24 August 2021

Dr Ayesha Verrall,
Associate Minister of Health
Parliament Buildings
Wellington

Dear Minister,

You may recall that I sent you a policy paper titled *Another Unfortunate Experiment: New Zealand's Transgender Medicine and its Impact on Children* during the campaigning period before the election. (I had spoken to you briefly about it at the Rongotai Women's Branch event at the West Plaza celebrating your candidacy.)

The information in that paper and much that has happened since warns of the dangers of implementing a conversion practices bill which could see parents and others criminalised, and counsellors, psychotherapists and doctors castigated, for cautious approaches at a time when internationally there is widespread retreat from the kinds of gender medicine treatments for children and young people that are routinely followed in New Zealand.

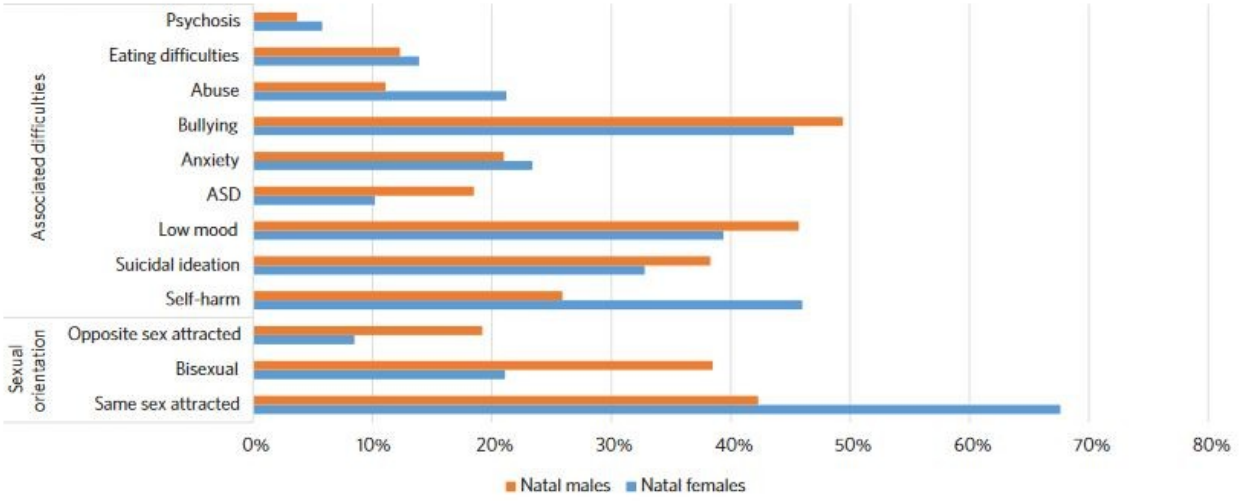
The purpose of this letter is to update you with what has happened since we completed our paper in August last year. These changes amplify that the caution we were advising was warranted. Court cases, practice changes by overseas governmental agencies and professional associations, as well as new research, have made the case for affirmative social transition and medication a much less credible and more harmful option.

It surely behoves you as the responsible Minister, and the government that has proposed the legislation, to have a keen awareness of the concerns that are exercising many people, including those in your own Ministry who recently advised against legislating. I am very concerned that a new law could serve to embed current affirmative approaches to gender medicine and will make it harder to assess the evidence for and against medical transition if not affirming children in their perceived gender journey becomes illegal.

Perhaps relevant to the New Zealand Bill is that an attempt to pass similar legislation in Canada has been allowed to lapse.

As a lesbian, surely you should be concerned about the research that shows almost 70% of girls and more than 40% of boys offering themselves for sex change medicine are same sex attracted. Gay and lesbian young people are uniquely vulnerable to a diagnosis of gender dysphoria when stereotypical ideas of sex roles are overlaid with homophobia. Surely exploratory questioning about why their lives seem intolerable in their own bodies and about their sexual orientation are vitally important in helping these young people to make their way through their confusion and unhappiness.

The following graph is from a paper published in 2020 and which analyses 2012 research on the mental health co-morbidities and sexual orientation of transgender patients.



