QUEENSLAND VINE REVIEW: DRAFT RESPONSES TO SUBMISSION QUESTIONS

1. OVERVIEW

This document is designed to assist with responding to the independent review into Stage 1 and Stage 2 hormone therapies in Qld's public paediatrics gender services. On 28 January 2025, the Queensland Government announced an independent review (Review), led by Professor Ruth Vine (Lead Reviewer), with the support of a panel of expert reviewers (the Reviewers).

The Review will consider the evidence and ethical considerations and provide policy advice to the Queensland Government regarding the use of puberty suppression (Stage 1) and gender affirming (Stage 2) hormones for children and adolescents with gender dysphoria in Queensland's public hospital system.

We understand that the only way to make a submission is through the approved form on this website: https://www.health.qld.gov.au/research-reports/reports/review-investigation/hormone-therapies-review

Below are the questions being asked of respondents in the approved form. Please note that each of the **substantive questions** have a limit of 5000 characters (which is around 800 words).

We recommend that you put your draft responses into a Word document first (using the Word count function) and retain a copy – we understand that once submitted, you will not receive a copy of your submission.

This is a shared resource for individuals and organisations wishing to contribute to the review of stage 1 and stage 2 gender treatment in Queensland. It is a living document, and further contributions are welcome in Part 2 – wherever possible please add a link to source.

There are also other resources available which are simplified and more suitable for community / lived experience response:

- Equality Australia's community guide
- Open Doors Youth Service guide
- Transcend guide.

In Part 3, feel free to share any relevant resources that people can draw on for their submissions.

2. QUESTIONS AND DRAFT RESPONSES

QUESTION	RESPONSE
1. What range of hormone treatments do you understand are available for gender dysphoria in children and adolescents ?	• No hormone treatments are prescribed for trans children in Australia. Commencement of puberty is a criterion for puberty blockers in trans youth, hence all are adolescents. • Pubertal suppression – GnRH antagonists, commonly referred to as Lucrin medication, is commenced after the onset of puberty (tanner stage 2) and is temporary pause of the progression of puberty to relieve the distress experienced by trans adolescents by continued secondary sex development such as breast growth in those assigned female sex and voice deepening in those assigned male sex • Anti- androgens are also used as alternative to Lucrin to provide partial testosterone blockade for people assigned male at birth – oral tablets • Unlike the NHS/UK (where it was mandatory to be on Lucrin/puberty suppression before hormones, regardless of adolescent age or pubertal stage), Australian guidelines and gender clinics adopted an individualised and less invasive approach to pubertal suppression, avoiding the use of Lucrin (an intra muscular injection) in adolescents later in puberty or for whom alternatives existed to target key areas of distress e.g. oral norethisterone (a contraceptive pill) instead of Lucrin to suppress menstruation for those whom breast development was complete • Once Lucrin is ceased, natal puberty resumes or a neo-endogenous puberty begins with prescription of hormones. • Masculinising and feminising hormones – testosterone and estrogen ○ Testosterone – IM injections – short term (2-week cycle) and longer term (12-week cycle), pellet implants (6 months), gel (daily) • Estrogen – oral (daily), gel (daily), patches (2-3 days) • **Why does hormone treatment exist for adolescents:** Access to gender affirming healthcare is considered a social determinant of health. Trans people of all genders and ages have better health outcomes and can participate more fully in life when they are part of communities and systems that accept, respect and include them. • Developing a body that is incongruent with their gender identity is experienced as highly distressing by many trans adolescents. There are the impacts of stigma and discrimination, but there is also a deep internal experience of dysphoria for many that is relieved when the body is paused from changing; masculinising or feminising in a way that is congruent with gender identity. To support understanding, compare the experience of cis males who develop healthy but unwanted breast tissue (gynecomastia). They are often highly distressed by the appearance of 'female-like' breasts and are offered surgery to remove this tissue to support a 'male- like' chest appearance. • **There's not enough availability:** A minority of trans young people in Australia starting puberty can access puberty blockers, although, local research demonstrates that the number of those accessing these is less than 5%. Most trans young people and adults report difficulty accessing the gender affirming care they seek. - Source: *Writing Themselves In 4* – 1697 trans participants aged 14-21- 72.3% (n = 1,024) reported ever wanting to affirm their gender medically. - Just 29.4% (n = 301) reported that they had taken steps to affirm their gender medically - most often with hormone therapy (87.4%, n = 263). - Only 4.5% (n = 76) had accessed puberty blockers and 59 participants (3.5%) had accessed a surgical intervention. - Over two-thirds (64.3%; n = 90) of non-binary participants reported that puberty blockers had been denied, 45.9% (n = 83) of trans men and 22.9% (n = 8) of trans women were also denied puberty blockers. • Refer to recommendations of 2024 independent evaluation of Qld paediatric gender services (QCGS review) – finding it to be evidence-based, safe and aligned with best practice but lacking sufficient resourcing and recommended expanding services, particularly in regional areas.

