Submission To the Independent Review of Puberty Suppression and Gender-Affirming Hormones for Children and Adolescents with Gender Dysphoria in Queensland Health Facilities

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Australian Human Rights Commission

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2 Foreword

1. The Australian Human Rights Commission (Commission) welcomes the opportunity to make this submission. The focus of the Commission's submission is to ensure that all responsible parties uphold and protect the human rights of children and adolescents when seeking and accessing healthcare services. Children and adolescents have the right to the highest standard of health and health care. This right includes the right to access medically prescribed hormone treatments for transgender and gender diverse adolescents to manage gender dysphoria, in accordance with evidence-based guidelines.
2. Governments are responsible for ensuring that all children can exercise their right to access health care services. Support for children and adolescents with gender dysphoria requires a range of medical disciplines (e.g. general practice, paediatrics, endocrinology, nursing, gynaecology, psychology, psychiatry, bioethics, speech pathology). Practitioners also need to be sensitive and aware of the individual's life circumstances and needs, including external pressures, constraints and stigmas they may experience.

3 Response to Consultation Questions

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

3. The Commission understands that hormone treatments prescribed for the treatment of persistent gender dysphoria range from puberty suppression agents or 'puberty blockers' (e.g., gonadotropin-hormone releasing analogs [GnRHas]) to gender affirming hormone therapy or 'cross sex hormone therapy' (GAHT; e.g. oestradiol and anti-androgen agents, or testosterone). Access to these prescribed treatments depends on the age, physical development sexual maturity rating (SMR) of the person presenting, as well as other factors and assessments.
4. The Commission encourages the Review to refer to the submissions and expertise of medical clinicians who work with trans and gender diverse children and young people, the research and expertise that has informed peer-reviewed standards of care, and those with lived experience of being prescribed hormone treatments for gender dysphoria as well as their families. Clinicians may provide a comprehensive list of hormone treatments available.

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 hormone treatments:

5. Critical human rights considerations that relate to any discussion or form of treatment relating to gender affirming care, for those aged under 18 years, are:

- Best interests of the child (Article 3 of the Convention on the Rights of the Child (CRC))
- Right to a child's identity (Article 8 of the CRC)
- Right of the child to participate in decisions affecting them (Article12 of the CRC).
- Right of the child to freedom of thought, conscience and religion (Article 14 of the CRC)

- Right to the highest attainable standard of health (Article 24 of the CRC and Article 12 of International Covenant on Economic, Social and Cultural Rights (ICESCR))
- Right to life (Article 6 of the International Covenant on Civil and Political Rights (ICCPR))
- Right to be free from discrimination (Article 26 of the ICCPR).

6. The Commission has previously submitted (Re Alex (2004), VSC 456) that:
   (a) A child has a right to live with a transgender identity, free from discrimination, under international human rights law;
   (b) It is in the child's 'best interests' to have that right respected;
   (c) A child's right to live with a transgender identity should not be limited by a narrow definition of 'transgender identity' that relies on medical or surgical intervention. There is a right to choose how that identity is expressed
7. In accordance with Articles 12 and 14 of the CRC, a child has the right to express their views freely in all matters affecting them and to have their views given due weight in accordance with their age and maturity. Their views on any medical treatment are useful and essential. Critical to participation is ensuring children and adolescents' informed consent to any treatment(s) offered. Informed consent must be provided in language and formats that are accessible to children and adolescents.
8. Children also have the right to preserve their identity, and identify their own gender, in accordance with Article 8 of the CRC. There is no one-size-fits-all, objective measurement or test method for gender identity. The authority on someone's own experience and feelings ultimately rests with that individual. The aim of any evidence-based medical treatment should therefore be to support the child or adolescent to understand their gender identity in an open-ended process, and to support them and their parent or guardian to facilitate a decision on whether to undergo possible treatments.
9. Best practice guidelines (see citations in next response) suggest that a multidisciplinary team is best placed to make the decision as to whether to prescribe stage 1 or stage 2 hormone treatments after clinical intake and assessment sessions, with these experts basing their decision on individual clinical profiles.
10. The right to the highest attainable standard of health, including access to services, safe treatment, and a supportive environment, is protected by Article 24 of the CRC and Article 12 of ICESCR. This includes non-

discriminatory access to healthcare. The right of a child to participate in decisions affecting them is also protected by Article 12 of the CRC.

