Motions

GENDER DYSPHORIA

The Hon. F. PANGALLO (15:53): I move:

1. That a select committee be established to inquire into and report on young people seeking assistance for gender dysphoria in South Australia and related matters, with particular reference to:

(a) the health care and related support services provided, and options available, to children, adolescents and young adults seeking services for gender dysphoria or other gender identity related issues in South Australia, and their parents, guardians and families;

(b) the role, rights and obligations of parents and guardians of minors seeking services for gender dysphoria or other gender identity related issues;

(c) the public funding of health and education services in South Australia in relation to sex-related and gender-related issues; and

(d) any other related matters.

2. That this council permits the select committee to authorise the disclosure or publication, as it sees fit, of any evidence or documents presented to the committee prior to such evidence being presented to the council.

I wish to speak on the motion in my name. It deals with the issue of gender dysphoria and gender-affirming care. Gender dysphoria is defined as the distress that trans people can feel because of the incongruence of their gender identity and gender presumed at birth or sex characteristics.

This subject is perhaps one of the most complex and controversial medical issues confronting our society today, from the troubled children and adolescents being engulfed by it, to medical and mental health professionals grappling with the ethics and standards being applied to treat this condition, our educators, who are being confronted by young people uncertain about who they are as they map their learning future through a maze of other personality problems, and finally to the families being torn apart over the welfare of their own children through the phenomenon and sudden surge of gender transformation and ideology.

This social contagion, relatively obscure in the last century, and mostly associated with prepubescent boys, is now sweeping the world at such a frenetic pace that it is becoming increasingly difficult to determine whether the practices and policies being promoted by government-funded interest organisations and other self-interest groups, then being put in place by well-meaning medical institutions, are helping individuals or is it causing them more harm than good in the long term; is it evidence based?

This is the intent of the select committee I am proposing. I understand there are many members in this place who may find this difficult to engage with because of the sensitivity of the subject matter involved. I want to make clear my own position, which I have not taken lightly. It is not to be seen as a reflection of any preconceived views or hysterical prejudices about the transgender community.

This is all about having a balanced perspective and learning more, so that we as legislators can take a far more responsible approach in dealing with it. To ignore it would be at the peril of those we are trying to assist. I fully expect to be attacked by the transactivists and ideologs who dominate this arena. However, I want them to participate and contribute, to put aside the vexed politics. Yet, raising it in the proper context of a public debate still attracts fury, hate and retribution.

A respected children's psychiatrist was suspended by the Queensland hospital where she worked because she raised her professional concerns. A Tasmanian councillor is facing charges of inciting hate speech, all because she voiced an opinion that contained nothing of the sort of inflammatory language she is being accused of.

A Victorian MP, Moira Deeming, was castigated by her own former party, the Liberals, for her stance. Senator Alex Antic has probably copped it since introducing his private member's bill to stop puberty blockers being given to children under 18. We saw what happened to federal Liberal candidate, Catherine Deves, last year for her views against transwomen in women's sport. On it goes.

In the transactivist world it seems you can have an opinion if you agree with them, and without it fuelling contempt and derision. But they are losing sight of what is being sought by some of the world's leading health professionals and organisations, as well as the confused and distressed families and individuals caught in the crossfire.

People should never be intimidated or afraid to speak up for their beliefs or silenced by the dictatorship of minorities, as award-winning French clinical psychologist Celine Masson and French child psychiatrist Caroline Eliacheff describe it after being subjected to activist attacks for their research, which suggested that some trans identified children and adolescents rushed into medicalised treatments were not trans at all but were influenced by activity on social networks and peer contagion, which is a form of social contagion, where children can be influenced by the behaviours within their network of friends.

That may well apply in Australia and explain the surge in gender dysphoria amongst girls and people on the autism spectrum. Transgender advocates define transgenderism as a belief that a person was born in the wrong body and the body must be adjusted to fix those beliefs, an assumption that the mind is correct and cannot be questioned. There is a term for this: psychological solipsism. An example of this type of thinking is a person with anorexia nervosa, who believes they are fat when in fact they are thin.

