Social Transitioning in Schools: The Risks & Harms.

LEGAL, PHYSICAL AND PYSCHOSOCIAL IMPLICATIONS OF GENDER IDENTITY IDEOLOGY IN SCHOOLS

IN DEFENCE OF CHILDREN

AWW Inc. sub-committee

Social Transitioning in Schools: The Risks & Harms.

Contents

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Introduction

There is now compelling evidence suggesting that socially transitioning a child is a "conveyor belt" to medical transition, and that medical transition can cause catastrophic and irreversible damage to a child. Therefore, schools that actively engage in instructing and reinforcing gender ideology to their students may find themselves liable in negligence for breach of duty of care.

Schools principally exist as establishments for imparting education and fostering learning. Presenting 'gender identity' as an undeniable fact does not constitute education, but rather indoctrination into a contested belief system, given that it is a concept that cannot be empirically proven.

Schools seem to have taken it upon themselves to teach gender ideology and to also initiate and foster social transitioning. Instruction in gender ideology and also social transitioning are the key commencing components of the 'gender affirmative approach', a therapeutic model used to address gender dysphoria, and which has been shown to catastrophically and irreversibly damage children.

It's crucial to understand that gender dysphoria is a diagnosable mental health condition, not an identity. As such, we contend that addressing gender dysphoria or incongruence falls beyond the professional expertise of educators. And it should be noted, despite the promise that gender transition is key to ameliorating the suffering of gender-dysphoric youth, systematic reviews of evidence failed to find trustworthy evidence of such improvements.

This piece delves into the potential dangers, misconceptions, and damaging effects associated with the social transitioning process for children experiencing dysphoria. It also explores the resultant implications/infringement upon the rights of their peers, safeguarding risks and the potential legal ramifications for schools.

We advocate for the acceptance of all children's individuality and affirm their worth, while also ensuring that all children are protected from discrimination or interference based on their gender non-conforming appearance, self-expression or behaviour.

1. Student Duty of Care

Our goal is for each student to cultivate their adult personalities, and to live freely, visibly, and openly in society. We do this by providing a school environment that is supportive of students' identity exploration and is neutral with regard to identity outcomes.

In doing so, we need to consider the legal principle of negligence and the duty of care owed by schools to students that arises from this principle. This principle states that schools are obligated to take suitable precautions to safeguard students from potential harm (see our section below entitled "**The Legal Risk**"). This principle is a fundamental aspect of school management and adherence to regulations, and most staff members have likely discussed it extensively in relation to matters such as accidents, allergies, field trips, bullying, and occupational health and safety.
As we contemplate this duty of care in relation to LGB students or those identified as

transgender, it becomes an area filled with considerable potential for harm. This is a fairly complex domain, which pertains to the psychological and medical care of children.

Currently in this era of gender affirmation, schools are taking an active role in *socially transitioning* children by encouraging (among other things) the changing of names, pronouns, uniform and allowing them to enter single sex spaces and sports of the opposite sex, often without the parents' knowledge or permission. This violates a parents' right to know their child has gender dysphoria, which is a diagnosable mental condition, not an identity. It also violates Article 5 of the United Nations Convention on the Rights of the Child (to which Australia became a signatory in 1990); 'Governments should respect the rights and responsibilities of families to guide their children…'

2. Social transitioning is not a neutral act with regards to identity outcomes.

We must acknowledge the statement by Dr. Steven Levine[1] that "*social transition is a significant procedure with deep implications for a child's long-term physical and mental health*."

There's room for debate whether the school, in transitioning a child, is confirming an existing 'transgender identity' or, for most youngsters, is in fact creating a transgender identity. Absent such intervention, up to 80-98%[2] of children experiencing body-gender dissonance are likely to reconcile these feelings once they have completed puberty.

All evidence points to the concept of gender identity or transgender identity **as a belief supported by no empirical evidence**. First, the concept of gender identity was born of a disproven original theory popularised by John Money in the 1960's and famously proven wrong when he attempted to raise a boy who had been accidentally castrated from a botched circumcision as a girl. Money believed that gender identity was socially constructed and therefore, after being raised as a girl for the first 30 months of life the boy would continue to identify as a girl. That didn't work, and the boy now known as David Reimer eventually reclaimed his birth sex, but sadly committed suicide as an adult.

Secondly, those who believe in the concept of '*gender identity'* have no settled definition on what that is, and how that can be rationally applied. The "essentialist" camp believes everyone has an internal sense of gender identity, but there is no agreement on whether there are 2 genders, 112, or as many as there are people in the world. The "performance" camp advocated by Judith Butler (an advocate of post-modern queer theory) says gender identity is something we choose to perform. [3]

Prior to 2010, and for the larger Australian population today, the vast majority of people do not have an internal sense that they have a gender identity that is separate from their physical body, and don't subscribe to any concept of gender identity.

Last, empirically speaking, a collective of over 100 clinicians and researchers[4] globally have expressed that there is no scientific proof backing the concept of "gender identity,"[5] nor is there any lab test or diagnostic technique that can conclusively distinguish between a person identifying as transgender and one who does not. A person's transgender status

can be self-asserted or encouraged by schools, parents, or online LGBQTIA youth communities; however, there's no medical scan or test that can definitively diagnose or detect a *gender identity*.

Any method that isn't backed by evidence doesn't align with the instructions stipulated by the national "Inclusion Support Program Guidelines" from the Commonwealth Department of Education. The positive education, mental health, and wellbeing of students hinges on "implementing Evidence-Based models for an all-encompassing school approach". Among the two models extensively adopted in Western Australian government schools is the "School-Wide Positive Behaviour Support" (SWPBS) Framework, which strongly recommends concentrating on evidence-based decision making.[6]

3. Social Transitioning a 'conveyor belt' to Medical Transitioning

Dr Levine has testified in many court cases relating to transgender rights, both in the United States and abroad. Dr Levine has strongly advocated against allowing social transition for gender-dysphoric youth, describing it as setting them on a 'conveyor belt' to medical transition.[7],[8],[9] He has also advocated against access to gender affirming medical care, most notably testifying in the case Bell v Tavistock[10],[11],[12] and has likened it to the medical experimentation[13] performed by Nazi Germany[14] during the Holocaust[15].