11. These rights include children's choice to pursue non-medical ways to affirm their gender. Many trans and gender diverse children and adolescents in the eligible age range for the prescription of hormones do not desire them, and that is a primary factor when deciding not to prescribe hormone treatments.
12. The Commission also notes that the 2024 external clinical service evaluation of the Queensland children's gender service found that only 'one-third of children and adolescents who have had a comprehensive assessment from the multidisciplinary team, and have the capacity to consent, are prescribed medical treatment such as puberty blockers and/or gender affirming hormones along with ongoing support'.
13. In these cases, young people may explore alternative ways to affirm their gender.
14. The Commission notes that relevant non-medical supports may include: supporting social transition (i.e. using different names and/or pronouns socially, changing aspects of gender expression such as hair style, clothing); guidance on legal processes related to changing name and gender on formal identification documents; supporting family through psychoeducation; peer support and family therapy; psychotherapy and exploratory therapy, which are part of a broad toolkit to support children and adolescents with gender dysphoria, rather than standalone alternatives to hormone treatments.
15. Importantly, the Commission notes every person's right to life in accordance with Article 6 of the ICCPR. Barriers to accessing gender affirming care have been shown to increase risk of suicidality in trans and gender diverse children, adolescents and adults. Inquests at the Victorian Coroner's Court into the suicides of five transgender young people echoed these findings (Giles, 2024).
16. The Commission notes the following relevant references:

- Coleman E, et al. (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, Vol 23, Suppl 1, pp. 1-259. (WPATH SOC v8) (for criteria for prescribing stage 1 pubertal suppression medications or hormones)
- Telfer, M.M., et al. (2020) Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents

Version 1.3, (ASOC) The Medical journal of Australia, Vol 209, Issue 3, pp. 132–136.

- The Swiss National Advisory Commission on Biomedical Ethics (2024) 'Medical treatment for minors with gender dysphoria: Ethical and legal considerations' opinion paper no 43, (relevant discussion of ethical and legal considerations surrounding general exclusion from treatment on grounds of attributes, including age, and autism spectrum disorder diagnosis or other disabilities)
- German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy (2025): S2k guideline 'Gender Incongruence and Gender Dysphoria in Childhood and Adolescence - Diagnosis and Treatment' English Version. AWMF Registry No. 028 – 014. version 1.0. (noted for correlation of "puberty blockers with improved general functioning and peer relations, and reduced depressive symptoms, suicidal ideation, and behavioural and emotional problems in trans and gender diverse young people")
- François Brezin, et al. (2024) Endocrine management of transgender adolescents: Expert consensus of the French society of pediatric endocrinology and diabetology working group. Archives de pediatrie: organe officiel de la Societe francaise de pediatrie, S0929-693X(24)00176-3. Advance online publication.
- Rosenthal S. M. (2014). Approach to the patient: transgender youth: endocrine considerations. The Journal of clinical endocrinology and metabolism, Vol 99, Issue 12, pp. 4379–4389. (which notes the risk of clinically significant distress at the onset of puberty for transgender adolescents)
- Chen D, et al. (2021) Psychosocial characteristics of transgender youth seeking gender-affirming medical treatment: baseline findings from the Trans Youth Care Study. The Journal of Adolescent Health: official publication of the Society for Adolescent Medicine, Vol 68, Issue 6, pp.1104–1111. (which notes that accessing GnRHa lead to reported comparable rates of mental health and wellbeing to the population average, which may reflect the benefits of early access to gender affirming care)
- Hembree, W. C., et al. (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. The Journal of Clinical Endocrinology and Metabolism, Vol 102, Issue 11, pp. 3869–3903.
- Turban JL, et al. (2020) Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. Pediatrics, Vol 145, Issue 2, e20191725. (which

notes access to treatment with pubertal suppression during adolescence resulted in lower odds of lifetime suicidal ideation among transgender adults who wanted this treatment)