French journalist and author Pauline Arrighi, in her recently published book, *The Ravages of Gender*, asks: 'Is gender reassignment always the solution for these young people? Can a child really be trans?' Pauline says that the majority of transgender child or adolescent cases she explored were in fact young people suffering from psychosocial difficulties that were brushed aside in favour of an illusory gender affirmation.

I hope members in this place know me by now as someone who delves into matters for the right reasons and probes to get answers so we can have a better understanding to help us make informed decisions. I have spent months researching and reading a lot of material from all sides. I have spoken to medical, legal and teaching professionals. I have met with families. I have spoken with individuals who have gone through the treatment.

There is no point in abstaining from this debate nor pretending there is not anything here that needs to be addressed because it might be perceived as politically unpleasant to upset an already marginalised and psychologically vulnerable group in our community from the attention it receives. We need a mature discussion, not one which is polarising. There is a lot of misinformation, emotive language and, surprisingly, a lack of credible scientific evidence, despite what you might hear.

There is a striking division globally within the medical and mental health professions about the treatment of gender dysphoria. On one side, there is support for intervention and criticism for delays they say could be harmful. On the other side, there is the view that these interventions are unnecessary and harmful, calling for a more cautious approach to the medical affirmation model.

Many international jurisdictions are moving in this direction, including France, Sweden, Denmark, the UK, the US and Finland, which issued new guidelines that emphasise that psychotherapy be first considered before medical interventions for the treatment of gender dysphoric youth and no sex change surgery for minors.

American states have followed, while Sweden's largest children's hospital, the Astrid Lindgren, stopped prescribing puberty blockers and cross-sex hormones to children under 18. Britain's Tavistock gender clinic had to be closed after a review by British paediatrician Dr Hilary Cass exposed an activist-driven culture and concerns over their treatments, particularly in rushing children onto puberty blocking drugs without any prior investigation of their complex psychiatric issues.

A landmark UK High Court case in 2020 dismissed the claims by affirmative therapists and found that minors were not capable or competent enough to give their consent to gender transition and taking puberty blocking hormones. The National Association of Practising Psychiatrists says its main areas of concern include the child's capacity for informed consent and the medical risks, known and unknown, of treatment with puberty blocking drugs, sex hormones and surgery before the age of 18.

Dr Georgie Swift, the psychiatrist involved in setting up the gender clinic at the Women's and Children's Hospital in North Adelaide, told a psychiatry conference only last month that the evidence for gender affirming treatment was not robust. Here is what she told the conference:

> I'm reasonably confident to say that no matter where you stand on gender-affirming health care for children and adolescents, that you agree that we need more evidence—our evidence isn't robust, it isn't good enough.

In other words, the evidence is weak. She went on to say there were many unknowns in gender medicine, and the impact of quality of life and mental health, and that professionals were still waiting for more evidence. So what is happening here? We have doctors who are conducting a live social experiment with young patients without the proper professional, ethical and efficacy protocols being undertaken for a clinical trial.

According to the South Australian Women's and Children's Health Network, the gender service follows treatment guidelines issued in 2018 by Melbourne's Royal Children's Hospital and promoted as standards of care—and which concedes there is a scarcity of high-quality published evidence. An expert in evidence-based medicine, Professor Gordon Guyatt, has described the Victorian guideline as an untrustworthy source.

The latest data, between 2014 to 2019, shows there were around 4,000 children and young people receiving puberty blockers from five Australian medical institutions, with 157 of them in South Australia. Referrals to the Women's and Children's Hospital gender clinic rose from 44 in 2017 to 116 in 2020. I am still waiting for updated figures since filing an FOI earlier this year, but it is likely to have continued the rapid upward trajectory.

SA Health in July released its statewide gender diversity model of care to deal with the increased awareness of trans, gender diverse and non-binary persons. It is a sincere document, and it, too, admits we are dealing with an emerging area of health care, and that new evidence must continue to be reviewed as part of ongoing monitoring to ensure that future service delivery models and clinical pathways continue to be evidence-based. I believe this is what we all want to achieve.

It goes on to say that trans, gender diverse, and non-binary TGD and B people are at greater risk, among other things, of self-harm and suicide compared with their peers. They based this on a study that is more than 13 years old. Their quoted figures are disputed, and factual figures show it is overstated.

