

Gender questioning children and family law: an evolving landscape.

Paper for the Australian Family Law profession*

Belle Lane

Barrister, Victorian Bar

Acknowledgments

Thank you to Professor Kasia Kozłowska, Dr Alison Clayton and Professor Patrick Parkinson for their significant assistance.

*This paper has had some additions, amendments and clarifications to the one presented to the Federal Circuit and Family Court of Australia (FCFCOA) in April 2023.

Given the evolving science in this area, this paper will act as a dynamic resource which will be updated to keep pace with developments. Feedback and comments or corrections are welcome.

INDEX

Introduction	6
A Terminology	8
Information children receive about gender identity and pathways	10
“Gender forest”	11
“Genderbread person”	11
B Brief history of gender identity concerns	12
Dutch studies.....	14
International best practice	20
Framework.....	22
Methodology	22
Applicability of the studies	23
Follow up	23
Deviation from the protocol.....	23
C Current context.....	24
Increasing presentations	24
Changing case mix.....	26
Sex ratio / age	26
Mental health	27
Autism.....	27
Reasons for the changes.....	28
Competing discourses lead to different approaches	28
Gender affirming treatment - novel endocrinological and surgical approach.....	29
Developmental / biopsychosocial model	30
Westmead approach	31
Reasons for increased presentations	31
Gender Affirming Treatment.....	31
Alternative views	32
Understanding increased presentation of neurodiversity	33
Increased presentation of co-morbid mental health.....	33
Theory of minority stress.....	33
Approaches to medical care	35
Psychotherapeutic treatments.....	35
Gender affirming treatment	36
Developmental / biopsychosocial model	38
Westmead model	38
Australian Standards of Care	39
Changing international landscape.....	42
Finland	42
Sweden	42
Norway	43
France	43
England and Wales	43
D Gender affirming treatment - Stages of Treatment.....	45
Stage 1: Puberty Suppression	45
What is puberty?	45

Asserted benefits of Puberty blockade	47
Impact on gender dysphoria	47
Positive impact on mental health / avoidance of negative impact.....	48
Positive impact on suicidality	52
Risk of suicide for transgender identified children and young people	53
Impact of puberty blockers on suicide risk	57
Management of suicide risk	59
Fully reversible?.....	59
Age children start on puberty blockers	60
How long do children remain on puberty blockers?	60
Risks of puberty blockers	61
Bone density	61
Risks to fertility	62
Sexual function	64
Brain development	65
Pause or a single medical pathway?.....	67
Stage 2: Cross-sex hormones	68
Risks of cross-sex hormones (also called Gender Affirming Hormones (GAH))	71
Persistence and Risk of Regret.....	75
Persistence.....	75
Regret	76
Detransition.....	79
Stage 3: Surgery	81
Fertility.....	83
Breastfeeding.....	83
Sexual function	83
E The Current State of the Law in Australia.....	83
Determining what is appropriate in an evolving medical debate.....	86
Applications to Court	86
Expert evidence	88
F Key issues for consideration	89
I. Nature and purpose of the proposed treatment.....	89
Grading of evidence.....	91
II. Thoroughness and reliability of the diagnostic process	92
Diagnostic & Statistical Manual of Mental Disorders, 5th Edition (DSM-5-TR)	92
DSM-5-TR Gender Dysphoria in childhood.....	93
DSM-5-TR Gender Dysphoria in Adolescents and Adults	94
ICD 11.....	95
Impact of Complex Presentation on Diagnostic Process.....	97
Differential diagnosis.....	99
Formulation	100
Iatrogenic causation	100
III. Consideration of alternative less invasive treatments.....	100
Harm minimization under the Australian Standards.....	101
Is psychotherapy gender suppression?	101
Gender exploratory therapy	103
Social transition / affirmation.....	103
Increased social transition.....	104
Risks and concerns about social transition	105

IV. Informed consent of parent(s) and child	107
Gillick competence	108
New South Wales	108
South Australia	108
Queensland.....	109
United Kingdom.....	109
Levine model of informed consent	111
Erroneous assumptions	113
Quality of evaluations.....	113
AusPath model for informed consent	114
Comparison of models: AusPath and Levine.....	115
Information provided	116
Conclusion	116
Bibliography	118
Appendix A: What are the 72 other genders?.....	127
Appendix B: Possible directions	131
Appendix C: Possible questions for the experts	134

Introduction

1. Medical affirmation of gender dysphoric children and adolescents is currently one of the most controversial areas of medicine. Gender affirming treatment, as it is known, has become the dominant pathway in Australia and until recently, internationally. The treatment pathway involves 3 stages: puberty blockade, cross-sex hormones, and surgery. There is a lack of clinical consensus about what is being treated, the diagnostic process, whether a diagnosis is required, the asserted benefits, risks and outcomes of the medical pathway and what alternative pathways exist. This is occurring in a highly politicised atmosphere, with legislative changes that impact the rights of parents and professionals, all of which is making discussion of issues and concerns difficult.
2. As a result of the decisions of the Full Court of the Family Court of Australia in *Re Jamie* (2013) 278 FLR 155, *Re Kelvin* (2017) FLC 93-809 and a single judge in *Re Imogen (No.6)* [2020] FamCA 761, medical gender transition of children to treat gender dysphoria is allowed where the child, the parents and the clinicians agree. Since these decisions the evidence base around what is called “gender affirming treatment” has moved rapidly and much more is known about the asserted benefits of the medical pathway and risks. Alternative treatment pathways have returned to prominence. In an adversarial system the Court relies upon parties and their expert witnesses to bring this information before it, so that it can make decisions in the best interests of children. Until recently this has not occurred, and the Court has been left without evidence of the raging international and national debate about the evidence base for gender affirming treatment.
3. In the 1990s, Dutch researchers developed a medical protocol to treat a very small number of young people who were thought likely to become transsexual adults. The treatment protocol was released prior to research being undertaken. When research was subsequently undertaken, the research subjects were hand-selected and subject to strict eligibility criteria which acted as some safeguards. The Dutch protocol was scaled up internationally prior to the release of the results of the research. In the last 10-15 years, there has been a dramatic increase in the number of children seeking gender affirming treatment and the treatment has been given to children who would never have met the eligibility criteria of the Dutch protocol.
4. The Dutch studies are held out as a gold standard which provides the foundation for the current gender affirming treatment model of social and medical affirmation of gender identity. However, there are significant concerns about quality and applicability of the studies to the current cohort of children presenting at gender clinics.
5. Paediatric gender services have experienced a dramatic increase of young people presenting and a change of case mix, with more than half of the young people presenting being adolescent girls. Further, many of the children have complex mental health, neurodiversity, and adverse childhood experiences. Most of these children would have been excluded under the original Dutch protocol, however now almost all the safeguards of the original Dutch protocols have been removed. Treatment is now based on a child’s subjective identity in a child-lead process, a situation unheard of in other areas of medicine.
6. There is a raging debate in the Australian and international medical community about gender identity, gender dysphoria, the reasons for the increased numbers of children presenting with gender dysphoria, the complexity of their presentation, what is being diagnosed, treatment pathways and how informed is the consent of parents and young people.

7. In the last 3 years, there has been greater international scrutiny of the medical evidence underpinning gender affirming treatment. The Dutch studies would not meet the standards of evidence-based medicine today. There are concerns about selection bias, methodological flaws, skewed outcomes, and applicability. The asserted positive results of the Dutch studies are questioned and have not been able to be repeated in subsequent studies, yet the gender affirming treatment pathway remains. Over time awareness of risks of harm of puberty blockers, cross-sex hormones and surgery have increased and underlying assumptions such as puberty blockers acting as a pause have been discredited.
8. International meta reviews have cast doubt upon this model and the studies underpinning it. As a result of this evidence, some countries / States have reversed course, some stopping the medicalisation of children and young people altogether and others trying to restore safeguards. It seems that the only area of agreement is the paucity of quality research in gender medicine.
9. The complexity of the scientific issues is summarised in a 2023 study from Westmead hospital, NSW:

“...at the current point in time there is much to be done in the field of gender dysphoria. In the era of evidence-based medicine, the evidence-base pertaining to the gender-affirming medical pathway is sparse and, for the young people who may regret their choice of pathway at a future point in time, the risks for potential harm are significant. At the current point in time, key research priorities include: a better understanding of factors that underpin the recent increase in presentations in adolescent girls; the long-term effects of puberty blockers and cross-sex hormones on brain development and other physical parameters; long-term mental health outcomes; sexual function and fertility outcomes, and overall functional outcomes both for the subset of young people who remain content with the choice of medical gender affirmation and the subset who come to regret this choice of developmental pathway.”¹
10. Even though more cases involving gender questioning children are coming before the Court, very few are contested. Even if parents have concerns about their child’s diagnosis, treatment, or informed consent, many feel as though they must choose between their concerns and a relationship with their child. Most people cannot afford the costs of litigation to properly explore the medical evidence. As such, in an adversarial system where there is no contradictor, the Court is frequently left with only the evidence from the treating specialists. The Court has been left largely unaware of significant developments.
11. The Court’s decisions have the potential to impact children and young people’s physical and mental health and well-being for the rest of their lives, in ways that are more profound than in usual parenting cases. There are of course significant impacts on families, often with gender dysphoria dividing families.
12. This paper considers the 3 stages of medical treatment: stage 1 puberty blockade, stage 2 cross-sex hormones and stage 3 surgery. What are the asserted benefits and risks of the treatment pathway. The medical evidence underpinning the asserted benefits is weak and the risks potentially profound and lifelong, including impacting fertility and sexual function.

¹ Elkadi, J, C Chudleigh and K Kozłowska, “Developmental Pathway Choices of Young People Presenting to a Gender Service with Gender Distress: A Prospective Follow-Up Study” (2023) *Children* 10 314 [3] and [20].

13. We see that far from acting as a pause, puberty blockers almost inevitably lead to cross-sex hormones, meaning that children are embarking on a single medical pathway of stages 1 and 2.
14. The paper considers informed consent and examines two recent models, raising questions about the information which parents and children have received, their capacity to understand it and the extent of influence on decision-making by outside factors. Further what is children and young people's capacity to give informed consent to impacts that are well beyond their experience and understanding, in particular the likely impairment of fertility and sexual function.

A Terminology

15. Some of the following terminology is used in this paper. The Court is likely to hear many of these terms used in evidence in Court.
16. Sex: humans as with other mammals have dimorphic sex development: male and female. For over 99% of the population, their sex is determined at conception, is observable at birth and is unambiguous. Sex is determined by chromosomes at conception, typically each sperm carries either an X or Y chromosome, all eggs carry one X. The chromosome of the fertilizing sperm determines which chromosomes the embryo cells will inherit. Chromosomes set the organism up to produce gametes. Sex is expressed through genitalia, cells, chromosomes and being set up to produce gametes. It is observable in humans from about 6 weeks gestation.

While there are Disorders of Sexual Development (DSDs), they are rare and are said to prove the rule of sexual dimorphism. This long-established scientific fact has been challenged by Dr Fausto-Sterling who claims that 1.7% of the population are intersex. However, this includes 1.5% of the population who have "late onset (non-classical) Congenital Adrenal Hyperplasia" which involves an enzyme deficiency affecting males and females and is accompanied by no ambiguity in genitalia or reproductive organs and is compatible with women having children. Once this population is removed more accurate figure for intersex is 0.018%.² Where a person's chromosomal or genital presentation is unclear, their sex can be identified by production of gametes. "There are only two types of gametes: small ones called sperm that are produced by males, and large ones called eggs that are produced by females. There are no intermediate types of gametes between egg and sperm cells. Sex is therefore binary. It is not a spectrum."³

Confusion is created by the terms gender and sex being used interchangeably. I will use the word sex, not gender, to refer to sex and male and female.

17. Gender: the DSM-5-TR⁴ says that gender denotes the public, sociocultural (and usually legally recognised) lived role as boy, girl, man, woman, or more recently other gender. Biological factors are seen as contributing with social and psychological factors to gender development.⁵ The definition is not that easy to understand. An earlier DSM definition of gender being any given society's norms and expectations regarding behaviours, experiences, roles of people according to their sex (male or female), is easier to understand. Gender ideology sees gender akin to a "sexed

² Stock, Prof Kathleen, "Material Girls: Why Reality Matters for Feminism" (Fleet, 2021) [55]-[56].

³ Soh, Dr Debra, "The End of Gender: Debunking Myths about Sex and Gender Identity in Our Society." (Threshold Editions, 2021) [17]

⁴ Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR).

⁵ DSM-5-TR [511].

soul”: that is fixed and immutable and emerging, therefore not subject to influence. Confusingly gender is also used as a polite word for sex.

18. Assigned at birth: the term “assigned at birth” has been recently invented and means that one’s sex is “assigned” not identified upon the viewing of genitalia at birth. The term is without scientific basis and more representative of political lobbying. See notes on sex above. The DSM-5-TR uses the term sex-assigned at birth.⁶ Sometimes this is shortened to AFAB – assigned female at birth and AMAB - assigned male at birth.
19. Gender identity: is the subjective experience of gender. This is often described as “one’s own internal sense of gender”, an individual’s maleness, femaleness or other gender. The DSM-5-TR notes a “proliferation” of gender identities in recent years.⁷ See Annexure A for a list of 72 other genders.
20. Cisgender: the DSM-5-TR states this describes individuals whose gender expression is congruent with their birth assigned gender.⁸
21. Gender incongruence: The World Health Organization (WHO) International Classification of Diseases (ICD-11) defines this as when a person does not identify with the gender associated with their sex, thereby experiencing incongruence between the gender associated with their sex and their experience or expression of themselves.⁹ An easier definition may be when a person feels incongruence between their identity and their sex.
22. Gender expression: is how an individual expresses their gender identity: clothes, mannerisms, speech, hair, activities etc.
23. Gender-related distress: refers to a feeling of distress (dysphoria) pertaining to gender that may or may not meet the DSM-5-TR criteria for gender dysphoria.¹⁰
24. Transgender: the DSM-5-TR says this refers to a broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender.¹¹
25. Transsexual: denotes an individual who seeks or has undergone social transition and may involve medical transition.¹²
26. TGD: is an acronym for trans and gender diverse.
27. Gender dysphoria: the DSM-5-TR refers to the clinically significant distress that may accompany the incongruence between a person’s gender associated with their sex and their experience or expression.¹³

⁶ DSM-5-TR [511].

⁷ DSM-5-TR [511].

⁸ DSM-5-TR [511].

⁹ The International Classification of Diseases (ICD) version 11 (ICD-11) has moved this term to sexual health chapter as part of the depathologisation of the condition.

¹⁰ DSM-5-TR [511].

¹¹ DSM-5-TR [511].

¹² DSM-5-TR [511]-[512].

¹³ DSM-5-TR [511].

28. Gender affirming treatments: the DSM-5-TR describes these as “medical procedures (hormones or surgeries or both) that aim to align an individual’s physical characteristics with their experienced gender.”¹⁴ This is sometimes called GAT or gender affirming medicine.
29. Persistence / persist: refers to the child / young person’s cross-gender identity persisting, potentially through adolescence and into adulthood
30. Desistence: generally refers to:
 - A. Children / young people whose gender identity and/or gender related distress has resolved or disappeared, this being the foundation of their presentation to a gender service.
 - B. In the case of those whom have been diagnosed with Gender Dysphoria and commenced a transgender pathway, the act of desisting from the transgender pathway includes cessation of social transition, puberty blockers, cross-sex hormones, or a combination of these elements.¹⁵
31. Detransition: refers to children / young people who have at least commenced medical transition and cease transition. This includes those who transition back to the gender identity associated with their sex.
32. Non-binary: An “umbrella term referring to individuals who experience their gender as outside of the gender binary.” The term includes people whose “genders are comprised of more than one gender identity simultaneously or a different times (eg: bigender), who do not have a gender identity or have a neutral gender identity (eg: agender or neutrois), have gender identities that encompass or blend elements of other genders (eg: polygender, demiboy, demigirl), and/or who have a gender that changes over time (eg genderfluid).”¹⁶
33. Eunuch: this is a new gender identity in the WPATH SOC 8, released in September 2022. Eunuchs are males who “wish to eliminate masculine physical features, masculine genitals, or genital functioning. They also include those whose testicles have been surgically removed or rendered non-functional by chemical or physical means and who identify as eunuch.”¹⁷
34. The terminology is made more confusing when we add in the issue of sexuality. In gender identity ideology, homosexuals are not men or women who are same sex attracted, they are people with a female gender identity who are attracted to people with a female gender identity, or people with a male gender identity who are attracted to those with a male gender identity.

Information children receive about gender identity and pathways

35. The terminology and concepts are confusing to many adults and quite different from how gender dysphoria is conceptualised in Family Law.
36. Children and their parents receive information from a variety of sources. The following are visual representations used for children at gender clinics.

¹⁴ DSM-5-TR [511].

¹⁵ Elkadi (2023) [2].

¹⁶ The World Professional Association of Transgender Health (WPATH) released its 8th version of its Standards of Care of Transgender and Gender Diverse People, Version 8 (SOC 8) (2022) and included non-binary [S80].

¹⁷ WPATH, SOC 8 Chapter 9 Eunuchs [S88].

“Gender forest”

37. The gender affirming treatment is explained to children and young people by pictures such as the “gender forest” from Maple Leaf House as part of John Hunter Children’s Hospital and New South Wales health.¹⁸

“We are all part of the biodiverse gender forest. Every tree is different. We can label the trees but they are just that... labels.”



