LISTEN TO THE EVIDENCE, LISTEN TO OUR YOUNG PEOPLE

EQUALITY AUSTRALIA'S SUBMISSION TO THE INDEPENDENT REVIEW OF STAGE 1 AND STAGE 2 HORMONE THERAPIES IN QUEENSLAND'S PUBLIC PAEDATRICS GENDER SERVICES

24 July 2025

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INTRODUCTION

On 28 January 2025, the Queensland Government announced an independent review into Stage 1 treatment (puberty blockers) and Stage 2 treatment (gender affirming hormones), led by Professor Ruth Vine and supported by a panel of expert reviewers (the Reviewers).

The announcement came in the wake of the sudden and alarming introduction of Health Directive QH-HSD-058, which indefinitely restricts care to all new adolescent patients seeking to access the Queensland Children's Gender Service (QCGS), even those who were on a current care pathway and had been approved to commence medical care for their gender.

Over 100 human rights organisations, human rights lawyers, academics, and health, community-controlled organisations and groups wrote to the Queensland Premier to raise our concern about the cessation of this medically necessary, clinically indicated care – refer to Appendix A.

This submission by Equality Australia responds to the consultation questions published by the Reviewers on the Queensland Health website. We have completed the online submission form but as hyperlinks were not available, we send this written submission for ease of access to citations.

In summary of our submission, we contend that:

- the trans experience is an aspect of human diversity, being trans is ancient and recognised in most First Nations cultures, including in Aboriginal and Torres Strait Islander songlines.
- the global standard of care for trans and gender expansive children is social support with no medical intervention, and for adolescents, a multi-disciplinary team working with the young person and their family to identify the best pathways for that young person to express their gender authentically.
- gender affirming healthcare can include many different and combination supports. One component of gender affirming healthcare is medical intervention.
- the gender affirming model of trans health is the accepted standard of care, built through decades of consensus and supported by an undeniably strong body of evidence.
- accessing gender-related medical care is an individualised, personal and unique experience.
- delay and denial of clinically indicated medically necessary healthcare is harmful, unethical, discriminatory and contrary to human rights, and exposes medical professionals to legal risks.
- young people must be allowed to live their lives as themselves, safely, and with dignity.

ABOUT US

Equality Australia is a national LGBTIQ+ organisation dedicated to improving the wellbeing and circumstances of LGBTIQ+ people and their families. Equality Australia has been extensively involved in contributing to legal and policy reform relating to LGBTIQ+ communities including trans people.

Equality Australia's work with and for trans people of all genders is also overseen by its TransEquality Council, a national advisory body made up of trans leaders, representing diverse backgrounds and trans-led organisations. Equality Australia coordinates and draws upon a national network of representatives from over 100 LGBTIQ+ community groups and other relevant sector organisations, and a large database and social media network of thousands of individual supporters.

RESPONSES TO CONSULTATION QUESTIONS

What range of hormone treatments do you understand are available for gender dysphoria in children and adolescents?

In cultures across the world and throughout history, trans people have always existed. In Australia, we have the oldest trans community on the globe, with Aboriginal and Torres Strait Islander clans and nations holding language, ceremony and community roles on country for Sistergirls, Brotherboys and trans mob (TransHub, 2020).

Australian research of school aged students (Marino et al., 2024) has consistently shown that between 2-4% of young people may be trans or gender questioning, many of whom will seek healthcare related to their gender. Timely access to gender affirming healthcare, including indicated medical treatments for trans adolescents, is a key protective factor of wellbeing (Grant et al., 2025).

However, across Queensland this is now absent, presenting a serious and avoidable health crisis for a small population group, internationally recognised as shouldering poorer health outcomes, particularly when access to essential healthcare is denied, and when self-determination, autonomy and agency are compromised.

No hormone treatments, including puberty blockers, are prescribed to trans children (pre-pubertal) in Australia (Telfer et al., 2020). The only treatment recommended for gender incongruence and any related distress in children is supporting social affirmation, rather than any pharmacologic treatment (ibid). This may include using a different name or pronoun and wearing clothes or having a hair style that expresses gender most authentically for the child (TransHub, 2020).

Commencement of puberty (tanner stage 2) is one of the first clinical criteria for puberty blockers. This means that all young people accessing gender affirming medical treatments in Australia are adolescents.

A Gonadotropin-Releasing Hormone analog (GnRHa) such as Lucrin can be offered after puberty starts to temporarily pause the physical progression of puberty, providing relief for instance, to trans boys starting menstruation and developing breasts, and for trans girls with a deepening voice and hair growth (Sax, 2024). Additionally, and importantly, non-binary adolescents may also seek pubertal suppression to maintain an androgynous gender expression.

When a person's body develops incongruently to their known sense of gender, it can be highly distressing, confusing and confronting for that individual, particularly when living in non-affirming environments. A deep internal experience of dysphoria may arise from this incongruence in a trans adolescent, and from associated misgendering, rejection or not being supported to express gender authentically, alongside experiences of stigma, discrimination and violence (TransHub, 2020).

