Submission on the Conversion Practices Prohibition Bill - Fully Informed

Executive Summary

Members of the justice committee,

Fully Informed is a group of people from across NZ concerned about the legality and long-term impacts of prescribing puberty blockers to gender dysphoric adolescents. We believe that current practice does not give effect to the right to informed consent and that the Bill will further undermine this right.

The Bill ignores the experimental nature of the treatment of paediatric gender dysphoria and the polarised professional environment and lack of oversight in which clinicians operate. By favouring a singular explanation for a complex medical condition in law the Bill serves to entrench an experimental medicalised approach to treating gender dysphoria. The New Zealand Government must exclude gender identity from the Bill and conduct a comprehensive independent review into the treatment of pediatric gender dysphoria, as has been the case in Finland, Sweden and the UK.

Legislators must ensure that the rights of children and young people to access non-invasive, psychotherapeutic care that explores the social, psychological, and trauma-related influences on gender dysphoria are upheld. In the course of providing such care, therapists may need to challenge deeply held beliefs and their right to do so should not be rendered ambiguous by lay interpretations of the Bill. The exclusion for "*identity exploration*" provided in the Bill's definition of conversion practice does not adequately exclude psychotherapy that explores underlying issues that may be influencing gender dysphoria. Given that an expected outcome of such therapy (recommended by the National Association of Practicing Psychiatrists[1]) is a resolution of gender dysphoria and a change in gender identity, the Bill places the rights of children and young people to access this care at risk. The Bill also lacks an exclusion for parents who similarly explore the underlying causes of their child's gender dysphoria as is their right.

Fully Informed recommends that:

1) References to '*gender identity* should be removed from the Bill.

If '*gender identity*' remains:

2a) The Bill's definition of conversion practice be amended to exclude "*treatments and practices that explore and understand the underlying social, psychological and trauma-related influences on gender identity and any psychiatric comorbidity*", and

2b) an exemption "*parents or legal guardians*" added to clause 5(2).

Introduction

The proposed definition of conversion practice includes "*gender identity*". This definition creates a singular, legally endorsed explanation for a child's opposite-sex identification: that they have an inherent opposite-sex self, and this is given legal weight at the exclusion of other explanations. The Bill, therefore, prejudices the treatment of gender dysphoria (a complex closely related condition) in children and young people towards an experimental opposite-sex imitation pharmaceutical and surgery-based model, and away from a psychotherapeutic model.

There is no evidence that a child who declares an opposite-sex identity must have an inherent gender identity that is fixed in the same manner as sexuality.[2,3] If this was true then we would support the Bill as written. While there is nothing wrong per se with identifying with the stereotypical manners of the opposite sex, or believing that you are the opposite sex, when a child with an opposite-sex identity also experiences distress with their sexed body (gender dysphoria) the question becomes how the distress should be treated.

Section I breaks down circumstances reported by experts and in the scientific literature in which a child can come to suffer from gender dysphoria and mistakenly believe that they are the opposite sex. These circumstances are more common than many realise and include homosexuality, homophobic bullying, autism, sexual abuse, and parental loss. Based on this literature, reports from gender clinics, and media reports in NZ it is likely that a majority or substantial plurality of children and young people presenting with gender dysphoria in NZ are homosexual or bisexual and would grow up to be adults without gender dysphoria.

Section II highlights how the primary treatment regime for gender dysphoria divides into two highly polarised schools of thought "medical intervention" and "psychotherapeutic", and measures the evidence and support for the two regimes from national health authorities and health professional bodies.

Section III describes how the Bill, by failing to address the polarised environment in which treatments operate, will make the advertisement and practice of the psychotherapeutic approach fraught with accusations of criminality. Psychotherapists and counsellors are in high demand in NZ and have other options than pursuing a specialist psychotherapy that risks career-threatening accusations even if circumstances do not reach the threshold for prosecution. In doing so, the Bill effectively shuts down the psychotherapeutic approach in New Zealand.

Section IV describes how the Bill will prejudice conversations parents may have with their gender dysphoric child to explore the causes of their child's gender dysphoria and identification with the opposite sex.

Section V describes how the Bill could lead to the coercion of gender dysphoric adolescents to accept puberty-blocking treatment under an understanding of (real or imagined) legal threat against their parents. Parents may (quite reasonably) express a preference for the psychotherapeutic approach over a treatment that is banned or highly restricted in other countries. The Bill, therefore, undermines the child's rights to consent to treatment free from coercion as defined in the Health and Disability Commissioner Act (HDCA) 1994 and at common law.

Section VI proposes the amendments that can be made to the Bill to avoid the outcomes described above.