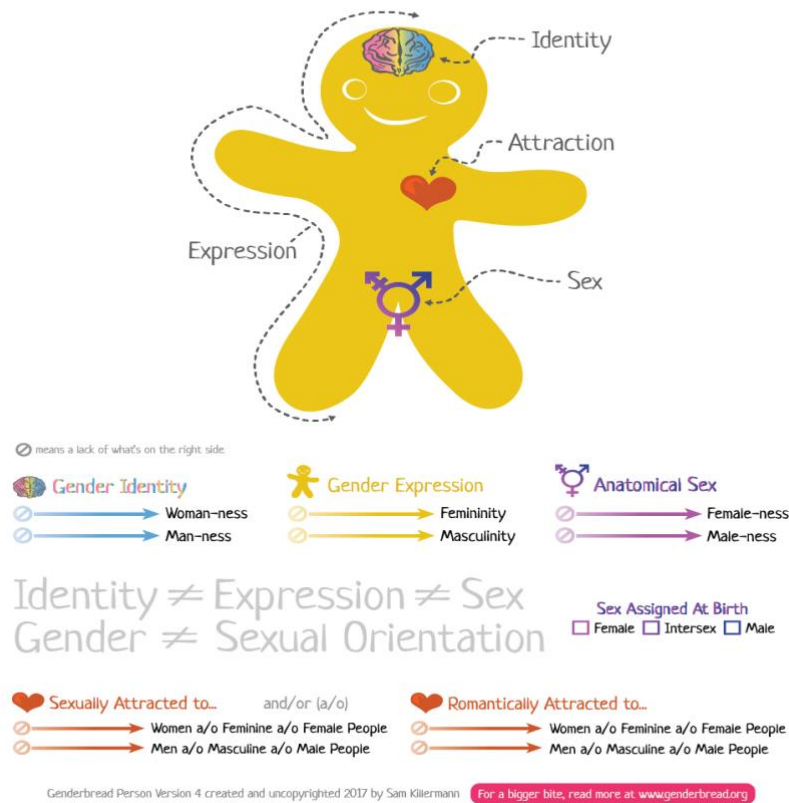
38. The Maple Leaf House “gender forest” takes the children on a pathway which emphasises medical treatment, discussing hormones and surgery. It makes no mention of psychological assistance for the child/young person or the family. Co-morbid mental health, adverse childhood events and neurodiversity seen as quite separate from the gender identity / dysphoria.

“Genderbread person”

39. Another resource is commonly used with young children at Australian gender clinics is the “genderbread person”. There is also a gender unicorn with the same information.

¹⁸ NSW Government, Maple Leaf House - Transgender & Gender Diversity (Web Page, 2023) <https://www.hnekidshealth.nsw.gov.au/specialist_services/gender>.

The Genderbread Person v4 by its pronounced METROsexual group



40. Endocrinological treatment is described by gender affirming clinicians as “medically necessary” to alter the child’s body and improve the young person’s mental health and support them to fully develop.¹⁹ A denial of endocrinological intervention described as discrimination and breach of human rights, that is, denial of “medical care”²⁰ and a denial of a child or young person’s fundamental human right to authenticity.

B Brief history of gender identity concerns

41. Transsexualism, transvestism, gender identity disorder, gender incongruence and more recently gender dysphoria are names for a condition in which a person does not identify with the gender associated with their sex, thereby experiencing incongruence between the gender associated with their sex and their experience or expression of themselves. Gender dysphoria has an additional element of distress.
42. Cross gender identification has been known in medical literature since about the mid 19th century.²¹ However it was only in the mid-20th century that transsexualism as a concept emerged after the discovery of cross-sex hormones and advances in plastic surgery.²² In the United

¹⁹ World Professional Association of Transgender Health (WPATH) “Standards of Care Version 8” (Web Page, 2023) <<https://www.wpath.org/soc8>> [18] and [55].

²⁰ WPATH, “Standards of Care Version 8” [14].

²¹ The first medical paper on transsexuality was published in 1869 by German psychiatrist Karl Friedrich Otto Westphal.

²² Biggs, Michael, “The Dutch Protocol for Juvenile Transsexuals Origins and Evidence” (2022) *Journal of Sex and Marital Therapy* [2]. (Biggs (2022(b))).

Kingdom (UK) hormonal and surgical treatment for transgender adults began around 1966.²³ In the United States (US) the first adult surgery occurred in 1965.²⁴ Medical treatment was available in the Netherlands for adults from 1972.²⁵ The Diagnostic and Statistical Manual (DSM) III first included the diagnosis of transsexualism when published in 1980.

43. Specialist clinics for children and adolescents with gender identity problems were founded in Toronto, Canada in 1975, the Netherlands in 1987 and London, UK in 1989. The London clinic saw on average 14 patients per annum over its first 10 years and the Netherlands clinic averaged 9 patients per year for the first 7 years.²⁶ In all countries the first line treatment for was counselling. Young people had to wait until they were 16-18 years old before being referred to an adult clinic for hormonal intervention and gender reassignment surgeries were not performed before 18 years.²⁷
44. Dr Kenneth Zucker, from the Toronto gender clinic, considered that a child or adolescent in distress is not reducible to one problem. To reach an accurate diagnosis treaters needed to look at the whole child.

“Some children latch onto gender dysphoria as a way of coping with trauma or other distress. A therapist needed to question the patient’s understanding of gender in order to determine why the patient might have fixated on that as a source of their problems. What beliefs did the patient have about boys or girls? Why did the child or adolescent come to believe changing gender would lead to a happier life? The goal of the questioning was often to challenge the notion that biological sex was the source of the patient’s problem, and, wherever possible to alleviate the dysphoria.”²⁸

45. It was accepted that most gender-dysphoric children would desist from their cross-sex identification by adulthood. As there was no accurate way to predict which children would persist in their cross-sex identification and which would desist, the only option was to wait. However, for the small cohort of children whose cross-sex identification would persist into adulthood, this meant going through puberty which would bring irreversible changes making it more difficult to pass as an adult of the opposite sex. This is particularly true for males.
46. In 1994, the American Psychiatric Association’s Diagnostic and Statistical Manual 4 (DSM-4) was published and the term transsexualism was replaced with Gender Identity Disorder. The new term reduced some of the stigma associated with the term “transsexual”, but the cross-gender identification remained a diagnosable condition. The protocol at the time in the DSM-4 and other guidelines was for a lengthy diagnostic process which took place in several stages, as it was accepted that 80-95% of prepubertal children with gender identity disorder will no longer

²³ Cass, Hilary, “The Cass Review: Independent review of gender identity services for children and young people: Interim report” (2022) [26] [2.1] (Cass Review - Interim (2022)).

²⁴ Joyce, Helen “Trans: when ideology meets reality” (Oneword, 2021).

²⁵ Van der Loos et al, “Children and Adolescents in the Amsterdam Cohort of Gender Dysphoria: trends in diagnostic and treatment trajectories during the first 20 years of the Dutch Protocol.” (2023) *Journal of Sexual Medicine* Vol 20(3) [1].

²⁶ Biggs (2022)(b) [2].

²⁷ Biggs (2022)(b) [2].

²⁸ Shrier, Abigail, “Why Marci Matters” (Blog, 7 October, 2021) <<https://abigailshrier.substack.com/p/why-marci-matters>> [123]-[124].

experience a gender identity disorder in adolescence.²⁹ There was concern that for those that did persist with their cross-gender identification into adulthood, their outcomes were poorer.

Dutch studies

47. In the 1990s the founder of a gender clinic in the Netherlands, psychologist Peggy Cohen-Kettenis started referring young people with gender dysphoria (aged 16-17 years) to an Amsterdam clinic for endocrinological intervention prior to receiving cross-sex hormones.³⁰ Males were given medications to prevent erections and cause breast tissue to grow and females were given medication to stop menstruation.³¹ The first 22 of the young patients from the Dutch clinic were followed up in their 20's, 1-5 years after gender reassigning surgery. Their psychological outcomes were compared to a group of transsexuals who had transitioned later in adulthood in previous decades. Cohen-Kettenis found that the young patients had better psychological functioning and more easily passed in the desired "gender role".³²
48. Associate Professor Michael Biggs³³ identifies problems with the findings of the initial study of young people. First, the young adults had transitioned in a more tolerant era than the older adult cohort. Secondly, they were still young at the time of follow-up, and most had no sexual partner. Thirdly and importantly, they had not yet reached an age at which they might regret their inability to conceive children. Finally, they have not been followed up since.³⁴
49. In the mid-1990s, Cohen-Kettenis pushed to decrease the age limit for hormonal interventions from 16-17 years to 12 years. This had the effect of removing a significant safeguard, going through puberty. Cohen-Kettenis hypothesised that if they carefully selected gender-dysphoric children who would likely be transgender identified for the rest of their lives, they could intervene medically before puberty and prevent the development of secondary sex characteristics. This would improve the cosmetic outcomes and as such their mental health might be improved.³⁵ The researchers asserted that if gender identity disorder persisted into early puberty it was likely to highly persistent.³⁶ Further, they considered that puberty blockers were fully reversible, "no lasting undesired effects are to be expected."³⁷ Cohen-Kettenis called this model of care "The Dutch model" in a paper published in 1992.³⁸ This treatment model was established before the research was started, it was also known as the Dutch Protocol. Assertions about the rates of persistence and reversibility of puberty blockers remain contested today.

²⁹ Cohen-Kettenis, et al "The Treatment of Adolescent Transsexuals: Changing Insights" (2008) *Journal Sex Medicine* Vol 5 [1893].

³⁰ Biggs (2022)(b) [3].

³¹ Biggs (2022)(b) [3].

³² Biggs (2022)(b) [3].

³³ Associate Professor Michael Biggs, sociologist at Oxford University, United Kingdom. His research areas are political sociology and social movements. He is also on the board of the Society for Evidence Based Gender Medicine (SEGM).

³⁴ Biggs (2022)(b) [3].

³⁵ Biggs (2022)(b) [3]; and Levine, SB, E Abbruzzese and JW Mason, "Reconsidering informed consent for transidentified children, adolescents and young people" (2022) *Journal of Sex & Marital Therapy* Vol 48(7).

³⁶ Cohen-Kettenis (2008) [1895].

³⁷ Biggs (2022)(b) [4].

³⁸ Cohen-Kettenis, PT, "A gender clinic for children and adolescents: The Dutch model." (1992) Presented at International Conference on Gender Identity and Development in Childhood and Adolescence, March, 1992, St. George's Hospital, London, England.

50. The number of children presenting to the Dutch clinics was very small. By 2000, only 7 children under 16 years had been administered puberty blockers (GnRHa).³⁹
51. In the early 2000's Dutch researchers hand selected a group of young people who despite many years of psychotherapy their gender dysphoria had not abated.⁴⁰ To further qualify for early intervention, the adolescents had to meet the following criteria:⁴¹
- A. Diagnosed with Gender Identity Disorder
 - B. Have had persistent gender dysphoria since childhood
 - C. Have physical changes of puberty to at least Tanner Stage 2-3 so that they have experienced some of their biological puberty (see Tanner Stages at paragraph below)
 - D. No other "serious comorbid psychiatric disorders that may interfere with diagnostic assessment" for example autism
 - E. Live in a supportive environment
52. Between 2000 and 2008, 196 adolescents were identified as meeting the selection criteria and initially referred to the study. Of the 196, only 140 participants were selected to participate. From the 140, 29 were prescribed cross-sex hormones as they were over 16 years. The other 111 were determined as eligible to start puberty blockers. The first 70 of those who were selected to start on puberty blockers and proceeded to cross-sex hormones were selected for this study. There were 33 males and 37 females.⁴² Importantly 97% of the selected cases were same-sex attracted to their sex, either exclusively (88.6%) or to both sex-sexes (8.6%). Only 2.8% reported opposite sex attraction.⁴³ The researchers received funding from Ferring Pharmaceuticals, the manufacturer of triptorelin.⁴⁴
53. The children / young people were assessed twice in the study, first at puberty suppression and secondly right before commencing cross-sex hormones. The children ranged in age from 11-17 years⁴⁵ and the average age of the children being treated with puberty blockers was almost 15 years.⁴⁶ On average the children were on puberty blockers for 2 years. There was no control group so there was no evidence about other children in the same situation who were given other treatments.
54. The intention was that those who wanted to desist could cease puberty blockers and those that persisted would have an easier transition.⁴⁷ The results of the first study were released in 2011.⁴⁸ The authors reported improvement in some psychological measures, including "fewer behavioural and emotional problems" and improvement in general functioning but feelings of anxiety and anger

³⁹ Biggs (2022)(b) [4].

⁴⁰ Cohen-Kettenis (2008) [1893].

⁴¹ De Vries, Annelou LC, Thomas D Steensma, Theo AH Doreleijers, and Peggy T Cohen-Kettenis, "Puberty Suppression in Adolescents With Gender Identity Disorder: A Prospective Follow-Up Study" (International Society for Sexual Medicine, 2010) [2277]; Cohen-Kettenis (2008) [1893].

⁴² De Vries (2011) [2277].

⁴³ De Vries (2011) [2278].

⁴⁴ Block, Jennifer, "Gender dysphoria in young people is rising – and so is professional disagreement" (2023) British Medical Journal Vol 380 [3].

⁴⁵ De Vries (2011) [2278].

⁴⁶ Levine (2022) [13]; De Vries (2011) [2278].

⁴⁷ Joyce (2021) [72]; De Vries (2011) [2277].

⁴⁸ De Vries (2011).

remained stable.⁴⁹ As expected, there was no amelioration of the gender dysphoria or changes in body image. Further, the results were not uniform, with females reporting significantly more feelings of anger and anxiety and a significantly lower global assessment of functioning.⁵⁰

55. The authors offered various explanations for the results: puberty suppression allowing for smooth transition into desired gender role, the belief that gender reassignment will be offered if needed. Possible limiting of stigmatization and discrimination because the adolescents received extensive family and social support. Finally, and importantly the adolescents were

“all regularly seen by one of the clinic’s psychologists or psychiatrists. Psychological or social problems could thus be timely addressed. All of these factors may have contributed to the psychological well-being of these gender dysphoric adolescents.”⁵¹

56. The Dutch researchers were unable to establish the extent to which puberty blockade contributed (if at all) to the patients’ well-being.

57. All of the 70 children enrolled in the study from 2000-2007 continued on to cross-sex hormones.⁵² This was a most surprising result and appeared to be celebrated as the clinicians having accurately selected the children who would continue to be gender dysphoric in adulthood.⁵³ However, as there was no control group, the researchers wouldn’t be in a position to know what caused the young people to continue.

58. The Dutch protocol was hailed as a success prior to the release of the results. At the time, Cohen-Kettenis was on the Board of the Harry Benjamin International Gender Dysphoria Association (HBIGDA). This was a US advocacy group which subsequently became the World Professional Association of Transgender Health (WPATH) in 2007. The Dutch Protocol and the WPATH Standards of Care developed as interrelated processes. Puberty suppression was recommended in the 2001 Standards of Care for transgender health.

59. International paediatric gender clinics started prescribing puberty blockers for gender-dysphoric children, the Canadians not long after the Dutch, the US around 2007 and the English around 2014.⁵⁴ This was the start of medically blocking children’s physical development to treat their psychological distress.⁵⁵

60. In 2007, endocrinologist Norman Spack headed up the first dedicated paediatric gender service in the US at the Boston Children’s Hospital and began using the protocol.⁵⁶ Dr Spack, Cohen-Kettenis and her Dutch colleagues wrote the Endocrine Society’s first clinical practice guideline in 2009, by which time puberty had been suppressed in just over 100 gender dysphoric young people.⁵⁷

⁴⁹ De Vries (2011) [2281].

⁵⁰ De Vries (2011) [2280].

⁵¹ De Vries (2011) [2281].

⁵² Joyce (2021) [73].

⁵³ Joyce (2021) [73].

⁵⁴ Joyce (2021) [73].

⁵⁵ “Episode 6: Gender intervention: treatment or experiment?” Gender: a Wider lens podcast (Stella O’Malley, 15 January 2021).

⁵⁶ Biggs (2022)(b) [6].

⁵⁷ Block (2023) [3].

61. The Dutch Protocol was established as the standard for transgender medicine, the World Professional Association for Transgender Health (“WPATH”) Standards of Care 7 and Endocrine Society Guidelines relied upon the Dutch experience as proof of the benefits of paediatric gender transition.⁵⁸ The model “gender affirmative care” emerged.
62. The second Dutch study followed 55 of the original 70 adolescents identified above.⁵⁹ Of the remaining 55 participants, 22 were males and 23 were females. The group were given puberty blockers mean age 14.8 years, cross-sex hormones at mean age 16.7 years and surgery at mean age 19.2 years.⁶⁰ The clinical approach included both medical and mental health support with “regular sessions, treatment when necessary”.⁶¹ The young people were assessed before being given cross-sex hormones and then after surgery. As such it was not possible for the Dutch to distinguish the impact of these 2 interventions, nor separate cross-sex hormones and surgery from the impact of psychological assistance.
63. Three of the participants developed obesity and diabetes and were ineligible for surgery. The surgeries were vaginoplasty for male to female patients and breast removal and ovarian hysterectomies for female to male transition.⁶² The patient group was reduced further as one patient died from complications from surgery, and 3 more refused to be contacted or dropped out.⁶³
64. Final outcomes were measured when the young people were followed up around 18 months after surgery between the ages of 19-22 years.⁶⁴ The authors concluded “gender dysphoria had resolved, psychological functioning had steadily improved, and well-being was comparable to same-age peers.”⁶⁵ Some criticisms of the study’s conclusions are:
 - A. The study sample was small, with final outcomes available for subsets of patient ranges from 32 to 55 patients.⁶⁶
 - B. The short follow-up time and no further follow up.⁶⁷
 - C. The researchers switched the questionnaires which compromised the assessment of gender dysphoria (so a boy who wanted to be a girl answered the male questionnaire at baseline and the female questionnaire post-surgery which asked to respond to non-applicable questions like “I hate menstruating because....”).⁶⁸
 - D. Failure to mention death rate exceeding 1%.⁶⁹

⁵⁸ Van der Loos (2023) [2].

⁵⁹ De Vries, Annelou LC, Jennifer K McGuire, Thomas D Steensma, Eva CF Wageaar, Theo Dreleijers and Peggy Cohen-Kettenis, “Adult Psychological Outcome After Puberty Suppression and Gender Reassignment” (2014) Paediatrics Vol 134(4).

⁶⁰ De Vries (2014) [696].

⁶¹ De Vries (2014) [697].

⁶² De Vries (2014) [697].

⁶³ Levine (2022) [12].

⁶⁴ Biggs (2022)(b) [8].

⁶⁵ Biggs (2022)(b) [8].

⁶⁶ Biggs (2022)(b) [8] - Dutch authors acknowledged a selection bias could exist between adolescents of the original cohort that participated in this study compared with non-participants; De Vries et al “Adult Psychological Outcome After Puberty Suppression and Gender Reassignment” (2014) Paediatrics Vol 134(4) [703].