The evidence supports his stance. As a result of the systematic review of the evidence over the last 3 years, reversals in the practice of "gender-affirming" interventions for youth are already underway in Finland[16], Sweden[17], England, the UK[18], and most recently in the state of Florida, and 18 of the 50 states in USA. The Royal Australian and New Zealand College of Psychiatrists (RANZCP)[19] no longer privileges the gender affirmation approach. NAAP's Guidelines[20], and GETA's Clinical Guide for Therapists working with gender-questioning youth[21] call for psychotherapy to be the first line of treatment for youth who are uncomfortable in their body.

In addition, Australia's largest medical insurance provider, MDA National, in recognising the risks of 'gender affirming care' for minors, has recently released this statement:

> *"In response to the high risk of claims arising from irreversible treatments provided to those who medically and surgically transition as children and adolescents, MDA National is restricting cover for practitioners in private practice. From 1 July 2023, MDA National will introduce the following exclusion in your Professional Indemnity Insurance Policy.*
>
> *We will not cover you or make a payment when the claim against you arises in any way out of:*
> - *your assessment that a patient under the age of 18 years is suitable for gender transition; or*
> - *you initiating prescribing of gender affirming hormones for any patient under the age of 18 years*

We consider it appropriate that the assessment and initial prescribing for patients transitioning under the age of 18 years occurs with the support and management of a multi-disciplinary team, in a hospital setting."[22]

School administrators and institutions should be aware that directing children towards social transition almost always leading to *medical or surgical pathways of 'gender-affirming*

care'[23], carrying serious risks and implications (i.e. promoting social contagion and exposing schools to legal action). Furthermore, there is limited evidence that medical transition leads to positive outcomes.[24]

4. Assessment of a 'mature minor' is not the school's expertise.

If a school references the 'mature minor' concept, suggesting that a child might have adequate Gillick competence to consent or comprehend the implications of social, medical, or surgical transitioning, to then justify putting them on the transition pathway. First, the 'mature minor' concept is traditionally evaluated in a clinical setting by trained healthcare professionals. It is not assessed by K1-K12 teachers based on gender non-conforming behaviors, non-compliance to gender stereotypes and vulnerabilities, or phases children might be going through due to societal influences or contagion.[25] Secondly, children and adolescents are too young to assume their current gender identity is permanent. Adults should know that young people's sexual orientations and gender identities fluctuate as they gain more life experiences.[26]

Regarding an in depth discussion of Gillick competence please examine: Section E: "The Current State of the Law in Australia" from Barrister Belle Lane's "Paper for the Family Law Profession Gender Identity in children and adolescents"[27]

5. Medical, Surgical & Social Risks

As adults we must be aware of our responsibilities in understanding the harms, risks and social consequences to social transitioning, which are these:

Puberty Blockers[28]

- Short term: headaches, hot flushes, weight gain, tiredness, low mood and anxiety, reduction in bone density, bone fractures, blurred vision, vision loss.
- The Karolinska Institute (Sweden) has also reported liver damage, unexplained weight gains, mental health problems, spinal fractures, osteopenia, and failure to grow.
- Increase in behavioural and emotional problems in girls, including an increase in wanting to "deliberately try to hurt or kill self."
- Loss of fertility/sterilisation as gametes won't develop.
- Loss of sexual function and capacity to orgasm: young people given GrNHa at tanner Stage 2 who go onto cross-sex hormones will remain 'orgasmically naïve' which may impact their ability to enjoy intimate relationships.
- Level of puberty resumption after GnRHa use is stopped: unknown.
- Effects on brain development: unknown. Concerns raised about negative impact on IQ, long-term spatial awareness, reaction time and missing out on a window for critical cognitive development.
- Impact on the growth of all major organs; heart, lungs etc.
- June 2022 the FDA received 60,400 reports of adverse reactions to common GnRH agonists, (puberty blockers), including over 7,900 deaths.

Binding[29]

- Negative health effects from chest binding that may not show for years[30].
- 97.2% of respondents reported at least one negative outcome from binding. The most common symptoms were: 1. back pain (53.8%), 2. overheating (53.3%), 3. chest pain (48.8%), 4. shortness of breath ((46.6%), 5. itching (44.9%), 6. bad posture (40.3%), 7. shoulder pain (38.9)
- Additional symptoms include; rib fractures, rib or spine changes, shoulder joint "popping", muscle, wasting, numbness, headache, fatigue, weakness, light-headedness/dizziness, cough, respiratory infections, heartburn, abdominal pain, digestive issues, breast changes, breast tenderness, scarring, swelling, acne, skin changes, skin infections.

Tucking[31]

- There are case studies of both infertility and testicular torsion[32] occurring from tucking.
- Itching, rash, testicular pain, penile pain, and skin infections.

Cross-Sex Hormones, Mental Health & Surgery[33]

- Surgical removal of breasts; denying girls full sexual pleasure in adulthood, as well as the ability to breastfeed should they become mothers. In Australia, girls as young as 15 years old have had their breasts removed.[34]
- Impaired sexual function from surgeries, puberty blockers and hormones[35]
- Surgical removal of reproductive and sexual organs, and erogenous zones initiated for children as young as 9 to 13 years old who are not mature enough to give meaningful informed consent.
- Irreversible body modification such as facial hair, male-pattern baldness, permanently deepened voice and enlarged clitorises in women.
- Years spent suffering depression and mental health problems because comorbidities[36] were not accurately assessed or responded to with appropriate therapies.
- Female-to-male genital reconstruction surgery that has a high negative outcome rate[37], including urethral compromise and worsened mental health.
- A range of negative health outcomes from transition surgeries is outlined here[38] and here[39].
- Sterilisation of LGB, autistic and troubled young people with issues of abuse, self-hate, trauma, internalised misogyny, and victims of trans-indoctrination[40] or internalised homophobia[41].

Cultivating a culture of Deceit and Parental Disrespect and removing child safeguarding[42]

Apart from physical harm, promoting a culture of dishonesty is unacceptable. If a school encourages children to conceal or misrepresent their social transitioning to their parents, it is fostering a culture of deceit. This demonstrates a lack of respect for the family unit and presumes that the teacher is more capable of guiding the child's future than their own family. Schools should not encourage dishonesty or deception among staff or students.

Furthermore, there's a child protection concern when adults advise children to withhold information from their parents; typically, adults who do this are exposing children to potential harm. We remain unaware of the potential damage that could result from a school encouraging individual students to disregard the biological truths and act as if they don't exist. Additionally, we are uninformed about the psychological repercussions on children who are asked to assist in the social transitioning of a classmate; the impacts of this have yet to be assessed. As per Dr. Hillary Cass's assertion, children are not developmentally prepared to shoulder such a responsibility, and it's not suitable to impose this upon them.