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 (Sax, 2024). Dysphoria eases for most trans people with access to social, medical and/or legal gender affirmation.

Australian guidelines (Telfer et al., 2020) and the many public gender clinics operating across the country have adopted a more individualised, less-invasive approach than other countries for adolescents in later puberty, or for whom alternatives exist that target key areas of distress. This includes using Norethisterone (an oral contraceptive pill) to suppress menstruation in trans boys and non-binary adolescents presumed female at birth who have already developed breasts, and anti-androgen tablets for partial testosterone blockade in trans girls and non-binary adolescents presumed male at birth, instead of prescribing a GnRHa.

Once GnRHa medications or other treatments mentioned above are ceased, natal puberty resumes (Sax, 2024), or a neo-endogenous puberty begins with gender affirming hormones, if sought and clinically indicated for the adolescent.

For those seeking masculinisation, options include a daily testosterone gel, or short term (2-week cycle) and longer term (12-week cycle) intramuscular injections. For feminisation, options include daily estrogen gel, oral tablets or weekly patches (TransHub, 2020).

A minority of trans young people in Australia starting puberty access puberty blockers, and many seeking access are denied, particularly non-binary young people. Local research demonstrates that the number of trans young people of any gender accessing blockers is less than 5% (Hill et al., 2021; Strauss et al, 2017).

Most trans young people and adults report difficulty accessing the gender affirming care they seek (ibid).

GnRH analogs were first developed more than half a century ago, and the exogenous application of estrogen and testosterone have been in use for over a century. The use of hormones in trans population groups has documented history from at least 1910 in Berlin, Germany (TransHub, 2020).

One of the largest single risk factors for poor mental health, including suicidality, in all population groups of trans young people, is denial of affirmation (Grant et al., 2025; Pace et al., 2024).

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:

Factors for no medication or hormone treatments?

The primary reasons for not using puberty blockers are because it is too late for treatment to be effective, or the trans adolescent does not wish to use puberty blockers or hormones for medical gender affirmation.

Just like most other health interventions in Queensland, it is general, standard practice that a comprehensive assessment of the patient's suitability for treatment is undertaken in alignment with established clinical guidelines and standards of care. The patient, their family and a multi-disciplinary team of clinicians work together to determine and progress the best interests of the adolescent, including the option of no treatment (Telfer et al., 2020; Children's Health QLD, 2024).

Contraindications, risks, benefits, monitoring and potential outcomes for gender affirming medical treatments are discussed in-depth with patients and their family to support informed decision making (ibid).

A number of reliable and validated assessment tools have been developed in Australia and many countries around the world to better understand an individual's goals and needs, and if additional referrals and treatment pathways are indicated, including peer support for parents and community connection for the family (Donaghy, 2024).

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, trans children, adolescents and adults, and their families (The Lancet, 2018)

The Australian guidelines depart from practice in the UK and US by recommending that social affirmation be led by the child; and that informed consent, coexisting health issues, family support and puberty suppression duration be considered on a case-by-case basis, instead of non-individualised factors such as chronological age as criteria for commencement of hormones (ibid).

Non-maleficence emphasises the obligation to avoid causing harm to others. In healthcare, this translates to prioritising patient safety and well-being by preventing or minimising potential harm from medical intervention, or the lack thereof. 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. Withholding puberty blockers following an assessment that they are indicated can mean a trans young person experiencing high levels of distress that impacts self-esteem, exacerbates depression, anxiety and self-harm, that can lead to disengagement from academic, community and social connection. Trans young people who are affirmed and supported to access the care they need have been found to be happier, leave their bedrooms and go outside, stay in school, engage in physical activity, spend time with friends, find a job and get on with life (Amos et al., 2025).

For example, managing unwanted breasts and menstruation can be highly distressing for male adolescents who are trans (i.e. trans boys), and later mastectomy surgery comes at far great physical, emotional and financial cost and complication risk than Lucrin or using a contraceptive pill.

Not providing treatment can be the right option in some cases but it is not a neutral decision. Providing no treatment when it is indicated as in the 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 and endorsements 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 the First Principles of reducing harm. Doctors are being forced to deny clinically indicated medications that have clear and proven benefits.

Factors for Stage 1 hormone treatment?

The WHO International Classification of Diseases 11th Revision (ICD-11) features a new Sexual Health Chapter that includes robust and rigorously developed indications for Gender Incongruence of Childhood (pre-pubertal) and Gender Incongruence of Adolescence and Adulthood (cannot be assigned prior to onset of puberty) (WHO, 2019). These indications of Gender Incongruence do not require gender-related distress but rather a persistent desire for gender affirmation, the ICD-11 thus importantly removes all mental health related indications of the trans experience previously included in the ICD-10 (ibid). A diagnosis of Gender Dysphoria, meaning gender-related distress, is described in the DSM5 (ibid).

For trans young people, delays to accessing puberty blockers in a timely manner will lead to the irreversible development of natal secondary sex characteristics (breast development, voice deepening, facial and body hair, fat distribution) and a significant probability of gender-related distress including gender dysphoria (Francis et al., 2025).