⁶⁷ Biggs (2022)(b) [8] - In 2021, Cohen-Kettenis acknowledged that a truly proper follow-up needs to span a minimum of 20 years.

⁶⁸ Biggs (2022)(b) [8].

⁶⁹ Biggs (2022)(b) [8].

E. Failure to evaluate physical health outcomes.⁷⁰

65. Dr Steven Levine⁷¹, psychiatrist commented in a 2022 article that the reported psychological improvements were quite modest, with half of the psychological measures showing “no statistically significant improvements” and the other half “marginally significant at best.” The scores for anxiety, depression and anger did not improve. Even the change in overall function, which was the area of most impressive changes, remained in the same range before and after treatment.⁷²
66. There has been no further follow-up of the 55 participants.⁷³ There was not follow up of the 126 patients who did not participate in the study.⁷⁴
67. Levine states:

“What the studies failed to show, however, is that these physical changes resulted in meaningful psychological improvements significant enough to justify the adverse effects of treatment – including the certainty of sterility.”⁷⁵
68. As a result of Dutch studies, there was significant political debate about the inclusion of gender identity in the DSM. The issue was whether including gender identity disorder was in fact pathologizing an identity rather than identifying a true disorder.
69. In 2013, the Diagnostic and Statistical Manual 5 (DSM 5) was released and changed the diagnosable condition from gender identity disorder to gender dysphoria. Gender dysphoria refers to the distress that may accompany the incongruence between a person’s gender associated with their sex and their experience or expression of gender. The change in definition shifted the focus to the distress caused by the incongruence rather than the identity itself.⁷⁶ The DSM-5 introduced a separate diagnosis of gender dysphoria in children.
70. By 2011, the eligibility criteria / safeguards of the Dutch protocol were watered down in the World Professional Association (WPATH) Standards of Care (SOC) version 7 (SOC 7). In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:⁷⁷
 1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);
 2. Gender dysphoria emerged or worsened with the onset of puberty;

⁷⁰ Abbruzzese, E, SB Levine, and JW Mason, “The Myth of “Reliable Research” in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies – and the research that has followed” (2023) *Journal of Sex and Marital Therapy* [5].

⁷¹ Dr Steven Levine, psychiatrist is known for his work in human sexuality, particularly sexual dysfunction and management of gender dysphoria. He was chair of the 5th edition of the Standards of Care for the Harry Benjamin Foundation, which later became WPATH. He also served on the DSM-IV subcommittee on gender identity disorders.

⁷² Levine (2022) [10].

⁷³ Joyce (2021) [73].

⁷⁴ Levine (2022) [12].

⁷⁵ Abbruzzese (2023) [4].

⁷⁶ DSM-5 TR [512].

⁷⁷ WPATH SOC 7 [19].

3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;
 4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.
71. On 1 January 2022, the WHO classification of diseases and health issues, ICD 11⁷⁸ came into effect. ICD-11 further depathologised gender incongruence by moving the condition into the sexual health classification.
 72. In September 2022, SOC 8 was published online. It describes ICD-11 as:

“..the *Gender Incongruence* diagnosis is placed in chapter on sexual health and focuses on the person's experienced gender identity and any need for gender affirming treatment, that might stem from that identity. Such developments, involving a depathologization (or more precisely a de-psychopathologization) of transgender identities, are fundamentally important on a number of grounds.”⁷⁹
 73. SOC 8 notes that some countries no longer require a diagnosis before commencing medical transition and recommends that countries requiring a diagnosis move to ICD-11:

“For countries requiring a diagnosis for access to care, the health care professional should be competent using the latest edition of the World Health Organization's International Classification of Diseases (ICD) for diagnosis. In countries that have not implemented the latest ICD, other taxonomies may be used; efforts should be undertaken to utilize the latest ICD as soon as practicable.”⁸⁰
 74. Importantly SOC 8 also removed the minimum age requirements for hormonal and surgical interventions and included new categories of non-binary and eunuchs.
 75. The DSM-5 Text Review (DSM-5-TR) was published in March 2022. It retains the diagnosis of Gender Dysphoria and therefore the requirement of clinically significant distress. Importantly the text review clarified that the required clinically significant distress “does not refer to distress related to stigma, a distinct although possibly co-occurring source of distress.”⁸¹ The DSM-5-TR specifically recognises the possibility of a person experiencing “an intermediate or alternative gender”, thereby leaving the categories of gender identification wide open.⁸²
 76. There are two distinct diagnostic frameworks in operation internationally. Since only a tiny minority of cases come before the Family Courts in Australia, it is unclear which diagnostic frameworks are used by the various gender clinics at any one time.

⁷⁸ ICD-11 Homepage <https://www.who.int/standards/classifications/classification-of-diseases>

⁷⁹ SOC 8 [S15]

⁸⁰ SOC 8 [S32]

⁸¹ Diagnostic and Statistical Manual 5 Text Review [511] (DSM-5 TR).

⁸² DSM-5 TR [513].

77. The Australian Standards are due for review and it is likely that they will closely follow SOC 8.
78. What the above history shows is a significant push towards the depathologization of gender incongruence and removal of restrictions to access medical transition. This move to a rights based approach to medical transition has significant implications for children and young people.

International best practice

79. The Dutch Studies and protocol are held by gender affirming practitioners as a gold standard of research.⁸³ Gender affirming clinicians rely upon them as the foundational studies for the gender affirming treatment recommendations.
80. In a 2022 FCFCOA case the child’s treating paediatrician from an Australian paediatric gender clinic gave evidence that:

“Use of puberty blockers in trans adolescents from early puberty has been considered international best practice for more than 30 years with commencement of its use in Europe in the late 1980s and in Australia from 2004. Commencement of puberty blockers at Tanner Stage 2 is consistent with the peer-reviewed international clinical guidelines; the World Professional Association for Transgender Health (WPATH) Standards of Care version 7 (2011) and version 8 (2022), the Endocrine Society Guidelines (2018) and the Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents (2018).⁸⁴”

81. The above-named guidelines are intended to provide guidance to health care professionals. However, critics argue that this “best practice” is based on flawed research.

Summary of concerns about the Dutch studies and protocol

82. Recent studies which are referred to in more detail in this paper challenge the utility and appropriateness of the Dutch studies and protocol. The Dutch selection criteria were:
 - A. Diagnosed with Gender Identity Disorder
 - B. Have had persistent gender dysphoria since childhood
 - C. Have physical changes of puberty to at least Tanner stage 2-3 so that they have experienced some of their biological puberty
 - D. No other “serious comorbid psychiatric disorders that may interfere with diagnostic assessment” for example autism
 - E. Live in a supportive environment
83. As set out below in more detail, the sociocultural demographic of the children and young people presenting has changed internationally:⁸⁵

⁸³ Abbruzzese (2023) [4].

⁸⁴ Known as the Australian Standards.

⁸⁵ Kaltiala, R, et al "Time trends in referrals to child and adolescent gender identity services: a study in four Nordic countries and in the UK" (2020) Nord J Psychiatry 74(1) 40-44 (Kaltiala (2020)(a)); Kaltiala, et al "Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria" (2020) Nord J Psychiatry 74(3) 213-219 (Kaltiala (2020)(b)); Kozłowska, Kasia, et al "Attachment Patterns in Children and Adolescents with Gender Dysphoria" (2021) Frontiers in Psychology Vol 11 (Kozłowska (2021)(a)); Kozłowska, K, et al "Australian Children and adolescents with

- A. The most common group presenting are adolescents with late onset history of gender dysphoria. Criterion B of the protocol is not met.
 - B. The young people have significant co-morbid mental health issues. Criterion D of the protocol is not met.
 - C. There is frequently significant family dysfunction, meaning that criterion E is not met.
84. Further, children are often receiving medical intervention at earlier ages, so criterion C might not be met.
85. Recent studies from Australia, Sweden, Norway, and the United Kingdom indicate that the young people’s mental health problems persist and are not cured by gender affirming medical treatment.⁸⁶
- “Among adolescents diagnosed with transsexualism, difficulties in adolescent development and functioning in life domains appropriate to late adolescence do not disappear with cross-sex hormone treatment. Cross-sex hormone treatment may alleviate depression and anxiety but does not have a positive impact on psychiatric comorbidities at large. Even deterioration as regards psychiatric treatment needs and functioning occurs during the first year of cross-sex hormone treatment. Not all psychiatric and psychosocial problems in adolescents displaying gender dysphoria are secondary to gender identity issues and will not be relieved by medical gender reassignment. An adolescent’s gender identity concerns must not become a reason for failure to address all her/his other relevant problems in the usual way.”⁸⁷
86. In summary, there are significant concerns that a treatment protocol that was designed for “genuine transexuals”⁸⁸ is being applied to a population of children and adolescents who for various reasons wish to self-identify as trans or gender diverse.
87. As a result of these concerns Finland and Sweden have put in additional safeguards for children and adolescents— to ensure that individuals who do not meet the strict criteria screened out.

More detailed analysis of the Dutch studies and protocol

88. In 2023, a detailed analysis of the Dutch studies was released citing significant concerns about the quality and application of the Dutch studies.⁸⁹ The concerns are categorised as follows:
- A. The framework of the studies.
 - B. The methodology.
 - C. The applicability of the studies to the current cohort of children / adolescents presenting at gender services.
 - D. The length of follow-up.
 - E. Current deviation from the Dutch protocol

gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service” (2021) *Human Systems: Therapy, Culture and Attachments* Vol 1(1) (Kozłowska (2021)(b)).

⁸⁶ Kaltiala (2020)(b); Elkadi (2023); Carmichael, P, et al, “Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK” (2021) *PLoS ONE* Vol 16(2) e0243894.

⁸⁷ Kaltiala (2020)(b) [6].

⁸⁸ This term may be contested but meaning young people whose transgender identity would persist through adulthood

⁸⁹ Abbruzzese (2023).

Framework

89. Dutch researchers began to medically transition adolescents in the 1980s and early 1990s, just as medicine was undergoing a paradigm shift from “empirical evidence”, which was based on expert opinion and often minimal research, to “evidence-based medicine” and its focus on quality comparative clinical research to determine optimal treatment.⁹⁰
90. Critics say that when looking at the Dutch studies from today’s vantage point, they would have been considered to be most consistent with the “innovative practice” framework. The framework allows clinicians to implement untested but promising interventions for a condition which if left untreated would have dire outcomes, when existing treatments seen ineffective; and when the number of patients is small.⁹¹ The number of adolescents suffering from gender dysphoria in the 1990s was exceedingly small. Critics say the methodological deficiencies in the research should not be regarded as a failure, as it was not the intention of the Dutch researchers to produce reliable reproducible research.⁹²
91. Innovative practice is described as a double-edged sword, which can advance medical practice but can also promote harmful or non-beneficial intervention. Therefore, it is an ethical requirement that as soon as viability of a new intervention is demonstrated under the “innovative practice framework”, research must move to high quality clinical research settings which establish that the benefits outweigh the risks. This prevents “runway diffusion”, “the phenomenon whereby the medical community mistakes a small innovative experiment as a proven practice, and a potentially non-beneficial or harmful practice “escapes the lab”, rapidly spreading into clinical settings.”⁹³ It is asserted that this is what happened with gender affirmative treatment, it rapidly entered general clinical practice worldwide “without the necessary rigorous clinical research to confirm the hypothesized robust and lasting psychological benefits of the practice.”⁹⁴ The rapidity of translation as a gold standard in medical practice is particularly startling since one of the outcomes is infertility. In other medical settings, potential loss of fertility would require discussion at hospital ethics committees.⁹⁵

Methodology

92. The Dutch studies are said to suffer from high risk of bias from multiple sources:⁹⁶
- A. First the subject selection assured that only the most successful cases at each treatment stage were included in the results.
 - B. Secondly, the measurement of the outcomes and switching of the questionnaires as set out above, renders the outcomes with respect to gender dysphoria entirely invalid, as it guaranteed a drop in gender dysphoria scores.

⁹⁰ Abbruzzese (2023) [2].

⁹¹ Abbruzzese (2023) [3].

⁹² Abbruzzese (2023) [3].

⁹³ Abbruzzese (2023) [3].

⁹⁴ Abbruzzese (2023) [3].

⁹⁵ Note in NSW legislation specifically considers medical treatments that may result in permanent loss of fertility, see Children and Young Persons (Care and Protection) Act 1998 (NSW).

⁹⁶ Abbruzzese (2023) [5].

- C. Thirdly, confounding as the young people received both psychotherapeutic and endocrinological intervention. This makes it impossible to determine if medical intervention, psychological therapy, or psychological maturation led to the few modest improvements.
93. Critics note that the Dutch studies did not evaluate the physical health outcomes of gender affirming treatment, despite adverse effects of hormonal treatment on bone and brain health had been hypothesized from the start.⁹⁷

Applicability of the studies

94. Critics assert that the findings of the Dutch studies are not applicable to most of the youth seeking treatment today, those presenting are suffering from post-pubertal onset gender dysphoria and significant mental illness, two clinical presentations which the Dutch “explicitly disqualified from their studies.”⁹⁸ Noting also that the Dutch specifically excluded autism, a diagnosis (or subclinical traits) which features significantly in the young people presenting today.
95. Dr William Malone, endocrinologist, says relevantly:

Most of the youth presenting for care today would have been explicitly disqualified by the original Dutch protocol, as most have significant mental health comorbidities and post-puberty onset of trans identities. This fact has been recognized by the principal investigators of the Dutch protocol itself, who have recently begun to sound the alarm about the potential misapplication for their protocol and who suggest that psychotherapy – rather than gender reassignment – is more appropriate for many of the currently presenting cases.⁹⁹

Follow up

96. The follow-up of patients so soon after the surgery at the ages of 19-22 years is said to be insufficient. The young people were not at an age of brain maturation and at a time when they may begin to regret their sterilisation. Further, there is no information about the impact on their sexual function and sexual relationships. In 2021, Cohen-Kettenis said that a truly proper follow up needs to span a minimum of 20 years.¹⁰⁰

Deviation from the protocol

97. Importantly, medical transition is said to be frequently initiated much earlier than recommended by the original protocol. Levine says that the Dutch researchers were aware that most children would have a “spontaneous realignment of their gender identity with sex” by going through early to mid-stages of puberty.¹⁰¹ The average age of the children in the Dutch study to start puberty blockers was 15 years and cross-sex hormones at nearly 17 years. In contrast, the age to commence

⁹⁷ Abbruzzese (2023) [5].

⁹⁸ Abbruzzese (2023) [3].

⁹⁹ “Episode 5: Hormonal Interventions — from Fringe to Mainstream: A conversation with Dr. Will Malone” Gender: a Wider lens podcast (Stella O’Malley, 8 January 2021); Williams, Grace, “Dutch Puberty Blocker Pioneer: stop blindly adopting our research” (Blog, 16 March 2021) <<https://4thwavenow.com/2021/03/16/dutch-puberty-blocker-pioneer-stop-blindly-adopting-our-research/>>.

¹⁰⁰ Biggs (2022)(b) [8].

¹⁰¹ Levine (2022) [13].

puberty blockers has been reduced to Tanner Stage 2, as early as 8-9 years and cross-sex hormones are commonly prescribed, at least in the US, at 14 years.¹⁰²

98. “The fact that children are transitioned before their identity is tested against the biological reality and before natural resolution of gender dysphoria has had a chance to occur is a major deviation from the original Dutch protocol.”¹⁰³
99. Dr Hilary Cass in March 2022 said that in fact the “Dutch Approach” provided for children and young people with neurodiversity and/or complex mental health problems to be routinely given therapeutic support in advance of, or if appropriate, instead of hormonal intervention. Dr Cass contrasted this with the UK approach where criteria to have accessed therapeutic support prior to starting hormone blocking treatment “do not appear to be integral to the current NHS process.”¹⁰⁴
100. The results of the Dutch studies have not been able to be replicated in subsequent studies. Discussion below.

C Current context

Increasing presentations

101. Historically gender dysphoria affected a very small percentage of the population, primarily pre-pubescent males¹⁰⁵ and cases were rarely seen in Family Courts. In 2013, the DSM 5 estimated about 0.005% to 0.014% of males and 0.002% to 0.003% of females were diagnosable with gender dysphoria. Although it was noted that these figures may be underestimates as not all patients present to speciality clinics.¹⁰⁶ In 2022, the DSM-5 TR stated that there are no large-scale population studies of gender dysphoria. Based on the number of people seeking “gender affirming treatment”, the prevalence for diagnosis of gender dysphoria is assessed to be less than 1/1,000 (<0.1%). However, self-identification as transgender in the United States and Europe suggest higher numbers.¹⁰⁷
102. The number of children / young people referred to specialised gender clinics has increased dramatically internationally in the last 10-15 years, and in Australia in the last 10 years. In England and Wales presentations at the Gender Identity Development Service (GIDS), the largest gender clinic in the world, increased from around 50 children in 2009 to over 2,700 in 2019/2020.¹⁰⁸ A 5,400% increase. The US had one paediatric gender clinic in 2011 to over 60 in 2021 along with “countless therapists and doctors in private practice.”¹⁰⁹

¹⁰² Levine (2022) [13].

¹⁰³ Levine (2022) [13]; Van Der Loos (2023) [5] average age for puberty blockers for males was 14 years and females was 15.5 years.

¹⁰⁴ Cass Review - Interim [18].

¹⁰⁵ Aitken, M, et al, “Evidence for an Altered Sex Ratio in Clinic Referred Adolescents with Gender Dysphoria” (2015) *Journal of Sexual Medicine* Vol 12(3) 756–763.