- Green AE, et al (2022). Association of Gender-Affirming Hormone Therapy With Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth. The Journal of Adolescent Health: official publication of the Society for Adolescent Medicine, Vol 70, Issue 4, pp. 643–649.
- Kennedy, N. (2025). Harming children: the effects of the UK puberty blocker ban. Journal of Gender Studies, pp. 1–17. (noted as an analysis of data relating to transgender children and adolescents and their parents to measure impact of UK ban on stage 1 hormone therapies, including sharply declining mental health, increased depression, social isolation, anxiety, stress, self-harm, school avoidance and suicide ideation).
- Giles, I. (2024) Inquest into the death of Heather Pierard (Case id. COR 2021/ 002457) Coroner's Court of Victoria
- Giles, I. (2024) Inquest into the death of Matt Byrne (Case id. COR 2021/001636) Coroners Court of Victoria
- Giles, I. (2024) Inquest into the death of Natalie Wilson (Case id. 2020/004857) Coroners Court of Victoria
- Giles, I. (2024) Inquest into the death of Bridget Flack (Case id. 2020/006727) Coroners Court of Victoria
- Giles, I. (2024) Inquest into the death of 'A S' (Case id. COR 2022/ 002415) Coroner's Court of Victoria.

Concerns have been raised about reversibility or irreversibility of hormone treatment. Do you have concerns about this for Stage 1 or Stage 2 Treatment?

17. The Commission's response to this question relates to all stages of treatment (i.e. including Stages 1 and 2 of hormone treatment, and for other treatment options).
18. As noted above, all children have the right to the highest attainable standard of health and health care, including access to services, safe treatment, and a supportive environment (Article 24 of the CRC and Article 12 of ICESCR). Children also have 'the right to express those views freely in all matters' affecting them (Article 12 of the CRC), which includes decisions that affect their health.

19. The Commission notes the following studies, guidelines and evidence reviews relevant to reversibility and irreversibility of hormone treatments. The Commission encourages the Review to refer to the expertise of medical practitioners who are experts in transgender health care, and those with lived experience:

- Van Der Loos M.A.T.C, et al. (2023). 'Bone Mineral Density in Transgender Adolescents Treated with Puberty Suppression and Subsequent Gender-Affirming Hormones'. JAMA Pediatrics, Vol 177, Issue 12, pp. 1332–1341.
- Soliman AT, et al (2023). Long-term health consequences of central precocious/early puberty (CPP) and treatment with Gn-RH analogue: a short update. Acta bio-medica : Atenei Parmensis, Vol 94, Issue 6, e2023222.
- Arnoldussen M, et al. (2022). Association between pre-treatment IQ and educational achievement after gender-affirming treatment including puberty suppression in transgender adolescents. Clinical Child Psychology and Psychiatry, Vol 27, Issue 4, pp.1069–1076.
- Pang KC. (2023). Successful restoration of spermatogenesis following gender-affirming hormone therapy in transgender women. Cell Reports Medicine, Vol 4, Issue 1, 100858.
- Waldner RC, et al. (2023). Leuprolide Acetate and QTc Interval in Gender-Diverse Youth. Transgender Health, Vol 8, Issue 1, pp. 8488.
- Headspace. (2024) The association between gender-affirming care and youth mental health and wellbeing outcomes: An evidence summary.

20. These references address effects of GnRHas and GHAT hormone treatments on bone density, and the Commission notes the existing body of research assessing cardiovascular factors, metabolic changes, and cancer. These references also indicate that studies have not evidenced GnRHa treatments negatively impacting on intellectual quotient (IQ) and academic success, or on executive function performances. These treatments were also found to have positive effects on mental health and psychosocial outcomes, academic success, executive function performances.

