



**Submission to the inquiry on School Refusal:
“School I can’t and School Phobia”**

Intersex Human Rights Australia (IHRA)

December 2022

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1 Introduction

Thank you for the opportunity to make a submission to the Education and Employment References Committee for inquiry and report on the national trend of school refusal and related matters.

Our submission will focus on the schooling experiences of people with innate variations of sex characteristics;¹ the experiences of young people who feel invisible, misinformed about their bodies, unsafe or unwelcome in mainstream school settings. This is a subject with which we have considerable knowledge and insight. Our submission draws attention to issues affecting intersex youths and children and encourages the committee to develop a nuanced approach.

In this submission we make four main observations:

1. Whilst the Australian COVID-19 shutdowns have been a source of anxiety and social dislocation for many school-age children, the prevalence of school refusal post-shutdowns is, in our view, mostly unrelated to this trauma. Rather, COVID-19 home-schooling arrangements have shown a generation of young people that if they do not feel safe in schools, there are alternative ways that allow them to feel better. We expect that many submissions will make this observation, so we do not elaborate on it further.
2. The reasons why children feel unsafe in schools are diverse and complex. One important reason is that students who are categorised by schools as LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex, plus) can feel invisible, misinformed about their bodies, unsafe, unwelcome and lack a sense of belonging. This lack of visibility and acceptance is exacerbated by the fact that education professionals (like many in the general community) work from an aggregated and often superficial understanding of LGBTQI+. We believe that what is needed is a disaggregated perspective that differentiates between the lived experiences of different populations within the rainbow alliance. It is important here to note that intersex **is not** an identity category. The intersex population does not have a shared gender identity. Rather, intersex is a biological variation. We address this further below.
3. Young Australians with intersex variations often report poor schooling experiences. We submit that most Australian schools (and education professionals working in them) lack sound understanding of the experiences of children with intersex variations. Not only are many people in the community ignorant about the lived experiences of people with innate variations of sex characteristics, but misinformation and incorrect assumptions abound. Children with an intersex variation are a small but significant subset of young people who express school refusal or school phobia.

¹ This term is used interchangeably with other terms including 'intersex variations' and 'people with intersex variations.'

4. Intersex Human Rights Australia (IHRA) provides authoritative information and advice on the needs and circumstances of people with an intersex variation or innate variation of sex characteristics. We urge the committee, in developing a holistic view of the causes and solutions to school refusal, to take account of young people with intersex variations, and the views of the intersex human rights movement and community as to how they can best be supported to be successful and settled in school and, more broadly, their lives.

1.1 About us

IHRA is a national charitable organisation run by and for people with innate variations of sex characteristics. We promote the health and human rights of people with innate variations of sex characteristics, including rights to bodily autonomy and self-determination. Our goals are to help create a society where intersex bodies are not stigmatised, and where our rights as people are recognised. We build community, evidence, and capacity, and provide education and information resources. Our staff and directors engage in work promoting consistent legislative and regulatory reform, reform to clinical practices, improvements to data collection and research and curriculum development and education. We also work to grow the intersex movement and the available pool of advocates and peer support workers, and address stigma, misconceptions and discrimination.

Our work is conducted in line with a 2017 community-developed advocacy platform, the Darlington Statement, which sets out priorities for the intersex movement in our region (AIS Support Group Australia et al. 2017) ([discussed in greater detail here](#)). Together with Intersex Peer Support Australia (IPSA, previously known as AIS Support Group Australia), we comprise the Darlington Consortium.

This submission has been written by:

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- Dr Aileen Kennedy, a legal academic at University of New England School of Law, and a director of IHRA, and
- Dr Alice De Jonge, a legal academic and senior lecturer at Monash University, and a director of IHRA.