A reanalysis of a landmark UK study found 34 per cent of children aged 12 to 15 reported their mental health had deteriorated after taking puberty blockers for one year while 29 per cent saw their psychological health improve. No mental change was reported by 37 per cent of the children who had been on blockers for 12 months. Overall, 71 per cent reported a decline or no change in their mental health after one year of treatment, yet the main argument for introducing puberty blockers to the under-16 age group was the potential to relieve psychological distress while the children explored their gender identity.

The SA Health document does not provide alternatives of care, nor does it reference anywhere the shift away from rushing into puberty blockers and cross-sex hormones, nor does it provide advice about people who decide to detransition. It also fails to explain in any detail the 2022 report by Dr Cass following the Tavistock clinic fiasco, which notes a lack of safety data for puberty blockers, uncertainty about their rationale, and concern about their effects on the adolescent brain.

Consequently, the NHS in the United Kingdom will restrict puberty blockers to clinical trials, yet here these life-changing experimental drugs come with little warning of possible side effects, apart from bone density deterioration. In fact, treatments can start from the age of 10 to 12, and lead to sterility before they become adults.

The authors of that UK study, Professor Susan McPherson from the University of Essex, and retired social scientist Dr David Freedman, regarded the comparatively high levels of psychological deterioration among surveyed children as concerning.

Swedish psychiatrist and researcher Professor Mikael Landén, who took part in a 2021 review of the evidence base for medicalised gender change with minors, says studies in this area of youth gender dysphoria are of low quality and would not be accepted as evidence in other areas of science. He said and I quote:

> I do want the best care for each and every one.
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> [But] we don't know [if the medical treatment for dysphoria] is good or bad. Why should you require [a] lower level of evidence for this patient group then you do for all other patient groups?
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> You do subject people to lifelong, very strong medical treatment, even surgery. You are amputating parts of [a patient's] body.

Psychiatrist Jillian Spencer, an advocate for the cautious approach than affirmation-only treatment models for gender dysphoria, was alarmed, saying it begs the question: why on earth are puberty blockers still being prescribed?

I met with Jillian recently and was most impressed by her breadth of knowledge on the subject and her passionate advocacy. Children's Health Queensland stood her down from the state's children's hospital for speaking out. During her address on October 14 to the Royal Australian and New Zealand College of Psychiatrists, Dr Swift admitted there was much they still did not know about the improvement in medicalised gender transition and its impact on quality of life and mental health.

In saying they were still waiting for sorely needed evidence, Dr Swift claimed there was enough evidence that interventions brought benefits to some patients and, furthermore, that working with low-quality evidence was not unusual in child psychiatry. She said, and I again quote:

> 'We did lots of things that don't have robust, excellent evidence.' A reference to prescribing children and adolescents anti-depressant drugs that were researched for adults.

You only have to look at some of the past treatments that were hailed as breakthroughs by the medical profession, only for them to end up being scandals resulting in harm and costly legal action.

Despite the potential side effects, including infertility and impaired sexual function, in Australia these drugs are being prescribed 'off label' for gender dysphoria, which means no drug company has ever had to prove to a regulator that puberty blockers are safe and effective. Therefore, potential risk for litigation must be something that Australian doctors and all governments, including South Australia, must now seriously contemplate. It is already happening overseas, especially in the United States, where gender-specific law firms are gearing up for large class actions as more come forward to either detransition or who have suffered from the transition process.

A Compass poll conducted last month found that over 74 per cent of Australians oppose the use of irreversible puberty blockers and cross-sex hormones or body-altering surgeries with likely irreversible side effects, like infertility on children under the age of 18. Over 78 per cent of Australians are opposed to primary school children being taught they can change their sex and gender through social transitioning, puberty blockers, hormone treatment and surgery if they want, while 64 per cent of Australians disagree with primary school children between the ages of five and 10 being taught about opposite sex and same-sex sexual practices in the classroom as part of the curriculum.

I want to highlight this example brought to my attention only this week, an incident in a classroom at one of Adelaide's top private schools, where sex lessons under the state government approved curriculum were given to a group of puzzled nine year olds. Two were left visibly upset and distressed by graphic images of naked men and women shown to them and the accompanying themes of the discussions.