Source: Griffin I. Et al *Sex, gender and gender identity: a re-evaluation of the evidence*

Apparently accepting that these decisions are not straightforward, former Labour MP Georgina Beyer has been quoted as saying

> *[A]ll interventions require proper oversight. This profound life-changing stuff needs to be done with scrutiny and duty of care.*
>
> *Policy decisions need to be taken beyond people who have a stake in the outcome. I question the qualifications some of the people involved have to inform policy makers. It wouldn't hurt to review these things. ("*Challenging the Born Identity"*, NZ Listener,* June 26 2021)

Our original paper

Our original paper made the case that the guidelines promoted by the Ministry of Health are harmful to children and young people for the following reasons:

- An 'affirmative only' approach has overtaken earlier 'watchful waiting' where upwards of 80% of children would have desisted as they matured. Research shows that there is now almost 100% transition to cross sex hormones and often surgery of those medicated with puberty blockers. This surely begs the question of whether puberty blockers are a pause button as gender clinicians claim.
- Uniquely in New Zealand, the practice guidelines for gender medicine propose early social transition and free use of blockers, while requiring only the child's self-diagnosis.

- The affirmative treatment regime ignores a significant tranche of the scientific literature that advises against medicine and surgery being the default solution to gender dysphoria. Also ignored is significant evidence of poor prognosis, particularly for mental health, in both the short and long term.
- There has been a massive increase in people seeking to transition. Amongst the cohort of transgender people there has also been a marked change in recent years from older and mostly male to younger and mostly female people.
- Especially amongst girls and adolescent women there is increasing evidence of social contagion leading to transitions in friendship groups. This was unknown in the literature until a decade ago, yet the causal factors for this new syndrome have not been investigated.
- In New Zealand's transgender medicine guidelines, children and young people are able to consent to a treatment path related to their unique self-perception, but there is no requirement for analysis of how that perception arose. Prior trauma, sexual abuse, serious mental health conditions, autism, anorexia and homophobia, as well as issues of sexism, misogyny, higher pornography consumption and the resulting expectations of sexual partners, remain unexamined as likely causes of gender dysphoria. This is because New Zealand's mental health professionals are not called on to address these issues, nor to be part of a transgender diagnosis.

Since the paper

Since we published and circulated the paper in 2020, the problems with New Zealand's approach to gender medicine for children and young people have become obvious. We have been approached by many parents of children going through transition who have been thoroughly traumatised by the health system. They have taken on trust goodwill, only to have met with health professionals who have ignored their child's wider context and have instead concurred with the child's self-identification as transgender.

These parents have been ambushed at meetings and on occasion their children have been offered puberty blockers only minutes into a consultation or even when the appointment has been made for an unrelated reason. It is parents like these, concerned with their children's overall well-being, and seeking diagnosis that addresses the root causes of the belief that the child is 'another gender', who now risk being criminalised if they insist on a proper diagnosis or a 'wait and watch' approach.

Changes overseas

The so-called Dutch protocol – the treatment model used in a radically adapted form here – is being dropped in many other countries. In the Netherlands, the authors of the original Dutch study have reported their concern that it is being used to endorse the more recent explosion of adolescent gender confusion (sometimes called rapid onset gender dysphoria or ROGD) which their research predated. De Vries describes this as follows:

> *A new developmental pathway is proposed involving youth with postpuberty adolescent-onset transgender histories. These youth did not yet participate in the early evaluation studies.*

In the United Kingdom, the National Health Service has begun an independent review of the UK's sole gender clinic, the Gender Identity Service (GIDS). But they have already withdrawn information that puberty blockers are safe and reversible. They now advise that for gender dysphoria

> *most treatments offered at this stage are psychological rather than medical. This is because in many cases gender variant behaviour or feelings disappear as children reach puberty.*

Keira Bell is a young woman who identified as male, took testosterone and was given a mastectomy. She subsequently realised her transition was a mistake and took a judicial review against the GIDS service. The resulting decision in late 2020 found in her favour on three planks, all of which are relevant in New Zealand:

- The Gillick test for informed consent does not cater for situations where a decision made in childhood will affect lifelong health, including sexual function and fertility. It was judged that children cannot consent to treatment that they are too young to comprehend, irrespective of the amount of information provided.
- The available research confirms our assessment that puberty blockers lead almost inexorably to further treatment, usually sex hormones and often to genital, breast and other surgery. This calls into question whether blockers are in any sense 'a pause button'. (Other research confirms this: see De Vries et al. 2011; Carmichael 2016, 2018). Further research shows that 80% of children (Cantor 2017) spontaneously desist during puberty if left untreated.
- The treatment is experimental, with little information about long term outcomes.

After the judicial decision, the National Health Service had to change its service specification, which GIDS then had to follow. Several other jurisdictions have also changed their practice. In Sweden and in Finland government guidelines had a 180 degree reversal of their previous approach. In Ireland the government has had to indemnify practitioners

against the likelihood of court cases, while the Irish College of General Practitioners has reversed their guidance that puberty blockers are safe.

Closer to home, Western Australia has banned the use of puberty blockers at a gender clinic without a court order. The Australian National Association of Practising Psychiatrists has changed its advice, its guidelines now saying that:

> *While respecting young people's views about their gender identity, this guide does so as part of the totality of their developmental and holistic clinical picture, and incorporates these into the clinical formulation. This approach requires that a comprehensive bio-psycho-social assessment be conducted before recommending specific treatment.*

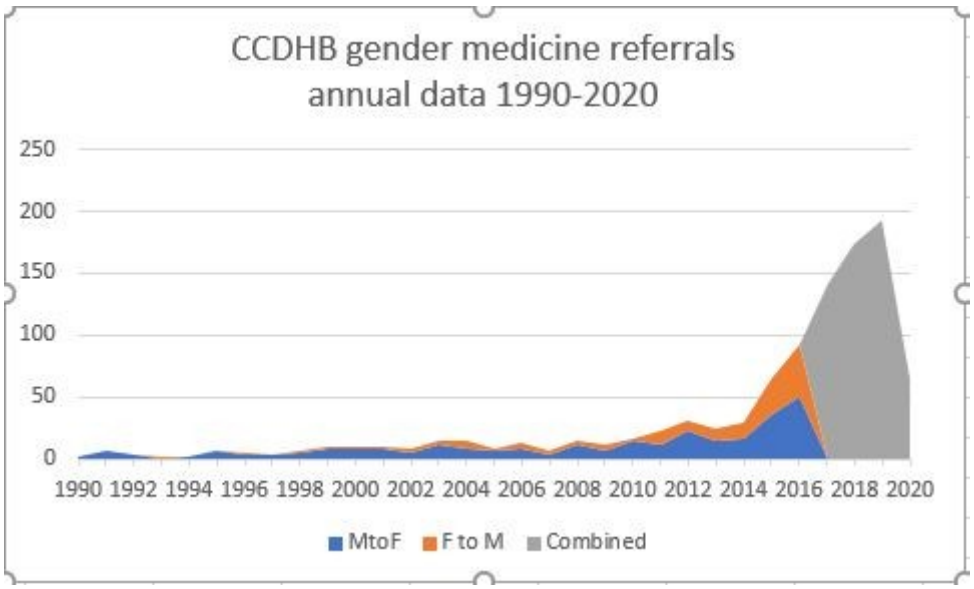
A research team associated with the Westmead Children's hospital in New South Wales has identified that young people presenting with gender dysphoria typically have a significantly greater load of adverse childhood events than their peers. Their subsequent research suggests:

> *... the need to bring into play a biopsychosocial, trauma-informed model of mental health care for children presenting with gender dysphoria. Ongoing therapeutic work needs to address unresolved trauma and loss, the maintenance of subjective well-being, and the development of the self.*

New Zealand's *Guidelines for Gender Affirming Healthcare for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa* is available on the Ministry of Health website. In stark contrast to these changes noted above, it continues to advise that the self-affirmation by a child or young person that they have a 'transgender identity' should be acknowledged as the truth. There is no diagnosis required by clinicians. Treatment to support the child in the journey towards their chosen gender identity includes affirming the child's belief with social transition and at puberty to prescribe puberty blocker medication. The Ministry's website still advises that blockers are safe, fully reversible and are able to prevent 'an unwanted puberty'.