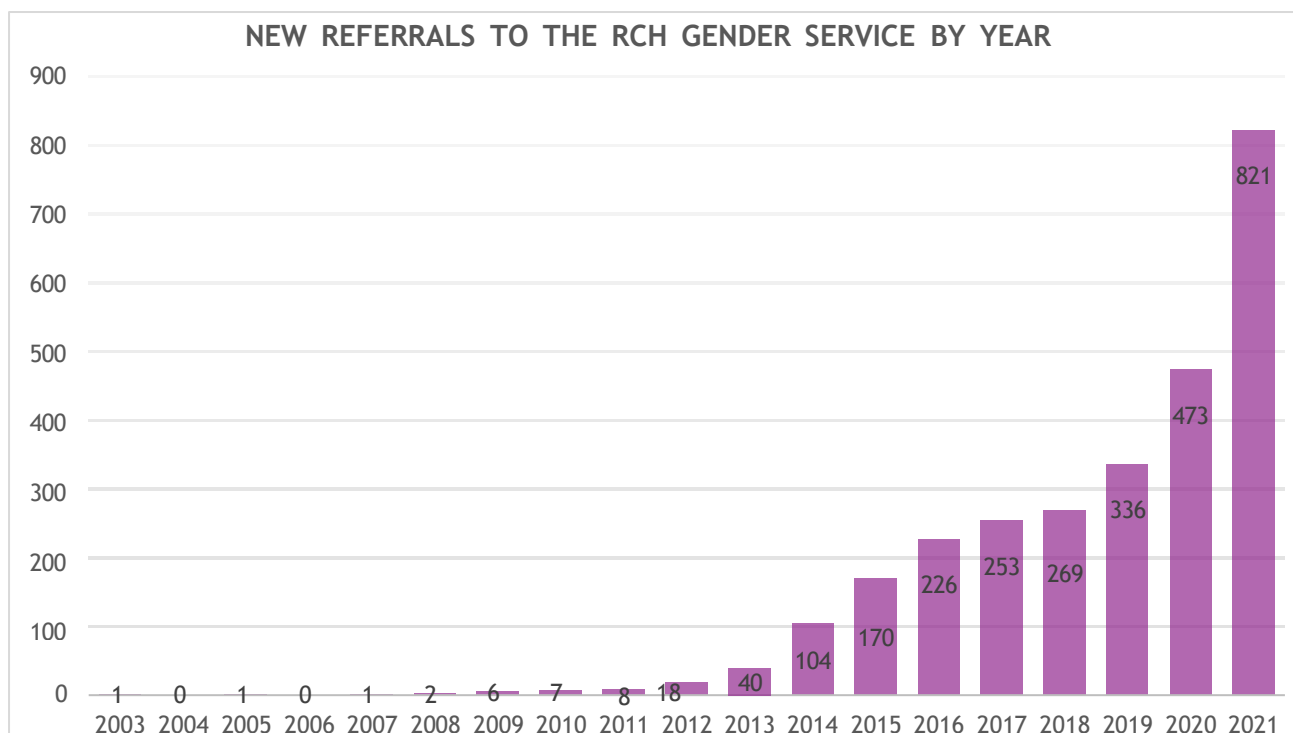
¹⁰⁶ DSM-5 (2013) [454].

¹⁰⁷ DSM-5-TR [515] - Different methods across studies make comparisons difficult. Self-identification as transgender ranges from 0.5% to 0.6%; experiencing oneself as having an incongruent gender identity 0.6% to 1.1%; feeling that one is a person of a different sex 2.1% to 2.6%; desire to undergo medical treatment 0.2% to 0.6%.

¹⁰⁸ Cass, Hilary, “Review of Gender Identity Services for Children and Young People” *British Medical Journal* (Opinion, 10 March 2022) <https://www.bmj.com/content/376/bmj.o629> (Cass BJM (2022)).

¹⁰⁹ Bazelon, Emily, “The Battle Over Gender Therapy” (Article, 15 June 2022) <<https://www.nytimes.com/2022/06/15/magazine/gender-therapy.html>>.

103. The Royal Children’s Hospital’s Gender Service (RCHGS), in Melbourne is the largest specialised gender service in Australia and considers itself as “one of the most highly respected in the world.” The RCHGS sees children up to 17 years, with their youngest patient 3 years. The RCH clinicians received the first referral for gender identity disorder in 2003. The Gender Service was established in 2012 as the referrals increased. RCHGS has experienced a dramatic rise in referrals increasing from 8 referrals in 2011 to 821 in 2021. The below table is from the RCHGS 2022 newsletter.¹¹⁰



104. In 2023, Melbourne, Victoria researchers asserted that 1.2% to 2.7% of young people “are TGD”, meaning identify trans and gender-diverse.¹¹¹ If this is correct, then the matters coming before the Court are likely to dramatically increase. In the United States, in 2023, it was claimed that 2 to 9% of high-school aged youth are transgender and non-binary.¹¹²

105. In Australia children and young people may receive medical interventions at public gender services and at private clinics or through private practitioners. Some states such as Victoria and NSW have multiple clinics. The actual number of children / young people attending upon gender clinics and gender practitioners), their treatment and outcomes are unknown. This presents a significant problem for research and is particularly concerning considering the long-term medical implications of endocrine treatment which will be discussed below. The lack of follow up is an issue identified as problematic at GIDS and one which the NHS propose to correct in their “Future Service model.”¹¹³

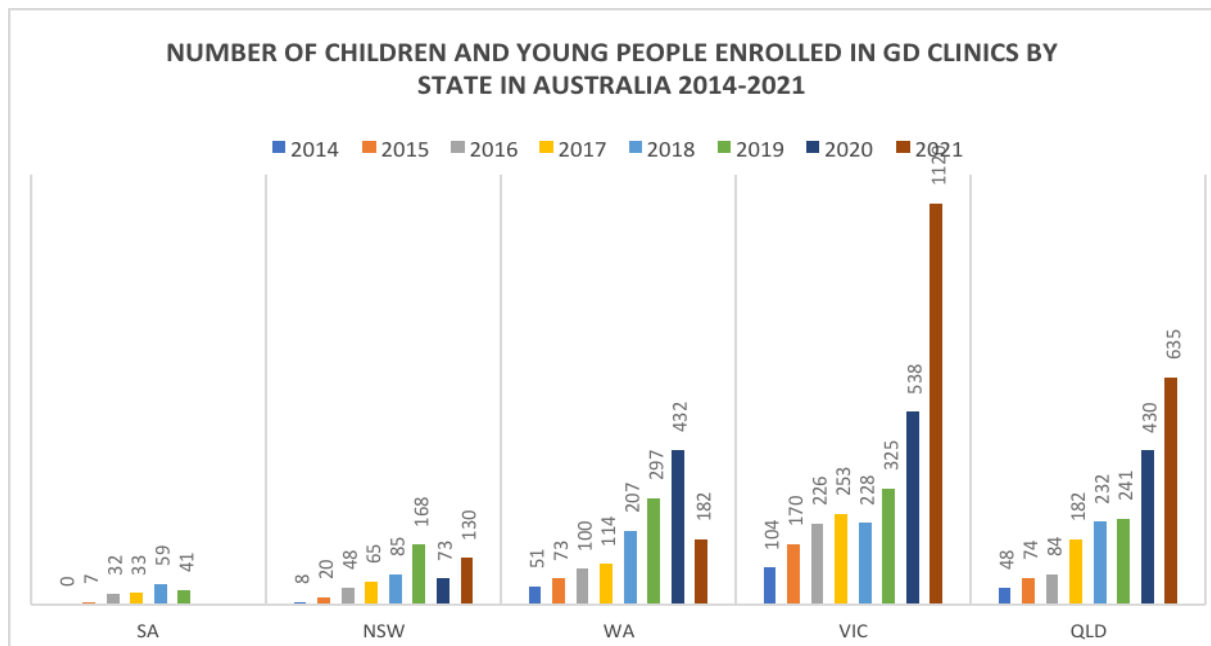
¹¹⁰ Royal Children’s Hospital Gender Service Newsletter, 13 April 2022.

¹¹¹ Engel, Linda, et al “Assessment of Quality of Life of Transgender and Gender-Diverse Children and Adolescents in Melbourne, Australia, 2017-2020.” (2023) JAMA Network Open 6(2) e2254292.

¹¹² Chen, Diane., Berona, Johnny et al “Psychosocial Functioning in Transgender Youth after 2 Years of Hormones.” *The New England Journal of Medicine* (2023) 388;3 [241].

¹¹³ National Health Service England, “Interim Service Specification: Specialist service for children and young people with gender dysphoria (phase 1 providers)” (2022) [8] 8.1.

106. A study of patients from five public hospital gender services in Australia¹¹⁴ revealed that the numbers of children presenting does not reflect the population of each state.¹¹⁵ It raises the question as to what other factors might be influencing the variations between States in Australia.



Changing case mix

Sex ratio / age

107. Historically the small number of children presenting to gender clinics were primarily prepubescent males. They usually had a history of early childhood non-gender conforming behaviour and were described as having early childhood onset gender dysphoria.¹¹⁶ In recent years there has been a dramatic rise, both in Australia and internationally, of young people, primarily females, presenting to services in adolescence. They are referred to as presenting with “late-onset”, “rapid-onset” or “adolescent-onset Gender Dysphoria.”¹¹⁷

108. The experience of Westmead Children’s Hospital Gender Service is similar to international experience, with adolescents who had no prior history of gender distress during early development presenting with sudden-onset gender distress.¹¹⁸ As the authors of the 2023 Westmead study state:

“The absence of prior history raised questions that this particular group of adolescents were being drawn to the construct of gender dysphoria because of some evolving social process. In particular, we wondered whether gender dysphoria provided an uncomplicated framework for understanding

¹¹⁴ Queensland Children’s Hospital Gender Clinic; The Children’s Hospital Westmead Gender Clinic; The Royal Children’s Hospital, Melbourne; Perth’s Children’s Hospital Gender Service, CAMHS; Women and Children’s Health Network, SA.

¹¹⁵ Kenny, Dianna, “Number of Children enrolled, receiving puberty blockade and cross-sex hormones in five gender clinics in Australia, 2014-2021” (Blog, 29 October 2022) <<https://diannakenny.com.au/number-of-children-enrolled-receiving-puberty-blockade-and-cross-sex-hormones-in-five-gender-clinics-in-australia-2014-2021/>> .

¹¹⁶ Tollit, May, Maloof, Telfer, Chew, Engel and Pang “The clinical profile of patients attending a large Australian pediatric gender service: a 10-year review” (2021) International Journal of Transgenderism [4].

¹¹⁷ Elkadi (2023) [3].

¹¹⁸ Elkadi (2023) [3].

(and also for resolving) the inner distress that had arisen in the context of adverse childhood experiences and the challenges and existential distress associated with adolescence, especially in this turbulent, uncertain social and political period.”¹¹⁹

Mental health

109. The children and young people currently presenting at Gender clinics in Australia and internationally have a complex profile. Researchers from Westmead Children’s Hospital Gender Service have published reports on a 5-year study (2013 to 2018) of patients presenting at the service. The 2021 report described the children presenting with a complex picture of neurodiversity, comorbid mental health issues and adverse childhood events (ACEs):

The clinical characteristics of the children were comparable to those described by other paediatric clinics providing gender services: a slight preponderance of biological females to males (1.4: 1); high levels of distress (including dysphoria about gender), suicidal ideation (41.8%), self-harm (16.3%), and suicide attempts (10.1%); and high rates of comorbid mental health disorders: anxiety (63.3%), depression (62.0%), behavioural disorders (35.4%), and autism (13.9%). The developmental stories told by the children and their families highlighted high rates of adverse childhood experiences, with family conflict (65.8%), parental mental illness (63.3%), loss of important figures via separation (59.5%), and bullying (54.4%) being most common. A history of maltreatment was also common (39.2%).¹²⁰

110. Westmead hospital clinicians also noted higher rates of high-risk attachment patterns and unresolved trauma in children presenting to their gender service when compared to age and sex matched children from the community.

Akin to children with other forms of psychological distress, children with gender dysphoria present in the context of multiple interacting risk factors that include at-risk attachment, unresolved loss/trauma, family conflict and loss of family cohesion, and exposure to multiple ACEs.¹²¹

Autism

111. Autism Spectrum Disorder (ASD) is:

“a neurodevelopmental condition diagnosed based on significant challenges with social-communication and a restricted, repetitive pattern of interests and behaviour. It affects approximately 1% of the worldwide population and is associated with higher rates of co-occurring conditions (eg depression and anxiety; as well as with a higher risk of suicide than the general population).”¹²²

112. It is accepted that there is an over representation of autism spectrum traits in people with gender dysphoria.¹²³ A Royal Children’s Hospital Gender Service (RCHGS) 10-year study from 2007 to

¹¹⁹ Elkadi (2023) [3]-[4]; Littman, Lisa MD, MPH, “Rapid Onset of Gender Dysphoria in Adolescents and Young Adults: a Descriptive Study” (2017) *Journal of Adolescent Health* Vol 60(2) Supplement 1 S95-S96; Society for Evidence Based Gender Medicine (SEGM), “Sharp increase in Incident of Gender Dysphoria in Children and Young People” (Blog, no date) <<https://segm.org/>>.

¹²⁰ Kozłowska (2021)(b).

¹²¹ Kozłowska (2021)(a) [1].

¹²² Kallitsounaki, A and D Williams, “Autism Spectrum Disorder and Gender Dysphoria/Incongruence. A Systematic Literature Review and Meta-Analysis” (2022) *Journal of Autism and Developmental Disorders*.

¹²³ DSM-5-TR [515].

2016 reported 16.2% of the children having a diagnosis of ASD, compared to ~ 3% prevalence of ASD among Australian children.¹²⁴ In 2022 a systematic literature review and meta-analysis found that the prevalence of ASD diagnoses in gender diverse / gender incongruent people was 11% as opposed to 1% in the general population. The reasons for the over-representation of children and young people with ASD have not been adequately researched and are not well-understood. However, a 2022 literature review and meta-analysis has concluded that there is:

- A. “a positive relationship between ASD traits and gender dysphoric / gender incongruent feelings among people from the general population;
- B. an increased prevalence of gender dysphoria / gender incongruence in the autistic population; and
- C. an increased prevalence of ASD diagnoses and ASD traits in the gender dysphoria / gender incongruent population.

Overall these findings suggest the existence of a link between ASD and GD/GI that warrants the investigation of mechanisms that could explain that link and the intensification of clinical attention to autistic GD/GI individuals.”¹²⁵

113. The DSM-5-TR recognises the difficulty in differentiating potential co-occurring gender dysphoria from an autistic pre-occupation “because of the concrete and rigid thinking around gender roles and/or poor understanding of social relationships characteristic of autism spectrum disorder.”¹²⁶ There are specific guidelines which apply when diagnosing a child or young person with autism with gender dysphoria which will be discussed later.¹²⁷

114. Professor Hilary Cass, paediatrician, was commissioned by the National Health Service (NHS) in the United Kingdom to undertake a review of gender identity development services in England and Wales. The Cass Review is ongoing and has provided valuable information to assist in better understanding this complex area. As Professor Cass states the reasons for these changes in presentation of children and young people have not been adequately investigated or understood.¹²⁸

Reasons for the changes

Competing discourses lead to different approaches

115. Despite inclusion of the term gender dysphoria in the DSM-5 TR, there is significant debate about what it is. As Dr Hilary Cass¹²⁹ in her interim report into her review of gender identity services in the England and Wales said, in March 2022:

¹²⁴ Tollit (2021) [8].

¹²⁵ Kallitsounaki (2022). (GD/GI means gender dysphoria / gender incongruence)

¹²⁶ DSM-5-TR [520].

¹²⁷ Strang, JF, et al “Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adults.” (2018) Journal of Clinical Child & Adolescent Psychology Vol 47(1) 105-115.

¹²⁸ Cass BMJ (2022) [1].

¹²⁹ Dr Hilary Cass was commissioned by the National Health Service (NHS) in the UK in 2019 to chair a policy working group to review published evidence on the use of hormone treatments in children and young people with gender dysphoria. In 2020 this was extended to conduct an independent review into the broader clinical approach and service model for this group. See Cass BMJ (2022).

At present the professional community does not have a shared understanding about the meaning of gender dysphoria in young people, and the extent to which it can be an inherent and immutable phenomenon, or a more fluid and temporal response to a range of developmental, social, and psychological factors. In the absence of more open discussion about this fundamental question, the research that is available will continue to be interpreted from varying ideological standpoints.¹³⁰

116. The lack of agreement about what gender dysphoria is creates significant issues in the diagnostic process. What is being diagnosed?
117. The diagnosis of and approach to gender identity and gender dysphoria is subject to international controversy. There are two main discourses: what is called the “Gender Affirming Treatment” (which comes from Gender Identity theory) and a more traditional medical or harm minimisation model relying on the principles of evidence-based medicine. These two models have very different ways of conceptualising sex, gender, identity, and gender dysphoria which leads to very different assessments, diagnoses, and treatment approaches.

Gender affirming treatment - novel endocrinological and surgical approach

118. Gender affirming treatment: where affirmation of the child’s gender identity equates with social and medical transition, if the child so desires, to “correct the identity/body mismatch.”¹³¹ Each person is said to be born with a gender identity which is not subject to influence. The gender identity is said to “come into our awareness in the first years of life, usually consolidating by age six.”¹³² The Westmead authors note that although the gender affirmative model “explicitly acknowledges that “gender identity and expression [should be] enabled to unfold over time, as the child matures, acknowledging for fluidity and change”(Hidalgo et al., 2013: 287-288) the available options under this model were strongly influenced and constrained by the imminent approach of puberty.”¹³³ In Australia gender affirming treatment with a focus on the approach of puberty is the dominant model and is promoted by the Australian Association of Professionals in Transgender Health (AusPath), the Royal Children’s Hospital Melbourne and the Australian Standards.¹³⁴
119. Gender affirming treatment is said to be based upon the Dutch model but departs from it, as set out above. Gender affirming treatment represents a significant ideological shift in which a child / young person’s body is altered to more closely align with their subjective psychological current identity. It is an essentialist idea: gender identity just is, and it is not secondary to anything else. The proponents believe that each person is born with a gender identity that is independent of their sex and the child will reveal this gender identity over time. The gender identity is not subject to change or influence. The identity may be male or female or some combination thereof.
120. Gender identity theory, which underpins the model, has gained political and social traction in the last 10-15 years. Professor Kathleen Stock identifies 4 core beliefs¹³⁵:

¹³⁰ Cass BMJ (2022) [1].

¹³¹ Kozłowska (2021) [72].

¹³² Queensland Government, “Information for parents of children diverse in gender or sexuality” (Brochure, January 2019) <<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/CHQ-Gender-clinic-Information-for-parents.pdf>>.

¹³³ Kozłowska (2012) [72].

¹³⁴ Australian Professional Association of Transgender Health (AusPATH).