Are their innocent brains developed enough for them to understand, while bewildered parents have no say or can question what is being taught? Is it even the right approach to sex education in our already complex and complicated school system where teachers are dropping out in droves because they cannot cope with the tide of social change and expectations?

But going back to that Compass poll, 74 per cent do not believe that boys who identify as girls should be allowed access to girls change rooms and sports teams and vice versa and 66 per cent oppose criminal charges for parents and grandparents who question their child's intention to change gender, while 77 per cent of Australians do not believe that teachers should be disciplined or lose their registration if they fail to use the preferred pronouns of a child identifying as a gender other than their biological sex.

I met with a concerned parent recently who told me his disturbing story of what was happening with his child and allow me to read what he gave me. He states:

> I'd like to share with you my experience with the WCH gender clinic here in Adelaide. Between 2019 and 2021 my once very happy and girly daughter had started to become withdrawn and very conscious of her changing body, wearing baggy clothes. Nothing her older sister hadn't done—seemingly normal pre pubescent behaviour.
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> Around March 2021, then 10 years old, she came out as trans—identifying as a boy, wanting to use a boys name and pronouns. When I asked why she felt this way, she said it was because she didn't like the way women are treated. My concern was this wasn't about gender identity, it was a response to learning what it can mean to be a woman.
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> I wanted her to see a counsellor—her mother (my ex) preferred to affirm her gender and get a referral to the gender clinic because her reading told her that that's how you prevent suicide in an adolescent with Gender Dysphoria.
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> We saw a social worker on initial intake at the clinic. I asked for a follow up appointment for my daughter and a phone call so I could air my perspective without my daughter in the room. The appointment and that call never came.
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> In the first 45 min psychiatric interview 6 weeks later I raised the question of motive, of root cause for my daughter's distress. By now well aware that talking about fear of being a woman wouldn't get her what she wanted, my daughter played it down, emphasising her dysphoria. Eventually she did say she didn't like the way women are treated, especially that men rape women.
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> 'Has anything like that ever happened to you?' the psychiatrist asked. 'Not really,' my daughter said. Did this mandatory reporter treat that as a red flag? No–she just suggested my daughter talk to her mum about it and never mentioned it again.

At the second 45 min appointment a diagnosis of gender dysphoria was announced and in front of my kid, puberty blockers were recommended. When asked for my consent I said I had concerns but was cajoled into the next appointment, trying to avoid increasing my daughter's distress. In the Gender Clinic's mind we were in a race against the clock—now approaching 12 years of age puberty was around the corner. That my daughter had flipped from identifying as a boy to being gender fluid to non-binary and was on the 3rd name change was of no concern. There was no effort to explore family dynamics, developmental history and pre-existing mental health conditions and all that other good stuff in the National Guidelines—the clock was ticking.

At the next appointment with a paediatrician the puberty blocker fact sheet was summarised for us—the only risks to be worried about apparently were bone density loss, unknown outcomes for height and a sore arm, and can you please sign here to proceed with the treatment. When I asked about the other risks on the fact sheet—the hot flushes, tiredness and mood changes, the unknown short and long-term effects on social and cognitive development—I was told there was not enough data. Why is there not enough data? Because there has never been a controlled study into the use of puberty blockers for the treatment of gender dysphoria—the drug company does not list gender dysphoria as one of the conditions the drug is intended to treat. It's use for this purpose is off label and therefore experimental.

Had enough information been divulged for informed consent? Hell no. Especially making sure the 11-year old knew what she was agreeing to.

When I asked for a treatment plan I learnt that the WCH's idea of ongoing mental health support and mine were poles apart. Once a month psychiatric appointments? [No.] Once every two months? [No.] Try an 'assessment' once every six months and we recommend patients obtain private counselling. In short, the Gender Clinic is delivering treatment for which it isn't resourced to provide the necessary ongoing support, even though they said they provide ongoing mental health support in a recent statement to a member of the SA Legislative Council.

I was excluded from the next appointment—whether by my daughter's mother or by the clinic, or both, I will never really know.