2. As well as the views and preferences of children and adolescents and their families, what other factors do you think a practitioner should consider when deciding whether to prescribe the following:	
(a) Factors for no medication or hormone treatments?	• Like all health interventions an assessment of the patient's suitability in alignment with clinical guidelines, the wishes of the patient and family and a multi-disciplinary team of developmentally informed practitioners should be considered in determining the best interest of the adolescent including the option of no treatment. • Based on empirical evidence, multi-disciplinary clinician consensus, and results of non-randomised and observational studies, the peer reviewed Australian guidelines were developed in consultation with practice experts, transgender children and adolescents, and their families. Reviewed in The Lancet the guidelines departed from practice in the UK and US by recommending social transition be led by the child; that informed consent, coexisting health issues and family support along with puberty suppression duration be considered ahead of chronological age as criteria for commencement of hormones. • Figure 1 in journal article Donaghy, O. J. E., Cobham, V., & Lin, A. (2024) describes the factors in assessment to be considered in detail, including a reliable and validated measure of gender-related distress in adolescence developed in Australia, in collaboration with trans people. https://doi.org/10.1080/26895269.2024.2378378 https://www.tandfonline.com/doi/full/10.1080/26895269.2024.2378378 • Not providing treatment can be the right option in some cases but it is not a neutral decision. No*n-maleficence* emphasizes the obligation to avoid causing harm to others. In healthcare, it translates to prioritising patient safety and well-being by preventing or minimising potential harm from medical interventions. It's often summarised as the principle of "first, do no harm" • Immediate and future harm can be caused by failing to prescribe puberty blockers and hormones when they are clinically indicated and sought by the patient. For example, withholding puberty blockers following an assessment that they are indicated may lead to a trans male experiencing high levels of distress that impacts self-esteem, exacerbates depression and/or anxiety or self harm impacting on academic and social functioning. Managing a female chest profile whilst living in their authentic male gender is experienced as highly distressing by some adolescents and later masectomy surgery comes at far great physical, emotional and financial cost and complication risk risk than Lucrin. • Providing no treatment when it is indicated is in best interest of the adolescent is unethical. Clinics across Australia assess patients using rigorous and evidence-based frameworks, guidelines and models of care, based on clinical consensus and global standards of care. Patients are assessed to determine clinical indication to commence puberty suppression or hormone therapy as per recommendations from all major medical associations in Australia. • In light of the suspension of care, Queensland doctors currently face significant ethical complications that are contrary to First Principles of reducing harm in not prescribing medications as indicated by clinical guidelines and professional medical associations. • Contraindications for gender affirming hormone treatments exist and are discussed with patients as part of the extensive discussions about risk and benefits to support decision making.