6. Do the benefits of youth gender transitions outweigh the risks of harm? [43]

The argument that gender activists acting as third party advisors to schools have made, supported by activist driven research[44], is that gender/sex incongruence creates such suffering that social, medical and surgical transitioning is "lifesaving", despite the risks, and that schools and parents need to align children to their 'authentic selves' to alleviate that suffering. However, systematic reviews failed to find trustworthy evidence of any such improvements. Nor can it be claimed to be "lifesaving" when we are seeing an alarming 19 fold increase of suicide after transitioning[45] as compared to the general public.

In Dr Steven Levine's article "Current Concerns About Gender-Affirming Therapy in Adolescents[46]", he concludes that medical and surgical gender transition has not resulted in credible mental health improvements. He examined the effectiveness and potential risks of medical gender transition treatments, such as puberty blockers and cross-sex hormones, for gender-dysphoric youth. Despite the promise by activists that gender transition is key to ameliorating the suffering of gender-dysphoric youth, systematic reviews of evidence failed to find trustworthy evidence of such improvements.

I have summarised the main points:

i. Systematic reviews of evidence, including those conducted by the National Institute for Health and Care Excellence (NICE) and various health authorities around the world, found little to no evidence that these treatments improve key areas of mental health for youth undergoing gender transition.

ii. For puberty blockers, the studies that reported positive outcomes were deemed unreliable due to poor methodology. Most studies suggest little change in critical outcomes like gender dysphoria, mental health, body image, and psychosocial impact.

iii. For cross-sex hormones, the potential improvements in mental health were uncertain and had to be weighed against the risks of hormonal interventions. Some health authorities concluded that for most adolescents, the risks of hormones outweigh the benefits.

iv. Reviews are limited by short-term follow-up due to the relatively recent scaling of gender-transitioning youth practices (since about 2015). However, long-term studies of adults who transitioned years ago do not show lasting mental health improvements, with

some suggesting potential treatment-associated harms.

v. The article cites a 30-year Swedish study that found notably high rates of suicide and elevated all-cause morbidity and mortality among transitioned adults compared to peers. Other long-term studies also failed to find improved mental health outcomes with hormones or surgery.

vi. Similarly, a Dutch study found higher suicide death risk in transitioned individuals at every stage of transitioning.

vii. Two US-based studies indicated high rates of mental health problems, including depression, anxiety, substance abuse disorder, suicidality, and physical health issues among adults who identify as transgender. The cause of these health disparities is often attributed to minority stress, discrimination, and barriers to healthcare.

viii. The possibility that the mental health of some trans persons may be inherently compromised is not often discussed. Some gender specialists expressed concern in 2022 about the quick diagnosis and rush to irreversible body-modifying interventions for trans-identifying adolescents.

7. Disruption of natural maturation process of youth

Answering the question; "Who am I?" is the central objective of an adolescent's developmental process[47]. It does not assist a youth's maturation process. If we take an approach of a one-size fits all 'gender affirmation', we disrupt the natural course of individual identity exploration.

While respecting young people's views about their gender identity, one needs to acknowledge that childhood and adolescence is a time of rapid physical and psycho-social growth and profound personal development, during which young people may question their identity, sexual orientation, and gender.

It is important to understand that children and adolescents are not mature enough to assert that their current gender identity is fixed. It should be acknowledged by adults that the sexual orientations and gender identities of young people are prone to changes and evolution as they accumulate more experiences in life.[48]

As the child matures and progresses through puberty this questioning usually transforms and resolves, and the young person, in the majority of cases, up to 98%, accepts his/her biological sex and adult body. Social and medical transitioning, however, concretises what could otherwise be a transient and relatively harmless process of identification to explore, or gain attention or popularity beneath the broad transgender umbrella.

8. The Autistic, Same-Sex Attracted and/or Abused Child

Evidence is emerging that the majority of children presenting to gender clinics fit one or more of the following categories:

- have Autism Spectrum Disorder;
- are same sex attracted;
- have been subject to childhood maltreatment and abuse.

For each of these categories, social and medical transition is not an appropriate response to treating the discomfort and distress of these children.

For the autistic child, it is the autism that is causing them to feel different. This child needs specialist autism treatment to assist the child to understand this. That child can then become settled in their body. The rates of suspected autism for minors with gender dysphoria have ranged from 20% to 50%. For example, the Gender Development Identity Service at Tavistock, UK (now closed down) estimates that as many as 35% of its gender patients had autism. This is alarming given that less than 2% of children in the UK are thought to have an autism spectrum disorder. Certain countries and States in the United States have banned gender affirming care for minors. Missouri, a State in the US, has also banned gender affirming care for all autistic people (both adults and minors).

For the same sex attracted child, an "active watchful waiting" treatment is required. This is because more than two thirds of those youth who would normally grow out of this will grow up to be gay or bisexual, as there is a high correlation[49] with gender non-conformance, homosexuality, and bisexuality. What children are typically told if they are gender nonconforming is they are 'born in the wrong body' because they have a "gender identity" that does not match the gender norms or behaviour expected of their sex. In line with this idea, a female child more likely to grow up lesbian is expected to present as a (trans) boy, and a gender non-conforming male child is expected to identify as a (trans) girl. This in effect communicates to a homosexual child that it is not normal or acceptable to be homosexual and they need to conform to a heterosexual norm. (This is reiterated when school definitions of 'lesbian' or 'gay' do not acknowledge that these children are 'same sex' attracted and instead, define them as 'same gender identity' attracted.)

For the abused child, intense therapy is required to help the child recover from their trauma. In this case, telling a child that medical transition will cure their distress is clearly preposterous and no doubt negligent. For an example of the evidence for this, a gender service situated in The Children's Hospital at Westmead, NSW, Australia examined the clinical characteristics of children presenting with gender dysphoria. This study found that the developmental stories told by the children and their families highlighted high rates of adverse childhood experiences, with family conflict (65.8%), parental mental illness (63.3%), loss of important figures via separation (59.5%), and bullying (54.4%) being most common. A history of maltreatment was also common (39.2%).

While it is popular at this time for teachers to assume they are *affirming* an existing 'transgender identity' it is for most proto-homosexual, Autistic and vulnerable youth[50]

creating[51] a transgender identity. Because without this type of interference up to 80-98% of children that have an incongruence or disconnect with their body will grow out of it once through puberty.