¹³⁵ Stock (2021) [11].

- (a) Each person has an important inner state called a gender identity.
- (b) For some people, inner gender identity fails to match their biological sex, which is assigned to them at birth by medical personnel. These people are called trans people.
- (c) Gender identity, not biological sex is what makes you a man or woman or neither.
- (d) The existence of trans people generates a moral obligation upon all of us to recognise and legally protect gender identity and not biological sex.

121. Gender identity theory has developed through linguistics¹³⁶ and social theory¹³⁷. Linguist Judith Butler who is very influential in queer theory says that gender is a performance: being a man/male or a woman/female is not a materially stable state but a kind of repeatable performance.¹³⁸ Further, Butler says linguistic categories, including scientific and biological ones, are not a means of reflecting existing divisions in the world, but a rather a means of creating them. That is the categories of man/male and woman/female did not exist before language.¹³⁹ Transwoman and biologist Julia Serano put forward the idea that transwomen are a kind of woman like any other. Transwomen are women because they hold a female gender identity and cis women also have female gender identities, therefore women are defined not by any medical or legal process, or physical features or behaviour, but rather by possession of a female gender identity.¹⁴⁰ The same radical idea applies to men.

122. The gender identity that a person (regardless of age) is said to hold is entirely subjective and therefore not able to be empirically tested or validated. Some argue that the subjective nature of the gender identity creates a significant risk of over-diagnosis. Gender identity is seen as something which is not subject to influence.¹⁴¹

123. Gender identity theory has become the dominant political discourse which informs many governments, universities, and schools, causing potentially unintended consequences for parents and children and young people.

Developmental / biopsychosocial model

124. The more traditional medical view, which I will call a developmental / biopsychosocial model,¹⁴² is described by the clinicians at Westmead:

“This perspective emphasized that children’s conceptions of themselves are still developing through the teenage years and that they can be harmed when clinicians unquestioningly accept the individual child’s assertion of gender identity or when clinicians fail to challenge the child’s beliefs pertaining to that identity or fail to understand the developmental trajectory that had brought the child to what is often a place of distress and suffering. It highlighted that gender

¹³⁶ Stock (2021) [20].

¹³⁷ Stock (2021) [22].

¹³⁸ Stock (2021) [21].

¹³⁹ Stock (2021) [20].

¹⁴⁰ Stock (2021) [22].

¹⁴¹ Queensland Government (2019).

¹⁴² The terms that I have used are likely to be contested.

dysphoria and the child's suffering did not arise de novo but needs to be understood and contextualized in relation to the child and family story."¹⁴³

125. The developmental model uses a biopsychosocial approach to identify and address the child's needs including gender concerns. Proponents of this model are concerned about the poor evidence base for both the certainty of a child / young person's identity and the benefits to the child of the medical pathway - especially when weighed against the risks arising from medicalisation.
126. Decisions about medicalisation are considered best left to adulthood, when the young person's brain matures and they have more life experience to understand the implications of the impacts on future fertility, sexual function etc.

Westmead approach

127. The clinicians who founded the gender service at Westmead Children's hospital and conducted the study used a biopsychosocial (systems) approach. This model looked at the diverse, interrelated biological, psychological, family, social, political, and ecological factors that come together to the emergence of distress and related conditions (such as gender dysphoria). This approach is more in line with the approaches in the UK and Scandinavia in its focus on screening and psychological assistance to address the young person's needs. It does however give the option of a medicalized pathway of endocrine interventions for children and young people, noting concerns about capacity for informed consent.¹⁴⁴ Information about the model used by the current team at Westmead is not available in the published literature or otherwise.
128. There was a significant emphasis on the children and family having psychological assistance during the assessment and diagnostic process and beyond. Clinicians aimed to restore the well-being of the child and the family so that they could make the best decision about treatment pathways for the gender dysphoric child, including endocrinological interventions.¹⁴⁵

Reasons for increased presentations

129. The reasons for the dramatic increase in referrals are the subject of intense debate.

Gender Affirming Treatment

130. Associate Professor Michelle Telfer¹⁴⁶ argues that the increase is because young "trans and gender diverse people" (TGD) feel more comfortable to come out as societal values are changing and there is greater societal acceptance.¹⁴⁷ No evidence is provided to establish this assertion.

¹⁴³ Kozłowska (2021)(b) [73].

¹⁴⁴ From 2017 Australian law allowed medical gender transition for children and adolescents where the child, their parents and the clinicians consent. See discussion on Australian law later in this paper.

¹⁴⁵ Kozłowska (2021)(b) [73]; Elkadi (2023) [3].

¹⁴⁶ Associate Professor Michelle Telfer was the Director of the Gender Service from 2012 to 2022. In 2023 she was appointed acting Chief of Medicine at the RCH for 6 months. A/Prof Telfer was the lead author of the Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents. ("The Australian Standards").

¹⁴⁷ Organizations such as the World Professional Association of Transgender Health (WPATH) and the Australian equivalent, AusPath refer to children and young people as "trans and gender diverse" (TGD) to include non-binary and other gender identities. See Auspath, "Australian Standards of Care and Treatment Guidelines for trans-and Gender Diverse Children and Adolescents Version 1.3" [2].

Further, it does not explain the dramatic change in sex ratio from males to females. When asked about why more females are presenting, the response from gender affirming advocates is that they agree the number of presentations of females and males should be equal. They argue that prejudiced attitudes towards feminine boys prevent them from expressing their authentic selves and attending gender clinics. There is no data to support this assumption. Further, there is not a similar increase in older females.

131. Similarly in SOC 8, the guidelines do not adequately explain the dramatic increase in children and adolescents with gender incongruence.
132. The Australian Standards says that “trans or gender diverse” is part of the natural spectrum of human diversity.¹⁴⁸ Children are said to be “born that way”, despite there being little evidence of a biological factor determining one’s gender identity.¹⁴⁹ Many other clinicians may agree about human diversity, they would at the same time express concern about the dramatic increase in population and change of demographic.
133. The number of gender identities has grown, and the potential is endless as shown by a list of 72 other gender identities currently in use (attached).¹⁵⁰
134. Some gender ideologists go further and argue that sex is not binary. A sexologist Dr Fausto-Sterling argued that there are 5 sexes: male, female, merm, ferm and herm.¹⁵¹

Alternative views

135. As Associate Professor Michael Biggs points out, the assumption in gender identity ideology (and gender affirming treatment) is that these children and young people presenting at gender clinics are “juvenile transsexuals”, whose destiny is fixed.¹⁵²
136. An alternate view is that the vast majority of these children and young people are questioning their identity as a normal part of development. A combination of biological, social, and psychological factors will influence their current identity and its development. Given most children and young people’s transgender identity is likely to be transient and will not persist into adulthood¹⁵³ their current identity should not be cemented, particularly through endocrinological intervention.
137. A developmental / biopsychosocial model notes the dramatic increase and change of case mix requires interrogation as does the likely impact of peer influence.¹⁵⁴ It points to the rigid and outdated sex-stereotype criteria for diagnosis meaning that children who display gender non-conforming behaviour may be labelled “trans” and are therefore at a greater risk of being diagnosed with gender identity concerns.

¹⁴⁸ Australian Standards of Care [2].

¹⁴⁹ Bradley, Susan, “Understanding Vulnerability in Girls and Young Women with High-Functioning Autism Spectrum Disorder” (2022) *Women* 2 64-67 [65].

¹⁵⁰ See Annexure A – Allaraka, Shaziya, “What Are the 72 Other Genders?” (Medicine Net, 2022) <https://www.medicinenet.com/what_are_the_72_other_genders/article.htm>.

¹⁵¹ Fausto-Sterling, Anne, MD, “The Five Sexes” (1993) *The Sciences* Volume 33, Issue 2, March-April. This idea has not been generally accepted in science.

¹⁵² Biggs (2022)(b).

¹⁵³ We will discuss the issue of persistence, but the statement is supported by many studies.

¹⁵⁴ Littman, Lisa “Parent Reports of adolescents and young adults perceived to show signs of rapid onset gender dysphoria” (2018) *PLoS ONE* Vol 14(3) [6].

Understanding increased presentation of neurodiversity

138. It is common ground that there is an overrepresentation of children with ASD presenting with gender identity concerns. This is particularly the case for females.
139. Under the gender affirming model, there is an absence of discussion around the high rates of ASD other than to note an association.¹⁵⁵ Gender affirming practitioners do not consider autism to have any causal relationship with gender dysphoria. Gender dysphoria is not seen as subject to any influence but rather an identity which emerges to reveal authenticity.
140. Critics offer alternate views. Professor Susan Bradley, child psychiatrist who founded the first academic clinic for children and adolescents with Gender Identity Disorder in Canada expressed concern about the trajectory for girls with ASD and the risk of over-diagnosis.

Developmentally, these young girls have typically had trouble making friends and often feel rejected and left out of peer groups. Their interests are often less mature than that of their peers and they do not really understand why peers are not very interested in them as friends. Their self-esteem is usually impacted by this rejection, which becomes particularly acute as they enter adolescence when peer groups become socially very important. They often think of themselves as different in some way that they find hard to explain. Crushes on popular girls are not uncommon in many teens, but, not knowing this, the emotions that are aroused may make these young women feel increasingly “weird”. In the current culture of politically correct affirmation of gender dysphoria, it translates into meaning that you are “trans”, which, for many young women, is less anxiety-provoking than being lesbian. Most have not had a prior history of gender dysphoria but their belief that they have found an answer to their distress, along with their style of rigid thinking, makes it hard to self-reflect in terms of other possible explanations for their feelings. Being welcomed by “trans” advocates acts as the external push. Young women who have gone through this and have subsequently de-transitioned have been very helpful in that they have gained an understanding of their experience and have realized that transitioning did not relieve their original feelings. Most have reported accepting that they are lesbian, especially when they enter into a relationship in which they are accepted for who they are.¹⁵⁶

Increased presentation of co-morbid mental health

Theory of minority stress

141. Gender affirming clinicians claim that the child’s comorbid mental health issues are caused by the discrimination, bullying and social exclusion experienced by trans-identified children and young people.¹⁵⁷ The Royal Children’s Hospital’s website says relevantly:

“Trans and gender diverse children and adolescents have considerably higher rates of depression, anxiety, self-harm and attempted suicide compared to their cis-gender peers. This is due to their experiences of stigma, discrimination, social exclusion, bullying and harassment. Increasing evidence demonstrates that with supportive, gender affirming care during childhood

¹⁵⁵ Australian Standards of Care [9].

¹⁵⁶ Bradley (2022) [65].

¹⁵⁷ Australian Standards of Care [3].

and adolescence, harms can be ameliorated and mental health and wellbeing outcomes can be significantly improved.”¹⁵⁸

142. The claim that “harms can be ameliorated, and mental health and well-being outcomes can be significantly improved”¹⁵⁹ through social and endocrinological interventions is often repeated and highly contested.
143. Critics say the assertion that causation flows in only one direction is overly simplistic but perhaps comforting to parents and children. Are these children suffering from gender dysphoria and their co-morbidities arise from ill-treatment as is suggested? Could they also be children who are suffering from mental health problems, and they believe that transitioning from their sex will address their issues? Could there be a more complex relationship between them? The Westmead clinicians acknowledge the difficulties in untangling gender dysphoria from co-morbid factors and the uncertainties in the available literature on longitudinal outcomes. They reported “the need for ongoing therapeutic work to address unresolved trauma and loss, with the maintenance of subjective well-being and the development of the self.”¹⁶⁰
144. This asserted causal relationship cannot be reconciled with the many children and young people whose co-morbid mental health issues predate their gender questioning.¹⁶¹ It does not account for co-morbid mental health issues that may be caused or exacerbated by other issues such as ASD / ADHD. ASD is associated with higher rates of suicide.¹⁶² Further, it does not contemplate a relationship between gender dysphoria and other conditions such as ASD, which is not well-researched or understood.
145. When co-morbid mental health is characterised as caused by the gender dysphoria it is seen to add weight to the diagnosis and the urgency of treatment. As so many children with gender dysphoria are presenting with complex mental health issues, it is important to examine the underlying biological, psychological, and social causes of the loss of their mental health before determining treatment pathways.
146. In gender affirming treatment, mental health co-morbidities seem to fall into one of two categories, those that are characterised as unrelated to the gender dysphoria and those that are caused by ill treatment arising from the gender incongruence. The risk is that a gender service may only treat the gender dysphoria and other co-morbid mental health and neurodiversity issues are dealt with by another service, such as a Child and Adolescent Mental Health (CAMHS) unit. There may or may not be communication between the two. The gender service may describe itself as multi-disciplinary but that does not equate to the child’s co-morbid mental health or concerns being dealt with by or in conjunction with the gender service and the child being treated holistically.

¹⁵⁸ The Royal Children’s Hospital Melbourne, Adolescent Medicine, Gender Service (Web Page) <<https://www.rch.org.au/adolescent-medicine/gender-service/>>.

¹⁵⁹ Australian Standards of Care [3].

¹⁶⁰ Kozłowska (2021)(b) [71].

¹⁶¹ Levine (2022) [3].

¹⁶² Biggs, Michael, “Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom” (2022) Archives of Sexual Behaviour Vol 51 685–690 (Biggs, 2022(a)) [4].

Developmental / biopsychosocial model

147. The developmental model and the Westmead model consider that there are many biological, psychological, and psychosocial factors influencing the development of identity, including co-morbid mental health and that there can be a complex relationship between them. Under these two models the child / young person's loss of mental well-being, including gender concerns is treated. Clinicians maintain an open mind as to outcome for the young person. Ongoing psychological assistance plays an important role to assist "the young persons to navigate their own development including but not limited to their understanding of their own issues relating to gender and emerging sexuality."¹⁶³

Approaches to medical care

148. The treating practitioner's belief about gender identity will inform the diagnosis and treatment approach.

Psychotherapeutic treatments

149. Prior to 2010-2015 psychotherapy involved helping the child to feel more comfortable in their own body with the belief that gender is quite malleable at a young age and gender dysphoria will likely resolve itself over time. There is a risk that this approach would likely be characterised as a "conversion practice" and would be illegal in some Australian states which have anti-conversion therapy legislation. It is important to note that historically the children were presenting in early childhood with a long way before any further intervention would even be considered.

150. Another psychotherapeutic model called "watchful waiting" was also used extensively. In this model the children and young people engaged in gender exploratory psychotherapy without seeking a particular outcome and given time to see how their identity developed. These psychotherapeutic models were the dominant models until around 2010-2015, correlating with the arrival of the DSM-5 and the move towards medicalisation.

151. Psychological interventions for gender dysphoria have regained prominence and have developed with a modern approach, that is a neutral stance as to outcome. In the last 2 to 3 years Finland, Sweden and the United Kingdom have developed alternative approaches to medicalisation.¹⁶⁴ France and Norway have also amended their approaches to medicalisation emphasising the need for psychological assistance.

152. Criticisms about the lack of therapeutic assistance have also come from proponents of gender affirming care. In 2021 Erica Anderson,¹⁶⁵ clinical psychologist, and Dr Laura Edwards-Leeper,¹⁶⁶ psychologist, in an op-ed in the Washington Post argued that gender exploratory therapy is a key step and questioned by therapists are not providing it. They noted the "skyrocketing" numbers of

¹⁶³ Elkadi (2023) [16].

¹⁶⁴ Elkadi (2023) [4].

¹⁶⁵ Erica Anderson, a clinical psychologist, is a member of the American Psychological Association committee writing the guidelines for working with transgender individuals. She is a former president of the U.S. Professional Association for Transgender Health and a former board member of the World Professional Association for Transgender Health.

¹⁶⁶ Laura Edwards-Leeper, the founding psychologist of the first pediatric transgender clinic in the U.S., is the chair of the Child and Adolescent Committee for the World Professional Association for Transgender Health. She served on the American Psychological Association committee that authored guidelines for working with transgender individuals.

adolescents presenting to gender clinics and the lack of curiosity about how mental health and other issues may be contributing to children's gender dysphoria. They wrote:

"The standards of care¹⁶⁷ recommend mental health support and comprehensive assessment for all dysphoric youth before starting medical interventions. The process, done conscientiously, can take a few months (when a young person's gender has been persistent and there are no simultaneous mental health issues) or up to several years in complicated cases. But few are trained to do it properly, and some clinicians don't even believe in it, contending without evidence that treating dysphoria medically will resolve other mental health issues. Providers and their behavior haven't been closely studied, but we find evidence every single day, from our peers across the country and concerned parents who reach out, that the field has moved from a more nuanced, individualized and developmentally appropriate assessment process to one where every problem looks like a medical one that can be solved quickly with medication or, ultimately, surgery. As a result, we may be harming some of the young people we strive to support — people who may not be prepared for the gender transitions they are being rushed into."

....

".. comprehensive assessment and gender-exploratory therapy is the most critical part of the transition process. It helps a young person peel back the layers of their developing adolescent identity and examine the factors that contribute to their dysphoria. In this stage, patients reflect on the duration of the dysphoria they feel; the continuum of gender; the intersection with sexual orientation; what medical interventions might realistically entail; social media, Internet and peer influences; how other factors (e.g., autism, trauma, eating disorders/body image concerns, self-esteem, depression, anxiety) may help drive dysphoria, rather than assuming that they are always a result of dysphoria; family dynamics and social/peer relationships; and school/academic challenges. The messages that teens get from TikTok and other sources may not be very productive for understanding this constellation of issues."¹⁶⁸

Gender affirming treatment

153. In Australia it appears that the concerns of Anderson and Edwards-Leeper are not engaged with. The entire premise of the gender affirming treatment model is that the child is the only person who truly knows who s/he truly is. The role of medical and other professionals and parents is to affirm socially and medically the child's subjective "felt sense of gender" at the child's pace. Gender is something to be affirmed, not explored, in the sense of being curious about factors that may have led a child to their current gender identity.

154. All decision-making should be led by the child / young person wherever possible¹⁶⁹, with obvious limits that clinicians consider that medication is appropriately timed. There is no age limit prescribed for decision-making, the process is child led. Adherents to this model support the child to "correct" a social / body mismatch by supporting social transition: including change of look,

¹⁶⁷ The WPATH Standards of Care were version 7 at the time of the article.