(b) Factors for Stage 1 hormone treatment?	• Medical necessity, timeliness and harm reduction. • For trans young people, delays to accessing puberty blockers in a timely manner will lead to the irreversible development of secondary sex characteristics (breast development, voice deepening, facial and body hair, fat distribution) and significant gender-related distress including gender dysphoria. • Puberty blockers are commenced following onset of puberty and are a temporary and short-term medicine that halt the production of oestrogen and testosterone hormones that lead to irreversible changes as part of progression of puberty. • Post-pubertal adolescents do not benefit from puberty blockers. • Diagnosis of gender incongruence in childhood and gender incongruence in adults and adolescents as described in ICD-11 **Factors for consideration:** • Informed Consent including detailed discussion of risks and benefits. • Pubertal stage. • Patient and family wishes. • Fertility discussion/counselling. • Developmental history including adjustment of assessment for neurodiverse patients • Genetic/family history • Physical health including baseline bone scans, blood tests, diet and fitness level. • Mental health including trauma if present, and any treatment or management to consider. • Drivers of mental health symptoms. • Family attunement and attachment security. • Cognitive capacity, communication challenges, thought processes. • Emotional maturity and stage of development. • Location and mobility - regional, rural, metro, outer-metro. • Minority stress and intersectionality, • Culture and language. • Aboriginality. • Spirituality / religion. • Sexuality. • Interests/likes/dislikes/hobbies. • Friends and social groups. • Social connection and engagement with community – which may improve with access to care. E.g. the confidence to just go out in public, go to school, hang out with mates etc. • Studies from the Netherlands have the longest duration of follow-up, including at least 4 studies of more than 40 years duration, commencing 1972 to 2015. Studies counted N = 1360 trans children/adolescents and more than N = 6,793 subjects overall. ▪ https://pubmed.ncbi.nlm.nih.gov/29463477/ ▪ https://pubmed.ncbi.nlm.nih.gov/29463477/ ▪ https://www.ncbi.nlm.nih.gov/pubmed/35666195 • https://www.ncbi.nlm.nih.gov/pubmed/35666195 ▪ https://www.ncbi.nlm.nih.gov/pubmed/29463477 ▪ https://www.ncbi.nlm.nih.gov/pubmed/29463477 ▪ https://www.ncbi.nlm.nih.gov/pubmed/36273487 ▪ https://www.ncbi.nlm.nih.gov/pubmed/36273487 ▪ https://www.ncbi.nlm.nih.gov/pubmed/3350756

(c) Factors for Stage 2 hormone treatment?	• Similar factors as above for Stage 1. • Providing a (young) person the opportunity to more congruently exist in community, increasing connections and participation. • Pubertal development alongside peers with endogenous hormone therapy may be a protective factor and improve safety. • Puberty blockers are primarily a short-term treatment while the adolescent develops in maturity and age. • Puberty blockers create a statis for the adolescent and may not alleviate gender-distress for those seeking full masculinisation or feminisation of the body, available only via Stage 2 hormone treatments. • Green, DeChants, Price & Davis (2022) demonstrated in large study (n=11,914) that gender affirming hormone treatment for trans young people under 18 years is associated with lower odds of recent depression and of a past-year suicide attempt. https://pubmed.ncbi.nlm.nih.gov/34920935/
(d) Factors for other treatment options?	• No other evidence-based options are available. • The Sax Institute evidence review commissioned by the NSW Government stated "There is a lack of evidence from which to draw any conclusions regarding the effectiveness of psychosocial interventions for treating children and young people with gender dysphoria. 2. Only one paper empirically examined the effect of psychological support for a cohort of transgender adolescents (level D)." • Not everyone wants hormone treatment, but withholding hormone treatment from people who seek it is harmful.
3. Concerns have been raised about reversibility or irreversibility of hormone treatment. Do you have concerns about this for?	
(a) Concerns for Stage 1 hormone treatment?	• In addition to extensive peer reviewed research, NSW & QLD governments have conducted evidence reviews and clinic/service reviews on gender affirming medical treatments and how they are managed in Australia. • Australian trans healthcare with minors is different to the UK and many of Cass' recommended changes for the UK mirrored existing practice in Australia such as 'providing individualised, comprehensive and family centred care'; 'ongoing academic and education functions embedded within service delivery', 'multi-professional workforce integrating mental health services, medical treatments and access to endocrine and fertility services' and her advice to build research capacity through a national network of independent clinics. Cass reviewed a model of care foreign to Australia, limiting the relevance of her recommendations here. Furthermore, the methodology of the review has been heavily criticised in the UK and internationally. • Independent evidence review from the Sax Institute stated "Puberty suppression for TGD adolescents appears to be effective, safe, well tolerated and reversible, thus allowing the adolescent to explore their gender identity before embarking on irreversible, or partially irreversible, treatment (NHMRC levels III-2–IV). • "…the consensus of the evidence supports that the treatments are effective in terms of mental health, psychosocial outcomes, and the induction of body changes consistent with the affirmed gender in pediatric GD patients. The evidence also supports that the treatments are safe in terms of changes to bone density, cardiovascular risk factors, metabolic changes, and cancer." https://le.utah.gov/AgencyRP/downloadFile.jsp?submissionId=287 • Denying access of stage 1 treatment for young people who have been assessed as gender incongruent and would benefit from this treatment is a major concern. • All studies say that there is only improvement, or no benefit. None have found that being on puberty blockers has caused detriment. • All studies demonstrate the same positive direction of results in favour of interventions. All clinical guidelines outline clear monitoring parameters and frequency during all hormone treatments