Puberty blockers are commenced following the onset of puberty and are a temporary and short-term medicine to halt the production of estrogen and testosterone hormones that lead to irreversible changes as part of progression of puberty (ibid). Puberty blockers are not gender affirming per se, as they simply stop unwanted changes, rather than producing affirming masculinising or feminising physical changes of the body. 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.

Post-pubertal adolescents do not benefit from puberty blockers and may instead be prescribed specific treatments to cease menses or reduce testosterone, or may progress immediately to gender affirming hormone treatments (stage 2), if indicated (Telfer, 2020).

Key factors for prescribing puberty blockers include patient and family wishes, informed consent, clinical indication, medical necessity, pubertal stage, timeliness and harm reduction.

Additional factors comprehensively explored prior to any initiation of medical treatment include assessing cognitive capacity, maturity and Gillick Competence, fertility, developmental history, physical and mental health, family dynamics and attachment, location and mobility, intersectional identities, religion, culture and Aboriginality, and interests and social connection.

There is a significant and well-established body of research that explores puberty suppression using GnRHa medications (Rew, 2021), with the longest duration of follow-up coming from the Amsterdam gender clinic in The Netherlands. This included longitudinal studies of 6793 trans people followed for more than 40 years, including 1360 participants enrolled as young people, commencing 1972 to 2015 and exploring trends in prevalence, treatment, regret, height, and progression from puberty blockers to hormones (Wiepjes et al., 2018; Boogers et al., 2022; van der Loos et al., 2022).

The medical treatment of cis (non-trans) children with precocious puberty has also been extensively studied for over 50 years (Kim, 2015).

In 2023, a similar example to the Queensland gender services ban occurred in the US state of Utah, when the State Legislature banned gender affirming medical care and commissioned the Utah Department of Health and Human Services to deliver a systematic review of the evidence for gender affirming medical treatment for trans young people. This produced the largest systematic review of the evidence conducted to date, with a report ('The Utah Report') delivered in May 2025 (Francis et al., 2025) determining that treatments are safe, effective and improve mental health and psychosocial outcomes.

Outcomes across these studies with trans young people included decreased suicidality across the lifespan, improved affect and psychological functioning, and improved social connection (Rew, 2021). The vast majority of peer reviewed systematic reviews support the conclusion that gender affirming medical care is safe and effective (Francis et al., 2025).

Stage 2 hormone treatment?

The factors for gender affirming hormone treatment (Stage 2) are largely the same as those outlined above for Stage 1, namely patient and family wishes, informed consent, clinical indication, medical necessity, timeliness and harm reduction. The key difference is a desire for masculinisation or feminisation of the body, rather than a pause of unwanted and distressing physical development.

Additional factors arise though once puberty has commenced, as physical appearance becomes much more gendered and thereby potentially intensifying experiences of gender-related distress and gender dysphoria.

A large and recent study (n=11,914) demonstrated that gender affirming hormone treatment for trans young people under 18 years was associated with lower odds of recent depression and of a past-year suicide attempt (Green et al., 2022).

Gender affirming hormone treatments of testosterone for trans boys or estrogen for trans girls allow a young person who seeks this the opportunity to more congruently exist in their lives, their bodies, and communities, thereby increasing connections and participation (ibid). Pubertal development with endogenous hormone additionally allows age-appropriate development alongside peers, meaning significant protective factors and improved safety (ibid).

The global standards of care, published by the World Professional Association for Transgender Health, provides guidance for clinicians to compare potential physical and psychological benefits and risks of starting gender affirming hormone treatment with the potential risks and benefits of delaying treatment (Coleman et al., 2022).

Local research, published in 2025, found that in a sample of 1,697 trans young people, support for gender affirmation—whether medical, legal, or social—was linked to significantly better mental health, reduced experiences of harassment and homelessness, and lower rates of suicidal ideation and attempts among young trans participants (Amos et al., 2025).

Factors for other treatment options?

No other evidence-based options are available.

The Sax Institute Evidence Review, commissioned by the NSW Government and published in 2024, found 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." (Sax, 140, 2024). One study exploring psychosocial interventions met the criteria for review by the Sax Institute, it found benefit for those participants engaging in both puberty blockade and psychosocial support, rather than psychosocial intervention alone (ibid). This suggests that an individualised combination approach to support trans young people works best; this is called gender affirming healthcare.

Not everyone wants gender affirming medical care, but withholding treatment from those who seek it has been well established as harmful (Francis et al., 2025).

Concerns have been raised about reversibility or irreversibility of hormone treatment. Do you have concerns about this for?

Concerns for Stage 1 hormone treatment?

The primary and critical concerns for puberty suppression in trans young people include the negative impacts of delay, denial and access, and the irreversibility of a natal puberty.

Denying access to medically necessary, sought after treatment for trans young people, where it has been appropriately assessed per guidelines as clinically indicated, could be considered a practice of suppression, and presents a serious and major concern for protecting and enhancing the rights, wellbeing and quality of life for all young people (cis and trans).