Estimates of numbers

Referrals for gender medicine in New Zealand are increasing rapidly. The graph below represents individual referrals to the Capital and Coast District Health Board's endocrinology service from 1990 to 2020.



The data in grey is sourced FROM AN OIA that did not differentiate referrals by sex. The earlier data was from a RESEARCH PAPER. The trajectory appears to have risen as sharply as the figures for the whole of the UK.

The figures are for referrals for medical treatment, so the likelihood of young patients being medicated is very high. Unlike for gender surgery, there are no official national data collected for these referrals. The DHB figures are only part of the story, as youth clinics and student health services also provide gender medicine. The true extent of the treatment cannot of course be gauged without data collection. But the CCDHB has less than 10% of New Zealand's population and so the figures could extrapolated be in the thousands each year. Referrals are believed to be increasing exponentially and gender clinics, struggling to cope, are calling on special interest general practitioners in community practices to manage the care. Other estimates are that puberty blockers prescriptions are running at at least five times the rate of those in Australia and the UK.

New Zealand assessment of puberty blockers

The problems with children and gender medicine are beginning to be acknowledged even in New Zealand. A summer research scholar reporting to Dr Sue Bagshaw and working within the Otago University medical school in Christchurch last summer carried out a literature review. While no paper has yet been forthcoming, the study's media release reported that there were unknown health impacts of the medications. Ethical issues identified included:

- *if this treatment is considered experimental,*
- *whether adolescents have capacity to understand and consent to medical treatment,*
- *and whether we do more harm by giving or withholding treatment.*

The urgent need for further research was identified. That blockers stop bone density from increasing as it should was noted as a concern, but brain development was not listed even though Dr Bagshaw has elsewhere said that "*What we don't know is the effect on brain development".* A survey of the relevant research on cognitive development lends weight to the idea that suppressing puberty does have detrimental cognitive effects.

The same New Zealand study assessed the literature as demonstrating improved psychological functioning from puberty blockers. But even this is open to question. A NICE (clinical standards) review written last year to support the Cass independent review of gender medicine in the UK, released to the public in April 2021, analysed many of the same papers as the Otago study but rated the evidence-base as "*very low*". Moreover, the NICE research confirms Professor Michael Biggs' assessment of the only controlled study of psychological well-being (Costa et al) which was that:

> *there was no statistically significant difference in global functioning.... between the group receiving GnRH analogues plus psychological support and the group receiving psychological support only at any time point.*

Dr Bagshaw's summer scholar's assessment has also been contradicted by the latest research from the *British Medical Journal* about the UK experience. Data from 44 children who were studied as part of a GIDS experimental cohort was summarised thus:

> *Puberty blockers used to treat children aged 12 to 15 who have severe and persistent gender dysphoria had no significant effect on their psychological function, thoughts of self-harm, or body image,*

Desistance and detransition

Meanwhile *A Follow-Up Study of Boys With Gender Identity Disorder*, the longest research study ever on dysphoric pre-pubertal boys, followed up carefully on data from the late 1980s and shows that a full 87.8% of them desisted from cross-gender beliefs. Those who persisted were strongly linked to a lower social class than those who desisted, suggesting that factors such as greater levels of trauma or of homophobia in more deprived communities could be the cause of persistence.

New research casts doubt on the explanations that the causes of mental health issues for transgender people are prejudice and discrimination. This is described in the New Zealand guidelines as minority stress theory. The Society for Evidence Based Gender Medicine argues that:

> *First, evidence shows that mental health issues often precede the onset of gender identity concerns. Second, long-term studies have not*

> *been able to demonstrate lasting mental health benefits of "gender-affirmative" (hormonal and surgical) interventions.These findings do not support the argument that minority stress is the primary reason for the high co-occurrence of GD and other psychiatric disorders.*

If mental health problems are not caused by minority stress, should they not be addressed as part of a full differential diagnosis? Testimony from detransitioners like Keira Bell cites issues such as trauma, complex family situations, homophobia and the lack of strong, non-stereotypical role models.