9. The influence of Social Influence, Gender Ideation or Social Contagion on girls

It should be noted that before 2012, gender dysphoria almost exclusively occurred in boys (roughly .01% of the population)[52]. But girls[53] are now the majority of children who are transitioning, and this is more to do with gender ideation; a fixation on a gender identity, through social influence[54] and contagion. (There are more than 95[55] gender identities thus far.) In research these girls are commonly referred to though as having ROGD[56], *rapid onset gender dysphoria*.

i) Social Influence[57]:

- In one study, almost 9 in 10 young people questioning their gender seemed to be subject to social influence.
- In one study, two-thirds of trans-identifying young people had one or more friends who were also trans.
- One study showed that, in 36.8% of trans-identifying young people's friendship groups, the majority of members identified as trans.
- One study found that, in almost two-thirds of cases, internet and social media usage seemed to go up just before a young person came out as trans.
- The madness of crowds': The social contagion of gender dysphoria in adolescents, governments and professional bodies.pdf by Diana Kenny, expert on Social Contagion.
- In one study of detransitioners, around half originally believed that transition would lead them to be "treated better" if they were "perceived as the target gender".
- There has been a roughly twenty-fold rise in the number of people seeking transition, with teenagers hugely over-represented.

10. The Ideological vs Evidence based approach.

Gender identity ideology has over the last 10 or so years been taught in universities and shared via diversity and inclusion audits through state and government corporations. Broadly speaking there are two major positions on gender affirmation which have significant consequences on the type of risks children may face, whether they are gender non-conforming, proto-homosexual, bisexual children, children vulnerable to social influence or with a history of maltreatment and trauma.

1. The gender identity affirmative approach takes a 'one size fits all' approach of affirmation based on the ideology that everyone has a 'gender identity', a recent ideology, and disproven theory propagated in the early 1960s in psychology.
2. The individually centered approach places an emphasis on biology and material evidence, and involves parents, qualified psycho-therapists, psychological and psychiatric professionals. **The gender identity affirmative approach carries with it a greater risk of harm.**

Table: Overview of the Gender Affirmation vs Individually centred Perspectives.

Full table here: https://bit.ly/3paMLlN By Catherine Karena & "Nancy Wake" (anonymous).

GENDER IDENTITY AFFIRMATION	INDIVIDUALLY CENTRED
ASSOCIATED BELIEFS & PERSPECTIVES (Emphasis on ideology)	ASSOCIATED BELIEFS & PERSPECTIVES (Emphasis on biology & material evidence)
• People can literally be born into the "wrong" body". • Gender is innate and sex is socially constructed. Gender is more important than sex in all instances. • Gender is determined by feelings and doesn't require verification by science. • Rights should be determined by gender identity. • Social/medical/surgical alignment is an unquestionable human right and essential for individuals of all ages if desired. • People of all ages can never be incorrect about their gendered identity including if it changes. • Disagreement with these beliefs is bigoted, phobic and abusive and constitutes actual violence.	• Some people believe that you can literally be born into the "wrong" body". All individuals have the right to have differing beliefs but not all beliefs are true, correct or helpful. • Transgender identities may reflect an underlying mental illness/mental health condition. • Both sex and gender expression are both important. Individual contexts will determine which is more important. • Rights may reflect both sex and gender but when in conflict sex takes priority as a biological entity with the more robust evidence base. • Social/medical/surgical interventions may be helpful and appropriate for some individuals, but developmental ability, mental health and other relevant issues must be factored into decision making. • Beliefs often change, particularly with age, including about gendered identity so caution should be given to all forms of transition. • Multiple factors contribute to gendered identity just like all other identities. • Disagreement and debate is necessary to advance knowledge.
Therapeutic Implications:	**Therapeutic Implications:**
• Aways affirm the individuals' beliefs and their desired actions related to gendered identity. Other beliefs and actions can be challenged as per usual practice. • Being TGD is not a mental illness or something to be treated or cured. • Advocate and facilitate policy and practice based on the above at all levels of influence. • Assessment, diagnosis and case formulation are helpful in identifying and treating mental health issues however these should not preclude transition. • The benefits of transition outweigh any potential negative effects. • Challenging or exploration of beliefs about gendered identity is unacceptable, abusive and constitutes conversion therapy.[58]	• Always affirm the individual but not all their beliefs and desired actions, similar to other forms of therapy. • Assessment, diagnosis, and case formulation are essential to understanding the individual and their gender identity. • All forms of affirmation constitute an intervention and intervention should be reserved until assessment and treatment of other significant issues are resolved and stabilized. • Challenging beliefs is a necessary and normal part of therapy. • Transition may be appropriate and helpful for some individuals but may be harmful and unhelpful for others. • All forms of transition have known and as yet unknown iatrogenic effects that must be considered and explored in decision making and therapy.

11. The threat of child suicide in the absence of gender affirmation – is this real?

Importantly, there are numerous false statistics being used that promote the idea that regardless of the harm of 'gender affirming care', the consequence will be suicide if the child is not affirmed. These are being cited by a number of LGBQTIA lobbies that benefit in pushing medical transitions for children[59] that depend on the suicide myth: "Trans children will kill themselves if they do not receive gender affirming care."

There is no significant risk of self-harm or suicide if puberty blockers, hormone treatment or gender surgery are not given to young people to transition to the appearance of the opposite sex.

Many parents have been told if they do not comply with 'gender affirmation care' "Better a live son than a dead daughter" Parents report this as emotional blackmail used to pressure them into compliance with drugs, hormones or surgery by Gender Clinics or Trans lobbies. However, in effect no parent will end up with a son from a daughter through body modification. Nor will they retain a fully functional daughter or son. What transition creates is a chemically altered child mimicking old-fashioned ideas of masculinity or femininity. We say this is reckless, children deserve safety and ethical care.

This trans rights narrative, while causing deep concern, is not supported by facts. Every suicide is a tragedy, and one suicide is a suicide too many. However, with such a serious issue, accuracy is critical. **Please refer to the following resources:**

Suicide Facts and Myths[60]
Stats for Gender -Suicide[61]
Time to put the mythology about suicide risks among trans into the dustbin of unscientific, transgender ideology, by Dr Michael Biggs[62]
Suicide by Adolescents Referred to the World's Largest Pediatric Gender Clinic[63]

In particular make note of the three false statistics that are frequently cited in support of high suicide rates:

41% by the National Transgender Discrimination Survey
45% by the Centre for Family Research at the University of Cambridge, commissioned by Stonewall.
48% by the LGBT charity PACE, led by Dr Nuno Nodin from the Royal Holloway University of London

The key takeaways of the resources and articles are:

- There is no high quality evidence to suggest that the overall attempted suicide rate of transgender youth is 41, 45 or 48 percent.
- People with psychiatric conditions – and sometimes neurodiverse conditions – are much more likely to die by suicide than gender dysphoric people.
- Suicide rarely has one cause: it is difficult for statistical studies on suicide to extricate gender dysphoria from other factors.
- Advocacy run research[64] results in biased data[65].