Section I - Factors Associated with Gender Dysphoria and Opposite Sex Identity in Children and Adolescents

The number of children and young people reporting to gender clinics has increased markedly in NZ and other countries in the last decade[4]. For example, a 2012/2013 study[5] in Finland reported that 2.2% of male and 0.5% female students aged 16-18 reported possible clinically significant gender dysphoria. In a 2017 follow-up with the same methodology, gender dysphoria had increased to 3.6% among males and 2.3% among females.

In New Zealand national figures do not exist. However the number presenting annually to the Welllington DHB for hormone treatment increased from 10 in the year 2000[6] to 193 in 2019[7]. The sex ratio also shifted from 10% female in 2000 to 40% female in the 2010's, and the median age dropped from around 30 years old to early 20's.

The causes for this increase, shift in sex ratio, and reduction in age of people seeking treatment with gender dysphoria are complex and not well understood.
However, gender identity is widely acknowledged to be malleable and responsive to social context. The guidelines used in NZ published by the Transgender Health Research Lab, University of Waikato, which promote the medical intervention model (hereafter "Waikato Guidelines")[8], acknowledge that gender identity can change in response to the social environment:

"*A person's gender identity..develops over time in response to complex interplay between nature, nurture and culture…*" (p. 12)

Legislators must ensure that laws dealing with gender identity do not assume that it is an inherent, fixed aspect, akin to sexuality when all parties agree that the reality is much more complex. The following sections outline interactions between homosexuality, homophobia, Autistic Spectrum Disorder (hereafter "autism"), sexual harassment and abuse that are known influence adolescent gender identity development.

Sexuality

The literature on gender dysphoric children is sparse considering the nature of the medical interventions. To our knowledge, **all studies that measured the sexuality of gender dysphoric children presenting to gender clinics report a majority were homosexual or bisexual**. Homophobic bullying is known to influence a change in gender identity to the opposite sex and this may explain the prevalence of the homosexual demographic presenting to clinics.

Netherlands

Wallien & Cohen-Kettenis (2008)[9] report that 60-70% of gender dysphoric adolescents in their study were homosexual. De Vries et al (2011)[10] report 62 out 70 enrolled gender dysphoric adolescents were homosexual. Staphorsius et al. (2015)[11] state the 20 "*adolescents [in the study] with [gender dysphoria] were all sexually attracted to partners of their natal sex*".

Canada

In Singh et al (2021)[12] 47-67% of a cohort of 139 gender-dysphoric boys were gay. When followed-up at a mean age of 20 88% of subjects were no longer gender dysphoric.

The 88% desistance figure is in line with guidelines published by Counties Manukau DHB in 2012[13]. The guidelines state that approximately 75% of children who claim to be "*born in the wrong body*" will not be trans adults (p. 20). For unknown reasons this important piece of information (which would surely influence parental decisions on whether to initiate medical interventions) does not appear in the more recent Waikato Guidelines.

UK

Studies in the UK have not tracked sexuality. However, the BBC reported[14] on transcripts of an internal review from clinicians at the Gender Identity Development Service (GIDS) —the main gender clinic in the UK. A sizeable minority of staff were worried about practices at the clinic and openly discussed their fears. They feared that some parents appeared to be homophobic and preferred a medicated transgender but outwardly "straight" child to a gay and gender non-conforming child.

"*Maybe we are medicating gay kids, maybe we are medicating kids with autism, maybe we are medicating traumatized children and if we are we're doing bad things to these vulnerable kids.*"
- GIDS clinician.

New Zealand

Clinicians also do not track data in NZ. However, the media have reported three cases of young lesbians in NZ who all identified as male when younger and suffered confusion as to their gender identity and sexuality[15–17]. Two of the cases began medical interventions, had subsequent poor mental health, then later realised that they were lesbian and/or had autism. One of the cases, reported in the Listener[17] earlier this year, confused her tomboyish preferences with innate male identity at odds with her female sex at age 10. Doctors in NZ affirmed her identity and she subsequently took puberty blockers at 14, then testosterone, had a double mastectomy at age 16, and a hysterectomy at 18 before realising that treatments were not helping and suffering profound regret. She still experiences dysphoria. The doctors who mistreated her have not been held accountable.