The increasing numbers of young people detransitioning or deciding to live as their birth sex is often happening only after significant medical and surgical 'treatment'. The young women, with deep voices, facial hair, mastectomies and often with infertility are faced with challenges in returning to their birth sex. A study of detransitioners shows that increasing maturity often precedes the return to identifying with their birth sex. A world-wide social media website intended solely for detransitioners now has 21,600 members and your colleague Louisa Wall has met with some New Zealand-based detransitioners who represent New Zealand's leading edge of this new and growing phenomenon.

International law as it applies to conversion practices

The regulatory impact assessment for the Conversion Practices Bill makes clear that the proposed law will impact on the Bill of Rights Act protections related to freedom of speech. But the Bill also undermines New Zealand's compliance with international conventions to which to which we are a signatory

In particular, section 19 of the International Covenant on Civil and Political Rights states that:

- *Everyone shall have the right to hold opinions without interference.*
- *Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds.... through any other media of his choice.*

The rights granted by the covenant currently include protection for those who do not believe in gender ideology and ubiquitous gender identities and who argue that New Zealand's gender medicine regime is resulting in the over-medication of (mainly lesbian and gay) young people. Making these stances unlawful, as the Bill risks doing, is therefore to be in breach of the covenant.

The International Convention on the Rights of the Child applies to all people under the age of 18 and recognises

- *that childhood is entitled to special care and assistance,*

- *that that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.*

- *that the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.*

Are children being given adequate protection and safeguards if they are being set on a path that will impact their future fertility, reduce their sexual enjoyment, expose them to unknown long-term health risks, life-long medical treatment and sometimes multiple surgeries? Is instilling in them the belief that their bodies and their minds are not a contiguous whole but mismatched giving them proper care and assistance? Who would think that medicine for children that will adversely affect their whole lives, backed by the threat of imprisonment for parents who seek to avoid this on their children's behalf, would meet the criteria for child protection in the Convention?

Research on conversion therapy and suicide attempts

Finally I wanted to comment on your speech in support of the Bill. You said that "*People subjected to conversion therapy have worse mental health outcomes. A paper in the American Journal of Public Health suggests twice the odds of experiencing suicidal ideation; a 75 percent higher risk of planning a suicide attempt."* The report appears to have been a study of young LGBTQ people where many of the original questions were provided with suicide warnings – thus feeding participants with the idea that this was a personal risk they faced. Many of the shortcomings of the paper – the dangers of self-selection, of ascribing causation to a cross-sectional study and the fact that prior poor mental health was not apparently tabulated against reported conversion therapy attempts – are discussed in an analysis of a similar recent piece of research.

However it is the original data and analysis on which the article is based that contains the most pertinent argument against implementing a punitive legislative response to conversion therapy for gender-questioning children. Two questions about conversion therapy gave remarkably different results. The report said

> *We asked youth separately whether someone attempted to convince them to change their sexual orientation or gender identity and whether they underwent conversion therapy, in order to fully capture the ways youth experience efforts to change their sexual orientation or gender identity.*

To the first question two thirds of respondents answered affirmatively. Only 5 percent said they had undergone conversion therapy. That such diverse perspectives arose in response to similar questions should strike fear into the heart of every parent, teacher and health practitioner. We know that there are those so wedded to medicating “transgender children” that they are prepared to present proper differential diagnosis as conversion therapy. Parents are completely disempowered if expressing concern will have them targeted as transphobic law-breakers and saying nothing will see them lose their child to a harmful ideology. The law will be used as a battering ram to break up their family. As for psychotherapists and counsellors, who among them will counsel gender dysphoric children if two thirds of their clients could, at any time, make an accusation that the person has tried to change them, which, under the proposed punitive law, will be interpreted as conversion therapy?

Yours sincerely

Jan Rivers

Karori

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