(b) Concerns for Stage 2 hormone treatment?	• In addition to extensive peer reviewed research, NSW & QLD governments have conducted evidence reviews and clinic/service reviews on gender affirming medical treatments and how they are managed in Australia. In Australia the NHMRC has funded the largest trans child & youth longitudinal cohort study in the world to investigate the research gaps and increase the evidence base (https://www.mcri.edu.au/news-stories/trans-youth-health-project-receives-mrff-grant) • While the UK's Cass review highlighted concerns with stage 2 hormone treatment, in fact many of the recommendations mirrored existing practice within Australia. • The Sax Institute found hormones were associated with "improved body image, decreased body dissatisfaction, reduced gender dysphoria and improved psychological wellbeing (NHMRC levels III-2–IV and below; includes one qualitative study). A key benefit of GAHT is that it appears to increase bone density following the negative impact of puberty suppression on bone density (NHMRC levels III-2–III-3)" • Denying access of stage 2 treatment for young people who have been assessed as gender incongruent and would benefit from this treatment is a major concern.
(c) What are they?	• As per (a) and (b) above – suggest you use this box for additional material on (a) and (b) if needed.

(d) Do you have any other concerns about the impacts of Stage 1 and/ or Stage 2 hormone treatments for children and adolescents in the short, medium and/ or long term?	No. The Review might be hearing about bone density, cognitive development, sexual function, fertility and de-transition but these are not concerns that justify banning or severely restricting treatment: • **Retransition and Regret – "**With regards to any misgivings that stakeholders may have about allowing paediatric patients to receive pharmacologic (and frequently surgical) treatments over concerns about future regret, we found (based on the N=32 studies that addressed it) that there is virtually no regret associated with receiving the treatments, even in the very small percentages of patients who ultimately discontinued them. Reasons for discontinuing GAHT are varied, but changed minds about gender identities is only a very minor proportion overall." Utah report – key 2025 report that found strong evidence for gender affirming care • **Rapid Onset Gender Dysphoria –** A concept that was based on a journal article that was heavily discredited for its severely biased sampling, methodological flaws, and misleading conclusions. • **Bone density** – many medications cause changes in bone density, and these are still prescribed even in older people where risk is higher eg prednisone. Bone density is actively monitored in the gender affirming model of trans health, we are aware that baseline bone density is routinely scanned for all in patients of QCGS. There are medications that can improve bone density. People can take calcium, Vitamin D and do more weight-bearing exercises. • There are no studies demonstrating that trans women may have more bone fracture problems later in life, this is conjecture. • Families will choose treatment based on a risk is to benefit analysis informed by their treating team. Young people, their families and doctors are best placed to make these choices, not politicians. All major medical associations, independent evidence reviews, clinic reviews and credible peer reviewed literature support prescription of these medicines to young people when clinically indicated • "In considering bone health and other health outcomes, optimizing bone density must be balanced with the known benefits of GnRHa for gender dysphoria, including decreased suicidal ideation - Concerns about skeletal losses become less significant in an adolescent with active suicidal ideations. While the significance of the risks may be unclear, there is strong evidence regarding the benefits of GnRHa in transgender youth: it can be a life-changing and lifesaving treatment for a vulnerable population who is at high risk for anxiety, depression, and suicide." https://pmc.ncbi.nlm.nih.gov/articles/PMC9793415/ • "In this cross-sectional cohort study of transgender youth on various GAHTs, total body BMD Z-scores were slightly below average. AMAB individuals on GnRHa monotherapy for a median of 10 months demonstrated the lowest BMD Z-scores within our cohort (**although still in the normal range**), and GnRHa duration negatively correlated with BMD." https://doi.org/10.1210/jendso/bvae045 • **Cognitive development –** Cognitive decline is not an observed concern in trans communities, amongst parents or emerging in the literature as an issue **at all**. ▪ The basis is a flawed idea that denying the brain "hormones" is causing some kind of brain damage like the study of sheep. • Puberty blockers have been prescribed to young people who have early puberty and has been the case for 50 years. • **Sexual function –** Studies published thus far suggest that the benefits outweigh the risks. • **Fertility -** Hormone treatment for trans women does not lead to permanent infertility. https://www.sciencedirect.com/science/article/pii/S2666379122004220 ▪ https://www.jpeds.com/article/S0022-3476(18)31269-1/fulltext ▪ https://www.jpeds.com/article/S0022-3476(18)31269-1/fulltext • "Fertility can be gained in those who undergo pubertal suppression and then discontinue GnRH agonists to allow endogenous puberty to progress, though there may be negative psychosocial implications of this process for some youth who may progress through puberty incongruent with their affirmed gender identity." • "A wide range of fertility preservation methods are considered in children, adolescents, and young adults with cancer, and in part inform options for transgender individuals de

