmative literature supporting the affirmative process. You will see repeated, time and again, blockers—safe and entirely reversible. You will hear about thickening of blood on estrogen—who cares? You will not hear about stuff on the head nor will you hear about the problems with this detransitioning. Your people are, in fact, confounding Rogers v Whitaker.

I have a lot more to say, but I would love to answer questions. I have written seven articles in *Quadrant*. May I table the names? I can even send you the articles, because they are referenced. We have mentioned the deposition to the [federal member. That was, in fact, written by me and there are 83 references there. I was not asking for a review by the RACP, because—I am a member and I will get struck off now—that is a bit like asking the arsonist what caused the bushfires. We have asked for a parliamentary inquiry into this. We have listed all this stuff and none of the things that I have said to you today are without a reference.

CHAIR: Procedurally, is leave granted for the tabling? Leave is granted. Briefly, because we do not have much time, in your opening statement I think you acknowledged that conversion therapy did cause harm. Can we get clarification for that?

Prof. Whitehall: Wait: your conversion therapy, not mine. Your conversion therapy is the administration of hormones and surgery to convert a child, against their chromosomes, to the opposite sex. You should criminalise that one. Mine is wait and see, and help and support the child through.

CHAIR: I will rephrase: can I get your view, does conversion therapy cause harm?

Prof. Whitehall: No. In children, there is no evidence whatsoever. I think you guys are being led up the garden path by this kind of spectre of medieval torture on children, which is not there.

CHAIR: That goes against what we have received from people who have shared lived experience, who talk about the harm and the higher incidence of suicide.

Prof. Whitehall: You have some anecdotes of people who are disaffected with this. We do not know what happened in their stories. There is a handful of them who are giving anecdotes that they were harmed by it; that is true. In all medicine, you are balancing off the side effects. You are looking at a few people like that, whereas you are looking at the promise of castration and cerebral effects and so forth, and the established 20 to 30 times higher rate of suicide in transgendered adults. You are balancing them off: anecdotes versus epidemiological work.

Mr BERKMAN: Professor Whitehall, you expressed concern that, in your practice, under this legislation, you would go to jail for 18 months, if I understood that correctly.

Prof. Whitehall: If you win, yes.

Mr BERKMAN: Sorry, if we win? Do you mean if this bill were enacted?

Prof. Whitehall: I am being facetious. If this bill is enacted and I was practising in Queensland—I will tell you this—

Mr BERKMAN: I am sorry, I have a follow-on question. Is that your understanding?

Prof. Whitehall: That is my reading of your bill, yes.

Mr BERKMAN: In practice, do you exercise reasonable professional judgement in providing safe and appropriate health services?

Prof. Whitehall: Yes, I hope so.

Mr BERKMAN: In that case, the bill should give you every confidence that—

Prof. Whitehall: No, we have already—

Mr BERKMAN: Excuse me, if I can just complete what I am saying. The bill is explicit in subsection (3) under the definition of 'conversion therapy' that, in those circumstances, the practice is not considered to be conversion therapy. I am confused about your reading of the bill and your assertion that you think you will go to jail for 18 months when, at the same time, you purport to exercise reasonable professional judgement in providing safe and appropriate health services.

Prof. Whitehall: Yes, because I do not trust the ambiguity of all this wording. That is the issue. Last week, I had a woman come to me with a child. He is 13 years old and he thinks he is a boy. We discussed this in general for about an hour and a half. She said, 'Will you help?' I said, 'You don't know what you are asking me', because if I do not refer him immediately to the transgender clinic I am committing a sin of omission; if I go ahead and try and make him comfortable in the skin in which he was born I am committing a sin of commission. If I was in Queensland—and I said, 'I'm going to Queensland in a week'—I could go to jail for 18 months for that.

Mr BERKMAN: That would be incorrect, because we are looking at legislation that has not yet passed. I want to rewind—

Prof. Whitehall: But do you see what that did to me? I have been in paediatrics for a long time. For the very first time in my life, I thought, 'Oh, am I going to take this kid on, at this stage of life?'