¹⁶⁸ Anderson, Erica and Edwards-Leeper, Laura "The mental health establishment is failing trans kids: Gender-exploratory therapy is a key step. Why aren't therapists providing it?" The Washington Post 24 November 2021 <https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/?ref=quilllette.com>

¹⁶⁹ Australian Standards of Care [5].

name, pronouns, and medical (endocrinological and surgical) intervention to change the child's body to align more closely with the child's sense of gender.

155. Associate Professor Telfer, from the RCHGS, has described the affirmative model as having 3 elements:

- A. respecting the child / adolescent,
- B. listening to what the child / adolescent has to say and
- C. trusting the child / adolescent knows who they are and what they need.¹⁷⁰

The child's self-determination extends to timing and extent of social and medical transition.

156. The timing of medical intervention is frequently strongly influenced by the imminent approach of puberty.¹⁷¹ Pre-pubescent children may be fast-tracked as puberty approaches.¹⁷²

157. In September 2022, WPATH released Standards of Care 8 which includes a new section on adolescents due to the large number of adolescents presenting at clinics. It also includes new gender identities such as being non-binary or a "eunuch". It removes all age limits for treatments.

158. Proponents of the gender affirming treatment model assert that the science is settled. In a 2022 Family Law case a treating paediatrician gave evidence that:

"The WPATH SOC-8 guidelines are also consistent with the Australian Standards of Care and Treatment recommending puberty suppression to commence at the start of puberty for trans males.

In addition, major US medical and mental health organisations including the following: American Medical Association, American Academy of Pediatrics, American Psychological Association, Federation of Pediatric Organisations (The Federation of Pediatric Organisations consist of The Academic Pediatric Association, American Academy of Pediatrics, American Board of Pediatrics, American Pediatric Society, Association of Medical School Pediatric Department Chairs, Association of Pediatric Program Directors, and Society for Pediatric Research) have publicly published their support for gender affirming care.

Given X's circumstances as described above, combined with the established peer-reviewed and published medical evidence for the therapeutic benefits of gender affirming care, and the fact that all credible national and international treatment guidelines recommend puberty suppression for trans adolescents from early puberty, it is my professional opinion that it would be unethical to deny him access to this treatment."

159. Extraordinarily, the paediatrician failed to alert the Court to the significant international debate about the evidence base for gender affirming care. The medical guidelines of England and Wales,

¹⁷⁰ A/Prof Michelle Telfer speaking at panel on screening of Georgie Stone movie.

¹⁷¹ Kozłowska (2021)(b) [72]. Australian Standards (2018) [10].

¹⁷² The RCHGS has a specific protocol to enable children approaching puberty to be fast tracked.

Sweden, Finland, Norway, and multiple States of the US must be implication be characterised as not credible.

160. It is also worth noting that the Australian Standards (2018) of which Associate Professor Telfer was the lead author say this about the evidence base:

“As mentioned above, the recommendations made in this document are based primarily on clinician consensus along with previously published standards of care from the World Professional Association for Transgender Health (WPATH), treatment guidelines and position statements, and findings from a limited number of non-randomised clinical studies and observational studies. It is clear that further research is warranted across all domains of care for trans and gender diverse children and adolescents, the finds of which are likely to influence future recommendations.”¹⁷³

Developmental / biopsychosocial model

161. Under a developmental / biopsychosocial approach the first line treatment is psychological assistance to similarly explore the reasons for the child’s loss of wellbeing and a biopsychosocial approach is taken to the child / young person’s mental health needs, including neurodiversity. The aim is to help the child / young person develop a deeper understanding of themselves and restore their well-being. An open mind is held as to outcome. The psychological assistance is referred to as gender exploratory therapy, which will be discussed further below.
162. Medical interventions for gender dysphoria are seen as risky and experimental with asserted benefits not supported by evidence. Due to the lack of evidence base they are to be avoided if at all possible. This model holds serious concerns about the capacity of children and young people to give informed consent to the impacts of medical treatment on their future fertility, brain development, bone density, bodily health, and sexual function. Some proponents of this model would rule out medicalisation of children and young people and others allow it under certain strict conditions. The difficulty even with an approach of allowing medicalisation under ‘strict conditions’ is that there is no diagnostic tool for identifying those who will inevitably go on to lead a transgender life as an adult and those children or teenagers who will later become more comfortable with their sex.
163. The clinician, not the patient, is responsible for assessment, diagnosis, and treatment. Importantly a diagnosis of gender dysphoria does not inevitably lead to social and/or endocrine interventions.
164. Practitioners adopting this model are almost certainly not working in gender affirming clinics, but more likely to be in private practice.

Westmead model

165. The practitioners at Sydney’s Westmead Children’s Hospital Gender Service acknowledged the concerns of the developmental model. They report that many children and their parents were seeking medical intervention as they equated affirmation with medical intervention and believed their suffering would be completely alleviated with medical treatment.¹⁷⁴ Due to their clients presenting with significant co-morbid mental health issues, adverse childhood experiences and the

¹⁷³ Australian Standards (2018) [2]

¹⁷⁴ Kozłowska (2021)(b) [84].

significant risks of treatment, the adopted a comprehensive assessment process, involving 4 steps:¹⁷⁵

step 1: initial phone screen triage by clinical psychologist and later a nurse consultant. Only children who potentially met diagnosis for gender dysphoria and were under 16 years were screened in.

step 2: first-level screening assessment including psychosocial assessment and puberty staging undertaken by a paediatrician.

Step 3: comprehensive psychiatric biopsychosocial assessment (individual and family) with psychiatrist, psychologist, and registrar. A pre-requisite to referral to stage 3 was current engagement with a psychologist, psychiatrist, or other qualified therapist). As children and the family would require ongoing psychological support to work through the issues that had contributed to the child's distress and presentation to the gender service, regardless of the outcome of the psychological medicine assessment.

Step 4: the children / young people who were diagnosed with gender dysphoria and who were actively seeking medical intervention, were referred to a paediatric endocrinologist for consideration for menstrual management or puberty suppression.¹⁷⁶

Australian Standards of Care

166. Currently, most if not all of the paediatric gender clinics in Australia offer gender affirming treatment. The gender affirming treatment model is a narrow model of social and medical transition which is prescribed by the 'Australian Standards of Care and Treatment guidelines for Trans and Gender Diverse Children and Adolescents'¹⁷⁷ ("the Australian Standards").

167. Critics note that the title of the Australian Standards is misleading as there are in fact no official or authorised government-commissioned standards for assessing or treating gender dysphoria. The so-called Australian Standards of Care are a position statement which was published in the Medical Journal of Australia in 2019.¹⁷⁸

168. The Australian Standards were first released in February 2018. Associate Professor Michelle Telfer was the lead author. The Australian Standards are said to have been based upon the World Professional Association of Transgender Health (WPATH) Standards of Care version 7 (2013) which in turn were based upon the Dutch protocol.¹⁷⁹ The Australian Standards sets out the development process as the first draft was based on the WPATH Standards of Care. They were

¹⁷⁵ There is no evidence in published literature whether the current team at the Westmead Children's Hospital Gender Service continue to follow this model.

¹⁷⁶ Elkadi (2023) [3].

¹⁷⁷ Australian Standards of Care.

¹⁷⁸ Elkadi (2023) [5]; See Telfer, MM, MA Tollit, CC Pace, and KC Pang, "Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents" (2019) Medical journal of Australia Vol 209(3) 132–136.

¹⁷⁹ The most recent is called "SOC8" which was released in September 2022. Elkadi (2023) [2].

then reviewed by “TGD¹⁸⁰ support organisations, TGD children, adolescents and their parents” and further feedback was then sought from clinicians across Australia.¹⁸¹

169. The final document was endorsed by the Australian and New Zealand Professional Association for Transgender Health. Associate Professor Michelle Telfer, the lead author of the Australian Standards, was president of AusPath from September 2018 until July 2020 and an executive member and Vice-President from September 2014 to September 2018. She was also the head of the RCHGS from 2012-2022, which in 2021 was Australia’s largest paediatric gender service.¹⁸²

170. Critics have raised concerns about the same clinicians being involved in the development of the Dutch protocol, WPATH Standards and Endocrine Guidelines. The concern is that each group’s development of their clinical recommendations and affirmation of the other’s approach is not truly independent.

171. The following table shows the cross-over of people in the 3 organisations.

2006 Dutch Protocol ¹⁸³	2001 WPATH Guidelines (SOC 6) ¹⁸⁴	2009 Endocrine Guidelines ¹⁸⁵
<p>Authors: <u>Henriette A Delemarre-van de Waal</u> (Amsterdam Gender Clinic / VU Hospital, Amsterdam) <u>Peggy T Cohen-Kettenis</u> * (Amsterdam Gender Clinic/VU Hospital in Amsterdam)</p> <p>Financial Support from Ferring Pharmaceuticals</p>	<p>Committee members: <u>Walter Meyer III</u> (**) Walter O. Bockting <u>Peggy Cohen-Kettenis</u>* <u>Louis Gooren</u>* 14 other members</p> <p>** President of WPATH *WPATH board member</p>	<p>Authors: Wylie C Hembree <u>Peggy Cohen-Kettenis</u>* <u>Henriette Delemarre-van de Waal</u>* <u>Louise Gooren</u>* <u>Walter Meyer 3rd</u> ** Norman Spack Vin Tangpricha Victor Montori</p>

172. Arguably, these concerns are relevant to Australia with the connections between the authors of the Australian Standards, RCHGS and AusPath.

173. AusPath states that it has a majority of trans directors on its board and all sub-committees have trans health professionals.¹⁸⁶ While it may be admirable for clinical practice to be informed by lived experience there are concerns about the mix of advocacy and medical recommendations. A significant criticism of GIDS in the UK was its close association with advocacy group Mermaids and the extent of Mermaid’s influence on the decision-making in the service.¹⁸⁷

¹⁸⁰ Trans and gender diverse.

¹⁸¹ Telfer (2019) [132].

¹⁸² Tollit (2021) [1]

¹⁸³ Delemarre-van de Waal, H and Cohen-Kettenis, PT “Clinical Management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects” (2006) *European Journal of Endocrinology* (2006) 155 S131-137 [131]

¹⁸⁴ The Harry Benjamin International Gender Dysphoria Association’s Standards of Care For Gender Identity Disorders, Sixth Version (February, 2001)

¹⁸⁵ Hembree, WC, Cohen-Kettenis, P, Delemarre-van de Wal, H, Gooren LJ, Meyer, WJ et al “Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline.” (2009) *Journal of Clinical Endocrinol Metabolism* 2009; 94(9):3131-54

¹⁸⁶ AusPath “Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy” (2022) [3]

¹⁸⁷ Barnes, Hannah, “Time to Think: The Inside Story of the Collapse of the Tavistock’s Gender Service for Children” (Swift, 2023).

174. From 2020 onwards there has been an increase in the intensity of the debate. Critics are informed by important international meta reviews principally from the UK and Scandinavia and Australian studies which cast doubt upon gender affirming treatment and the quality of the evidence base underpinning it.

175. In 2022, AusPath released “Australian Informed Consent Standards of Care for Commencing and Managing Gender Affirming Hormone Therapy” (Informed Consent Standards). The Informed Consent Standards reinforce AusPath’s support for a gender affirming treatment, despite international and national debate within the medical profession and significant contrary medical evidence. The AusPath president and vice-president have confirmed their commitment to client led medicalisation:

“In 2022 the evidence is clear that medical gender affirmation, for those who seek it, is clinically relevant and medically necessary. Access to hormones improves quality of life and strengthens wellbeing, and denial of care dramatically impacts the health of trans people of all genders.”¹⁸⁸

“...we know that these national guidelines will save lives.”¹⁸⁹

“These Standards of Care are intended to assist and enable clinicians across Australia to better meet the medical gender affirmation needs of their trans women, trans men and non-binary patients.”¹⁹⁰

The guidelines “unapologetically centre the trans person seeking hormonal intervention and empower the clinician to facilitate this access.”¹⁹¹

“...trans patients are the experts of their own lives and the final authority on their own gender.”¹⁹²

176. The Westmead Hospital clinical team considered the WPATH Guidelines and the Dutch protocol, and “found that the evidence base for all aspects of treatment was sparse, especially relating to long term outcomes.”¹⁹³ The authors of the Australian Standards themselves acknowledge the lack of high-quality evidence to support their recommendations for the Australian Standards:

“The scarcity of high-quality published evidence on the topic prohibited the assessment of level (and quality) of evidence for these recommendations.”¹⁹⁴

177. The Australian Standards (and Informed Consent Standards) promote social and medical affirmation of gender identity, which as the Westmead clinicians describe, is just one opinion in a range of opinions as part of ongoing medical discourse.¹⁹⁵ In almost all cases coming before the Court, medical affirmation is presented as the only model.

¹⁸⁸ AusPath (2022) [3].

¹⁸⁹ AusPath (2022) [3].

¹⁹⁰ AusPath (2022) [3].

¹⁹¹ AusPath (2022) [3].

¹⁹² AusPath (2022) [4].

¹⁹³ Elkadi (2023) [2].

¹⁹⁴ Telfer (2019) [132]-[133].

¹⁹⁵ Elkadi (2023) [6].

178. The Australian Standards provide the basis of most information to Governments, parents, children, schools and the community about gender identity, dysphoria and treatment pathways in Australia.

Changing international landscape

Finland

179. The Council for Choices in Health Care in Finland, after meeting for 12 months to develop recommendations for treatment of children with gender-related distress, released recommendations in 2020. The recommendations emphasised the importance of psychosocial support (including assessment and any necessary treatment with psychiatrist and psychologist) and restriction of assessment for medical interventions to specialised, multi-disciplinary, tertiary-units at two hospitals. They also ruled out surgical interventions for minors.¹⁹⁶

180. After publication of the Finnish guidelines, the clinicians in the two gender services have required that children and adolescents must complete the following before undertaking the full diagnostic assessment for gender dysphoria and eligibility for medical interventions:

- A. completion of psychosocial intervention to support identity exploration;
- B. treatment to remission of any severe mental disorders; and
- C. the young person must have entered at least the early stages of puberty.¹⁹⁷

Sweden

181. In 2021 the Swedish National Board of Health and Welfare (NBHW) published guidelines which represented a significant departure from previous guidelines in 2015. The guidelines have been updated in 2022 reflecting a more conservative approach to treatment of gender related distress in young people.

“The NBHW deems that the risks of puberty suppressing treatment with GnRH-analogues and gender affirming hormonal treatment currently outweigh the possible benefits and the treatment should be offered only in exceptional cases. This judgment is based mainly on 3 factors: the continued lack of reliable scientific evidence concerning the efficacy and safety of both treatments, the new knowledge that detransition occurs amount young adults, and the uncertainty that follows from the yet unexplained increase in the number of care-seekers, an increase particularly large among adolescents registered as female at birth.”¹⁹⁸

182. The exceptional cases must meet 3 criteria:

- A. Onset of gender related distress in childhood;
- B. Persistence over time; and
- C. High levels of distress with the commencement of puberty.¹⁹⁹

¹⁹⁶ Elkadi et al (2023) [4].

¹⁹⁷ Elkadi et al (2023) [4].

¹⁹⁸ Elkadi et al (2023) [4].

¹⁹⁹ Elkadi et al (2023) [4].

183. The guidelines emphasise the importance of complex multidisciplinary assessments within specialised setting and medical treatment to take place within a research framework to increase knowledge.²⁰⁰

Norway

184. In March 2023, the Norwegian Healthcare Investigation Board recommended that Norway follow Sweden, Finland, and England in restricting youth access to gender transitions due to a number of concerns. First, the rapid rise of gender dysphoria in adolescents, the high burden of mental illness, high prevalence of neurocognitive conditions, the lack of evidence base and interventions when identities are still forming. The report noted that the age of consent for sterilization in Norway is 25 years.²⁰¹

France

185. The National Academy of Medicine in France, noted the position of the Swedes and released a press release in February 2022, stating that “a great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects, and even serious complications, that some of the available therapies can cause.” Although hormonal interventions are permitted in France with parental authorisation at any age “the greatest reserve is required in their use given the side effects such as impact on growth, bone fragility, risk of sterility, emotional and intellectual consequences and, for girls, symptoms reminiscent of menopause.”²⁰²

England and Wales

186. Arising from similar concerns, in 2020 the National Health Service (NHS) commissioned an independent review into gender identity services for children and young people in England and Wales, the Cass Review. Professor Hilary Cass, paediatrician, past president of the Royal College of Paediatrics and Child Health leads the review. An interim report was released in 2022 and the recommendations are summarised as follows:²⁰³

- A. Closure of the Gender Identity Development Service for children and young people (“GIDS”), [which was the largest gender identity service for children and young people in the world.] Open regional centres led by experienced providers of tertiary paediatric care to ensure focus on child health and development, with strong links to mental health services. These will generally be specialist children’s hospitals.
- B. Services should have established academic and education functions to ensure ongoing research is embedded within the service delivery model.
- C. Services should have an appropriate multi-professional workforce to enable them to provide an integrated model of care that manages the holistic needs of this population.

²⁰⁰ Elkadi et al (2023) [4].

²⁰¹ Latest from SEGM < <https://www.segm.org/>>.

²⁰² Academie Nationale de Medicine, “Medicine and gender transidentity in children and adolescents” (Press Release, 25 February 2022) < <https://www.academie-medicine.fr/la-medicine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en>>.

²⁰³ Elkadi (2023) [5].

