The Gender Centre
Est.1983

05 May 2024

The Australian Human Rights Commission,
Call for Submission

Dear Commissioner,

Lauren O'Brien and GENDER CENTRE submission to the Australian Human Rights Commission; current and emerging threats to TGD Human RIghts

Thank you for the invitation to submit to the AHRC current and emerging threats to TGD Human Rights Scoping project.

The Gender Centre is the oldest ongoing trans-specific service in Australia and possibly the world. The GC is renowned for its comprehensive support and services for the transgender and gender diverse (TGD) community. It operates as a peak state-wide multidisciplinary centre, recognised for its broad range of specialised services aimed at facilitating the exploration of gender identity and assisting in the alleviation of gender dysphoria. The Centre is deeply committed to supporting trans and gender expressive individuals throughout their journey, enabling them to explore and live their authentic sense of self.

This submission is a letter drafted by Lauren O'Brien, Dr James Allen, and Eloise Brook and outlines Ms O'Brien's call for a more detailed examination into the circumstances around the death of her son Noah. In particular that the Australian Human Right's Commission might conduct an audit from a human right's perspective of the breakdown of care that Noah experienced in relation to his treatment at the Sydney Children's Hospital Westmead.

I look forward to your response and any steps that you might be considering to improve the lives of TGD people, children and families in Australia.

Yours Sincerely,

[redacted]

On behalf of,
Phinn Borg
Executive Director
NSW Gender Centre

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The Gender Centre
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Services for the trans
and gender diverse community

Lauren O'Brien and Gender Centre Submission to the Australian Human Rights Commission

05 May 2024

Re: Threats to Trans and Gender Diverse (TGD) Human Rights

Submission to the Australian Human Rights Commission on behalf of the Gender Centre

To: The Australian Human Rights Commission

Thank you for the opportunity to provide a submission to the consultation on the rights of trans and gender diverse people. I am writing on behalf of Noah, my child who died by suicide at the age of 14 on January 26, 2023. I hope that sharing this story might be useful in advancing the welfare of other gender diverse children. If the Commission felt that it would be useful, I would be interested in engaging in further discussion. LGBTIQASB+ rights, including the rights of transgender and gender diverse people fundamentally begin as the rights of children. It is from this perspective that I wish to speak.

1. Protecting children from harm before, during and after development of their identity.

Gender diverse children and LGBTIQASB+ children are unique in that there is a period in which they and their parents are unaware of their diverse identity. Most minority identities occur in a manner where the parent's identity aligns with the child's identity. Parents make the best possible decisions they can for the welfare of their child. Even so, accidental, and unintentional harm can occur prior to a parent becoming aware of their child's identity.

The trauma of invalidation of a child's identity can be incredibly significant. If a child holds an apprehension of disapproval, disgust or rejection from their parents, family, or community this creates enormous stress for a child. Most children who belong to a minority will observe their parents responding to prejudice in a protective manner. For a considerable number of LGBTIQASB+ children, they will observe their parents ignoring or failing to challenge expressions of anti-LGBTIQASB+ prejudice in daily life or the media. Others will observe their parents behaving in a manner that generates fear that if their true identity were known, their place in their family and community could be at risk. Even an act as seemingly insignificant as a sigh and changing the channel in response to an ordinary depiction of LGBTIQASB+ on television can send a potent and often unintended message to a child who has not made a disclosure.

Almost every parent of an LGBTIQASB+ child begins a journey of learning and acceptance. It would be wonderful if we could make reasonable and proportionate efforts to bring this journey of acceptance forward to a time where doing so can prevent harm.

2. Support for parents

Parents are motivated by love and care for their children. They make decisions based upon the best information available to them at the time.

In an ideal world, parents would be provided with accurate public health information about the possibility of having a child who develops an LGBTIQASB+ identity. This information could be provided in a range of settings including antenatal, maternity and post-natal clinics, general practice, and any child or family health setting. Healthcare professionals and every respected health and education institution would be required to have sufficient knowledge and cultural competence to ensure that every child was safe and supported. Every health profession regulator, accrediting body and health delivery organisation would have a published policy covering: the rights of LGBTIQASB+ children; competency standards regarding LGBTIQASB+ health; and a reasonable and proportionate education strategy to address knowledge gaps, bias, and prejudice within the workforce.

If I had been provided with public health information about children with a diverse gender there is a very real possibility that I would have recognised that Noah's was gender diverse far earlier. This could have led to earlier referral to a medical service. The delay in recognising Noah's circumstances led to the loss of opportunity for treatments that could have significantly improved Noah's wellbeing.