21. The Commission also notes Headspace's evidence summary (2024) which states that 'GnRHa is correlated with improved general functioning and peer relations, and reduced depressive symptoms, suicidal ideation, and behavioural and emotional problems in trans and gender diverse young people.'

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?

22. The focus of gender-affirming healthcare must be on the child or adolescent's best interests, and consent to any prescribed treatment must be properly informed.

23. Practitioners must carefully weigh the best available medical evidence and consider the risks and benefits. Risks include fertility loss and the possibility that a child or adolescent may later reidentify with their birth-registered sex. The benefits include improved mental health and interpersonal functioning.

24. The Commission notes from its consultation and research that those who are supported when affirming their gender (whether this affirmation is medical, legal or social) experience stronger health outcomes and wellbeing, and less suicidal ideation and self-harm.

25. In addition to previously cited work, the Commission refers to:

- Amos, Natalie et al. (2025). Mental Health and Wellbeing Outcomes Among Trans Young People in Australia Who Are Supported to Affirm Their Gender. The Journal of Adolescent Health: official publication of the Society for Adolescent Medicine, Vol 77, Issue 1, pp. 51–58.
- Tordoff DM, et. Al (2022) Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA network open, Vol 5, Issue 2, e220978.
- Doyle DM, et al (2023). A systematic review of psychosocial functioning changes after gender-affirming hormone therapy among transgender people. Nature Human Behaviour, Vol 7, Issue 8, pp.1320–1331.
- Cavve, B. et al (2025) Twenty-five is not a neurobiologically determined age of maturity for gender-affirming medical decision-making. Psychoneuroendocrinology, Vol 180, 107555.

26. The Commission is aware of a small minority of people who identify as transgender at some stage of their life, including in childhood and adolescence, may later identify with their birth-registered sex and no longer consider themselves to be transgender. Reidentification (also referred to as detransitioning) has received significant media attention and has been used as an argument against all forms of gender affirming healthcare, including hormone treatments. Evidence suggests that children and adolescents who discontinue treatment and reidentify with

their birth-registered sex are a small proportion of those who have accessed treatment.

27. The Commission notes that research and studies focusing on patients who reidentify with their birth registered sex identified multiple drivers for the decision to discontinue treatment, including pressure or lack of support from a parent or family, clinician stigma, and excessive experiences of discrimination.

- Boskey, E. R. et al (2025) A Retrospective Cohort Study of Transgender Adolescents' Gender-Affirming Hormone Discontinuation. Journal of Adolescent Health, Vol 76, Issue 4, pp. 584.
- Cavve BS, et al (2024) Reidentification With Birth-Registered Sex in a Western Australian Pediatric Gender Clinic Cohort. JAMA Paediatrics, Vol 178, Issue 5, pp. 446-453.
- Expósito-Campos, P, et al (2024). A qualitative metasummary of detransition experiences with recommendations for psychological support. International journal of Clinical and Health Psychology, Vol 24, Issue 2, 100467.
- MacKinnon KR, Kia H, Salway T, et al. (2022) Health Care Experiences of Patients Discontinuing or Reversing Prior Gender-Affirming Treatments. JAMA network open, Vol 5, Issue 7.
- Yaish, I., et al. (2025). Low detransition rates among 709 adult gender-affirming therapy recipients, motives and risk factors: Results from a systematic follow-up study. International Journal of Transgender Health, pp. 1–11.
- Irwig, M.S. (2022) Detransition Among Transgender and Gender-Diverse People-An Increasing and Increasingly Complex Phenomenon. The Journal of Clinical Endocrinology and Metabolism, Vol 107, Issue 10, e4261–e4262.

28. The right to wellbeing and health of any adolescent who reidentifies with their birth-registered sex is the primary concern of that person's multidisciplinary treating team.

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?