Importantly, no studies conclude that puberty blockers cause adverse events, however most studies have found that delays to timely medical care for trans young people does lead to adverse events (Francis et al., 2025).

The Utah Report found that "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", and that "policies to prevent access to and use of gender affirming medical care in young people cannot be justified based on the quantity or quality of medical science findings or concerns about potential regret in the future, and that high-quality guidelines are available to guide qualified providers in treating paediatric patients who meet diagnostic criteria." (Francis et al., 90-91, 2025).

Findings from the Utah Report also clearly refute the myth that puberty suppression and gender affirming hormone treatments for trans young people are 'experimental', which the Cass Review (Cass, 2024) had incorrectly concluded by using one particular systematic review with data extracted from only 24 studies (Ludvigsson, 2023), whereby the Utah Report found over 200 studies with data extracted from 89 studies (Francis et al., 2025).

The Australian guidelines (Telfer, 2020) differ considerably to clinical practice in the UK, with many of the recommendations from the Cass Review mirroring existing practice in Australia. The Cass Review recommended an approach that includes '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' along with further advice to build research capacity through a national network of de-

centralised, hub and spoke clinics. All of which form the foundation of gender affirming medical care in Australia (ibid).

In addition to extensive guidelines, peer reviewed research, systematic review and synthesis, NSW (Sax, 2024) and Queensland (Children's Health QLD, 2024) governments have also conducted evidence reviews and clinic/service reviews on gender affirming medical treatments and how they are managed in Australia. Both reviews concurrently found that gender affirming healthcare and treatments are safe, delivered to a high quality and meet the standards of Australia's health systems.

The NSW Sax Review explored studies published between 2000-2023 and found that "puberty suppression for trans adolescents appears to be effective, safe, well tolerated and reversible" (Sax, 31-33, 2024).

The Utah Report also concluded that "the consensus of the evidence supports that [gender affirming medical] treatments are effective in terms of mental health, psychosocial outcomes, and the induction of body changes consistent with the affirmed gender in paediatric trans patients, the evidence also supports that the treatments are safe in terms of changes to bone density, cardiovascular risk factors, metabolic changes, and cancer" (Francis et al., 91, 2025).

Studies demonstrate the same positive direction of results in favour of patient-centred and individualised medical interventions for trans young people. All clinical guidelines outline clear monitoring parameters and frequency during all hormone treatments. The standard of care for trans young people in Australia is best practice and world leading.

Further, the National Health and Medical Research Council (NHMRC) of the Australian Government has recently funded several significant longitudinal cohort studies through its Medical Research Future Fund, including enabling the establishment of the largest study of trans young people ever conducted in the world (MRFF, 2024).

This study led by the Murdoch Children's Research Institute, alongside the Australian Research Consortium for Trans Youth and Children (ARCTYC), is creating a national data registry (currently excluding Queensland due to the ban) that seeks to improve the delivery of hormonal treatments (puberty blockers, estrogen and testosterone), explore non-medical treatments and compare different gender affirming health care models for trans young people (MCRI, 2024).

Concerns for Stage 2 hormone treatment?

As per response to Concerns for Stage 1 hormone treatment above. Trans adolescents in Australia may access gender affirming hormone treatments in accordance with local (Telfer, 2020) and global standards of care (Coleman et al., 2022).

There are well-established risk factors for delaying or denying indicated masculinising or feminising hormone treatments for those who seek it, including increased or exacerbated suicidality, suicide attempt, and self-harm, as well as disengagement from help-seeking, preventive healthcare, metabolic screening, cancer screening and immunisations, alongside a higher likelihood of smoking and engagement in high risk practices (Pace et al., 2024; Menino, 2018; Olsavsky et al., 2023; Amos et al., 2025).

The Sax Review found that the use of feminising or masculinising hormones has been associated with improved body image, enhanced wellbeing, decreased body dissatisfaction, improved appearance congruence, reduced gender dysphoria, better executive and cognitive function, reduced depression, reduced anxiety, reduced suicidality, reduced behavioural problems, and improved quality of life. (Sax, 2024).

Evidence on overall safety, including cardiometabolic, renal, and physiological factors, indicates that serious adverse effects linked to the use of gender affirming hormone therapy in young people are uncommon (ibid).

The Utah Report also concluded that it was in the expert opinion of the authors that restrictive policies to limit access to gender affirming hormone treatments for trans young people are not supported by the breadth or rigor of current medical evidence, nor by concerns regarding potential future regret. Moreover, comprehensive, high-quality clinical guidelines exist to assist qualified healthcare providers in safely treating young patients who meet established diagnostic criteria (Francis et al., 2025).

What are they?

As per answers to Concerns for Stage 1 treatment, and Concerns for Stage 2 treatment.

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 concerns are denial of services and delays in care, and the significant burden of poor health outcomes that delays and denial lead to. The studies are undeniable, and findings are repeated globally. Most major medical associations, local and global standards of care and guidelines, independent evidence reviews, clinic reviews and credible peer reviewed literature all support the gender affirming model of care for trans young people when clinically indicated and desired.