Further, an article[18] from Radio New Zealand in 2017 demonstrates how parents are not being informed that childhood opposite identification is associated with homosexuality and will most likely resolve as the child develops. A mother of a gender dysphoric child states that:

"*It was until she was actually eight that she specifically said, 'I'm a girl on the inside, please stop calling me a boy.' That was a little bit of a shock, in the back of our minds we thought we might be raising a gay child, but obviously sexuality doesn't come into it at that age.*"

The mother has been misinformed and her instincts were correct. Sexual desire does not develop until puberty but gender non-conforming behaviour and preferences are common in pre-pubertal children who will grow up to be LGB[19]. From the described circumstances it is entirely possible that her child is gay and was expressing stereotypically feminine preferences in the simplistic language appropriate to an eight-year old's stage of development "*I'm a girl inside*". The surprising thing is that point was never made by any of the clinicians involved despite the older Counties-Manukau guidelines making this point.

Homophobia:

A study[20] published in the *Journal of Youth Adolescence* found that homophobic name-calling amongst adolescents can change an adolescent's identification from their natal sex to the opposite sex:

"*Homophobic name calling emerged as a form of peer influence that changed early adolescent gender identity, such that adolescents in this study appear to have internalized the messages they received from peers and incorporated these messages into their personal views of their own gender identity.*"

The results are in line with the established findings of adolescent social-psychological development. Identities and self-concepts are malleable[21]. Children have a simplistic understanding of gender roles[22] and peer influence plays a role in identity development[23].

Members of the committee may wish to reflect on (a) how tragically common it is for children to strictly police gender norms: "*You're not a girl! You're a boy!*" etc, when (often gay) gender non-conforming peers do not conform to gendered expectations, and (b) the widespread potential impact this could have on adolescent gender identity development.

The study also raises complex questions regarding practices that suppress sexuality and/or gender expression that subsequently influence a child's gender identity.

As mentioned earlier, the BBC has reported on UK clinicians concerned that homophobic parents of gender dysphoric children preferred to have a 'straight' child and brought their child to the clinic for medical intervention with this aim. Consider the circumstance of parental homophobia influencing a child's opposite-sex identity. If the child is then 'affirmed' in their new opposite-sex identity by clinicians and medicated, the medical institution is now effectively complicit in the parent's homophobic practice.

The Bill prohibits parental attempts to convert a homosexual child in law, but, without acknowledging the connection between the childhood gender non-conformity and the opposite-sex identification of many homosexuals, the Bill could have the opposite effect to what is intended. Where the child has constructed an opposite-sex identity in response to chronic homophobia the Bill obscures clinical investigation. The clinician could take the hard road, question the child's identity as a construct and face accusations of 'conversion practice', or they could take the easy road and 'affirm' the child's now presumed innate identity.

Suppression of sexuality via puberty blockers

Consider also the physical effects of puberty suppression treatment on gay 11-16 year-olds who have not yet realised their sexuality (many do not realise they are homosexual until adulthood).

The same class of drug, GnRH agonists, is used to suppress the sexual desire of sex offenders (chemical castration). There is a significant legal and ethical debate on the use of blockers in treating sex offenders due to the impact on their human rights.[24]

The Bill's prohibition of practices that suppress sexuality —a well-established outcome of puberty-blocking drugs— therefore raises the question of the legality of puberty blockers after the Bill becomes law. Clinicians who prescribe puberty blockers may escape the Bill's legal consequences by arguing that they did not intend to suppress sexuality, it is only a side-effect of the treatment when applied to adolescents. But the distinction becomes less clear-cut when we consider that blockers are promoted as 'buying time' to make a decision[3], and that a clinician could come to the view that the absence of 'intrusive' sexual desire might have advantages for a troubled young person.

Whether intended or not, puberty (and consequently sexuality) suppression will have a detrimental impact for the young gay people treated with blockers who will not realise their sexuality until some time after the treatment ends (~ age 16). The fact that one has gender non-conforming tendencies stemming from one's sexuality and not from an innate opposite-sex identity would surely influence decisions on whether to proceed to cross-sex hormones and potentially surgery.

The irony is that Bill addresses an issue that the Ministry of Justice (MoJ) does not believe is widespread and cannot adequately define[25] while ignoring and unintentionally promoting the suppression of sexuality via a drug that was developed for precisely that function.

Autism

Several studies note the high rates of autism in gender dysphoric children presenting to clinics[26]. The reasons for this are not fully understood but some autism experts have reported how features of autism make it more likely for a child to mistake their differences for an innate opposite-sex identity. A study[10] cited by the Waikato Guidelines highlights the issue:

"*For example, it can be complicated to disentangle whether the gender dysphoria evolves from a general feeling of being just "different" or a whether a true "core" cross-gender identity exists in adolescents who suffer from an autistic spectrum disorder*"

Professor Christopher Gillberg is a world authority on autism and founding editor of the journal European Child & Adolescent Psychiatry. The Times reported[27] Gillberg's view that autistic children are vulnerable to seizing on an innate opposite-sex identity as the 'answer' that explained their differences. The children believed their problems could then be 'solved' by medical intervention.