(e) How much information about the short, medium and/ or long-term risks and/or benefits of Stage 1 and Stage 2 hormone treatment do you think a treating team should provide to a child or adolescent (and/or their parent or carer) before commencing treatment?	• Information including risks, benefits, monitoring, potential outcomes, what treatment does and doesn't do and risk mitigation strategies form part of all assessments, as per the global and Australian Standards of Care. • As much as the patient needs to make a decision based on the ratio of risk to benefit. It should be done in a child-friendly way, to ensure that the language is not too medicalised. • A similar amount as provided for other comparable treatments where risks need to be weighed against benefits of treatment. • There is no justification for a different process for these treatments for trans young people compared with other similar major medical decisions. Why is this patient group treated differently from others receiving treatment based on evidence? • In Queensland, no medication is given to children, only to adolescents. We've heard from families that all adolescents get a presentation called 'Healthier on Hormones' – PowerPoint – education session provided, in addition to consultations with medical prescribing doctors who will have more of a medical discussion. • Through the consent process which outlines risks as well.
(f) How would a treating team know that a child or adolescent (and/or their parent or carer) has understood the information given to them about those risks and/or benefits?	• For a child or adolescent: In the same way they would for any health matter (e.g. decision to have a vaccination, go on contraception, undertake chemotherapy, have an abortion), based on the principles of Gillick competence. Need to consider: - Maturity and understanding - Decision-making ability - Ability to reason and weigh information - Ability to communicate wishes/preferences/needs - Does child understand impact of treatment • Young people and their parents need to be provided with the opportunity to have clear and robust conversations with clinicians without the threat of their child losing the right to treatment. Questions do not mean that a child or family are not clear on wanting care. • *Re Lincoln* – sets out the factors precisely as to what needs to be considered by the treating team based on the child's interview with his psychiatrist. *Re: Lincoln (No. 2)* [2016] FamCA 1071 at [49]: - Ability to comprehend and retain both existing and new information regarding the proposed treatment; - Ability to provide a full explanation, in terms appropriate to the child's level of maturity and education, of the nature of the treatment; - Ability to describe the advantages of the treatment; - Ability to describe the disadvantages of the treatment; - Ability to weigh the advantages and disadvantages in the balance, and arrive at an informed decision about whether and when he should proceed with the treatment; - Acknowledgment that the treatment will not necessarily address of the psychological and social difficulties that the child had before the commencement of the treatment; ▪ Free to the greatest extent possible from temporary factors such as pressure of pain that could impair their judgment in providing their consent to the treatment.