29. The Commission notes that all hospitals and day procedures services are required to have informed consent processes that comply with legal requirements and best practice, as per the Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service Standards 2nd ed (2021), Australian Health Practitioner Regulation Agency (AHPRA)'s Professional Codes of Conduct (2024), and the Australian Charter of Healthcare Rights.

30. The CRC provides that children have the right to express their views freely in matters that affect them and to have those views given due weight in accordance with their age and maturity. The CRC recognises that children's capacity to make decisions about what affects their rights and interests develops over time.

31. Children have the right to a supportive medical environment, and to be meaningfully included in decisions that affect them. Parents/guardians should be provided with the information they need to support their child in decision making, and to provide direction to their child in the exercise of their rights in a manner consistent with the evolving capacities of the child (Article 12 of the CRC). Governments should ensure that the institutions, services and facilities responsible for the care or protection of children are aware of and conform with, the standards established by competent authorities (Article 3 of the CRC).

32. If multidisciplinary clinical teams at gender clinics agree that stage 1 or stage 2 hormone treatment is in the child or adolescent's best interest, they are required to share all relevant information about the benefits and risks of hormone treatments, and to tailor the delivery of this information to ensure it can be understood by the child/ adolescent and their parents/guardians.

33. The ASOC, the WPATH v8 SOC, and other guidelines cited outline what is necessary to provide informed consent. E.g. 'In the case of gender-affirming medical treatments, a young person should be well-informed about what the treatment may and may not accomplish, typical timelines for changes to appear (e.g. with gender-affirming hormones), and any implications of stopping the treatment' (WPATH SOC v8, p 61).

34. Treating teams should be supported to ensure all communication of risk and benefit is up to date with latest research and best practice. All practitioners working with gender diverse children and adolescents should have expertise in gender development and gender diversity in children, and general knowledge of gender diversity across the life span.

35. Given polarised public discourse and media coverage focused on this specialist area of medicine, all staff associated with the delivery of care to children and adolescents should have access to destigmatising information and material about diverse gender experiences, gender dysphoria and gender affirming care (recommendation. 11 of the 2024 Clinical Review). This will address disinformation and misinformation about gender affirming care, including hormone therapies, and reduce incidents of bias and misinformation which may act as barriers to access.

36. One consideration for informed consent which guidelines and the 2024 clinical review address is fertility. As with children and adolescents who undergo treatments for cancer which may impact fertility, adolescents undergoing hormone treatment should be provided with information and access to fertility preservation.

37. The Commission notes identified barriers to fertility preservation for trans and gender diverse adolescents and encourages the Review to refer to the health professionals with expertise in transgender health care and those with lived experience.

- C De Roo, et. Al. (2025) Fertility in transgender and gender diverse people: systematic review of the effects of gender-affirming hormones on reproductive organs and fertility. Human Reproduction Update, Vol 31, Issue 3, pp. 183- 217.
- Stolk, T.H.R. et al. (2023) Desire for children and fertility preservation in transgender and gender-diverse people: A systematic review. Best Practice & Research Clinical Obstetrics & Gynaecology, Vol 87, 102312.
- Nadgauda, A.S. et al. (2024) Barriers to fertility preservation access in transgender and gender diverse adolescents: a narrative review. Therapeutic advances in reproductive health, Vol 18, 26334941231222120
- Ashley, F. et al. (2021) Transgender Healthcare Does Not Stop at the Doorstep of the Clinic. The American Journal of Medicine, Vol 134, Issue 2, pp. 158-160.
- Pang, K. C. et al. (2022). Negative Media Coverage as a Barrier to Accessing Care for Transgender Children and Adolescents. JAMA network open, Vol 5, Issue 2, e2138623.

- Pace. C, et al. (2024) Safeguarding the health and wellbeing of transgender young people. The Medical journal of Australia, Vol 221, Issue 10, pp. 516–519.
- Puckett, J.A. et al. (2018) Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals. Sexuality Research and Social Policy: Journal of NSRC: SR & SP, Vol 15, Issue 1, pp. 48-59.
- McNamara, M. et al. (2023) Combating Scientific Disinformation on Gender-Affirming Care. Pediatrics, Vol 152, Issue 3, e2022060943.
- Billard, T. J. (2024) The Politics of Transgender Health Misinformation. Political Communication, vol 41, Issue 2, pp. 344–352.