It utilises work by Morgan Carpenter, an academic in bioethics at the University of Sydney School of Public Health, and executive director of IHRA,

2 Recommendations

In line with the a 2021 report by the [Australian Human Rights Commission \(AHRC\)](#), and the [Darlington Statement \(2017\)](#) we recommend policy and legislative reform to achieve the following:

- Include accurate and affirmative material on bodily diversity, including intersex variations, in school curricula, including in health and sex education.
- Provide education and awareness to teaching staff to develop content with intersex-led organisations and promote delivery by intersex people in schools.
- Promote affirmative policies and practices to support teaching staff with intersex variations.
- Promote policies in educational institutions and employment to recognise that some people born with intersex variations may benefit from accommodations and reasonable adjustments, including special needs requirements.
- The way that language is used in educational settings can have a profound impact on student experiences. Accordingly, educational staff should refrain from using pathologizing and stigmatising terminology such as ‘disorders of sex development’, not only because such labels are inherently disordering, but also because this promotes the belief that intersex characteristics need to be “fixed”.

We explain and justify these recommendations below, and identify how these changes can be achieved.

3 Background to this submission

IHRA defines intersex people in line with the definition adopted by the Office of the High Commissioner for Human Rights (OHCHR):

Intersex people are born with physical or biological sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that do not fit the typical definitions for male or female bodies (Office of the High Commissioner for Human Rights 2019)

It is vital to begin a consideration of these issues with an awareness of the impact of coerced or imposed medical interventions on young people with innate variations of sex characteristics routinely performed without medical necessity or personal consent, that affect all aspects of their lives (Jones 2016; Carpenter 2018b; Zavros-Orr 2021). (Jones 2016; Carpenter 2018b; Zavros-Orr 2021).

We acknowledge the diversity of intersex people in our diagnoses, identities, legal sexes assigned at birth, genders, gender identities, and the words we use to describe our bodies. At least 40 different intersex variations are known (Hiort 2013). Respondents to a large Australian sociological study in 2015 (Jones et al. 2016) identified over 35 different variations or other self-descriptors. We propose the use of terminology such as ‘innate variations of sex characteristics’ to facilitate legislative and regulatory protections

irrespective of diagnosis, age, agency, legal classification, or identity. We also specifically call out and reject pathologising or 'othering' medical classifications of intersex variations 'Disorders of Sex Characteristics' or sometimes 'Differences of Sex Characteristics', often abbreviated to 'DSD'.

Current material referring to people with intersex variations in school curricula and resource documents often describes this population as people with a gender identity issue, as a gender identity, or as a subset of gender diverse or transgender people. It is important that discussion of intersex in curriculum and resource documents is **not** described as a gender identity or mistaken for or conflated with being transgender or gender diverse.

It is important that education is inclusive. Given the secrecy, stigma and shame associated with being born with a variation in sex characteristics, perpetuated by limited public awareness (Carpenter 2013), collecting definitive data regarding prevalence is challenging. The best available estimate is that up to 1.7 % of the population has some form of intersex variation (Carpenter 2019). Some of those variations only become evident at puberty or later in life, and not all individuals with an innate variation of sex characteristics have access to affirmative information, free from misconceptions. It is important that school-aged children develop an understanding of diverse bodies and sex characteristics. This knowledge is important in terms of enhancing their agency, bodily autonomy and self-determination (Carpenter and Zavros-Orr 2021). Children need to know about and develop skills in talking about themselves and be aware of how they can access additional information and support if needed.

There are many reasons why student born with variations in sex characteristics may refuse to attend school or have school-based phobias. Jones et al (2016) provides the most comprehensive Australian accounts of the school experience of people with innate variations of sex characteristics. Of the participants in that study, 18% did not complete secondary school, compared to only 2% of the general population. All students with intersex variations who left school early attended schools where there was no specialist counselling support, nor was there any discussion on intersex variations in the curriculum (Jones et al 2016). Notably, most had left school at around 12 to 15 years old. The study explains,

Given that Australians must legally attend school until 15–17 years of age (depending on state laws), this high drop-out rate suggests that people with intersex variations may experience more problems either in school or during their schooling/puberty years, in ways that affect schooling success.

Additionally, information presented through sharing of lived experiences of members of IHRA and IPSA, we can say that young people with an intersex variation may miss out, refuse to attend or feel fearful when attending school because of:

- Surgery, surgical recovery and trauma associated with the treatment, stigma, silence, secrecy and a lack of knowing what has happened to them and why.
- Ongoing medical appointments and ongoing HRT treatments that affect the way they feel about and perceive themselves.
- Attending medical appointments and recovering from repeated medical interventions takes intersex children out of school frequently and disrupts their learning and socialisation.