A study[28] in the J*ournal of Autism and Developmental Disorders* finds links between autism traits and gender dysphoria and argues that autistic children are less likely to internalise stereotypes associated with their sex. Accordingly, consider how a girl with autism might respond when presented with the idea that 'everyone has a gender identity' yet find themselves
a) lacking any specific identification with feminine stereotypes,
b) more inclined to think and socialise in ways considered stereotypically masculine —another feature of autism, and
c) fearful of the bodily changes of female puberty.

An innate male identity offers the child an explanation and medical intervention offers a 'solution' to the experience of difference. Zahra Cooper, a young autistic woman from Kaitaia, believed she was a boy before detransitioning. Cooper took testosterone, but the physical changes prompted worsening mental health and two suicide attempts. After receiving an autism diagnosis:

""*That's when everything clicked," Zahra says. "And that's when I started doing some deep thinking."*

On the internet, she learned [autistic] people commonly struggle with gender identity issues. Experts say this is because of a tendency to think in black and white, to have a very fixed idea of the rules, and therefore look for reasons why they don't fit in - often landing on gender dysphoria as an answer."[15]

Unfortunately, the issue of misdiagnosis is compounded by the "one track mind" feature of autism. Australian autism expert Professor Tony Atwood explained this point in an article[29] in The Australian in 2020:

"*One of the characteristics of autism is what we call a one-track mind, and sometimes the issue of gender dysphoria...and changing gender becomes a special interest with a phenomenal knowledge and determination.*"

"Once they've changed gender, they still have autism and when (gender) transition doesn't solve their problems they think, Oh no, that was the only option I had, what's the point of life?"

An autistic child who believes they are the opposite sex with a 'one track mind' and 'phenomenal knowledge and determination' will no doubt become aware of a Bill prohibiting the suppression of gender identity. Members of the committee would do well to consider how such a child will interpret the Bill? Most likely the Bill will bolster the child's resistance to any suggestion that their differences stem from underlying issues to the detriment of their medical care.

For unexplained reasons, the Waikato Guidelines do not discuss the increased likelihood of misdiagnosis that comes with autism, despite citing a study that does discuss this issue. Instead, the guidelines, which are not evidence-based, emphasise how an autism diagnosis should not be a barrier to medical intervention.

Abuse

Many children and young people with gender dysphoria report traumatic childhoods[30]. The reasons for this are complex and individual cases will vary. Broadly, explanations fall into two non-exclusive camps:
1) A transgender status makes the child or young person vulnerable to stigmatism and abuse[8].
2) Gender dysphoria is a symptom of underlying traumatic experiences.

Evidence from clinicians at the Westmead Children's Hospital in Sydney finds support for the second explanation[31].

The clinicians found that children with gender dysphoria had 3 times as many adverse childhood events compared to non-clinical controls. Family conflict, loss via separation of a loved one, and bullying were common. 18% had been sexually abused and around half had mothers with mental illness. It is difficult to draw the conclusion that most or all of these adverse experiences (e.g. maternal mental illness) were due to a stigmatised transgender status. The clinicians conclude that these children have developed insecure attachment patterns and recommended comprehensive assessments and psychotherapy as the primary interventions.

The reported disproportionate rate of sexual abuse is particularly troubling when one considers that a feature of gender dysphoria is "*A strong desire to be rid of one's primary and/or secondary sex characteristics*"[32]. Childhood sexual abuse victims are also known to have body image issues, highlighting the importance of careful clinical investigation before reaching a diagnosis. Victims frequently lack any power to prevent abusers from acting again and can adopt maladaptive strategies to reduce their perceived vulnerability.[33,34]

For example, eating disorders are more prevalent in both sexual abuse victims and gender dysphoric adolescents[35,36]. Disordered eating appears to act in some cases as 'DIY puberty suppression. A report[37] in the International Journal of Eating Disorders describes the case of a 13-year-old girl with both an eating disorder and late-onset gender dysphoria. The girl had been sexually abused by her (now absent) father and had strained family relationships. She suffered mental health problems and began a pattern of disordered eating. The girl believed that "*maintaining a lower weight would prevent pubertal development including breast growth and menstruation*" and "*She reported any sexual activity as "gross." However, in later appointments she expressed a desire to have a female partner in the future.*"

She was treated for anorexia. The section which describes the emergence of male identity is worth quoting in full:

"*Approximately twelve months after the initial psychiatric assessment, after the patient ...had been fully weight restored for several months, the patient began dressing in clothes that would typically be worn by males and cut her hair short. She reported that friends were now referring to her with male pronouns and had replaced her traditionally female name with a typically male one. She voiced concern about her body developing and was adamant about not wanting breasts. In fact, she reported having thought about cutting her breasts open with a knife to remove the fat underneath. She also described having hit her breasts several times a day and questioned if that would stop her development. The patient expressed a desire to be a boy, but did not want to have surgery. The patient stated that she did not have a problem with eating anymore, but her main concern was a desire to be a boy. She expressed an interest in pubertal suppression. A referral to a gender identity*

clinic was suggested. The patient was in agreement, but mother was not supportive. Shortly thereafter, the patient dropped out of treatment."