- D. Staff should maintain a broad clinical perspective to embed the care of children and young people with gender uncertainty within a broader child and adolescent health context. Not all children want or require a medical pathway, and the staff require an appropriate skill mix to support different pathways.
187. The NHS accepted Professor Cass's recommendation of the closure of the GIDS and this is due occur in September 2023.
188. In 2022 the NHS released an interim specification guidance providing:²⁰⁴
- A. Clinical management approach should be open to exploring all developmentally appropriate options experiencing gender incongruence.
 - B. Being mindful this may be a transient phase, particularly for pre-pubertal children.
 - C. There are a range of pathways and outcomes.
 - D. Primary intervention for children and young people is psychosocial and psychological support and intervention.
 - E. The main objective is to alleviate distress associated with gender dysphoria and promote the young person's global functioning and wellbeing.
 - F. The relationship between gender incongruence and co-existing mental health, neuro-developmental and/or family or social complexities may not be readily apparent and will often require careful exploration.
189. In 2022, the Association of Clinical Psychologists in the United Kingdom released a statement that the Cass Review found the following:²⁰⁵
- A. GIDS took an approach that was predominantly affirmative, rather than exploratory.
 - B. Assessment was not standardised.
 - C. Mental health and neurodevelopmental assessments were not conducted comprehensively, leading to "diagnostic overshadowing" whereby gender dysphoria was attended to without taking into account any co-existing diagnoses.
 - D. Safeguarding procedures were lacking.
190. ACPUK also noted the change in demographic of children presenting with increase of females presenting at 3 x the rate of males. "Psychologists will need to carefully consider a complex array of social, political and cultural factors, as well as individual factors, when developing clinical formulations of distress with young people and their families."²⁰⁶ They note that many young people who experience same-sex attraction will question their gender or experience gender dysphoria and behave in gender non-conforming ways. The possible relationship between

²⁰⁴ NHS England, 2022.

²⁰⁵ Association of Clinical Psychologists UK "The Cass Review and its implications: psychologically informed considerations for the future" (Blog, October, 2022) < <https://acpuk.org.uk/the-cass-review-and-its-implications-psychologically-informed-considerations-for-the-future/>>.

²⁰⁶ ACPUK (2022) [1].

homophobia and gender identity exploration and dysphoria needs to be better understood.²⁰⁷ The health needs of detransitioners will also need to be addressed.²⁰⁸

191. In contrast, AusPath's statement in relation to the Cass Review considered that Australia was already acting largely in line with the recommendations of regional centres and psychological/psychiatric assessment being done before commencing medical treatment.²⁰⁹ AusPath expressed concern about statements in the review talking about "causation of gender incongruence. Such language is often used as a preamble to conversion therapy". The board does not support exploratory therapy which "is often used as a euphemism for conversion therapy".²¹⁰ AusPath was also concerned about statements questioning an affirmative approach to gender affirming care. AusPath rejected criticism of the international evidence in support of puberty blockers, saying "There is also accumulating evidence of the harm that ensues from denying puberty blockers and gender affirming hormone treatment."²¹¹

D Gender affirming treatment - Stages of Treatment

Stage 1: Puberty Suppression

What is puberty?

192. Dr William Malone adult and adolescent endocrinologist who gave expert evidence in *Bell v Tavistock* and described puberty as:

"Arguably the most significant developmental time for a human in terms of physical and psychosocial development. It is an integrated process of physical development, sexual maturity and as that occurs the individual has age-appropriate psychosocial interactions with peers and essentially figures out who they are and how they fit into being a human being, fit into their culture and society. It is a profoundly significant development process the transition from childhood to adulthood. It couldn't be more important in terms of an individuals' physical and mental health."²¹²

193. In terms of physical development, during puberty children develop secondary sex characteristics (breasts and periods for females and facial hair, deepening of voice, Adam's apple, broadening of shoulders, body hair and odour, for males.) Puberty suppression is used to avoid the further feminization or masculinization of the child's body. In the case of females, to avoid the young person later needing to undergo bilateral mastectomy, often called "top surgery" or "chest masculinisation". In the case of males, to avoid development of physical features which are likely to make it difficult to "pass" as a woman in society.

194. Puberty is discussed according to Stages:

²⁰⁷ ACPUK (2022) [2].

²⁰⁸ ACPUK (2022) [2].

²⁰⁹ AusPath (2022(b)).

²¹⁰ AusPath (2022(b)) [1]-[2].

²¹¹ AusPath (2022(b)) [2].

²¹² "Episode 5: Hormonal Interventions — from Fringe to Mainstream: A conversation with Dr. Will Malone" Gender: a Wider lens podcast (Stella O'Malley, 8 January 2021).

Tanner Stages in females	Age at the start	Noticeable changes
Stage 1	After the 8th birthday	None
Stage 2	From age 9–11	Breast “buds” start to form; pubic hair starts to form
Stage 3	After age 12	Acne first appears; armpit hair forms; height increases at its fastest rate
Stage 4	Around age 13	First period arrives
Stage 5	Around age 15	Reproductive organs and genitals are fully developed

Tanner Stages in males	Age at the start	Noticeable changes
Stage 1	After the 9th or 10th birthday	None
Stage 2	Around age 11	Pubic hair starts to form
Stage 3	Around age 13	Voice begins to change or “crack”; muscles get larger
Stage 4	Around age 14	Acne may appear; armpit hair forms
Stage 5	Around age 15	Facial hair comes in

195. A gonadotrophin releasing hormone analogue (GnRHA), usually “Lucrin”, is administered by intramuscular injection every 3 months. Associate Professor Biggs states that GnRHA drugs are licensed to treat precocious puberty in children, endometriosis and uterine fibroids in women, advanced prostate cancer and sexual deviance in men, with its impact on erotic interest. GnRHA drugs have never been licensed as a treatment for gender dysphoria.²¹³ In Australia, no drugs have been approved by the Therapeutic Goods Administration (TGA) or subsidised by the Pharmaceutical Benefits Scheme (PBS) for treatment of gender dysphoria. All prescriptions are off label.²¹⁴

196. It will be important to know if the child has a needle phobia and how this is proposed to be managed. Children with needle phobias were excluded from a UK study due to concerns about compliance with the treatment regime.²¹⁵ Another concern might be an increase in the child’s anxiety. In a recent Family Law case, a child with a needle phobia was admitted as a day patient,

²¹³ Biggs (2022)(b) [2].

²¹⁴ Elkadi (2023) [6].

²¹⁵ Carmichael (2021) [4].

was medically sedated and missed days of school to have a simple blood test. One parent was seeking for this child to have puberty blockers that would have involved regular injections.

Asserted benefits of Puberty blockade

197. In 2022, the president and vice-president of AusPath stated in the newly released Standards of Informed Consent for medical treatment for medical affirmation of transgender identity:

“In 2022 the evidence is clear that medical gender affirmation, for those who seek it, is clinically relevant and medically necessary. Access to hormones improves quality of life and strengthens wellbeing, and denial of care dramatically impacts the health of trans people of all genders.”²¹⁶

Impact on gender dysphoria

198. It may be asserted that puberty blockers will have a positive impact on the child’s gender dysphoria. The Dutch studies found that gender dysphoria remained the same for males on puberty blockers and worsened for females. The current scientific data does not support this conclusion. A 2021 UK study of 44 adolescents aged 12-15 years with persistent and severe gender dysphoria were administered puberty blockers (GnRHa). There was follow up of all at 12 months and 24 patients at 24 months. The findings were no changes in psychological function and “[g]ender dysphoria and body image changed little across the study.” The latter finding was said to be expected as puberty blockers only prevent the further masculinization or feminisation of the body, rather than changing the body in the child’s favoured direction.²¹⁷ All but one patient continued to cross-sex hormones,²¹⁸ which is consistent with their gender dysphoria not improving.

199. The number of children having their puberty blocked has dramatically increased in the last 10-15 years and yet they almost invariably continue to cross-sex hormones.²¹⁹ The reasons for this need to be better understood.²²⁰

200. There are psychosocial aspects to blocking puberty that the Court may consider, such as how blocking a child’s puberty may impact upon their relationship with their peers. For example, a female with a male transgender identity whose puberty is blocked, will not look like her male peers who are going through puberty. She will not attain a similar height, develop facial hair, change muscle and fat distribution, and have her voice change. As she is not developing sexually, she is unlikely to share their developing sexual interests. Similarly for a male, puberty blockade means that he won’t go through the physical and emotional changes and hormones surges of any of his peers, including development of sexuality. Puberty occurs at a particular age range and is also a psychosocial experience experienced with peers within a cultural context. If a young person ceases cross-sex hormones in their 20s and undergoes pubertal development at that time, what is the impact of experiencing these changes much later?

²¹⁶ AusPath (2022) [3].

²¹⁷ Carmichael (2021).

²¹⁸ Carmichael (2021) [1].

²¹⁹ To be discussed below.

²²⁰ Cass Interim Report [38] [3.31].

201. Puberty blockade may cause a child / young person to feel further alienated from peers as it may make it harder for a child to relate to the experience of his/her peers. In a 2021 German study²²¹ which looked at the impact of social transition on psychological functioning found that “[p]eer problems and worse family functioning were significantly associated with impaired psychological functioning, whilst the degree of social transition did not significantly predict the outcome.”²²²

Positive impact on mental health / avoidance of negative impact

202. In a 2022 Family Law case the child’s treating paediatrician gave evidence that:

“If [child] is denied access to care in the longer term, it will likely cause [child] emotional pain and distress for the remainder of his life as a male. It will subject him to the stigma, discrimination, bullying, harassment and abuse that the transgender community experience on a regular basis in our society. Adolescents with gender dysphoria who do not have access to gender affirming treatment suffer from very high rates of anxiety, depression, self-harm and suicide attempts.”

There is “established peer-reviewed and published medical evidence for the therapeutic benefits of gender affirming care”²²³

A recent study “demonstrated the long-term benefit of accessing puberty suppression during adolescence.”

203. The evidence does not support these conclusions. A 2015 study, Costa et al found no significant difference after 18 months in psychosocial functioning between a group of adolescents receiving puberty blockers plus psychological support, and a group receiving only psychological support.²²⁴ The Costa study was relied upon by the Finnish gender identity services in support of their policy change which now recommends psychotherapy alone as first line treatment.²²⁵

204. As set out above, the Carmichael study which sought to replicate the Dutch foundational studies, found that puberty suppression after 2 years did not produce any positive effects on mental health as there was no change in psychological function.²²⁶

“Young people experienced little change in psychological functioning across the study. We found no differences between baseline and later outcomes for overall psychological distress as rated by parents and young people, nor for self-harm. Outcomes that were not formally tested also showed little change.”²²⁷

²²¹ Sievert, Elisabeth, et al “Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria” (2021) *Clinical Child Psychology and Psychiatry Journal* Vol 26(1) 79-95.

²²² Sievert (2021) [79].

²²³ The reference is to WPATH Standards of Care 8, Australian Standards of Care, International Endocrine Society Clinical Practice Guidelines (2017).

²²⁴ Clayton, et al “Commentary: The Signal and the Noise – questioning the benefits of puberty blockers for youth with gender dysphoria – a commentary on Rew et al” (2021) *Child and Adolescent Mental Health* 27(3) 259-262 [2]; (Biggs (2022)(b) [9] commenting on Costa, R, et al “Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria” (2015) *Journal of Sexual Medicine* Vol 12 2206-2214.

²²⁵ Clayton (2021) [2].

²²⁶ Carmichael (2021) [2].

²²⁷ Carmichael (2021) [41].

205. The authors stated this contrasted with the Dutch studies which they asserted had found improved psychological functioning.²²⁸ Importantly Carmichael et al concluded “Larger and longer-term prospective studies using a range of designs are need to more fully quantify the benefits and harms of pubertal suppression in GD.”²²⁹

206. In March 2021, the UK’s National Institute for Health and Care Excellence (NICE) published systematic reviews of evidence of using puberty blockers (GnRH analogues) (PB) and cross-sex hormones (CSH) to treat gender dysphoria. The review failed to find convincing evidence that puberty blockers and cross-sex hormones are helpful. The NICE reviewers noted in relation to puberty blockers:

“The results of the studies that reported impact on the critical outcomes of gender dysphoria and mental health (depression, anger and anxiety), and the important outcomes of body image and psychosocial impact (global and psychosocial functioning), in children and adolescents with gender dysphoria are of very low certainty using modified GRADE. They suggest little change with GnRH analogues from baseline to follow-up.

Studies that found differences in outcomes could represent changes that are either of questionable clinical value, or the studies themselves are not reliable and changes could be due to confounding, bias or chance.”²³⁰

207. GRADE is said to be the most widely adopted tool for grading the quality of evidence and making treatment recommendations worldwide. GRADE has four levels of evidence quality or certainty: very low, low, moderate and high. When the quality of the evidence is very low certainty, “there is a high likelihood that patients will not experience the effects of the proposed interventions.”²³¹

208. In a letter to the British Medical Journal, Drs Pang and Telfer criticise the NICE review alleging that it ignores two decades of clinical experience as well as existing evidence showing the benefits of these hormonal interventions. The authors rely upon 3 listed reviews.²³² Dr Alison Clayton, psychiatrist, having read beyond the 3 systematic reviews relied upon by Drs Pang and Telfer in support of gender affirming medical treatment, concludes:

“A reading of these reviews reveals consistent comments noting the scarce and poor-quality empirical evidence base underpinning the use of puberty blockers and GAHT. These reviews emphasize that the reviewed studies are mostly subject to high risk of bias and confounding and more rigorous evidence is required.”²³³

209. It is not possible to analyse the various reviews in the paper. It is notable however that the systematic review by NICE is consistent with the Florida Medicaid Review and the policy changes

²²⁸ Carmichael (2021) [19]-[20].

²²⁹ Carmichael (2021) [2].

²³⁰ “Evidence review: Gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria.” National Institute of Health Care Excellence (NICE) October 2020 [45] <https://cass.independent-review.uk/nice-evidence-reviews/> (as part of The Cass Review).

²³¹ Levine (2022) [7].

²³² Pang, KC, J Wiggins and MM Telfer, “Gender identity services for children and young people in England” (2022) British Medical Journal Vol 377 825.

²³³ Clayton, A, “Commentary on Levine et al: A Tale of Two Informed Consent Processes” (2022) Journal of Sex & Marital Therapy Vol 49(1) 88-95. <https://doi.org/10.1080/0092623X.2022.2070565> (Clayton (2022)(b)) [4]

of the Swedish and Finnish health systems after the Swedes completed their own systematic review.

210. A 2022 study by Tordoff et al from the Seattle Children’s Gender Clinic, studied 104 young people aged 13 to 20 years, mean age 15.8 years who were seeking gender affirming care from August 2017 to June 2018. The study assessed the patients at 3, 6 and 12 months who were given puberty blockers or cross-sex hormones. The study concluded that gender affirming medical interventions were associated with lower odds of depression and suicidality over 12 months.²³⁴

211. Criticisms of the Tordoff study include:

- A. The authors did not differentiate between the two interventions, puberty blockers and cross-sex hormones, so one could not differentiate the impact.
- B. The actual data for the youth showed no change over time.
- C. The false claim of improvement derived from statistical comparison with youth from a clinic who had not received endocrinological interventions, whose mental health had worsened over time.
- D. The comparison group number 6 after 12 months.
- E. One obvious explanation is that the clinicians were following the WPATH recommendations against commencing medical intervention when an adolescent is experiencing an acute mental health crisis.

212. Jesse Signal, journalist, in a critique in 2022 of Tordoff concluded in relation to alleged improvement, that there was not statistical improvement from baseline to final wave of data collection. The PB/GAH children received gender affirming treatment and the “none” were the comparison group.

Time Point:	Baseline		3 Months		6 Months		12 Month	
<i>Exposure:</i>	<i>PB/GAH</i>	<i>None</i>	<i>PB/GAH</i>	<i>None</i>	<i>PB/GAH</i>	<i>None</i>	<i>PB/GAH</i>	<i>None</i>
N	7	92	44	38	59	24	57	6
Outcomes (no.,%)								
Moderate to Severe Depression	4 (57%)	54 (59%)	24 (55%)	29 (76%)	33 (56%)	13 (54%)	32 (56%)	5 (83%)
Moderate to Severe Anxiety	4 (57%)	47 (51%)	23 (52%)	23 (61%)	28 (48%)	10 (42%)	29 (51%)	4 (67%)
Self-harm or Suicidal Thoughts	3 (43%)	41 (45%)	13 (30%)	21 (55%)	25 (42%)	11 (46%)	21 (37%)	5 (83%)

213. At baseline, 59% of the treatment-naive children experienced moderate to severe depression. Twelve months later, 56% of the children on gender affirming treatment experienced moderate to severe depression. At baseline, 45% of the treatment-naive children experienced self-harm or suicidal thoughts. Twelve months later, 37% of the children on gender affirming treatment did. These are not meaningful differences: The children in the study arrived with what appear to be

²³⁴ Tordoff, D, et al, “Mental Health Outcomes in Transgender and Nonbinary Receiving Gender-Affirming Care.” (2022) JAMA Network Open Vol 5(2).

alarming high rates of mental health problems, many of them went on blockers or hormones, and they exited the study with what appear to be alarmingly high rates of mental health problems.²³⁵

214. Recently, the Florida Agency for Care Health Administration requested that the Division of Florida Medicaid review the treatment of gender dysphoria. To conduct the review, Medicaid engaged 5 clinical and technical expert assessments in the areas of: health care research, clinical psychology, plastic surgery, paediatric endocrinology and bioethcis. The 5 reports were released in May 2022, and the Florida Medicaid released its report on 2 June 2022.²³⁶

215. The Florida Medicaid report says:

“Available medical literature provides insufficient evidence that sex reassignment through medical intervention is a safe and effective treatment for gender dysphoria. Studies presenting the benefits to mental health, including those claiming that services prevent suicide, are either low or very low quality and rely on unreliable methods such as surveys and retrospective analyses, both of which are cross-sectional and highly biased. Rather, the available evidence demonstrates that these treatments cause irreversible physical changes and side effects that can affect long-term health.”

216. Florida Medicaid determined:

“the research supporting sex reassignment treatment is insufficient to demonstrate efficacy and safety. In addition, numerous studies, including the reports provided by the clinical and technical experts listed above, identify poor methods and the certainty of irreversible physical changes. Considering the weak evidence supporting the use of puberty suppression, cross-sex hormones, and surgical procedures when compared to strong research demonstrating the permanent effects they cause, these treatments do not conform to GAPMS²³⁷ and are experimental and investigational.”

217. Drs Brignardello-Petersen and Wiercioch are experts in health research methodology and specialise in “evidence synthesis to support decision-making” prepared a report on the quality / certainty of the evidence in relation to the effects of gender affirming therapies.²³⁸ The authors conducted a review of 61 systematic reviews, prioritised the most useful providing evidence for each of the outcomes. They abstracted the data from the systematic reviews, synthesised the best

²³⁵ Signal, Jesse, “Researchers Found Puberty Blockers And Hormones Didn’t Improve Trans Kids’ Mental Health At Their Clinic. Then They Published a Study Claiming The Opposite: A critique of Tordoff et al” (2022) <<https://jessesignal.substack.com/p/researchers-found-puberty-blockers>>.