- Bullying and social exclusion resulting in frequent absenteeism and high drop-out rates, more so than their endosex (non-intersex) peers.
- Non-inclusive and, at times, discriminatory school curricula (where intersex students and their experiences are not included or are incorrectly described).
- Body shaming and stigma, as imposed by external influences including teachers and peers, particularly in locker rooms, which can make it difficult for intersex children to participate in physical education (Carpenter 2016).
- Deprivation of lived experience and intersex elders to look up to which contributes to and reinforces the feeling of being the only one, feeling of isolation, shame and stigma. This can also link to a fear of being outed as having an intersex trait, or any disclosure of having a body perceived as stigmatised and different.

A survey of youth conducted in 2021 (Sanders et al. 2021) identified problems of invisibility and a lack of awareness of the needs and issues faced by young people with innate variations of sex characteristics. These young people need support in understanding and coming to terms with the impact of medical interventions, including non-consented surgeries, sterilisation procedures, and hormone treatments. These young people also require quality age-appropriate information about their variation in sex characteristics. This will help to reduce invisibility issues.

In May 2022, the Age newspaper reported on a psychological study conducted by a child psychologist Dr Michael Gordon. This study did not specify if the sample included children with innate variations of sex characteristics, but it reported that school refusal peaks in transition from prep to grade 1, between years 5-7 and year 9. These are periods of significant social and emotional development in a young person's life. We bring this to the committee's attention because these are also age groups where children may be having surgery or commencing hormone treatments.

In 2021, the ABC reported a news story on a child named Noah with an innate variation of sex characteristics (Gordon & Longbottom 2021). Noah describes how he wishes he had greater involvement in making decisions for his body and states: "I feel like I should [have been] left how I was born". Noah's case highlights the issues and stresses faced by young people born with an innate variation in sex characteristics. The reality for many children with innate variations of sex characteristics is that shame, stigma and a lack of support create unique social challenges, as compared to their endosex peers, thus limiting their capacities to build social confidence and foster friendship. This may affect a child's later development.

In their 2021 study, Henningham & Jones found that, of the fifty-one participants in their study, sixteen felt isolated and six felt "different" to their peers. Three participants recalled feeling like "social outcasts," four had experienced bullying, and three reported experiencing depression. Some former students commented (Henningham & Jones 2021, 606);

At each new school I was inevitably physically and verbally bullied. I remember my childhood as a miserable and defeated period of my life.

Anger was not allowed as a female. I was alone and very depressed . . . [I] tried to kill myself at 15 . . . I was not taken to a doctor or ER.

All the boys wanted to do was call me sissy, faggot and bash the shit out of me.

I generally did not conform well to male gender roles. I was often bullied and picked on for this. I did have a few friends, almost all girls and sometimes attended all-girl sleepovers which made me feel accepted and comforted.

Things got progressively worse from age 10 to 14, as it was obvious something was odd/wrong since I wasn't going through puberty 'like the other girls'. I was constantly bullied over it and it reinforced people's belief that I would become a lesbian.

As these statements indicate, students with innate variations of sex characteristics can experience difficulties in finding community and making social connections in educational settings. These obstacles impede a child's development of their sense of self and increase social isolation (Henningham & Jones 2021). To effectively comply with anti-discrimination provisions and promote inclusivity, schools must consider provide specific support to intersex students to help them manage their physical, mental and emotional health, including dealing with developmental issues, diagnosis, disclosure of health information, and the immediate and long-term consequences of medical interventions (Carpenter and Zavros-Orr 2021).

At this point in time, however, a lack of specific training and knowledge about intersex variations, and the experiences of intersex students results in schools being unable to effectively cater for the needs of these students. Inaccurate understandings and lack of awareness tends to misrepresent the needs of young people, perceiving them to be like those of LGBTQIA+ students and tend to address these needs via "one-size-fits-all" policies, funding models, and intervention programs. This lack of understanding ultimately contributes to the commonalities in the lived experience of people with variations of sex characteristics.

Schools should develop practices and policies in line with the Darlington Statement (AIS Support Group Australia et al. 2017).