The case highlights the need for comprehensive assessments and the complexity in determining causality. Did this child suffer abuse and poor mental health because she was innately a boy, or were the anorexia and her stated desire to be a boy and be rid of her breasts symptoms of past sexual abuse?

A similar finding in the NZ *Counting Ourselves* survey[38] found 50% of surveyed females who identified as male had suffered attempted rape and 33% had been raped. The survey does not report the life stage that the abuse took place but we expect that they most likely occurred before medical interventions because females under testosterone treatment are able to pass as men and would subsequently be less vulnerable to rape from heterosexual men. If the disproportionate levels of abuse as a female in fact took place prior to the emergence of a male identity, it raises further questions on whether direct traumatic experiences of female vulnerability was a factor in this population's desire to be male.

The psychotherapist tasked with assessing such cases will at some point need to ask questions that imply a lack of belief in the patient's declared gender identity. Without doing so, the therapist will have leapt to the unconfirmed explanation of an innate male identity and would be providing substandard care. The Bill makes this line of inquiry fraught with potential accusations of conversion practice.

Section II – Polarised Professional Bodies

Professional organisations are divided on their approach to gender dysphoria, supporting one of two approaches:

1) Pharmaceutical and surgical interventions to change the young person's body to resemble that of the opposite sex, under the rubric "*gender affirming care*" but referred to here more directly as "medical intervention".

2) Psychotherapy and/or parenting that explores the underlying causes of gender dysphoria —a practice that can be accompanied by a change in gender identity.

The division creates several problems for legislators and regulators which are outlined below.

The organisations that endorse the medical intervention approach include:

a) the World Professional Association of Transgender Health (WPATH) represented by local chapters Professional Asociation of Transgender Health Aotearoa (PATHA) and the Australian Professional Association of Transgender Health (AusPath) in New Zealand and Australia respectively[39].
b) The Australian Psychological Society (APS)[40]
c) The American Academy of Pediatrics (AAP)[41].

Organisations that endorse the psychotherapeutic approach include:

c) The National Association of Practising Psychiatrists (NAPP) (Australia)[1].
d) The Westmead Children's Hospital of Sydney[42].
d) COHERE - the national health advisory authority of Finland[43].
e) The Karolinska Institute — the Swedish medical university that awards the Nobel prize in medicine[44].

Organisations that have not endorsed the psychotherapeutic approach specifically but have highlighted the weak evidence base and risks of the medical intervention approach include:

f) National Institute for Health and Care Excellence (NICE) — the UK body responsible for the creation of clinical guidelines and assessment of medical evidence[45,46].
g) Centre for Evidence-Based Medicine (CEBM), Oxford University UK[47].

The division in professional opinion is not a minor difference in emphasis. Rather there is a fundamental disagreement over the degree of evidential support for recommendations, and over the legal consequences that should follow from deviating from the preferred approach.

For example, regarding the assessment of evidence compare and contrast statements from PATHA executive members and NICE on the evidence base for puberty blockers.

PATHA:
"*[t]here is good evidence that puberty blocking...significantly improves mental health and wellbeing outcomes*"[8] (p.17, cites a single study)

NICE:
"*The results of the studies that reported [on] mental health (depression, anger and anxiety)...in children and adolescents with gender dysphoria are of very low certainty...They suggest little change with [puberty blockers] from baseline to follow-up...Studies that found differences in outcomes could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding, bias or chance.*"[45] (p.13, cites 9 studies)

The two statements are not reconcilable. The first was written by a PATHA associated team that includes clinicians who prescribe puberty blockers "very freely"[48] and have a conflict of interest in creating guidelines that support this practice. The second claim was written by specialists in the assessment of medical evidence without any conflicts of interest. Needless to say, *Fully Informed* believes the NICE assessment to be more accurate.