12. What should we do to prevent harm to LGB, and children who identify as 'transgender'?

The table below presents a comparison between current school practices influenced by ideology, primarily promoted by re-branded Safe Schools Coalition; Inclusive WA and practices we recommend supported by up-to-date research. Followed by a general explainer of the existing federal laws pertaining to the inclusion of transgender or gender identity ideology, and state laws specific to WA supporting sex-based rights. Note WA Inclusive guidelines are in conflict with the law, the guidelines promote the law as the LGBQTIA influencers would like the law to be.

Table comparing current practices in WA and Recommendation[66]

Area	GII Ideological Practices	Recommendation
Parental Notification of social transition of child	Optional, determined based on the child's preferences.	Guaranteed, unless parents found unfit through formal proceedings with a child protective service.
Social transitioning of child to the appearance and gender norms & roles of the opposite sex.	Schools affirm child gender choice (changing name and pronouns, uniform, binders, or tuckers); no other options are provided.	Parents consult health professionals, traditional psychotherapy, exploratory individualized care, or no intervention. Any conversion therapy of any kind that conforms the child to the appearance of the opposite sex[67], not allowed, even with parental consent.
Toilets/Changing Areas	Based on gender identity*	Based on biological sex
Overnight Stays	Based on gender identity*	Based on biological sex
Sports Participation	Based on gender identity*	Based on biological sex after age 10
Breast Binders/Tucking	No prohibition on staff providing (*false*) understanding that there are 'safe' ways to tuck or bind.	Staff are prohibited from providing binders or other devices to change students' physical appearance, due to harm.
Gender Dysphoria Information Packet	Usually engage in ideological based training with LGBQTIA third parties.	Recommend objective, scientific information to assist parents in choosing the approach to support their children.
Scientific Basis	No research cited. Gender dysphoria or Social Contagion usually not mentioned at all.	Follow evidence-based research free of activist bias. Gender dysphoria, Social Contagion thoroughly discussed.
Language	Redefine same sex attraction as same gender identity attraction.	Do not redefine same sex attraction as a gender identity attraction, do not stigmatize or make homosexuality invisible.

Explainer:

***** The initial intention of the Federal Sex Discrimination Act (SDA) was to cease discriminatory practices against women in public domains. However, when the federal government included 'gender identity' in the SDA in 2013, they overlooked potential complications between 'sex' and 'gender identity'.

This includes instances where an individual with male biological characteristics identifies as a woman, or vice versa. Consequently, the SDA that was initially instituted to safeguard women has potentially allowed males (boys & men) to access female-specific spaces, services, and protections in the name of protection against discrimination based on gender.

The 2013 revisions to the Sex Discrimination Act have subsequently introduced a substantial problem, as they establish a direct confrontation between 'sex' and 'gender identity'. 'Sex' is a concept more firmly supported by stipulations such as the UN Convention to Eliminate Discrimination Against Women. Nonetheless, this vagueness has provoked complications.

For instance, when schools prioritise 'Gender Identity' and disregard 'sex', it results in a significant disagreement of legal principles and a clash of human rights between, for example, the rights of girls for safeguarding, privacy, and fair sports competition, which are backed by CEDAW, versus the rights a boy might claim if he identifies as a girl. This involves the asserted 'right' to receive the same treatment as a biological, legally recognised female, including access to female-only services, spaces, and provisions.

Schools are strongly advised to actively solicit specific legal guidance and whole-community consultation before permitting students to use bathrooms, changing rooms, dormitories, sporting activities, etc. designated for the opposite sex, and prepare to fully justify their position.

Nevertheless, it's worth noting that one could make a case for exclusion based on sex, citing reasons related to fairness, safety measures, and privacy given the following acts:

a) With regards to sport: Equal Opportunity Act 1984[68], Part II — Discrimination on ground of sex, marital status, pregnancy or breast feeding, Division 5 — Exceptions to Part II, Section 35.

Sport
(1) Nothing in Division 2 or 3 renders it unlawful to exclude persons of one sex from participation in any competitive sporting activity in which the strength, stamina or physique of competitors is relevant.

(2) Subsection (1) does not apply in relation to the exclusion of persons from participation in — (e) sporting activities by children who have not attained the age of 12 years.

In other words a person may discriminate against another person in a competitive sporting activity by restricting participation to persons of one gender of 12 years of age or more.

Also Section 42 of the SDA[69] provides that (1) Nothing in Division 1 or 2 renders it unlawful to discriminate on the ground of sex, gender identity or intersex status by excluding persons from participation in any competitive sporting activity in which the strength, stamina or physique of competitors is relevant. Section 10 of the SDA saves state laws which can operate concurrently with the Commonwealth law. However, there is an argument that the SDA exemption here is wider than the Error! Use the Home tab to apply Name Of Act/Reg to the text that you want to appear here.**,** and so (so far as it applies to WA schools) overrules it.

Further given there is a clash between sex and gender and in allowing natal males into female sport, there is an argument that this discrimination against natal females.

b) With regards to toilets, changing areas and overnight stays:

Under the Western Australian Equal Opportunity Act 1984, an individual identifying as the opposite sex can only be treated as if the opposite sex if they obtained a gender recognition certificate from the Gender Reassignment Board of Western Australia, established under the Gender Reassignment Act 2000. If a student identifies as the opposite sex but is not recognised as such by the State, **they do not have a right to single sex spaces pertaining to the opposite sex.**

We should take an approach that avoids political, social, religious, and ideological positions and does not single children out as a special class. We should aim to protect and safeguard the health, safety, and welfare of all children. Our national guidelines should prioritise the best interests of the child in accordance with human rights obligations under the United Nations Convention on the Rights of the Child [3].

The school should value all its students and staff and aim to create an inclusive culture, workplace and learning environment that protects everyone from unjust or unfair treatment based on age, sex, race, disability, religion and belief, pregnancy and maternity, sexual orientation, gender reassignment or marriage and civil partnership.