3.1 Darlington Statement, 2017

In 2017, IHRA coordinated the drafting of a community declaration which became known as the *Darlington Statement* (AIS Support Group Australia et al. 2017). Amongst other things, the *Darlington Statement* describes best practices when it comes to recognising the needs of people with variations of sex characteristics, and we recommend that it become a key reference in the setting of government policies affecting the intersex community. The *Darlington Statement* is a community consensus statement by Australian and Aotearoa/New Zealand intersex organisations and advocates, signed in March 2017 (AIS Support Group

Australia et al. 2017) call for the addressing of the following matters as they related to education, awareness and employment:

51. We acknowledge that stigma is often the result of misconceptions about intersex which is compounded by a lack of education and awareness.

52. We recognise that the stigmatisation and pathologisation of people born with variations of sex characteristics hinders self-acceptance, access to community, help-seeking, and accessing of services including healthcare.

53. We acknowledge the impacts of stigma, trauma and unwanted medical interventions on access to education and on employment, and consequences that include high rates of early school leaving, poverty, self-harm and suicidality.

54. We call for the inclusion of accurate and affirmative material on bodily diversity, including intersex variations, in school curricula, including in health and sex education.

55. We call on education and awareness providers to develop content with intersex-led organisations and promote delivery by intersex people.

56. We call on employer groups, governments, institutions and trade unions to develop affirmative policies and practices to support employees with intersex variations.

57. We call for policies in educational institutions and employment to recognise that some people born with intersex variations may benefit from accommodations and reasonable adjustments, including special needs requirements, workplace adjustments, job access assistance, and provisions for medical leave.

58. We acknowledge the vital importance of positive stories and role models and the existence of some positive media coverage of intersex people. We acknowledge that much media work unfortunately perpetuates the stigmatisation of intersex people and bodies. We call on the media to work with intersex-led organisations to improve their understanding of intersex people and our human rights issues.

59. We call for an end to the stigmatisation and unnecessary pathologisation of intersex bodies.

4 Understanding the lived experiences of intersex school-age children

Although not widely reported, medical treatments on intersex are coerced, often unnecessary, and carried out in a manner where secrecy and silence result in the truth being kept from them. Medical interventions include early genitoplasties, clitoral reductions, vaginoplasties and labioplasties, intended to make genital appearance and function fit gender stereotypes. In a media report on feminising surgeries in 2013, the Royal Children's Hospital Melbourne, Victoria, was reported to perform '10-15 genital reconstruction operations a year often on girls under the age of two', described as 'gender assignment or genital enhancement operations' (Bock 2013).

For example, secrecy and silence in the case of *Re A (A Child)* [1993] resulted in doctors making an incorrect decision for the intersex child. In this case, the 14-year-old child's (A) intersex variation was presented to his parents as an "abnormality" and, as a result, A underwent feminising surgical interventions shortly after birth [5], [10]. No comments were made to justify why A had undergone genital surgeries [16]. A was quoted asking medical practitioners 'make me back into a boy, just like I was when I was born' [11], demonstrating fault on part of the medical team involved in A's case. The case demonstrates that it not widely acknowledged that doctors do not always get it right or know what is best for the individual when the individual's life trajectory is only just beginning to unfold. In the same year, the hospital reported to the Senate an 'opinion' favouring early surgeries (Royal Children's Hospital Melbourne 2013, 7).

High numbers of masculinising surgeries take place each year in Australia, including hundreds of second or repeat surgeries and, in a sample year, more than a hundred 'erection tests' on children younger than 10 years of age (Carpenter 2022). Genital 'enhancement' might affect how children feel about their bodies during key transition periods in their life. Boys who are unable to urinate standing up often undergo multiple surgeries to ensure they can urinate 'appropriately' (McLennan 2021).

In cases where visible genital variation is evident at birth, the World Health Organization Foundation for the International Classification of Diseases 11 (2018a) suggests that gender assignment be made based on a doctor's subjective assessment of the technical results of masculinising genital surgeries and that genital surgeries must occur early.