PATHA base their Waikato Guidelines on the "Standards of Care" developed by their parent organisation WPATH. But this does not inspire confidence when the WPATH guidelines are not evidence-based and have failed to meet agreed standards of quality for clinical guidelines. Dahlen et al (2021)[49] report the results of a six-person team that reviewed the WPATH guidelines (amongst others) using a recognised guideline quality assessment framework. The review team gave the WPATH guidelines a score of 20 out of 100 for methodological rigour and 15 out of 100 for "Editorial independence". Five of the six reviewers were unable to recommend the WPATH guidelines.

Regarding the legal consequences, statements from three Australian organisations, one that supports psychotherapy and two that support medical intervention highlight how stark and acrimonious the 'gender debate' has become.

In May the President of NAPP, Dr Phillip Morris made a statement of support for the psychotherapeutic approach. "*Managing Gender Dysphoria/Incongruence in Young People: A Guide for Health Practitioners*".

"*Individualised psychosocial interventions (e.g., psychoeducation, individual therapy, school-home liaison, family therapy) should be first-line treatments for young people with gender dysphoria/incongruence. They should be undertaken before experimental puberty-blocking drugs and other medical interventions (e.g., cross-sex hormones, sex reassignment surgery) are considered.*"[1]

The second statement was made by AusPATH in June of this year, and was very likely to be in response to NAPP's endorsement of the psychotherapeutic approach the previous month:

"*AusPATH believes that psychotherapeutic (including psychoanalytic) approaches used outside and/or instead of gender affirming healthcare are experimental, risk harm, raise ethical concerns...To be unequivocally clear, AusPATH reaffirms its commitment to gender affirming healthcare, and asserts that any approach that would offer psychotherapy as an alternative to gender affirmative healthcare (i.e. offered while gender affirming healthcare is withheld or withdrawn) involves the risk of harm to the health and welfare of the clients concerned, whether they are trans youth or adults*."[50]

A third statement was made by Professor Damien Riggs a Fellow of the APS in 2019 and spelt out proposed legal consequences for a failure to comply with the medical intervention approach:

"*Therefore, it is important to consider how the treatment of young people is regulated. In particular, it will be important into the future for affirming treatment teams and gender centres to evaluate when legal action may be required if children are not receiving adequate parental support. This may include hospitals advocating to courts for treatment if it is otherwise being refused by legal guardians (i.e., with regards to puberty suppression). More broadly, it behoves all clinicians as mandated notifiers to consider when less-than-affirming approaches (either on the part of other clinicians or on the part of family members) may constitute forms of neglect, and to make reports as needed to the relevant bodies to ensure that young people receive the affirming clinical care that they need.*"[40]

In other words, if the parents do not consent to medical intervention and prefer a psychotherapeutic approach Professor Riggs believes that a) the courts should overrule the parents and enforce medical intervention, and b) parents and clinicians who advocate for non-invasive psychotherapy should be reported to the authorities. For parents, this may be the first step towards losing custody of their child. For clinicians, it may mean a career-ending black mark on their professional record.

The threat of losing custody is not hypothetical. The Australian reported last year how the parents of a 15-year-old girl lost custody of their child after refusing testosterone treatment.

"*The parents said they knew their daughter had been depressed and in need of help, but they wanted an independent psychologist to consider all possible underlying causes, not just gender issues, and to look into non-invasive treatment options.*"[51]

In summary, the situation is now so starkly polarised that a treatment that is banned in Sweden[44] is, in practice, mandatory in parts of Australia depending on the personal beliefs of the clinicians involved.

Captured Regulation

The polarised professional opinion creates several problems for legislators and regulatory agencies who may be tempted to leave the regulatory details to professional bodies. Legislators might hope that professional bodies could be trusted to create evidence-based codes of practice and clinical guidelines. In this line of thinking, what is and what is not 'gender identity conversion practice' does not need an overly explicit definition in the law or formal regulation because its everyday interpretation will become clear in these (presumably responsible) supplementary quasi-legal definitions.

But this view is a mirage. What prevents the APS (who may have members on this side of the Tasman) or PATHA from creating professional guidelines that leverage the Bill in support of mandatory medical intervention and censure clinicians who propose psychotherapy? The PATHA created guidelines -which have no official standing, but are linked on the MoH website- already strongly imply that the psychotherapeutic approach is highly suspect and harmful.

This problem is compounded by Minister Faafoi's widely reported[52] and ambiguous answers to direct questions regarding the parent's rights to refuse puberty blockers and determine their child's treatment. Even if Parliament has no intention of outlawing psychotherapy for gender dysphoria, once the Bill is enacted parents could reasonably come to an understanding that enrolling their gender dysphoric child in psychotherapeutic care would now be illegal.