4. In your view, are there areas of current practice relating to Stage 1 and/or Stage 2 hormone treatment for children and adolescents that lack sufficient evidence?	
	In Australia, the evidence base in favour of gender affirming medical interventions is significant, unequivocal and in many cases world-leading.
(a) If so, what is the impact of the evidence gap on clinical care?	Recognising and responding to misleading trans health research, a research paper authored by the Directors of all Major Australian public children's gender services https://www.tandfonline.com/doi/full/10.1080/26895269.2024.2289318 • We agree with the points in the above article that more research is needed, *but not that there are evidence gaps to justify any pause or cessation of care in the meantime.* • There are publications already on long-term outcomes – with more to come – Australia is leading the way on this. E.g. https://www.mcri.edu.au/news-stories/trans-youth-health-project-receives-mrff-grant • The national NHMRC study is reviewing the clinical guidelines as well, as they are best placed to do. • Shutting down care in Queensland is contributing to the evidence gap – Queensland isn't able to continue to provide data, even though in 2024 it was evaluated as an excellent, safe service. • Care isn't usually stopped entirely because of evidence gaps. In many areas of paediatric care there are evidence gaps as the drug companies may not want to study it because of risk / too difficult to study. E.g. in psychiatric care – many off label adult drugs are given to children for mental health / behavioural concerns – why are we not talking about that evidence-gap? • Further studies exploring gender euphoria are warranted, however the protective factors and preventive health benefits of gender affirming care across the lifespan are well established. • Utah report – "The conventional wisdom among non-experts has long been that there are limited data on the use of gender affirming hormone treatments in paediatric patients with gender dysphoria. However, results from our exhaustive literature searches have led us to the opposite conclusion." Page 90, Conclusions ▪ Francis, William; Giardino, Angelo; Hoffman, Michelle; Keeshin, Brooks; Kim-Butterfield, Yoon; Mihalopoulos, Nikki; Smith, Katherine; Smith, Alan; Strohecker, Jennifer (May 2025). Executive Summary. https://le.utah.gov/AgencyRP/downloadFile.jsp?submissionId=289 ▪ Francis, William; Giardino, Angelo; Hoffman, Michelle; Keeshin, Brooks; Kim-Butterfield, Yoon; Mihalopoulos, Nikki; Smith, Katherine; Smith, Alan; Strohecker, Jennifer (May 2025). Transgender Medical Treatments and Procedures Amendments (S.B. 16, 2023): Report to the Utah Legislature Health and Human Services Interim Committee. https://le.utah.gov/AgencyRP/downloadFile.jsp?submissionId=287 • Comprehensive annotated bibliography on trans health - https://docs.google.com/document/d/1q6oz6hP8DRYRr1l1WtC9c0lZYbAoL8gDqdmHi2bvB04/edit?tab=t.0
(b) What questions do you think further research should address?	https://www.mcri.edu.au/news-stories/trans-youth-health-project-receives-mrff-grant • All major Australian children's gender services are part of a national research consortium, ARCTYC, evaluating models of care and long-term health outcomes across 5 years. The studies are both retrospective and prospective and currently underway, currently QLD is unable to contribute to this world leading research: • This is likely to include a sample of 2500-5000 young people. Data will be from 2015 onwards, and they are also recruiting going forward. • Study started at the beginning of the year. Collection of data 2017-2021 – Melbourne and Perth. In Qld, it's taking longer as it's not in an organised database. Unfortunately, there will be data-gap created because Qld has ceased public care. • Likely publications will be made within 12 months from this reliable, ongoing dataset, and many more likely to be published in the next 5 years. • We welcome new and emerging research and evidence in this field.