Children undergoing such intervention are often administered anaesthetic at an early age and on multiple occasions. Adverse outcomes from early general anaesthetic may have an impact on children's information process capabilities and academic success (Ho, Fleming & Mizubuti 2017). Large-scale population studies in Australia have confirmed that exposure to general anaesthetic early in life can have adverse consequences for child development. Schneuer and others report:

Children exposed to general anesthesia before 4 years have poorer development at school entry and school performance. While the association among children with 1 hospitalization with 1 general anesthesia and no other hospitalization was attenuated, poor numeracy outcome remained (Schneuer et al. 2018).

Inappropriate hormonal treatment is also a factor for school refusal as hormones can affect the perceptual development of self and self in relation to others. An example can be found in the Family Court case of *Re: Kaitlin* [2017]. Kaitlin was born in 2000 with variations of sex characteristics diagnosed as 'hypopituitarism' meaning that her body did not naturally produce some hormones, including testosterone. Kaitlin was born with a male karyotype but identified as female from a 'very early age'. All of the medical standards and protocols insist that treatment of intersex children should be by highly specialised teams of experts following close and careful study and deliberation, including close consultation with the patient and parents. Apparently, this watchful attention over many years failed to reveal the fact that Kaitlin had developed a female gender identity from a young age. Kaitlin was prescribed male hormones when she was 12 in order to trigger male puberty. It seems the purpose and impact of this intervention were not explained to her adequately or Kaitlin misunderstood the purpose of the hormone treatment, as she deposed that her expectation was 'that the hormones would "make everything right, make my breasts grow and I thought

I would have a period within the month.”² This case demonstrates the profound impact that hormone treatments, especially inappropriate treatments, can have on a child’s developing sense of self.

The implications of medical interventions on children with variations of sex characteristics are significant. The committee should be aware of the following:

- Unnecessary medical interventions without personal consent have implications for how an individual might feel about their body and experience their development during their years of schooling.
- Medical examinations, typically regular, invasive, and often including close genital scrutiny, commencing from the time of diagnosis, can have profoundly stigmatising impact and bring negative attention to a child’s developing body.
- Minors often experience ongoing medical interventions. This might include hormone treatment and repeat genital surgeries. Genital surgeries frequently require multiple surgeries, either planned or to correct problems with earlier surgeries. Follow-up interventions are common following both feminising and masculinising surgeries.

Despite policy rhetoric which emphasises the important of psychosocial support, medical intervention and treatments are rarely accompanied by effective support mechanisms. Where support is provided it promotes a medical model of intersex and is not sensitive to individual psychosocial development (Roan, 2019). The 2013 Senate Committee Report and 2021 AHRC Report both recommend significant improvements to the provision of psychosocial support, including resourcing for independent peer support. With funding from LGBTIQ+ Health Australia and the Department of Social Services, IHRA is working to improve psychosocial support. In 2023 we will roll out a pilot project called ‘InterLink,’ which has been initiated with cooperation from Queensland Council for LGBTI Health. This work remains poorly resourced and precarious.³

4.1 Inclusive and Affirmative Practices

Every jurisdiction in Australia has anti-discrimination legislation that prohibits discrimination on a range of grounds including based on intersex variations. These protections apply equally to school-aged children. Furthermore, The Australian Student Wellbeing Framework (Australian Government Department of Education 2020) and the Keeping Safe: Child Protection Curriculum (Department for Education November 2022) apply to all students in school communities, including intersex students (SHFPACT and AGA, 2021). The implementation of inclusive strategies across all levels of schooling is a requirement of this framework. In Queensland, for example, educational policy drawing upon the *Anti-Discrimination Act 1991* (Qld), states that schools must provide **all** students who are intersex, same sex attracted or transgender with access to high-quality schooling that is free from discrimination (Department of Education). Victorian LGBTIQ Student Support policy

² Ibid.