Young trans people and their families will choose treatment based on a risks and benefits analysis informed by their treating team. Young people, their families and doctors are best placed to make these decisions.

Although refuted clearly in the Utah Report (Francis et al., 2025), the Vine Review may receive submissions seeking to prioritise matters of bone density, cognitive development, sexual function, fertility, de-transition and regret, but these are ideological concerns that are not based on the evidence and cannot be relied upon to justify banning or severely restricting treatment.

Detransition 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 gender affirming hormone treatments are varied, but changed minds about gender identities is only a very minor proportion overall" (Francis et al., 91, 2025). Research with 'detransitioners' has found participants express that detransition is misrepresented, marginalised and weaponised, often portrayed negatively or as externally pressured, leaving young people who reaffirm as cis, or as a different gender of the trans experience, unheard and isolated (Gelly, 2024). All who detransition deserve respect, support and care.

Rapid Onset Gender Dysphoria – A social contagion theory developed using parental data and published in one journal article that has been heavily discredited for its severely biased sampling, methodological flaws, and misleading conclusions (Turban et al., 2023; Vandendriessche, 2024; Kennedy, 2020; Hsu, 2022; Bauer, 2021).

Bone density – When evaluating bone health and related outcomes, efforts to optimise bone density should be weighed against the well-established benefits of puberty supressing treatment for trans young people, particularly the transformative and potentially life-saving role puberty blockers can play in reducing suicidal ideation in trans young people. Baseline bone density is actively scanned and then monitored for all patients of every gender clinic in Australia, including the QCGS. While there are supplements and exercises to support strong bone density, it is critical to note that even the lowest BMD Z-scores found in studies of trans young people on puberty blockers were still within the normal range (Roy et al., 2024).

In young people experiencing acute suicidal thoughts, concerns over potential skeletal effects become secondary (Guss, 2022). Guss also found no significant association between the use of puberty

suppression and future use of gender affirming hormones, indeed young people able to access puberty blockers were less likely to progress to hormone treatment within five years (ibid).

Cognitive development – Cognitive decline is not an observed concern in trans communities, amongst parents or evident in the literature whatsoever. This position is based on a study of sheep and seeks to perpetuate a myth that denying the brain "hormones" causes some kind of brain damage.

Sexual function – Studies published thus far suggest sexual function is retained but more broadly that the benefits outweigh risks (van der Meulen et al., 2025; Francis et al., 2025).

Fertility – Although gender affirming hormone treatments may not lead to permanent infertility, with fertility often returning with the cessation of treatment alongside a wide range of fertility preservation methods explored prior to the initiation of puberty suppression and hormones (de Nie, 2023; Nahata et al., 2019; Sax, 2024; Francis et al., 2025).

Trans boys; confused lesbians? – There is no evidence supporting the argument that trans boys are lesbians who are confused about their sexuality. Growing engagement with gender services can be attributed to the growing acceptance, understanding and recognition of the trans experience (Francis et al., 2025; Tolit et al., 2024).

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?

Considering that gender affirming medical care is simply medical care, there is no justification for a different process for trans young people compared with other similar major medical decisions. How much information shared with a patient and their families then should be the same as that provided for other comparable treatments where risks need to be weighed against benefits of treatment options.

The treating team should provide as much information as the patient needs to make an informed decision about their own healthcare, provided in an adolescent-friendly, developmentally appropriate way to ensure that the language is not too medicalised and so the patient is clear that there is not a pre-defined trajectory of engaging with gender affirming medical care, as it is always individual.

Information sharing before, during and after all assessments and appointments at gender services across the country, including at the QCGS, is the basis of the gender affirming model of trans health in Australia. The informed consent of the patient and/or their families (for non-Gillick Competent children) includes understanding treatment options, risks, risk mitigation strategies, benefits, monitoring, short, medium and long term impacts, potential outcomes, and what treatment does and doesn't do, as per the global and Australian Standards of Care (Coleman et al., 2022; Telfer, 2020).

In Queensland and indeed across Australia, we understand that medication is not given to children, only to adolescents. We've also heard from many families and family support organisations that all adolescents seeking treatment at the QCGS have historically been given a presentation and education session, in addition to further consultations and medical discussions with the doctors, nurses and allied health members of the Multi-Disciplinary Team.

The Australian Standards of Care (Telfer, 2020) and global standards of care (Coleman et al., 2022) offer clear guidance on the provision of clinically relevant education and information for trans children, adolescents and adults, and their families, including information and education that should be provided to pre-pubescent children and their families, adolescents presenting for gender affirming medical care, and the role of clinicians in the provision of this information including mental health professionals, paediatricians, endocrinologists, adolescent physicians, gynaecologists, andrologists, nurses, speech pathologists, GPs, bioethicists and legal practitioners.

The guidance also includes what capacity building education clinicians (particularly those who are not trans) may benefit from to better understand the trans experience and what the gender affirming model is, which is a patient-centred, individualised, non-judgemental self-determined (and not pre-determined) approach to social, medical and legal care and support. (Coleman et al., 2022).