5. Do you think this area of care has appropriate:	
(a) Clinical oversight?	• Yes. We have confidence in the clinical expertise of the statewide service as evidenced by the recent review of QCGS in 2024 – this was led by eminent Chief Psychiatrist John Allen – major a leader in national mental health reform. Psychiatrist Brett McDermott was an Australian of the year
(b) Governance oversight?	• Refer to QCGS 2024 evaluation which found it was sufficient but provided 25 recommendations including immediately increasing staffing, establishing a statewide network of public services, strengthened regional support, a governance committee for the delivery of statewide services, demonstrated leadership from QLD Health in support of trans young people and more. https://www.childrens.health.qld.gov.au/__data/assets/pdf_file/0036/289719/Queensland-Childrens-Gender-Service-External-Clinical-Services-Evaluation.pdf
(c) Regulatory oversight?	• National NHMRC review is best placed to provide an updated framework and clinical care guidelines. • No further regulatory oversight is required and these services should continue to be provided in multi-disciplinary teams within existing regulatory frameworks including under the auspice of specialist medical colleges
(d) Why/why not?	A recent review of the QCGS recently reviewed the service and found that the service was functioning well, with no indication of deficiencies in clinical, governance or regulatory oversight. The Queensland Children's Gender Service External Service Evaluation (2024) https://www.childrens.health.qld.gov.au/__data/assets/pdf_file/0036/289719/Queensland-Childrens-Gender-Service-External-Clinical-Services-Evaluation.pdf
(e) Should additional oversight or regulation be in place? If so, what?	Again, the review which reported in 2024 examined this question. Independent evaluation finds Queensland paediatric gender services safe and evidence-based - Ministerial Media Statements
6. Is there anything else you would like to raise about the current evidence base and ethical considerations for the use of Stage 1 and Stage 2 hormone treatments for children and adolescents?	- Evidence gap being weaponised against a marginalised community - Ethics of denying care, long waitlist, clinical guidelines and major medical body approval but not providing carte to just this group – discrimination where providing blockers for children with precocious puberty but not trans children. - Benefits of stage 1 and 2 hormone treatment outweigh the risks **Benefits outweigh the risks:** This study used the data of 1,697 trans youth drawn from a large survey of LGBTQA+ 14–21-year-olds in Australia: Mental Health and Wellbeing Outcomes Among Trans Young People in Australia Who Are Supported to Affirm Their Gender - ScienceDirect • Participants who felt supported to affirm their gender medically, legally, or socially, reported less suicidal ideation and self-harm in the past 12 months as well as lower psychological distress, lower anxiety, and greater happiness. Support for medical and legal affirmation was associated with less suicide attempt in the past 12 months.

3. OTHER HELPFUL RESOURCES

(a) Critiques of the Cass review

- It's a review of services in the UK, not Australian – not the same as how we've ever run in Australia. Recommendations in Cass are totally drawn from the system in the UK. Cass herself doesn't believe that her review is relevant in Australia.
- An Evidence-Based Critique of the Cass Review – Integrity Project
  - Section 1: The Cass Review makes statements that are consistent with the models of gender-affirming medical care described by WPATH and the Endocrine Society. The

Cass Review does not recommend a ban on gender-affirming medical care.

- Section 2: The Cass Review does not follow established standards for evaluating evidence and evidence quality.
- Section 3: The Cass Review fails to contextualize the evidence for gender-affirming care with the evidence base for other areas of pediatric medicine.
- Section 4: The Cass Review misinterprets and misrepresents its own data.

Section 5: The Cass Review levies unsupported assertions about gender identity, gender dysphoria, standard practices, and the safety of gender-affirming medical treatments, and repeats claims that have been disproved by sound evidence.

- Section 6: The systematic reviews relied upon by the Cass Review have serious methodological flaws, including the omission of key findings in the extant body of literature.
- Section 7: The Review's relationship with and use of the York systematic reviews violates standard processes that lead to clinical recommendations in evidence-based

- Gender-affirming care: the Cass Review is not an example of robust, ethical or methodologically sound research practices
- Cass Review out-of-line with medical consensus and lacks relevance in Australian context
- Letter from RANCP re Cass Review and College's findings
- "Cass Review contains 'serious flaws', according to Yale Law School". *The National*.
- Horton, Cal; Pearce, Ruth. "The U.K.'s Cass Review Badly Fails Trans Children". Scientific American. Retrieved **26 January 2025**.
- Xian, Sophia; Dietz, Elizabeth; Fabi, Rachel (**15 January 2025**). "Trans Experiences In Healthcare: Testimonial Injustice in Clinical Practice". Voices in Bioethics. 11. doi:10.52214/vib.v11i.13149. ISSN 2691-4875.
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(b) Medical consensus is that gender affirming care is safe and effective