³ See <https://ilink.net.au>

(Department of Education and Training 2020) states that to support LGBTIQ students, schools should,

- *ensure that their policies, practices and activities are inclusive and do not have the effect of treating any student adversely because of their sex, gender or sexuality*
- *take positive action to eliminate discrimination or harassment of students on the basis of their sex, gender or sexuality.*

It is not clear how this framework responds to the needs of youth with innate variations of sex characteristics, but it seems likely that the authors are presuming that children with innate variations of sex characteristics are identifiable though having an intersex sex or gender identity. This approach fails to address the needs of a population of people with innate embodied variations of sex characteristics and diverse identities. In South Australia, the Department for Education (October 2022) states that,

Schools and preschools should provide all children and young people with a quality education in a safe, supportive and inclusive environment, free from discrimination, bullying and harassment regardless of intersex status, sexual orientation, gender identity or gender expression. Sites must address sexual, homophobic, biphobic and transphobic bullying as part of their anti-bullying and harassment policy and be inclusive of all diversity.

The policy primarily addresses issues relating to transgender students and provides no specific guidance on the needs and circumstances of students with innate variations of sex characteristics. 'Intersex status' is unfortunately often misunderstood to refer to an identity population, and this erroneous interpretation is not managed in the policy.

As a minimum requirement, the following policies need to differentiate between and avoid conflating transgender identities and intersex variations:

- Tasmanian Government: Department of Education, *Supporting Sexual and Gender Diversity in School and Colleges Guidelines* <<https://publicdocumentcentre.education.tas.gov.au/library/Document%20Centre/Guidelines-for-Supporting-Sexual-and-Gender-Diversity-in-Schools-and-Colleges.pdf>>;
- ACT Government, *ACT Safe and Inclusive Schools (SAIS) Initiative* <<https://saisact.info/images/factsheets/What-is-ACT-SAIS-Initiative.pdf>>;
- State Government of Victoria, *Schools – Diversity and Equity Guidance* <<https://www.vic.gov.au/schools-diversity-equity-guidance>>;
- Government of Western Australia, *Equity and Inclusion Charter: People and Services Committee* <<https://www.education.wa.edu.au/dl/x1p863d>>;
- NSW Government (2022) *Rights and Accountability*, 'Transgender Students in Schools' <<https://education.nsw.gov.au/about-us/rights-and-accountability/legal-issues-bulletins/transgender-students-in-schools>>

At present, then, intersex experiences are repeatedly overlooked, misrepresented or underrepresented in educational curricula. However, they also need to be amended to specifically address the needs and circumstances of students with innate variations of sex characteristics.

Studies undertaken by Jones et al (2016) and Henningham & Jones (2021) demonstrate that schools need to do more to be inclusive. Stigmatisation and discrimination arise from a lack of awareness and understanding, and thus, affirmative and appropriate action from schools to teach students about their bodies in a way that respects their diverse identities and characteristics must be integrated into school curricula (Carpenter and Zavros-Orr, 2021).

A whole school approach, as proposed by Brömdal et al. (2021), can help to encourage such inclusivity. Such an approach requires schools to:

- Teach lessons exploring the full diversity of sex characteristics and discuss atypical sex development pathways to help to foster the comprehension of intersex existence and diversity (Carpenter and Zavros-Orr 2021)
- Use affirming language to describe intersex bodies such as “innate variations of sex characteristics” or “intersex variations” - as opposed to othering and pathologizing terms such as “disorders of sex development” or “intersex conditions”. The latter language framing intersex bodies as abnormal and needing to be “fixed” creates an educational environment that diminishes students’ agency to make decisions for their bodies with freely given, informed consent.

State-level policies must be aimed at making sure that all staff based in schools have a full understanding of the difference between transgender and intersex and what it means to be intersex, in line with the issues and concerns raised in this submission. We further propose that all teacher education programs (undergraduate and postgraduate) include content from a trauma-informed approach that supports and meets the needs of students with innate variations in sex characteristics. This learning must include a disaggregated understanding of diverse student groups, the nuances associated with bodily diversity, and that **all** student’s human rights are defended and endorsed. All students must have their social, emotional and educational needs met. To this end schools should endeavour to set up supporting practices that enable the students to feel known, understood and cared for - promoting their efficacious engagement with their chosen school.

4.2 Challenges to Affirmative Practices

In order to improve attendance and participation post-COVID-19 for students with variations of sex characteristics, it is crucial to understand and address the lack of knowledge and awareness about intersex variations and how they impact on lived experience. Inclusive practices must reflect human rights principles that support all of Australia’s young people through their vulnerable years - years that are associated with the establishment of a lifelong sense of being, belonging and becoming, as set out in the Early Years Education Framework.