We should affirm all children as worthy of acceptance and love, while ensuring all children protection from discrimination or interference based on their gender non-conforming appearance or behaviour.
Every child should be free to express their identity, but expressing an alternative gender identity or proposing to transition does not change a child's sex. We should not be encouraging youth to reject or hate their bodies. Just as we would not affirm anorexia with gastric binding, we should not be preparing girls to cut off healthy breasts by encouraging the use of harmful chest binders. Nor should we approve of the future removal of a boys healthy testicles by encouraging tucking.

The school should seek to establish and maintain an environment where all children feel secure, are encouraged to talk, and are listened to when they have a worry or concern.

The school should aim to respond to children with complex needs, or who are going through a difficult period in their life, and to support their health, wellbeing, and educational attainment.

The school should aim to treat all pupils with dignity and respect.

The school should not support stereotypes about the appearance, behaviour or interests expected of girls and boys, or women and men.

The school should do no harm. The consequences of **'gender-affirming care' or interventions** violate the legal responsibility of the school to protect students from risks of harm. This is because social transition is the gateway to irreversible medical transition.

As children grow and mature in their thinking, the consequences of sterility, loss of sexual function and various other health comorbidities associated with castration drugs (puberty blockers) and synthetic hormones, will very likely cause them much emotional, psychological, and physical suffering. Given that this harm could be seen as a clear extension of the school's interventions, it may open the school to litigation.

The school could be found negligent in its duty of care, for encouraging youth on a medical pathway when they are too young to consent, when their prefrontal cortex, responsible for decision-making, problem-solving, and understanding consequences is undeveloped such that they are unlikely to grasp the long-term consequences of transitioning by teachers with no remit or skills to advise.

Transitioning is an extreme course, that not only requires resilience and maturity, but which also can have significant unintended social implications. A child might face bullying, discrimination, or rejection from peers or family. It can be argued that it might be better to wait until the child is older and more equipped to handle these challenges.

Ultimately, decisions about transitioning are highly personal and should be made with the support and guidance of medical professionals, therapists, and supportive family members. It's essential to respect each individual's journey and self-identification, while also considering the potential risks and consequences.

13. Harms to LGB youth.

We must not conflate 'gay' with 'transgender' in language. The Child Family Community Australia (CFCA) Resource Sheet: LGBTIQA+ communities – a glossary of common terms, which is part of the materials for the 10 National Principles of Child Safe[70] Organisations, omits the definitions of same-sex attraction for Lesbian and Gay

children. According to the resource sheet:

"Gay: refers to a person who identifies as a man and is sexually and/or romantically attracted to others who identify as men. The term 'gay' can also be used for women who are sexually and romantically attracted to other women.

Lesbian: refers to a person who identifies as a woman and is sexually and/or romantically attracted to others who identify as women."

While the School Curriculum and Standards Authority[71] and the Same-Sex Relationships (Equal Treatment in Commonwealth Laws – Superannuation) Act 2008 (Cth) acknowledge same-sex attraction, this resource sheet, provided by LGBQTIA advocacy groups, does not. The definitions merge 'gender identity' with biological sex. The redefinition of lesbian and gay children to those who identify as such, rather than those with a same-sex orientation, mislabels gay children as 'transgender' within a 'Child Safe' school context. It often takes puberty and time, sometimes involving a journey through gender dysphoria, for gay children to understand their sexual orientation.

As observed, once a gay child is identified as trans, state education policies[72] may mandate schools to adhere to a "gender affirming" process. This might guide children towards seeking puberty blockers, cross-sex hormones, and sometimes surgery to modify their bodies and socially present as "straight." Denying the reality of same-sex attraction predisposes these youths to internalised homophobia and the notion that to be accepted or considered valid in a community, they must adhere to heterosexual norms.

This approach leads to situations where a female child, who is more likely to identify as a lesbian when she grows up, is expected to present as a (trans) boy, and a gender non-conforming male child is expected to identify as a (trans) girl. In a very tangible way, this can be seen as a form of *conversion therapy through gender identity.*

> "*It is vital for young people who identify as gay or lesbian to experience acceptance for who they are. Recognising that their sexual orientation is a normal aspect of human diversity allows them to seek out and connect with role models who are also gay, who maintain healthy same-sex relationships, and who challenge traditional gender norms. Having access to positive representations of gay women and men empowers these young individuals, helping them understand that they can defy gender stereotypes and still lead successful and fulfilled lives. They learn that happiness and achievement aren't tied to being of a certain sex, but rather embrace their nature. Being gay is perfectly alright."* (LGB Defence).

14. The Legal Risk

A duty of care that arises out of the legal principle of negligence is the legal obligation to take care to avoid harming others. The courts have held that the relationship of teacher/student has an automatic and undeniable duty of care. The courts have also

held that this duty of care is non-delegable. Due to the concept of vicarious liability, this means that the school itself is liable for a breach of this duty by a teacher. Hence, schools have a duty of care to avoid their students being harmed. It is a distinct possibility that schools may be in breach of this duty of care by teaching gender ideology to, and allowing the social transition of, its students.

The argument for "gender affirming care" put forward by the proponents of gender affirming care and medical transition (**Trans Industry**)[73] is that the child will commit suicide if he/she is not allowed to transition to the opposite sex. In other words, the Trans Industry contends that suicide is the "harm" that medical transition is trying to stop. The Trans Industry regularly cites various statistics to support this proposal. In our review of these statistics, (see **11. The threat of child suicide in the absence of gender affirmation – is this real?** above), it is clear that these are categorically false statistics and there is no additional suicide risk to these students if they are not socially or medically transitioned. In fact, evidence is emerging that suicide risk increases AFTER medical transition[74].

What is becoming very clear is that the real "harm" being done to these students is medical transition. As evidenced above, particularly in point **5. Medical, Surgical & Social Risks**, medically transitioning a child harms that child in very significant and permanent ways.

How Schools Can Be Involved In Promoting Gender Ideology

Whilst the teachers and the schools themselves are not clinically involved in medically transitioning children, there are a number of ways that teachers and schools are involved in the process:

- Socially transitioning a student almost always leads to medical transition (see **2. Social Transitioning is not a neutral act.** above). The schools that encourage students to transition, particularly without consent from the parents, arguably are actively guiding the students toward harmful medical procedures. If these schools did not allow social transition, it is likely, in the average case, that the student would not proceed to medical transition and then avoid being harmed.

- A student may wish to socially transition once he/she has become aware of gender ideology. A school that teaches and/or encourages gender ideology may be responsible for the student having a desire to transition, particularly in cases of social contagion.

- Overtly displaying trans/pride flags, forcing students to use pronouns different to the biological sex of another student, forcing students to use gender neutral toilets, allowing boys to play on girls sports teams and be involved in girls activities (and vice versa), and all other gender ideology reinforcing policies, can impact a student's mental state regarding gender.