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?

Please note that the submission form character limit for this question was 1000 instead of 5000, so the full answer is provided here.

For a child or adolescent, the same clinical approach of Gillick Competence is used that every other Multi-Disciplinary Team would utilise to be able to know if a young patient has understood the information provided about the healthcare they are seeking (e.g. decision to have a vaccination, go on contraception, undertake chemotherapy, have an abortion).

The treating team, as per standard practice, need to consider matters of maturity and understanding, decision-making ability, ability to reason and weigh information, ability to communicate wishes/preferences/needs and if the adolescent understands the impact of treatment.

It's important for young people and their families to have opportunities for clear and robust conversations with clinicians about their needs, goals and concerns. This also includes the ability to ask questions and explore different scenarios. For additional context, the case *Re Lincoln* sets out the factors precisely as to what needs to be considered by the treating team for a young person seeking gender affirming medical care. This case is based on a young trans boy's interview with his psychiatrist. *Re: Lincoln (No. 2)* [2016] FamCA 1071 at [49] found:

- 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; and
- 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.

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?

If so, what is the impact of the evidence gap on clinical care?

While more ethical and methodologically robust research is always needed, there are no gaps in evidence relating to gender affirming healthcare for young people that would justify any pause or cessation of healthcare.

However, to ensure a nationally consistent approach it was announced in January 2025 that the National Health and Medical Research Council (NHMRC) would undertake a full review, update and endorsement of the Australian standards of care for young trans people, commissioned by the Australian Department of Health and Ageing (Butler, 2025). This national review supersedes state-based processes and is intended to produce national guidelines. Interim advice on the use of puberty blockers is set to be completed by the middle of 2026.

More locally to Queensland, a 2024 independent evaluation of the QCGS, led by Associate Professor John Allan (former RANZCP President, former Executive Director of Mental Health Alcohol and other Drugs Branch in Queensland Health and former Queensland and NSW Chief Psychiatrist), found that the service was operating in an evidence-based and safe way that was aligned with national and international best practice. The evaluation identified though that the service was lacking sufficient resourcing and recommended expanding services, particularly in regional areas (QLD Gov, 2024).

There are, however, many unsubstantiated areas of social discourse that position trans people as being unable to make self-determined, autonomous decisions about our healthcare, bodies and lives. These arguments lack sufficient evidence (Skinner et al., 2023). Perceived evidence gaps continue to be weaponised against a marginalised community, however the ethics and impact of denying care and long waitlists remain underexplored. The scenario where clinical guidelines and major medical body approval are in place for medical interventions with different groups of young people, but care is denied for just one of these groups - also remains underexplored in research. This includes discrimination evident in cases where providing blockers for children with precocious puberty is permissible in Queensland, but not currently for trans children.

In Australia, the evidence base in favour of gender affirming medical interventions for trans people across the lifespan is significant, undeniably strong and, in many cases, world leading.

Clinical practice in the field of gender affirming healthcare continues to evolve alongside an ever-increasing body of research and review, such as the current NHMRC review. Much of this research comes to the same conclusions globally: that trans people who are supported to self-determine and affirm their gender - socially, medically and legally as they wish - have significantly better health outcomes and a higher quality of life compared to peers who are not supported.

There are many areas of paediatric healthcare where further research is warranted but may not be ethical (as is the case of Randomised Control Trials with trans young people) or whereby pharmaceutical companies may not want to progress research because of risk and difficulty. In psychiatric care for example, with limited evidence-base in support of these interventions, adult medications are prescribed off-label to children with behavioural concerns.

What questions do you think further research should address?

Further studies with trans young people that explore gender euphoria, discrimination and violence, homelessness, education disengagement, unemployment, family support and the lack of trans-affirming services are warranted, however the protective factors, preventive health benefits and impacts from the denial of gender affirming care across the lifespan are well established.

As outlined above, all Australian gender services for young people are now part of a national research consortium funded through the NHMRC called ARCTYC. This five-year project is evaluating models of care and the long-term health outcomes of 2500-5000 trans young people accessing healthcare to support their gender, except in Queensland.

These studies are currently underway and as data collection commenced in Melbourne and Perth services from 2015, include retrospective and prospective methodologies and data. Currently Queensland is unable to contribute to this world leading research, with data-gaps created due to the currently halted delivery of public care.

Findings are likely to be published within the next 12 months from this reliable, ongoing dataset, with many more likely to be published in the next 5 years. New and emerging research and evidence in this field is welcome.

Do you think this area of care has appropriate:

Clinical oversight?

Yes. We have confidence in the clinical expertise and oversight of the QCGS, as evidenced by the 2024 evaluation of this service, led by Associate Professor John Allan and experts across the field of trans health (Children's Health QLD, 2024). Psychiatrist Brett McDermott, also involved in review, was an Australian of the year nominee and a member of the Order of Australia.

Governance oversight?