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?

38. The Commission notes that medical practitioners and treating teams have protocols and guides for informing children, adolescents, and their families about treatment options, and for assessing Gillick competency and capacity to consent. These include Queensland Health's Guide to Informed Decision Making.

39. When a child or adolescent is assessed as mature enough to understand fully the nature and consequences of proposed treatment, the general rule at common law is that they are legally competent to make decisions about their medical treatment.

40. This rule was first developed in the UK case of *Gillick v West Norfolk AHA* and adopted by the High Court of Australia in *Marion's case [1992]*. Those decisions established that a child can give informed consent when the child 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'. This is an individualised assessment that depends on the capacities of the particular child and the nature of the proposed treatment. The determination of legal capacity varies 'according to the gravity of the particular matter and the maturity and understanding of the particular young person'.

41. Since the 2017 case of *Re Kelvin* in the Full Court of the Family Court, it is no longer necessary to seek court authorisation for gender affirming hormonal treatment carried out in accordance with best practice guidelines, where there is consensus between the child, their parents and treating doctors.

42. The treating team would need to assess Gillick competence and the adolescent's capacity to consent. Appropriate steps should be taken to ensure the child/adolescent and their parent/guardian are supported to understand their rights and the information being communicated. Necessary supports should also be provided to assist a child/adolescent to make decisions and participate in decision making, and to communicate their views, preferences, questions or decisions, as is expected with any other medical treatment, such as chemotherapy.

43. As the Commission said in paragraph 2.7 in submissions to the Family Court of Australia concerning Re Alex:

    a. [N]o presumptions should be drawn as to the issue of whether any individual child of any particular age can give informed consent to receive or refuse medical treatment and in each case the issue will depend on the complexity of the treatment issues involved and on the rate of development of each individual.

    b. As a matter of law (as well as a matter of fact), there is no fixed age at which a child can be said to be able to give legally effective consent to medical treatment (*Re Marion*,...) Practitioners need to determine Gillick Competence on the facts of each case for any medical treatment or procedure. The age at which a child will be able to give effective consent will be influenced by the individual attributes of the child as well as the complexity of the treatment issues involved. [See *Re Marion* and full text of para 2.7 for other authorities and references cited].

44. If professionals assess an adolescent and determine that they have the level of discernment required for Gillick competence, then the adolescent should be allowed to consent to medical treatment for any recognised condition, including gender dysphoria. In Australia, medical treatment for children with gender dysphoria requires parental approval. The consent of one parent may be sufficient where there is no evidence of a dispute (*Re CD [2024]*). The Family Court held that if there was a disagreement between an adolescent and a parent about whether treatment should be provided, it would be necessary for the Family Court to make an assessment about what is in the child's best interests (*Re Imogen (No 6) [2020]*).

45. To ensure the full rights of a child are respected, it should not be assumed that a child lacks the capacity to give informed consent, or the maturity to comprehend the consequences of starting a hormone treatment based only on their age, appearance, disability, condition or behaviour.

46. Even when children are not legally competent to make medical decisions for themselves, they have a right to be involved in medical decision making. In Re W [1992], Lord Donaldson MR held that the lack of Gillick competence *reduces* the weight that ought to be given to a young person's views and wishes. It did not mean those views and wishes should be disregarded entirely.

47. Recently, there has been increased discourse on the provision of gender affirming care for children and young people, including input invited through this review. Gender clinics have been scrutinised in media, and politicians have engaged in debates questioning the legitimacy of gender-affirming medical treatments for trans youth. This heightened scrutiny, along with the number of cases being brought before the Family Court, has contributed to an environment in which medical practitioners are already exercising an abundance of caution in their assessment of Gillick Competence and the prescription of hormone treatments.