- In some cases, school counsellors refer students to gender affirming practitioners[75], where the outcome is almost always medical transition. This is because in the "gender affirming care" approach, the practitioner does not undertake investigations or analysis as to whether the child has gender dysphoria or other comorbidities. Instead, it is the child who is the arbiter of whether he/she has gender dysphoria, and the practitioner merely facilitates the medical transition. In all other areas of medicine, the idea that any doctor would allow children to diagnose the cause of their own distress and then prescribe their own treatment, is not only unheard of, but would ordinarily be considered tantamount to medical malpractice.

The question of whether the school has breached its duty of care to its students is determined by examining whether:

- there is a **duty of care**;
- there was a **breach** of duty of care;
- the applicant incurred **loss, injury, or damage**; and
- the breach of duty **caused** the loss, injury or damage.

1. Duty of Care

As mentioned above, the courts have held that the relationship of teacher/student has an automatic and undeniable duty of care. Accordingly, this element is satisfied.

2. Breach of Duty of Care

Schools will breach their duty of care if they act with less care than a reasonable person would display in the circumstances. The question is whether a reasonable person would act to avoid harming students by ensuring that students are **not** instructed in the concepts of gender ideology at the school and also that students are **refused** the ability to socially transition in the school environment.

Given that there is now compelling evidence suggesting that socially transitioning a child is a "conveyor belt" to medical transition, there is a very strong argument that schools which are involved in the process of instructing students in gender ideology (see discussion regarding this involvement above) are acting with less care than a reasonable person would display in these circumstances. Such schools may find themselves liable for breach of duty of care as they are doing the exact opposite of how a reasonable person would act in the circumstances.

The unique medical nature of "gender affirming care" makes this liability more likely. As it is the child that determines whether they are to be medically and surgically altered (and therefore harmed), and not the medical profession, the schools may be held to be directly responsible for the student's transition and, accordingly, be in breach of their duty of care.

3. Loss, Injury or Damage

The evidence available demonstrates that medical transition can cause catastrophic and irreversible damage to a child - See **5. Medical, Surgical & Social Risks** above. Students who undertake transition will suffer from some or all of these harms. It is not hard to imagine that this element would be easily satisfied.

4. **The Breach of Duty caused the Loss, Injury or Damage**

Schools that instruct students in gender ideology and/or allow students to socially transition during school are leading those students down a path that inevitably results in medical transition. This is due to the nature of "gender affirming care".

As discussed above, there is now compelling evidence suggesting that socially transitioning a child is a "conveyor belt" to medical transition. Such a student, having decided that they are "trans", will then usually seek medical advice in order to facilitate medical transition. Inexplicably, the "gender affirming care" model prohibits medical practitioners from investigating whether a patient actually has gender dysphoria. In practice, the patient tells the practitioner that they have gender dysphoria, and the practitioner merely medically facilitates the transition. There would be a strong legal argument that, in some cases, the primary cause of a child's desire to transition is due to the introduction to gender ideology at school and/or the encouragement by the school of their social transition.

Accordingly, this element may not be difficult to satisfy.

That schools have been negligent in exposing children to gender ideology is currently being considered in the UK, the jurisdiction from which Australian negligence law derives. For example, parents are bringing a joint claim in negligence against the UK Department for Education for a failure to act on the foreseeable harms caused to children by gender ideology. (see Link Here[76]). We suspect this will be the start of many negligence cases against schools and against Departments of Education in jurisdictions that have such a duty of care.

Please examine an in depth discussion on "The Current State of the Law in Australia" from Barrister Belle Lane's "Paper for the Family Law Profession Gender Identity in children and adolescents"[77]

15. Policy Recommendations

The consistency of WA laws and policies is questionable, especially when they hinge on the belief system of gender identity ideology rather than on tangible, objective evidence. It's essential to consider that prioritising 'gender identity' over 'sex' does not adversely impact the privacy, safety, and psychological and physical health of the child concerned and their classmates. The necessity for privacy, dignity, and protection, especially among girls, is frequently dismissed as simple 'discomfort,' yet it can lead to physical and psychological damage, including bullying, intimidation, and sexual harassment by males. It's important that policies consider the needs of *all* children, rather than favoring the needs of one child over others.

We propose the following to discourage stereotypes, embrace gender non-conformity, and motivate children to understand that being male or female is not confined by a strict set of expectations. There are many ways to express boyhood or girlhood, and individuality should be celebrated.

We recommend:

Gender Ideology
There be a prohibition on teaching any form of gender identity ideology at schools.

Uniform
All items of school uniform and dress code apply equally to children of either sex. Any item that can be worn by a boy can also be worn by a girl, and vice versa.

Clothing requirements are based on sex only where this is needed for health, safety, and dignity, such as athletic protectors for boys and appropriate coverage of swimwear for girls.

Names and pronouns
Children may ask to be called by a different first name than that in their official records (for example a familiar or shorter version, a middle name, or a complete change of first name, including a name associated with the opposite sex).

Pupils who want to change the name they go by in daily use can do so by filling in a form available at student services, and this will be added to the register alongside their legal name. A confirmation will be sent to their parents.

If a child's name is legally changed by deed poll, parents should bring this information to the school office and records will be updated.

Pronouns are words that other people use to refer to a person (he/him or she/her). It is important for everyone to use accurate sex-based pronouns, the choice of "preferred pronouns" is not optional. For two reasons, first, to avoid situations where popular students can enforce compliance upon less popular students, thus ensuring that no opportunities for bullying arise regarding how individuals wish to be perceived. Second, enabling a single child to dictate the language used by other children is impractical; implementing a "preferred pronouns" policy discriminates against individuals who are neurodiverse, have learning disabilities, struggle with speech and language, or hold protected beliefs. It is also forcing them to lie about the sex of the child making the demand. The school will not agree to use different pronouns when talking about a child to their parents and during the school day.

Sports
Not all sporting activities at school are segregated by sex, but where they are this is for safety and fairness, particularly of female participants, or for "positive action" (such as encouraging girls to take up football).
In considering whether a sport, game or other activity should be offered separately to girls and boys, we consider the age and stage of development of the year group, not of each

individual.

Where sports are organised separately for girls and boys, this is by sex, not gender identity. All pupils are welcome to play in mixed sports and in sports with others of the same sex.