The 2024 evaluation of the QCGS (Children's Health QLD, 2024) found that the service was safe and delivered to a very high standard. The evaluation offered 25 recommendations to improve healthcare for trans young people across Queensland, including immediately increasing staffing, establishing a statewide network of public services, strengthened regional support, a governance committee for the delivery of statewide services and demonstrated leadership from Queensland Health in support of trans young people (ibid). The recommendations should be implemented without delay.

Regulatory oversight?

The NHMRC review of Australia's guidelines for trans young people 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 by multi-disciplinary teams within existing regulatory frameworks including under the auspices of specialist medical colleges.

Why/why not?

The 2024 evaluation of the QCGS (Children's Health QLD, 2024) found that the service was functioning well, with no indication of deficiencies in clinical, governance or regulatory oversight.

Should additional oversight or regulation be in place? If so, what?

Again, the review which reported in 2024 examined this question (Children's Health QLD, 2024). No additional oversight is required.

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?

Access to gender affirming healthcare in Australia is a social determinant of health and federal government priority (Australian Government, 2024). The vision and guiding principles of the National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025 – 2035, include promoting health equity for trans people with respect for their diversity, embedding preventive wellbeing throughout all life stages, ensuring care that is safe, supportive, and autonomous, enabling access to services that empower quality care and self-determined choices, and maintaining a focus on evidence-based continuous improvement (ibid).

The abrupt cessation of care in Queensland has caused serious distress, confusion and harm to health and denied the human rights of young people and their families. A government that has been elected on the promise of improving health in the regions has instead cut off care to all trans young people, while

disproportionately harming young people in regional areas where care was already scarce, with longer wait-times and fewer private pathways.

Health Directive QH-HSD-058 is incompatible with the rights enshrined in the *Human Rights Act 2019* (Human Rights Act), including the rights to privacy, right to health treatment, right to non-discrimination, rights of families and children, the right to expression and the right to life. The Health Directive is particularly indefensible from a human rights perspective because it denies treatment to young people who were already on a treatment plan and ready to commence care. This is not the least restrictive way to have actioned the decision. A legal challenge to this directive on the basis of the Human Rights Act is likely to succeed.

Requiring Queensland medical practitioners to withhold clinically indicated care exposes them to significant legal risk. This includes the potential for direct or indirect discrimination claims under the *Anti-Discrimination Act 1991* (Anti-Discrimination Act), where a patient argues that individuals with other medical conditions are permitted access to the same medications, and the differential treatment is based on gender identity. There is no applicable exemption under the Anti-Discrimination Act, as the weight of evidence supports the benefits of gender affirming care, making it highly unlikely that the public health exemption in section 107 would apply. Comparable risks also arise under the *federal Sex Discrimination Act 1984* (Cth), which protects young people from discrimination on the basis of gender identity.

Denying access to clinically indicated treatment due to a government directive (rather than clinical judgment) potentially breaches a medical practitioner's duty of care, leaving them exposed to medical negligence claims if a young person suffers harm as a result, such as worsening gender dysphoria, mental health deterioration or suicidality. This is particularly serious when the treatment in question (puberty blockers or gender affirming hormones) is supported by medical evidence, widely accepted clinical guidelines, and recommended by the treating team as being in the best interests of the patient.

Beyond legal and ethical risks are real and devastating human consequences. Young people who are unable to access puberty blockers or hormones when clinically appropriate can experience escalating distress, worsening gender dysphoria, anxiety, depression, and suicidality. Families are feeling helpless as they watch their children suffer, knowing there is safe and effective care available but inaccessible due to a policy barrier. These are not abstract risks — they are urgent, deeply personal experiences for young people who simply want to live as themselves, safely and with dignity.

RECOMMENDATIONS

We call on the Review to:

- affirm the strong and growing evidence base for gender affirming care, including the mental health benefits of timely access to treatment.
- advise the government to immediately reinstate access to puberty blockers and hormones where clinically indicated and in accordance with existing standards of care.
- publish the Panel's findings and recommendations in full, to promote transparency, accountability, and trust among affected families, clinicians, and the broader community.

Dear Premier Crisafulli,

When you came to power in October last year you made a commitment to govern "for all Queenslanders". You committed to prioritising the health and wellbeing of Queenslanders, particularly those in regional areas, by empowering frontline clinical staff and reducing patient wait times.

Only a few months later, contrary to expert medical advice and against the wishes of patients and their families, you have chosen to deny a small and particularly vulnerable group of young Queenslanders access to their essential healthcare.

We write to you as human rights organisations, human rights lawyers, academics, and health, community-controlled organisations and groups, concerned about the physical and mental wellbeing of trans children currently awaiting care and who already face increased risk of harm because of discrimination, social exclusion, bullying and violence.

The right to health is at the heart of this issue and it is our firm conclusion, based on the vast weight of scientific and medical evidence, that Directive QH-HSD-058 – *Treatment of gender dysphoria in children* (the Directive), is a serious and unjustifiable limitation of that right.

Queensland is one of only three states in Australia to have enacted a Human Rights Act and is the only state to enshrine in law the right to access health services without discrimination. Other rights that are unreasonably and disproportionately limited include the right to privacy (which includes a right to bodily autonomy), the right to non-discrimination, the rights of families and children, and the right to free expression.