Australia perpetuates a pattern of mishandling the human rights of infants, children and adolescents with innate variations of sex characteristics. Human rights breaches impact on the positive formation of self-concept, self-image, self-esteem and self-worth (Jones et al. 2016; Jones 2016; Zavros-Orr, 2021). Drawing on the work of Erikson & Erikson (1998) there are eight different stages of psychosocial protective development. This needs to be

considered and applied to the understanding and support of the needs of children born with a variation in sex characteristics. Additionally, Brunzell and Norrish (2021) discuss that trauma-informed, and strength base education must be informed by the evidence at hand, rather than turning a 'blind eye' to the potential trauma experienced by children in medical settings.

The issue of school refusal is complex and needs to be aligned with other issues impacting childhood. Consideration needs to be given to the diversity of needs of children aged 0-18. Children depend on others to meet their overall health and well-being needs, and therefore, their needs and concerns should not be aggregated or understood using adult frameworks. They are a generation unlike any other in that they have experienced lockdown and home-schooling (with all that that might have entailed). There are well-documented cases where there are profound abuses of children's self-determination and human rights. Family violence, poverty, and family breakdown are all factors that need to be considered that can also have health implications. Health is defined as:

a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity (World Health Organisation 2022).

Children born with a variation in sex characteristics may also experience domestic violence, sexual abuse and mistreatment. Hence, we advocate for an intersectional consideration of the injustices experienced by children whose complete health is being put at risk. We aim to eliminate harmful trauma experiences from children's lives as far as possible. Trauma is experienced by young people whose sense of being, belonging and becoming is thwarted by factors that lead them to want to withdraw or avoid contact (Hart & Shakespeare-Finch 2021). We know that this places young people at risk of suicidal ideation. We argue that medically invasive and traumatising examinations and treatments place children at risk of experiencing trauma and, in some cases, add to their emotional load. Furthermore, these treatments (often unnecessary) take children's focus away from the work of childhood – learning, playing, building friendships, and learning about their place in their family, community, and their world.

5 National Inquiries addressing the experiences of people with variations of sex characteristics

Australian governmental bodies have published two major national inquiries on the wellbeing, health and human rights of people with intersex variations:

- a 2013 report by the Senate of Australia Community Affairs References Committee on *Involuntary or Coerced Sterilisation of Intersex People in Australia*.
- a 2021 report by the Australian Human Rights Commission on *Ensuring Health and Bodily Integrity: Towards a Human Rights Approach for People Born with Variations in Sex Characteristics*. Sydney, Australia: Australian Human Rights Commission ('*Ensuring Health and Bodily Integrity*').

Australia has an international reputation as leading the advocacy promoting intersex human rights, and the fact of two powerful and robust government enquiries into the issues is testament to the advocacy work done by intersex organisations such as IHRA. Both inquiries produced detailed and comprehensive recommendations for implementing better human rights protections and more effective healthcare processes. However, to date the recommendations proposed following these inquiries have been not implemented in Australia. For example, in its 2021 Report, the AHRC recommended ‘the development of new resources to increase awareness of variations of sex characteristics in the community, educational, service and employment settings, and to reduce the associated stigma’ (recommendation 2)). These resources have not been developed.

The AHRC's work in acknowledging the impact of medical intervention and the need for securing the basic human right for people with innate variation in sex characteristics is profoundly important. The inquiry reported that many early surgical interventions are justified through appeals to gender stereotypes, fears of future stigmatisation, and overly loose conceptions of medical necessity and “therapeutic treatment” (*Secretary, Department of Health and Community Services v JWB and SMB* (1992); Australian Human Rights Commission 2021, 74). For example, the Family Court in the case of *Re Carla* [2016] permitted the sterilisation of a 5-year-old child. Justifications permitting such medical intervention involved gender stereotyping and presumptions surrounding Carla’s future sexuality (Carpenter 2017). It was also encouraged by the medical team that surgery occur prior to Carla commencing puberty, based upon an assumption that Carla would experience “less” psychological trauma [30]. However, professional bodies of psychiatrists and psychologists have rejected rationales for early intervention because the mental health consequences of such interventions without personal consent are grave (Australian Human Rights Commission 2021, 78 and 81). The 2021 AHRC and 2013 Senate committee reports provide a firm basis for legislative reform, and associated oversight, treatment standards, and resourcing of peer and family support and advocacy.