Is the evidence for Stage 1 and/or Stage 2 hormone treatment for children and adolescents sufficient?

48. Ongoing research and evaluation are vital to improving the quality of treatments and outcomes in all areas of medical care, including the treatment of gender dysphoria in children and adolescents.

49. The Commission encourages the Review to refer to the submissions and expertise of medical practitioners who are experts in trans health care and those with lived experience and provides the following relevant resources to guide consideration:

- LaFleur, J. (2025). Gender-affirming medical treatments for pediatric patients with gender dysphoria' evidence review. University of Utah College of Pharmacy, Drug Regimen Review Center, for the Utah Department of Health.
- Gawlik-Starzyk, A. (2025). Framework guidelines for the process of caring for the health of adolescent transgender (T) and non-binary (NB) people experiencing gender dysphoria - the position statement of the expert panel. Endokrynologia Polska, Vol 76, Issue 1, pp.1–28.
- 2022 World Professional Association for Transgender Health Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (see previous citation)
- 2024 German Society for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy Guidelines (see previous citation)

- 2024 French Society of Paediatric Endocrinology and Diabetology's Expert Consensus (see previous citation).

50. The Commission notes that paediatric specialists have prescribed GnRHas and the range of medications used as part of GAHT to children and adolescents to treat other conditions such as precocious puberty, some innate variations in sex characteristics, and specific hormonal disorders such as hypogonadism for decades. There is considerable evidence that these prescribed hormones are safe with appropriate adverse-effect monitoring. Results from this research may evidence that possible risks and side effects fall within an acceptable range when used in the treatment of different conditions.

51. The Commission notes that the validity of the evidence base supporting the prescription of GnRHas is only questioned in relation to its use as a treatment for gender dysphoria in children and adolescents, and that the pause on the prescription of GnRHas and GAHT is confined to their use as a treatment for gender dysphoria. This may result in trans and gender diverse children having unequal access to the highest attainable standard of physical and mental health.

52. The Commission is concerned that the politicisation and polarised public debate around gender affirming healthcare is having a significant and harmful effect on children's human rights, particularly their rights to participate in decisions that affect them, their right to their identity and their right to their access to health care.

53. The Commission provides the following relevant citations for consideration:

- Indremo, M., Jodensvi, A. C., et al. (2022). Association of Media Coverage on Transgender Health With Referrals to Child and Adolescent Gender Identity Clinics in Sweden. JAMA network open, Vol 5, Issue 2, e2146531.
- Strauss, P., Cook, A., et al. (2020). Associations between negative life experiences and the mental health of trans and gender diverse young people in Australia: findings from Trans Pathways. Psychological Medicine, Vol 50, Issue 5, pp. 808–817.

54. The Commission also notes concerns raised by trans and gender diverse adolescents and their families and the multidisciplinary clinical practitioners who work with them:

    a. that necessary clinical expertise, relevant lived experience and the existing scientific evidence base is being sidelined and devalued; and

b. that the current environment of politicisation and public speculation is preventing objective and evidence-based discussion of the social and medical framework required to ensure children and adolescents are receiving the best possible care.

55. The Commission considers that it is important to have regard to the best available evidence. The Commission recommends that lived experience, and the contributions of clinical professionals who work with trans and gender diverse children, adolescents and their families, be recognised as essential expertise, and given the appropriate authority and value as is routine in reviews of other medical treatments.

56. The Commission notes the bioethical opinion that unrealistically high standards of evidence should not lead to the dismissal of relevant clinical evidence and lived experience.:

a. "Scientific evidence of the highest quality (i.e. randomised controlled trials) is indisputably desirable, but it represents the exception in medical care. Such a quality standard is not always attainable and, if rigorously applied, would rule out a substantial proportion of established treatments in current medicine." (Swiss National Advisory Commission on Biomedical Ethics, (2024), opinion no. 43, pp. 19).

What questions do you think further research should address?