By now I had submitted in writing that I did not consent to the treatment. From my understanding of the Auspath guidelines and any information I could track down on the internet, I thought this would mean court authorisation would be needed for them to proceed. But no—the issue was escalated to the WCH Ethics Committee who authorised treatment to proceed without my consent. That's right—to stop my daughter receiving experimental treatment, I would have to take it to a federal court.

I sought legal advice and that advice was that I would be wasting my time and tens of thousands of dollars. The Family Court could be expected to request a second opinion and that second opinion would come from the [Royal Children's Hospital] in Melbourne, our foremost proponents in gender affirming care.

In the end it was me who had to sit down with [my] 11-year-old daughter and ensure she understood the risks—I read her the fact sheet line by line, took her through the drug company literature, explained what osteoporosis means, explained what it means to not be able to experience an orgasm—to an 11-year old. I told her again that there is a broad spectrum of femininity, that female puberty is daunting but transformative and that I would fully support her in that journey of self-discovery, but please don't let them use drugs to interfere with that process. In the end, the day before the first injection, my daughter decided not to proceed. Within days her sleep and anxiety levels improved, the cutting and talk of suicide stopped.

Today my daughter identifies as non-binary, goes by a gender-fluid name, her fourth name in two years, uses they/them pronouns. They continue to develop in their own unique way and I will always love them for whoever they are.

But we dodged a bullet—no doubt about it.

In October 2019 the National Association of Practising Psychiatrists wrote to the then federal health minister Mr Greg Hunt requesting a parliamentary inquiry into the treatment of gender dysphoria in Australia. In their words, not mine, the current approach to the treatment of gender dysphoria in children and adolescents under the age of 18 has become a controversial subject within the medical community. Today I call on our current federal health minister, the Hon. Mark Butler MP, to follow through on that request. Our gender clinics have allowed ideology to overtake their duty of care and the guiding principle to 'first do no harm', and our children deserve better.

I wish to table that letter as well.

Leave granted.

The Hon. F. PANGALLO: There is this, from *Parents With Inconvenient Truths About Trans*, a book that is a compilation of stories from parents suffering the condition they call 'parental dysphoria' when they must confront the social and emotional challenges presented when one of their children suddenly presents themselves as transgender. This excerpt is from a chapter titled 'A tragedy in slow motion', written by the heartbroken mother of a transgender teenager. Let me quote from that text:

It is hard to imagine any other medical condition with a serious life altering treatment where the diagnosis is solely dependent on the reliability and accuracy of a child's or young persons self-report. We were supposed to accept unquestioningly, the crazy notion that our female child became a boy overnight at the age of 17 and that she needed to alter her body to match this invisible internal identity. It was to us an obvious mental health issue. Our daughter had serious mental health issues over a three year period prior to her self-diagnosis of being transgender. There were serious red flags waving. These issues, these red flags, were all completely ignored by the medical profession.

The mother then goes on to say:

Parents understand social contagion among teens. We were teens once as well. Social contagions have always existed. What has changed is that today they are influenced by thousands upon thousands on social media and misinformation on the internet…yet instead of seeing this social contagion for what it really is, the medical profession has lost sight of the Hippocratic Oath and accepted the self-diagnosis of these young people. It beggars belief.

She went on to question the motives behind government-funded organisations like ACON and TransHub Australia and said that she had been labelled an abusive and unsupportive parent by medical practitioners who did not know her. Her chapter in the book ends like this:

We are truly in a war to save our children from harm. We need to stop the harm now. We are in the midst of an enormous medical scandal.

Here is a lesson for us from that Compass poll: 62 per cent, or approximately the same number of middle Australia who voted no in the recent referendum, say they are less likely to vote for a member of parliament who supports criminalising parents and grandparents who question their child's intention to change gender.

Again, this is why it is imperative we as parliamentarians, legislators, have a responsibility to be fully informed and be able to act in the best interests of our citizens and our children and grandchildren. Like me, I hope members in this place will research widely on this very important issue and come to a conclusion and an enlightened position in supporting this motion and an inquiry. We must avoid this becoming one of the biggest medical scandals of our time. With that, I commend the motion.

Debate adjourned on motion of Hon. I.K. Hunter.