The AHRC state that:

There is real risk that, without changes to oversight mechanisms, interventions will continue to be made that are not medically necessary and which could have been deferred under a precautionary approach. Current practice has included interventions that are based on psychosocial rationales, such as gender-conforming treatments. [...] current international and Australian clinical guidance allows clinicians to take psychosocial factors, such as cultural or social pressure, into account as relevant when considering whether an intervention should be proposed. (Australian Human Rights Commission 2021, 120)

We endorse the AHRC recommendations, and wish to highlight some key recommendations:

- legislative reform by Australian governments (national and state level) to ensure that medical interventions to ‘modify the sex characteristics of people born with variations in sex characteristics should be guided by a human rights framework’, with effective independent oversight, and with criminal penalties

- resourcing for peer support and advocacy organisations; development of new resources to increase awareness and reduce stigma, developed by community organisations with public funding
- new national guidelines for consistent and trauma-informed practice across sectors caring for the needs of young people, which are not intended to eliminate a need for framework legislation
- access to comprehensive care and peer support services (supporting the child and the family to find out about, understand and deal with any psychosocial impact)
- funding for community-led research and national data of children born with innate variations of sex characteristics, school refusal and school phobia.

To date, only one of eight States and Territories (the Australian Capital Territory ('ACT')) has published draft legislation to prohibit harmful practices on children with intersex variations (Chief Minister, Treasury and Economic Development Directorate 2022). One additional jurisdiction (Victoria) has sought advice on the form and content of possible legislation (Department of Health 2021).

6 Developing a nationwide framework for intersex inclusive school practices

A nationwide framework for intersex inclusive school practices must be developed in consultation with the intersex community and drawing on research and best practice models. It is critical from an intersex human rights perspective that a psychosocial framework builds on the whole school approach (Brömdal et al. 2021) is developed to make school safe and inclusive spaces for children with innate variations of sex characteristics. This submission brings attention to unconscious bias and discrimination experienced by children of school age born with a variation in sex characteristics that lead to them feeling invisible, misinformed, unsafe and vulnerable.

Education ministers, curriculum leaders, school leaders and teachers must develop an awareness of the needs of students with innate variations of sex characteristics. Their mandate is to meet the needs of **all** students. There should be parity in educational experiences between what endosex students experience and what intersex students experience. We hope, through curriculum reform and age-appropriate content, that this will eliminate discrimination and pathologisation of bodies with an innate variation in sex characteristics. Schools must develop inclusive, respectful, and responsive practices in support of young people with an intersex variation, whether or not they are disclosed (Brömdal et al. 2021; Zavros-Orr 2021).

Along with a whole school approach to the inclusion of children born with a variation in sex characteristics (Brömdal et al. 2021) we advocate for a move away from a 'one-size-fits-all' approach. Instead, there needs to be an approach that addresses the complexities of individual cases and considers person-centred approaches. We ask that consideration is

given to the intersectional needs of children aged 0-18 with clear and equitable funding and community consultation to build peer support systems that mitigate factors that decrease health, well-being, educational continuity, and future employability.

One of the most important aspects of the childhood years is knowing yourself (being, becoming) and making friends and significant connections (belonging). Body image in pre-adolescence encompasses adolescent and post-adolescent sense of self, self-image, self-esteem and self-worth. We argue that “doing no harm” (Amnesty International 2017) implies doing everything possible to support young people to thrive, complete their education and have career choices just like their endosex peers.

Children have testified that friendships are important to them (Henningham & Jones 2021). We know that children go to school to be with their friends. When their sense of being, belonging and becoming is thwarted in their early years and during critical transition period like puberty, by coercive practices, their capacities and willingness to make friends is also impacted with lifelong implications. Isolation is one of the key health and well-being factors impacting people born with innate variations of sex characteristics (Henningham & Jones 2021). Stigma, secrecy and silence also contribute to social isolation and can foster a negative relationship with one’s body and sense of self.

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