57. The Commission refers to the recommendations of the Sax Institute's 2024 Evidence Check update for the NSW Ministry of Health, 'Evidence for effective interventions for children and young people with gender dysphoria' (Bragge P, et al. (2024)), which made three main recommendations for research directions:

> 1. Long-term follow-up and cohort tracking: Existing identified cohorts from longitudinal studies should continue regular periodic follow-up to improve understanding of longer-term outcomes, including risks, benefits and potential economic related insights. The Commission notes that the Royal Children's Hospital Gender Service commenced a longitudinal cohort study in 2017.
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> 2. Collaboration and multicentre cohorts: Newly established research studies in Australia should collaborate as much as practicable with established research teams to build multicentre cohorts. Such multisite cohorts may also harness the power and promise of data linkage to understand, for example, service use behaviours and best investments for models of care.

3. Generalisability and bias reduction: Innovative study designs are needed that offer controls via appropriately recruited reference groups.

Do you think this area of care has appropriate oversight?

58. The Commission notes the importance of mainstream and specialist service knowledge for this type of care, as well as the importance of information and education for parents, caregivers and community leaders. Information sharing will ensure realisation of the human rights of all children, including trans and gender diverse children, particularly those rights under Articles 3, 8, 12 and 24 of the CRC, Articles 2, 16 and 26 of the ICCPR, and Article 12 of the ICESCR. Information sharing will require targeted assessment and appropriate resourcing that focuses on respectful, accurate, objective, clinical and community education.

59. The Commission has previously noted existing, detailed best practise frameworks for this area of paediatric care.

60. The Commission encourages the Review to refer to the submissions and expertise of medical practitioners who are experts in trans health care and to those with lived experience and notes the Queensland Children's Gender Service External Clinical Service Evaluation (2024) recommendations.

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

61. The Commission has intervened in several cases before the Family Court relating to the provision of stage 1 and stage 2 hormone treatment to children and young people

    (a) the Commission's submissions for Re: Alex [2004] FamCA 297,

    (b) the Commission's submissions for Re: Bernadette [2010] FamCA 94,

    (c) the Commission's submissions for Re: Jamie [2013] FamCAFC 110,

    (d) the Commission's submissions and supplementary submissions for Re: Kelvin [2017] FamCAFC 258,

    (e) Re: Imogen (No. 6) [2020] FamCA 761 (submissions are not public).

62. The Commission has argued that there is evidence of risks involved with withholding or delaying treatment, such as requirements for court authorisation outside of inter-family conflict. These risks had a

detrimental impact on the rights of affected children and young people. The Commission reiterates this view.

63. The Commission also notes that the introduction of further regulation and oversight will increase the burden placed on existing and future services if not paired with further resourcing for staff and governance enhancement. This could lead to staff reduction and extended wait times for children and adolescents with gender dysphoria and would be at odds with their right to healthcare and the right to form their identity. Previous clinical reviews have raised concerns over the distress and potential for harm caused by the duration of wait times prior to the current pause.

64. The Commission emphasises that subjecting health care services that prescribe hormone therapies for the treatment of gender dysphoria to greater oversight and regulation than other paediatric services risks disadvantaging trans and gender diverse children and adolescents on the basis of their gender identity.

Is there anything else that 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?

65. The Commission reiterates the importance of upholding the human rights of children when they seek to access gender affirming care, with particular consideration given to the best interests of the child, the right to participate in decisions that affect them, the right to their identity, and the right to access healthcare.

66. The Commission notes that the ability of health services in any community to be able to provide the necessary comprehensive, multidisciplinary health and mental health assessment and support to a child is dependent on the allocation and availability of appropriately qualified health and mental health professionals.

67. The Commission is concerned about some public commentary on the legitimacy of a highly specialised and sensitive paediatric medical practice. We are concerned that this process will contribute to further stigma and social rejection of trans and gender diverse people, jeopardise help-seeking behaviour and access to appropriate healthcare in children and adolescents suffering from gender dysphoria, and cause considerable distress and harm to a small and highly vulnerable cohort of young people.