The following is a selection of the latest position statements from Australian health bodies and the latest authoritative evidence reviews:

1. Sax Institute: Evidence for effective interventions for children and young people with gender dysphoria (1 February 2024)
   - Evidence Brief summary
   - Full Report
2. Endocrine Society - Endocrine Society Statement in Support of Gender-Affirming Care (May 8, 2024)
3. Royal Australasian College of Physicians (RACP) - Statement on gender dysphoria (6 March 2020) and 2020 RACP correspondence to Minister Greg Hunt.
4. Australian Medical Association - *LGBTQIASB+ Health Position Statement (6 February 2024)*

5. Royal Australian & New Zealand College of Psychiatrists - Position Statement 103 - The role of psychiatrists in working with Trans and Gender Diverse people (2023)
6. AusPATH/Transcend Puberty Blockers Factsheet (2024)
7. AusPATH/Transcend Puberty Blockers Evidence Brief (2024)
8. AusPATH/Transcend Medical Consent Fact Sheet (2024)
9. AusPATH - Public Statement on Gender Affirming Healthcare, including for Trans Youth (June 2021)
10. Australian Institute of Health and Welfare – LGBTIQ+ health portal
11. Australian Bureau of Statistics – Adult Trans Population Estimate
12. US medical professional endorsements (May 10, 2024)
13. World Health Organization – ICD-11 and Gender Incongruence
    - FAQ - WHO development of the guideline on the health of trans people

(c) Detransition isn't proven to be a common issue, and the reasons may not be that the person isn't trans

- Stats on reason for de-transition and its connection to transphobia / social pressure in vast majority of cases https://www.erininthemorning.com/p/largest-trans-survey-ever-top-reason?fbclid=IwQ0xDSwK4VtRleHRuA2FlbQIxMQABHqE-a7RDt_O6Lw64e6MruofNEdrUzyud8Jlc4UY_bHUriBJJans_wvbCilt4_aem_khqO6p02xZ8zyWYMGLojlQ

Frequently Asked Questions – Gender Affirming Care

- Trans young people population in Australia is unknown, however
    a. Future Proofing Study (October 2024) - Among 6388 participants, the overall proportion of trans young people was 3.3% (n=209)
- What is the gender affirming model of trans healthcare
    b. The World Health Organization defines gender affirming health care as "any single or combination of social, psychological, behavioural or medical (including hormonal treatment of surgery) interventions designed to support and affirm an individual's gender identity" (*Gender Incongruence and Transgender Health in the ICD*, n.d.)
    c. Gender affirming healthcare treats Gender Incongruence (a condition of sexual health in adults, adolescents and children), and is used to assist a trans person seeking to live as their experienced gender and to relieve the distress of gender dysphoria.
    d. FAQ - WHO development of the guideline on the health of trans people
- What are puberty blockers and what do they do
    e. Puberty blockers are a medicine that temporarily halt the production of oestrogen and testosterone hormones that lead to irreversible natal puberty.
    f. Puberty blockers are safe and reversible. They treat the early onset of puberty in cis young people and stop an unwanted puberty in trans young people.
    g. KID STATS:
        i. Writing Themselves In 4 – 1697 trans participants aged 14-21- 72.3% (n = 1,024) reported ever wanting to affirm their gender medically.

1. Just 29.4% (n = 301) reported that they had taken steps to affirm their gender medically - most often with hormone therapy (87.4%, n = 263).
2. Only 4.5% (n = 76) had accessed puberty blockers and 59 participants (3.5%) had accessed a surgical intervention.
3. Over two-thirds (64.3%; n = 90) of non-binary participants reported that puberty blockers had been denied, 45.9% (n = 83) of trans men and 22.9% (n = 8) of trans women were also denied puberty blockers.
4. Trans Pathways: 4.7% (n = 30) reported current/past use of puberty blockers as children or adolescents, 28.3% (n = 183) reported current/past use of masculinising/feminising hormones and 34% (n = 220) wanted hormones in the future. 35.4% (n = 251) had accessed medical transition and associated services. 16.1% (n = 31) of those were dissatisfied with the care they received.