The situation speaks to:
a) the lack of necessary policy work. MoJ have ignored or are unaware of the polarised context in which the treatment of pediatric gender dysphoria operates.
b) the need of legislators and regulators to be absolutely explicit regarding the intention of the law.

It is therefore pertinent to ask, is it the intention of the New Zealand Government and the Justice Committee to outlaw psychotherapy for the treatment of gender dysphoria? Or put another way, do members of the Committee believe that every child who states that they are the opposite sex, does so because they have an innate opposite-sex identity and no other explanations are likely?

If that is the case then members should have the courage of their convictions and amend the Bill to do so as seemingly desired by organisations such as APS, AusPATH and PATHA. If however, this is not the intention then the Government must amend it and remove all doubt that psychotherapy in this domain remains legal. The difficulty for legislators is that we are now in the select committee stage without any of the necessary policy work available and legislators may not feel prepared to grapple with such a complex issue.

Policy Review

The treatment of gender dysphoric children and young people has been under review by the national health bodies of UK, Finland, and Sweden. In all countries where a review has taken place

authorities have moved away from a medical intervention model and towards the psychotherapeutic model.

The shift has undercut the influence of WPATH and is not surprising in light of the shortcomings of the WPATH guidelines.

The UK review[53] (known as the "Cass Review" after chair Dr Hilary Cass) offers an alternative model to relying on WPATH. The Cass review is ongoing but has already commissioned and published the NICE evidence reviews of puberty blockers that contradict PATHA's assessment.

LGB, autistic and traumatised children and young people in New Zealand deserve a high standard of evidence-based care. When medical professionals cannot agree on treatment regimes the proper role of the regulator is to investigate and determine a path forward. The improper role is to hand one side in an acrimonious debate legal ammunition for silencing the opposing side.

The Government must remove references to 'gender identity and conduct a review into the treatment of pediatric gender dysphoria in NZ. In the event the Government does decide to include 'gender identity' the following sections spell out the anticipated impacts on the care of gender dysphoric children and young people.

Section III - Psychotherapy for Gender Dysphoria

The Bill will have a chilling effect on the rights of children and parents to access psychotherapeutic treatments.

First, if the APS issues guidelines to members that ambiguously describe exploratory psychotherapy as 'akin to' or 'a step towards' conversion practice referencing the equivalent Australian laws, then members on this side of the Tasman will be forced to conclude that the same applies here.

Second, an anticipated effect of the Bill is that the following statements will attract controversy, even if they remain strictly legal:

- '*Psychotherapy should be the first-line treatment for young people with gender dysphoria.*'
- *'If your child identifies as trans, the most likely outcome is that they will grow out it.*'
- '*Parents have every right to refuse puberty blockers and enroll their child in psychotherapy*',
- '*A possible outcome of psychosocial intervention is a change in gender identity from the opposite sex to the child's natal sex and this has the benefit of avoiding surgery and a lifetime of pharmaceutical use*.'

The statements are paraphrased from examples published by overseas medical bodies[1], a DHB[13] , and the scientific literature[42], but could be construed as supporting conversion practice by opponents. Professional bodies wishing to avoid controversy will simply choose to not make such statements. The Bill, therefore, restricts information on treatment options and undercuts the right to be fully informed as set out in the Code of Health and Disability Services Consumers' Rights.

Third, the question for therapists is not so much 'will the Attorney-General prosecute me for questioning a child's identity?', but rather 'if I accept an autistic 14 year old client with a "one track

mind", convinced that they are the opposite sex; and then take a line of inquiry that does not endorse their gender identity, will this client report me?'

The risks of a mere accusation are justified and damaging enough even if the most likely outcome is that it does not proceed to prosecution. To offer psychotherapy to gender dysphoric young people the therapist must therefore trust that troubled teenagers will act reasonably -a proposition that does not inspire confidence.

As Professor of Law Patrick Parkinson states in his submission[54]:

"*This is what lawyers call the 'chilling effect' of legislation. It has effects far beyond the actual prohibitions contained in the detail of the Act. People don't necessarily act upon the law as written. They act upon the law as they believe it to be, or from fear of what the law might be or how it might be misused.*"

"*The final version of Queensland's legislation provides mental health professionals with a similar exception, but evidence is emerging that mental health professionals are turning away patients who present with gender identity issues, and referring them to practitioners who live in NSW, where no such laws exist.*"

Section IV - Parental Counselling

On the eve of the close of submissions, Minister Faafoi's office issued a statement[55] attempting to allay fears that the Bill could interfere with parent's rights to counsel their children.