3. School and education

I assume that this topic will be well covered in other submissions. I would say that improved tolerance, diversity and inclusion in school is an issue that is directly relevant to the death of my child.

4. Healthcare

Noah was referred to the Gender Clinic at the Westmead Children's Hospital. It is my understanding that this service was affected by internal dysfunction and budget restrictions resulting in the number of children reaching care being significantly less than comparable institutions in other states.

Noah's referral was viewed as less urgent than those for children who had not entered puberty. While I understand that the range of options for medical treatment is considered greater before puberty, children who have a diverse gender and who have not achieved medical care before puberty are likely to face significantly more challenges than those who do, and their healthcare needs, particularly psychological support and treatment, are likely to be higher. Placing these children on a long wait list is effectively refusal of healthcare and is a failure to match healthcare funding to objective need. This process, resulting in effectively refusal of care also sends a harmful message of invalidation and unworthiness that resonates with existing relational trauma and invalidation. For

example, imagine a child who may have experienced a delay in referral due to the social, cultural, religious or moral judgement. They now experience further rejection and devaluation from the healthcare sector. These children and their families are just as worthy, and perhaps even more in need of, access to healthcare and support.

General practitioners and many other community healthcare providers are the first point of entry to healthcare for trans and gender diverse children. These professionals often do not have the knowledge and skill to assist the families of LGBTIQASB+ children. Competence in this area is currently viewed as optional and tends to only be available in inner city clinics. If the basic knowledge and competence required to care for LGBTIQASB+ people is not considered to be a universal requirement of every healthcare professional, then the LGBTIQASB+ children most in need of public health strategies to protect them from harm and healthcare to support their wellbeing will never have equity of access.

Standards of competence with LGBTIQASB+ health should exist for every healthcare profession. There must be a reasonable strategy to address the knowledge gaps and unconscious bias that exists within our current and future health workforce in Australia.

Every large healthcare service organisation in Australia should have a published LGBTIQASB+ inclusion policy and a clear and effective complaints policy for LGBTIQASB+ people who are concerned that they may have received less favourable treatment on the basis of their LGBTIQASB+ identity.

5. Child Protection and harm prevention

For LGBTIQASB+ children and youth who exist in unwelcoming or hostile environments, revealing their identity can increase their experience in all forms of abuse.

If we only address LGBTIQASB+ issues when a child reveals their identity, then we are requiring children to expose themselves to an unreasonable risk of more harm in order to benefit from child protection strategies.

The unique situation of LGBTIQASB+ children is worthy of greater prominence in the national strategy for protection of Australia's children. Whilst the evidence of harm occurring to LGBTIQASB+ children may not be a major point of entry to the state care system, and the harm often only becomes apparent in late adolescence, the source of the preventable harm occurs much earlier.

Every child safety organisation ought to have a published LGBTIQASB+ inclusion policy. They should also have a reasonable and authentic strategy to prevent harm to children motivated by anti-LGBTIQASB+ prejudice. These policies and strategies ought to meet a standard of best practice.

6. Ability to lodge complaints

The ability to lodge a complaint for LGBTIQASB+ children in hostile environments is impaired because they will naturally have a strong tendency to conceal their identity to avoid abuse and harm.

For this reason, the rights of LGBTIQASB+ children need some form of representation to enable complaints of an unreasonable risk of harm to be addressed. There may be a role for advocates like the children's commissioner or others to uphold these children's rights.

7. LGBTIQASB+ Children in Research

The National Health and Medical Research Council (NHMRC) is the peak authority on health and human research in Australia. The Australian Health Ethics Committee (AHEC) is one of two principle committees of the NHMRC and is comprised of members appointed according to expertise. The NHMRC Act does not make provision for a committee member with expertise in the needs of LGBTIQASB+ People. The Act does provide for a committee member with expertise in the needs of children with a disability.

The AHEC published the National Statement on Ethical Conduct in Research. Section 4 of the Statement identifies populations with specific ethical considerations however LGBTIQASB+ people are overlooked in this chapter. This is not objectively justifiable. There are many factors that would support the need to identify LGBTIQASB+ people in section 4 including: the unique circumstances of LGBTIQASB+ children; the intense interest of the community regarding medical care of gender diverse children; the historic and current criminalisation of LGBTIQASB+ people in Australia and internationally; pathologisation of LGBTIQASB+ People; and the high frequency of knowledge gaps and unconscious bias in healthcare and research professionals. It is not fair that LGBTIQASB+ children have not been treated equitably by the AHEC.