We consider that the Directive may be a decision that is not compatible with human rights, and the government has not given sufficient proper consideration of human rights, contrary to the Human Rights Act 2019. This decision is unreasonable, unnecessary and disproportionate, considering that:

- Concerns were raised about a Cairns sexual health service that is entirely separate from the Children's Hospital Gender Service, which provides the majority of care, and the Directive effectively stops all access to medication throughout the state.

- The Directive denies treatment to individuals already on a treatment plan who had not yet commenced medication, even if their treatment was set to begin immediately, causing huge distress to children and their families.

- The Directive is not set to be reviewed until 28 January 2026, and for children who have a short window prior to commencing puberty, this is clearly much too long to wait.

We implore you not to pursue a policy avenue that risks causing enormous harm to an already misunderstood minority, with potentially fatal outcomes if the issue is not resolved. Especially given an independent review only last year found the state's paediatric gender services were 'safe and evidence-based'.

In 2020, former health minister Greg Hunt received advice from the Royal Australasian College of Physicians (RACP) that stated withholding or limiting access to gender affirming healthcare would be unethical and have serious impacts on the health and wellbeing of young people.

To lead a government that truly governs for all Queenslanders you must not deny one especially vulnerable group their vital healthcare, causing them immense emotional distress and with the potential to result in great harm.

We call on you to:

- Revoke Directive QH-HSD-058 immediately

- Meet with the affected patient group and their parents

- Recommence care, consistent with best practice guidelines, throughout the state of Queensland.

Community, Health and Human Rights Organisations

Anglicare Southern Queensland (QLD)
Australian Injecting & Illicit Drug Users League (AIVL)
Australian Lawyers for Human Rights
Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM)
Anwernekenhe National HIV Alliance (ANA)
Asian Australian Alliance
Australian Council of Social Service (ACOSS)
Basic Rights Queensland (QLD)
Brain and Mind Centre, University of Sydney
Brisbane Southside Psychology (QLD)
Brisbane Youth Service (QLD)
Caxton Community Legal Centre (QLD)
City of Sydney
Chosen Family Australia
Community Living Association Inc (QLD)
Drummond Street Services
Gender Affirming Network QLD (GANQ)
Gender Health Australia
Headspace, Caboolture (QLD)
Headspace, Maroochydore (QLD)
Headspace, Rockhampton (QLD)
Holdsworth House Medical (QLD)
Human Rights Law Centre
International Women's Development Agency (IWDA)
Justice and Equity Centre
Kyabra (QLD)
Lived Experience Leadership Advocacy Network (LELAN)
National Mental Health Consumer Alliance
National Women's Safety Alliance
Noonga Reconciliation Group Inc (QLD)
North West Youth West Accommodation Service (QLD)
Open Minds (QLD)
Orygen
People with Disability Australia
Perth Inner City Youth Service
Picabeen Community Centre (QLD)
Queensland Advocacy for Inclusion (QLD)
Queensland Alliance for Mental Health (QLD)
Queensland Council of Social Service (QLD)
Queensland Independent Disability Advocacy Network (QLD)
Queensland Injectors Voice for Advocacy and Action (QuIVAA)

Queensland Network of Alcohol and other Drug Agencies (QNADA)
Rainbow Catholics Interagency Australia
Roses in the Ocean (QLD-based)
Scarlet Alliance, Australian Sex Workers Association
Sisters Inside (QLD)
True Relationships & Reproductive Health (QLD)
Victorian Mental Illness Awareness Council (VMIAC)
Warringu Aboriginal and Torres Strait Islander Corporation (QLD)
Youth Advocacy Centre (YAC) (QLD)
Youth Affairs Council of WA
Youth Family Service Ltd (YFS) (QLD)
Youturn (QLD)
Wesley Mission Queensland (WMQ) (QLD)
Zang! Records (QLD)

LGBTIQ+ Organisations
ACON
Albany Pride
Australian Professional Association for Trans Health (AusPATH)
Bi+ Community Perth
BlaQ Aboriginal Corporation
Diverse Voices (QLD)
Dowson Turco Lawyers
Equality Australia
Equal Voices
Forcibly Displaced People Network Ltd
Health Equity Matters
Interlink
LGBTI Legal Service (QLD)
LGBTIQ+ Health Australia
Living Proud
Minus18 Foundation
Open Doors Youth Service Inc (QLD)
Parents for Trans Youth Equity (PTYE)
Pride Cup
Pride in Law
QTrans (formerly ATSAQ) (QLD)
Queer and Trans Workers Against Violence (QLD)
Queerspace
Rainbow Affinity (QLD)
Rainbow Community House
Rainbow Families Australia

Rainbow Families Queensland (QLD)
Rainbow Futures WA
Rainbow Giving Australia
Thorne Harbour Health
Trans Justice Project
Transcend Australia
Transfolk WA
Transgender Victoria
Twenty10
WAAC
Youth Pride Network

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