Mr BERKMAN: You have referred to the DSM, which does recognise gender dysphoria as a condition to be treated professionally. I think it was representatives of the AMA who earlier today indicated their view that there are certainly circumstances in which transitioning will lead to the best outcome for a person. Do you accept that that is the case in some circumstances?

Prof. Whitehall: I have never seen that in my entire paediatric career.

Mr BERKMAN: So your view is that transition is never the appropriate outcome?

Professor Whitehall: I am not going to say never. You can never say never in medicine. I am just saying from what I have seen and what I have read, the vast majority of these children, if you do not go down the affirmative way—this is not my words; this is the DSM—will revert to an identity congruent with their chromosomes—this is their statement; not mine—as long as you do not mess them up on the way through. Now, that is my opinion. I think that with transitioning them, there is no evidence for benefit from this massive intrusion. There is no evidence for it. If you have evidence you could persuade me, but at the minute there is no evidence of benefit from this.

Mr BERKMAN: This morning we have heard from clinical practitioners who, in dealing with people, children included, and in dealing with gender dysphoria, do give treatment that supports those people and ultimately ends up in a process of transition. Are you saying that you do not think that in any circumstances that you have ever seen that could possibly be the best outcome?

Prof. Whitehall: You can never say never in medicine. I have not seen it and I am encouraged by all the statistics that show that the vast majority of those children will revert with watchful waiting support. That is the issue. Maybe there is an element that will get better or will improve—maybe, maybe—but I am yet to be convinced of it. I am accepting of the vast literature that says that they will revert to the identity congruent with their natal sex, by themselves. Those are not my words.

Mr BERKMAN: I guess what I am asking for is your view.

Prof. Whitehall: I accept that view.

Mr McARDLE: Professor, my colleague referred to subsection (3) under the conversion therapy definition. You heard him talk about 'reasonable'. He did not indicate that the Law Society gave an opinion that, when you consider the terms of subsections (1) and (3), there was confusion. I think that needs to be clarified for the record. I do not think you can simply look at one particular subsection in isolation. The society has made it very clear that they are concerned about how the subsections interact and what is banned in one section may well be accepted in another, and that is where the confusion, in their minds, rests to clarify that point. The only other point that I have, Professor, is this: I think you made it clear that, to your knowledge, studies do not exist to indicate the need for a criminal sanction; is that right?

Prof. Whitehall: I think a criminal sanction is a draconian concept. You are immersing yourself enormously in medical practice. You are criminalising psychiatry and psychotherapy. You are forcing me to write prescriptions and to put the child on a lifetime dependency on active medical care, by criminalising psychotherapy.

Mr McARDLE: Isn't it also dangerous, without clarity of wording, to put in place a regime that raises concerns in the minds of psychiatrists and psychologists to undertake this form of work in any sense, because you then do not have that wall of protection that young people should have in relation to identifying themselves by way of gender or sexual orientation? If they remove themselves from the field because of uncertainty, that will be a disaster?

Prof. Whitehall: Yes, and that is a very powerful thing. I felt intimidated. I am at the end of my career, but last week I felt intimidated by this question, 'Do I take this child on?' If it affects me, it is going to affect everyone, especially the younger people. They are the ones who are going to be intimidated. You are not going to have any young paediatricians. I asked 28 of my colleagues, 'Do you believe in this gender dysphoria treatment of children?' They said, 'No, we don't believe that at all.' There were 28 of them with 931 cumulative years of experience. They could only remember 12 children who were confused over their identity. Ten of them they remembered because of the associated psychiatric comorbidity. Two of them had been prolonged victims of child sexual abuse and that is how they remembered them. Do you know what they said to me? 'We don't believe in this. We've never seen this stuff, but don't mention me.'

Mr McARDLE: Thank you, Professor, for your time.

CHAIR: Thank you, Professor Whitehall, for your contribution today. I will close this public hearing.

The committee adjourned at 3.49 pm.