While the long-term best interests of transgender and gender diverse children may seem quite clear to those who work closely in the field, there is a very potent influence of bias that requires solid evidence to displace. Healthcare professionals and ordinary members of the community are frequently exposed to over-simplified representations of existing evidence and knowledge. Much of this information is harmful, yet because it resonates with preexisting and unaddressed biases or religious and moral judgements, those exposed to this information may feel that it is inherently more trustworthy and reliable.

Research conducted at the Gender Clinic at the Westmead Children's Hospital was published in 2023. This publication was misleading in the manner in which it created a headline "desistence rate" of 22%. I am sure that a more detailed discussion of this will occur in other submissions to the AHRC. I see this as a very recent example of why LGBTIQASB+ representation on the AHEC and/or the NHMRC would achieve improvements in health equity. The recent Cass review from the UK also supports improvement in the quality and volume of research conducted for the benefit of children who are gender diverse. While I do not have a deep knowledge of the contents of the report, and I am aware of some criticism of the review, it does seem that there is consensus for a much greater effort in this area of medical research. Improving the knowledge and skills of every human research ethics

committee in Australia, inclusion of a representative within the NHMRC or AHEC expertise and knowledge relevant to the needs of LGBTIQASB+ people, and inclusion in the National Statement on Ethical Conduct in Human Research would all seem to be quite reasonable options to explore in pursuit of improved outcomes for gender diverse people.

8. Children's access to accurate health information

The right of gender diverse children to accurate health information is often overlooked. Misinformation in the media, schools and healthcare organisations is not well addressed. In some instances, the provision of accurate information is mischaracterized as an attack on religious freedom or other rights. This is incorrect. The right of all children to accurate health information on gender, sexuality, and health ought to be above the views and attitudes of any segment of the Australian community or the views and beliefs of a parent. One person's right to freedom of thought, conscience and religion should not be applied in a way that blocks children's access to accurate health information and education.

9. Disclosure of personal interests and religious affiliations

It is generally accepted that religion is relevant to medical ethics. A clear example of this is that the NHMRC Act places a person with expertise in religion on the Australian Health Ethics Committee. Personal religious affiliations should be routinely disclosed in health research and where relevant healthcare.

Religious and moral judgement has been the basis of many laws that criminalise LGBTIQASB+ people. These are examples of population level strategies for change, suppression, or conversion. Religious and moral judgement has also been a major influence driving formal and informal conversion therapy practices.

The ongoing influence of religious and moral judgement continues in health policy and funding decisions; research design, approval, and funding; education policies and curricula; and many other sectors that influence the health and wellbeing of LGBTIQASB+ children.

Disclosure and management of personal interests and religious affiliations relevant to a person's role in LGBTIQASB+ health is potentially a fair, reasonable, and proportionate strategy to identify and address the risk of perceived potential conflicts of interest and unconscious bias or knowledge gaps causing disadvantage to LGBTIQASB+ people in decisions.

There are many examples of how the levels of evidence for decisions vary according to these unconscious biases. One such example relates to surgery on the genitals of children. Some surgery on intersex children or other procedures such as circumcision are seen as aligned with social, cultural or other values. Gender affirming surgery either for gender diverse children or adults is seen as not aligning with norms and values and are mischaracterized as merely cosmetic or in some segments of

the community as child abuse. Decision making processes that present themselves as evidence-based apply a much higher, almost unachievable standard of evidence for gender affirming surgery to receive public funding in contrast to comparable surgical interventions in settings that seem to fit more comfortably with the unconscious bias of the decision-making bodies or the predominant culture of our society.

10. Equality and equity in access to coronial inquests and other important mechanisms of review

Noah's death may have been preventable if the systems that impact direct healthcare provision, and public health education, were improved to benefit transgender and gender diverse children.

The NSW State Coroner has chosen not to hold an inquest into the death of my child. I find this decision difficult to understand. There are few areas of health and wellbeing in Australia that are equally affected by systemic errors and other causes of disadvantage. Our community and important decision-makers would all benefit from clear guidance on what the long-term best interests of transgender and gender diverse children are. I had hoped that in death, Noah would finally have a voice and that the modifiable factors that may have contributed to Noah's death would be courageously explored.

If Noah does meet the coroner's threshold for significance to hold an inquest, the final opportunity to uphold Noah's human rights and restore dignity in death is lost. Noah deserves to be honoured by meaningful learning and change from an examination of his death, that it might benefit others who are yet to face the challenges he did.