Trips away
Trips away are an important enrichment of school life. They should be planned with full risk assessment and seek to make them accessible to all. Children and parents with any concerns or anxiety about trips away should contact the organiser in advance to discuss particular needs. Sleeping arrangements are organised by sex, not gender identity.

Toilets and changing rooms.
Single-sex facilities are the simplest way of providing privacy for girls and boys over the age of eight.
Toilets and changing rooms should be segregated by sex, not gender identity.

All pupils are welcome to use the single-sex facilities that correspond with their sex. When single sex toilets are not provided for girls, girls stay home when menstruating, or reduce going to toilet when needed or engaging in sports for fear of harm, loss of privacy and discomfort. The needs of all students should not be abandoned for the desires of one. This creates in a child a sense of entitlement, that their wants trump the needs of many.

We however recognise that some children will not feel comfortable in single-sex facilities and will endeavour to provide alternatives for those who would feel more comfortable with greater privacy (such as single-occupancy unisex facilities).

Advocate Sex-Based Inclusion -rather than impoverishing a sex class by removing diversity.
Excluding that child from their sex-based class impoverishes that sex class from the greater diversity of expression that, that child represents. When it is suggested that a child should belong to the opposite sex due to their gender non-conformity, or that they are ’born in the wrong body’ the diversity of that class is diminished. It restricts a student's individual behaviour and freedoms to outdated gender norms, reiterates gender stereotypes, and limits the full range of individual expression.

The implementation of gender affirmation not only politicizes the child grappling with gender distress, but also impacts every other student in the school. As soon as one boy is labeled a 'transgender girl' by the school, all other girls are automatically categorized as 'cisgender girls'. This model indirectly pressures any girl who doesn't fit neatly into traditional feminine stereotypes to identify as non-binary. Under the framework of the gender identity model, there is no recognition or representation for girls or boys who don't adhere to stereotypical gender roles.

APPENDIX:

A. Resources:

https://segm.org – Society for Evidence Based Gender Medicine
https://Sex-Matters.org – Sex Matters is a UK-based not-for-profit organisation. They campaign, advocate, and produce resources to promote clarity about sex in public policy, law, and culture in the UK.
https://genspect.org/ Genspect is an international alliance of professionals, trans people, detransitioners, parent groups and others who seek high-quality care for gender-related distress.
https://www.transgendertrend.com/ An organisation of parents, professionals and academics based in the UK who are concerned about the current trend to diagnose children as transgender.
Melbourne Declaration on Educational Goals for Young Australians[78] National agreement between all state education departments on education goals Australia wide.

B. Human Rights Act Articles [79]referenced for this article:

Article 9: Freedom of thought, belief, and religion and Protocol 1, Article 2: Right to education

Article 9 protects freedom of thought or belief, whether religious or secular and Protocol 1, Article 2 establishes parents have a right to ensure that their religious and philosophical beliefs are respected during their children's education.

In practice:

- *The concept of 'gender identity' is a belief. Children and adults should not be compelled to accept a belief, in practice this means they do not have to believe, or act as if males or females can be of the opposite sex.*
- *Children should not be suspended or punished for not using gender identity pronouns, misgendering or complaining about the violation of their privacy and dignity with the opposite sex in their change rooms or toilets.*

Article 10: Freedom of expression

Article 10 protects your right to hold your own opinions and to express them freely without government interference.

- These rights are also enshrined in international law for children:

C. UN Convention on the Rights of the Child referenced for this article:

In Australia, all children are protected by the *United Nations Convention on the Rights of the Child*[80] (2). Of the Convention's 54 Articles, we consider the most salient to be the following:

Article 3: 'The best interests of the child must be a top priority in all decisions and actions that affect children.'

In practice: *Schools must decide if it is in children's best interests to:*

- *Teach children an ideology as fact, promoting language and concepts which are scientifically questionable and take away a child's right to understand biological facts.*

- *Force girls to share personal spaces with males and take away their rights to privacy and dignity as well as their right to assert their boundaries as a sex.*
- *Take away children's rights to name biological reality.*

Article 5: Governments should respect the rights and responsibilities of families to guide their children so that, as they grow up, they learn to use their rights properly.

In practice*: Teachers do not have the authority to facilitate childhood transition of students against the wishes of the student's family.*

Article 6: Children have the right to live a full life. Governments should ensure that children survive and develop healthily.

In practice*: Schools should not facilitate childhood transition which has been shown to cause lasting harm and prevent healthy development.*

Article 13: 'Every child must be free to express their thoughts and opinions and to access all kinds of information, as long as it is within the law.'

In practice: *Children should not be compelled to use pronouns or view other students as having a 'gender identity'.*

Article 16: Children have the right to privacy.

In practice: *Excluding children from facilities for the opposite sex is not bullying. Expectations will be stated clearly and respectfully by the school. Individual children will not be permitted to negotiate access to facilities for the opposite sex. The impact of males in girls' toilets and changing areas impact girls school attendance due to privacy needs around menstruation, urination, and vulnerability while in a state of undress. Where possible a gender-neutral toilet should be provided in addition to single sex toilets.*

Article 18: Both parents share responsibility for bringing up their children and should always consider what is best for each child. Governments should help parents by providing services to support them, especially if both parents work.

In practice: *Teachers should not usurp the rights of the parent to guide the child.*

Article 29: Education should develop each child's personality and talents to the fullest. It should encourage children to respect their parents, their cultures, and other cultures.

In practice: *We should not be boxing children's personalities into pre-packaged gender identities.*

Article 36 (other forms of exploitation): 'Governments must protect children from all other forms of exploitation, for example the exploitation of children for political activities, by the media or for medical research.'

In practice: Schools must be careful to ensure that children are not exploited by adult activists with a political or financial agenda. See 'The Business Model of Youth Transitioning'[81].

D. The applicable laws of WA and existing school guidance

The key documents concerning 'transgender diverse' students are given below. Trans activist influenced guidance, and laws often do not align, activist influencers present the law as they would like it, rather than as it is, i.e., Gender identity ideology trumping Sex based, or material-based reality.

1. Guidelines for supporting sexual and gender diversity in schools (2014)
    a. In 2019, the Premier Mark Gowan funded the re-branded Safe Schools' program; 'Inclusive Education WA' 1.4 million was spent creating resources such as their social transitioning program called "IEWA Guide to Supporting Students to Affirm their Gender"
2. *Sex Discrimination Act 1984* (Cth) *(Law)*
3. National Principles for Child Safe Organisations.
4. Equal Opportunity Act 1984 (Law)
5. Growing & developing healthy relationship

END NOTES

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