"*A family that reacts negatively, is struggling to accept, or is openly opposed to their child's...gender identity would not be considered to be performing a conversion practice unless they take some further action to intentionally persuade...the child to change...gender identity*"

MoJ are out of their depth. The statement lacks any awareness of the circumstances outlined in Section I in which an adolescent opposite-sex identity can develop. The Bill puts a normal response of parents to their child's plans for hormonal treatments on uncertain footing.

If the parents know or suspect that:
a) their child is gender non-conforming, gay or lesbian, or autistic, and
b) has suffered homophobic bullying, and
c) is fearful of bodily changes that come with puberty, and
d) that these circumstances are likely to underlie their child's recently developed opposite-sex identity, and
e) that the affirmation of this identity is almost certain to lead to pharmaceutical interventions (banned or under review in other countries) with unknown long-term health consequences,

then parents will naturally respond in such a way as to "persuade the child to change gender identity".

If a parent says "*You're not trans, you're autistic. You've never felt this way before*" is this attempting to "persuade their child to change gender identity"? It could certainly be read that way. Alongside a

refusal to consent to hormones potentially similar circumstances were enough for an Australian court to remove a child from parent's custody[51]. In the face of this threat, parents will feel powerless to do anything but comply with their child's simplistic, and very possibly mistaken, desire to 'become a boy'.

While there will be cases where the parents' response to these fraught and emotionally charged circumstances is not ideal, this is bad parenting, not criminal behaviour. The solution is not to criminalise or cast suspicion on parents acting to protect their child from iatrogenic harm, but to regulate treatments so that parents can be confident that this will not occur.

Section V – Coercion

The previous two sections have described how the clinicians' and parents' lay interpretations of the Bill will have a chilling effect on actions intended to help a child come to terms with an underlying issue.

This section considers how the Bill could lead to the coercion of a child to undergo puberty-blocking treatment due to the *child's understanding* of the Bill's legal implications.

Consider the following scenario, a gender dysphoric 13-year-old is presented with two options:
1. Puberty blockers and 'gender affirmation' suggested by the clinicians at the local clinic, or
2. Psychotherapy arranged by the mother, with the potential to lead to a change in gender identity.

The child's mother is concerned about the health impacts of (1) and would prefer the child to undertake (2), but the treatment decision-making is in practice a fraught negotiation between the clinicians, the child, and the mother in which the clinicians emphasise the child's supposed 'autonomy'.
The child (who of course has access to the internet) learns about the law prohibiting gender identity conversion and comes to believe that 'talking to counsellors who don't believe you're trans is conversion therapy' from a discussion forum, and that this means that 'mum could get in trouble' and could even 'go to prison for three years'.

Without informing the mother the child decides they want to protect their mother from the perceived legal threat and that accepting puberty-blocking treatment is the best means of achieving this outcome. The child will have acted under coercive circumstances created by the Bill. In the absence of the Bill, the child may have accepted the mother's preferred option and judgement about what was in her child's best interest.

The Bill, therefore, has undermined the child’s rights to consent to treatment free from coercion as defined in the HDC Act 1994 and at common law.

Section VI - Amendments

Legislators must a) take responsibility for the Bill's unintended negative consequences and b) avoid taking a side in a rapidly developing debate when the relevant policy work does not exist. The major effects of the Bill will not be in the courts but in the everyday family and therapeutic contexts. The audience for the Bill are lay (and often young) people grappling with complex issues and medical decision-making. Legislators must communicate to this audience via the law that Parliament has no intention of outlawing psychotherapy for gender dysphoric children and young people, even when therapy will likely be accompanied by a change in gender identity.

Recommendations:

1) Remove 'gender identity'.

The simplest way to mitigate the negative consequences of the bill is to remove references to 'gender identity' from clauses 5(1) and 5(2).

If legislators wish to keep gender identity we recommend:

2a) Adding an exemption for exploring the underlying influences on gender identity.

Clause 5(2) should be amended to include "treatments and practices that explore and understand the underlying social, psychological and trauma-related influences on gender identity and any psychiatric comorbidity"

2b) Adding an exemption for parents.

The complex exemptions found in clause 5(2) indicate that 5(1) is open to some interpretation. However, there is no exemption for parents in 5(2). The implication is that 5(1) could be more broadly applied to conversations between parents and their children. The lack of exemption for parents is notable because responsible parenting and exploratory psychotherapy are not entirely distinct, particularly when parents are attempting to understand issues that their child faces. The logical conclusion is that while 'health practitioners' are somewhat protected by clause 5(2), if a parent were to question the basis for child's gender identity in the same way they could suffer legal consequences where a 'health practitioner' would not.

This seems like a serious oversight and the Justice Committee should add an exemption for parents or legal guardians to 5(2) so that they have the equivalent protection.

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