²³⁶ Florida Medicaid, “Generally Accepted Professional Medical Standard on Determination on the Treatment of Gender Dysphoria” (2022). The 5 specialist studies were: Health care research: Brignardello-Petersen and Wiercioch performed a systematic review that graded a multitude of studies. Clinical psychology: Cantor provided a review of literature on all aspects of the subject, covering therapies, lack of research on suicidality, practice guidelines, and Western European coverage requirements. Plastic surgery: Lappert provided an evaluation explaining how surgical interventions are cosmetic with little to no supporting evidence to improve mental health, particularly those altering the chest. Pediatric endocrinology: Van Meter explains how children and adolescent brains are in continuous phases of development and how puberty suppression and cross-sex hormones can potentially affect appropriate neural maturation. Bioethics: Donovan provides additional insight on the bioethics of administering these treatments, asserting that children and adolescents cannot provide truly informed consent.”

²³⁷ Generally Accepted Professional Medical Standards.

²³⁸ Brignardello-Petersen and Wiercioch, “Effects of gender affirming therapies in people with gender dysphoria: evaluation of the best available evidence” (2022). Dr Romina Brignardello-Petersen is Assistant Professor at the Department of Health and Research Methods, Evidence, and Impact at McMaster University. Dr Wojtek Wiercioch is Postdoctoral Fellow at the Department of Health and Research Methods, Evidence, and Impact at McMaster University.

available evidence for each of the outcomes and assessed the certainty of the evidence using the GRADE system. The authors concluded in relation to puberty blockers they said that as there have been no controlled studies, comparing those with GD using puberty blockers with those with GD who have not,

“it is unknown whether people with gender dysphoria who use puberty blockers experience more improvement in gender dysphoria, depression, anxiety, and quality of life than those with gender dysphoria who do not use them.”²³⁹

218. In relation to suicidality they concluded, “[t]here is very low certainty about the effects of puberty blockers on suicidal ideation.”²⁴⁰

219. The 2023 Westmead study found that psychiatric co-morbidity did not go away over time, including with those with gender affirming medical treatment. 88% (44/50) were receiving treatment for ongoing mental health concerns, 4-9 years after their initial presentation.²⁴¹ The Westmead study had confirmed the outcomes of the Finnish study referred to at paragraph 79.

Positive impact on suicidality

220. In a 2022 Family Law case, the treating paediatrician gave evidence the following evidence,

- “X remains at very high risk of self-harm and suicide. He continues to take antidepressants for his depression and anxiety.
- If puberty blockers are refused, he could die of suicide. This is a very real risk for X.
- If puberty blockers are granted soon, X has a chance of getting on with his life and achieving his potential emotionally, psychologically, socially, educationally and vocationally...he will have a much better chance of survival with access to medical care that allows him to express his male gender identity.”

221. Despite the strong wording, after a few hours of cross-examination of the treating paediatrician, the Court was informed that matter had settled by consent. Orders were made restraining the administration of puberty blockers and cross-sex hormones, changing the child’s name or recorded sex or gender with the injunctions to expire when the child turns 16 years. It was reported that the case settled as the treating paediatrician withdrew the recommendation for puberty blockade.²⁴²

222. The threat of a child’s suicide weighs heavily on parents and on the Court. It will be potentially helpful to understand what the parent(s) have been told about risk of suicide to understand the extent to which that fear is informing their decision-making.

²³⁹ Brignardello-Peterson (2022) [3].

²⁴⁰ Brignardello-Peterson (2022) [3].

²⁴¹ Elkadi (2023) [18].

²⁴² Lane, Bernard “Gender Clinic backs away from puberty blockers in a trans test case.” Gender Clinic News (Substack) 26 November 2022

Risk of suicide for transgender identified children and young people

223. The asserted rates of suicide risk of transgender and gender diverse youth are very high. The Queensland Children's Hospital Gender Service fact sheet reminds parents of the alleged risks by including a quote from the parent of a "10 year old trans boy" featuring prominently on its information sheet.²⁴³

"The real concern was the statistic on suicide...I didn't want my son to be one so I supported him in the decisions ahead and informed him as best as possible."

224. Just in case parents thought they might not be responsible for the risk, the fact sheet continues and lays risk firmly at the feet of the parents.

"Studies show that strong parental support of their gender diverse child leads to a 95% reduction in suicide attempts, comparative to parents who are unsupportive or only somewhat supportive."²⁴⁴

225. The Queensland paediatric gender service flyer relies upon a self-reporting survey from TransPULSE, a trans advocacy group, from 2012. Their report states:

To attain a recent measure of suicide risk, we asked participants if they had considered suicide in the past year, and whether they had attempted it. Consideration of suicide was common, and was reported by 35% of youth whose parents were strongly supportive and 60% of those whose parents were not strongly supportive. Particularly alarming is that among this latter 60%, nearly all (57%) had actually attempted suicide in the past year. In contrast, only 4% of those with strongly supportive parents attempted suicide. While 4% is still far too high, the impact of strong parental support can be clearly seen in the 93% reduction in reported suicide attempts for youth who indicated their parents were strongly supportive of their gender identity and expression.²⁴⁵

226. The TransPULSE data was collected from participants aged 16 to 24 years who had received healthcare in Ontario. The data was collected by internet or paper survey.²⁴⁶ There was no evidence of follow up of the participants to ascertain the extent of the young person's consideration of suicide, the factors leading to it, its duration and intensity. Further there was no evidence of what actions the young people had allegedly undertaken which were self-described suicide attempts and whether they were in fact life threatening.

227. The asserted suicide rates usually stem from online surveys which rely on self-reporting, and frequently conflate suicidal thoughts and non-suicidal self-harm with serious suicide attempts and completed suicides.²⁴⁷

²⁴³ Queensland Government, "Information for parents of children diverse in gender or sexuality" (Brochure, January 2019) <<https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/CHQ-Gender-clinic-Information-for-parents.pdf>>.

²⁴⁴ TransPULSE, "Impact of Strong Parental Support for Trans Youth. A report prepared for Children's Aid Society of Toronto and Delisle Youth Services" (2012). Cited by Queensland Government, the online and paper survey was of 84 self-identified trans youth between 2009-2010 receiving healthcare in Ontario. (TransPULSE 2012).

²⁴⁵ TransPULSE (2012) [3].

²⁴⁶ TransPULSE (2012) [1].

²⁴⁷ Levine (2022) [8].

228. The RCH Foundation website states:

In Australia, societal attitudes to gender diversity have become more understanding, however there remains stigma and discrimination, particularly for young people. Australian data shows 80 per cent of transgender young people self-harm and 48 per cent attempt suicide before the age of 24.²⁴⁸

229. Results from the Trans Pathway are cited in the Australian Standards of Care. This was another online self-reporting survey in which there was no follow up. Some of the criticisms of such online surveys are that there is a risk of over-reporting, there is no follow-up to confirm that the action taken occurred and were in fact life threatening and no analysis of the potentially complex reasons for the action.

230. The young respondents in the Trans Pathways' survey were identified as suffering from significant mental health issues including:

- A. 76.4% experienced moderate to severe depression with 75.8% of those currently diagnosed receiving treatment.²⁴⁹
- B. 72.1% had symptoms of social anxiety and 92.2% displayed symptoms of social phobia and 62.1% reported moderate to severe anxiety symptoms this is despite only 55.3% having a current diagnosis of anxiety and 71.9% of those currently diagnosed receiving treatment.²⁵⁰
- C. 25.1% had been diagnosed with Post Traumatic Stress Disorder (PTSD), 10.7% were subject to a diagnosis at the time of completing the survey and 66.2% of those currently diagnosed were receiving treatment.²⁵¹
- D. 20.1% had been diagnosed with a personality disorder and 9% had a current diagnosis, of whom 55.7% were receiving treatment.²⁵²
- E. 16.2% had been diagnosed with psychosis, 2.6% had a current diagnosis of psychosis, of whom 52.9% were receiving treatment.²⁵³
- F. 22.7% had been diagnosed with an eating disorder, 5.9% had a current diagnosis and 48.8% of those were receiving treatment.²⁵⁴
- G. 47.9% had been diagnosed with gender dysphoria .
- H. 22.5% had a current diagnosis of Autism Spectrum Disorder (ASD) however 35.2% scored in a range that would "warrant further diagnostic tests for ASD".²⁵⁵

²⁴⁸ The Royal Children's Hospital Foundation, "Leading the way in transgender healthcare" (Blog, 7 December 2021) <<https://www.rchfoundation.org.au/2021/12/leading-the-way-in-transgender-healthcare/>> Evidence to this effect was given in a recent FCFCOA case.

²⁴⁹ Strass, P, et al "Trans pathways: the mental health experiences and care pathways of trans young people" (2017) [15].

²⁵⁰ Strass (2017) [16].

²⁵¹ Strass (2017) [17].

²⁵² Strass (2017) [17].

²⁵³ Strass (2017) [17].

²⁵⁴ Strass (2017) [18].

²⁵⁵ Strass (2017) [18].

I. There were also higher rates for drug and alcohol use.²⁵⁶

231. The Trans Pathways' survey respondents present with complex mental health issues; many were not receiving treatment. There was not an indication about the quality and extent of the treatment that was being provided and it was difficult to assess if it was sufficient or appropriate. One cannot conclude that any suicide attempts were attributable to a single cause, namely their transgender identity.

232. Critics argue statements such as the ones cited above promote a "transition or die narrative" which regards suicide risk in trans-identified youth as a different phenomenon than suicidal risk among other youth. This makes a false promise that transition will remove the risk of suicidal self-harm and risks blaming all the problems the patient is experiencing on their trans-identity, thereby failing to perceive and respond to other sources of distress.²⁵⁷

"Clinicians caring for trans-identified youth should be reminded that suicide risk in all patients is a multi-factorial phenomenon (Mars et al., 2019). To treat trans youths' suicidality as an exception is to deny them evidence-based care."²⁵⁸

233. When considering the question of suicide, there are four different things to consider:²⁵⁹

- A. Completed suicide, meaning death by suicide;
- B. Suicidality, meaning either thinking about committing suicide or attempting suicide;
- C. Non-suicidal injury, meaning injuring oneself without intending to die (cutting);
- D. Mental illnesses which are strongly associated with suicide and others which may be more strongly associated with non-suicidal self-injury.

234. An Australian Study in 2021 by Kozłowska et al from the Children's Hospital at Westmead confirmed significant co-morbidities in the children presenting at the hospital's gender clinic.²⁶⁰ The prospective study examined the clinical characteristics of 79 children aged 8 to almost 16 years (33 biological males and 46 biological females) presenting to the gender service. The children's clinical characteristics were:²⁶¹

- A. High levels of distress including dysphoria about gender;
- B. 41.8% experienced suicidal ideation;
- C. 16.3% had engaged in self-harm;
- D. 10.1% reported suicide attempts;

²⁵⁶ Strass (2017) [20].

²⁵⁷ Levine (2022) [8].

²⁵⁸ Levine (2022) [8].

²⁵⁹ Bailey, Michael and Ray Blanchard, "Suicide or transition: The only options for gender dysphoric kids?" (Blog, 8 September 2017) <<https://4thwavenow.com/2017/09/08/suicide-or-transition-the-only-options-for-gender-dysphoric-kids/>>.

²⁶⁰ Kozłowska (2021)(b).

²⁶¹ Kozłowska (2021)(b) [71].

235. Kozłowska found high rates of comorbid mental health disorders and high rates of adverse childhood experiences. In relation to comorbid mental health disorders: ²⁶²

- A. 63.3% suffering from anxiety.
- B. 62.% suffering from depression.
- C. 35.4% with behavioural disorders.
- D. 13.9% with autism.

236. In relation to adverse childhood events:²⁶³

- A. 65.8% experienced family conflict.
- B. 63.3% experienced parental mental illness.
- C. 59.5% experienced loss of important figures via separation.
- D. 54.5% experienced bullying.
- E. 39.2% experienced maltreatment, including sexual abuse.

237. There were no reported suicides in this Westmead study.

238. A 10-year study from the RCHGS also did not report any suicides and reported 24.8% of young people reporting a history of self-harm.²⁶⁴ It is puzzling that the RCH Foundation would rely upon the Trans Pathways' survey when it has its own peer-reviewed published study from which to draw.

239. The complex presentation of trans identified children and young people raises a live question about what has come first, are these children suffering from gender dysphoria and their co-morbidities are symptoms. Or are they children who are suffering from mental health problems and they believe that transitioning from their sex will address their issues?

240. Kozłowska et al acknowledge the difficulties in untangling gender dysphoria from co-morbid factors and the uncertainties in the available literature on longitudinal outcomes. They reported "the need for ongoing therapeutic work to address unresolved trauma and loss, with the maintenance of subjective well-being and the development of the self."²⁶⁵

241. In relation to suicide statistics, there are criticisms about the use of online surveys. Bailey and Blanchard opine that there is a risk of overreporting.²⁶⁶ Critics asserts that there is evidence that when respondents to such surveys are followed up, it turns out that they may not have taken life-threatening actions. Secondly, there is significant variation of suicide attempts by country, which is poorly understood, with the Netherlands attempted suicide rate about 1/3rd of the UK's gender dysphoric youth. Thirdly, the estimates collected from online surveys of youth tend to be higher than those obtained from clinical samples and importantly the data does not capture completed

²⁶² Kozłowska (2021)(b) [71].

²⁶³ Kozłowska (2021)(b) [71].

²⁶⁴ Tollit (2021).

²⁶⁵ Kozłowska (2021)(b) [71].

²⁶⁶ Bailey (2017).

suicides which represents a “significant knowledge gap.”²⁶⁷ The most reliable information will come from analysis of completed suicides.

242. In 2022 Associate Professor Michael Biggs released a study of completed suicides at the world’s largest gender clinic, GIDS, between 2010 to 2020.²⁶⁸ Biggs reported on suicides from 15,032 patients. There were 4 suicides in total, 2 of children / young people on the waiting list and 2 who were receiving treatment. This represents an annualised rate of 13 per 100,000 (or 0.00013%).²⁶⁹

243. Biggs found that the children / young people at GIDS were 5.5 times more likely to suicide than comparable age in the general population aged 14 to 17 years.²⁷⁰ However, this is not necessarily attributable to transgender identity. Children and young people at GIDS had high prevalence of eating disorders, depression, and ASD conditions all known to increase the probability of suicide.²⁷¹ The statistics from Biggs (2022) show an elevated risk of suicide among adolescents who identify as transgender, without adjusting for accompanying psychological conditions or other adverse experiences which may increase suicide risk.

244. A further study of 3 major youth clinics concluded that suicidality of trans-identified teens is only somewhat elevated compared to that of youth referred for mental health issues unrelated to gender identity issues.²⁷²

245. In 2022, the Victorian coroner released data on LGBTIQ+ people from 2012-2021.²⁷³ In the last 10 years the suicide statistics for young LGBTIQ+ people under 18 years were:

2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
4	-	-	2	-	-	1	-	2	1

246. The reasons for the young people’s suicide are not provided and so no conclusions can be drawn from this data.

Impact of puberty blockers on suicide risk

247. What is the impact of puberty blockade on suicide risk? A treating paediatrician in a 2022 family law case gave evidence that:

“Recent US research published in the journal *Pediatrics* (Turban et al. 2020) studying the mental health of more than 20,000 trans adults, demonstrated the long-term benefits of accessing puberty suppression during adolescence. This study’s findings included:

“After adjustment for demographic variable and level of family support for gender identity, those who received treatment with pubertal suppression, when compared to those who wanted pubertal

²⁶⁷ Society for Evidence-based Gender Medicine (SEGM), “Suicide by Adolescents Referred to the World’s Largest Pediatric Gender Clinic” (Blog, 19 January 2022) < https://segm.org/trans_youth_suicide_study>.

²⁶⁸ Biggs, Michael “Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom” *Archives of Sexual Behaviour* (2022) <https://doi.org/10.1007/s10508-022-02287-7>; (Biggs (2022)(a)).

²⁶⁹ Biggs (2022)(a) [3].

²⁷⁰ Biggs (2022)(a) [3].

²⁷¹ Biggs (2022)(a) [3].

²⁷² Levine (2022) [8].

²⁷³ Coroners Court of Victoria, “Suicide among LGBTIQ+ people” (2022).

suppression but did not receive it, had lower odds of lifetime suicidal ideation (adjusted odds ratio = 0.3; 95% confidence interval = 0.2-0.6%)

248. The clear implication of the above statement is that puberty blockade was demonstrated to reduce lifetime suicidal ideation. There was an asserted causal link.

249. Associate Professor Michael Biggs provided a detailed critique of the Turban (2020) study.²⁷⁴ Biggs notes this was a secondary study of 20,000+ trans adults in the USA who were recruited online. The sample excluded those who underwent medical intervention and then subsequently stopped identifying as transgender. The participants were not representative of the US population. 89 of the respondents reported currently taking puberty blockers, which could not have been the case as they were adults. Six measures of suicidality and 3 other measures of mental health and substance abuse were tested, with only 1 yielding “a statistically significant association”: the respondents who reported taking puberty blockers were less likely to have thought about killing themselves than were the respondents who reported wanting but not obtaining puberty blockers.²⁷⁵ There was no information about the respondent’s mental health during adolescence and “adolescents with severe psychological problems would have been less eligible for drug treatment, which confounds the association between treatment and suicidal ideation.”²⁷⁶ The causal direction could not be ascertained.

250. Dr Clayton et al says the study itself does not draw the conclusion of causation.²⁷⁷ The Turban (2020) study says relevantly that the limitations of the design of the study do not allow for determination of causation and “reverse causation” (individuals without suicidal ideation had better mental health and were more likely to be considered eligible for puberty blockers) was a plausible alternate explanation.²⁷⁸ Turban et al acknowledge:

“Reverse causation cannot be ruled out: it is plausible that those without suicidal ideation had better mental health when seeking care and thus were more likely to be considered eligible for pubertal suppression. The Endocrine Society Guidelines for pubertal suppression eligibility recommend that other mental health concerns be “reasonably well controlled.”²⁷⁹

251. Any assertion of the treating paediatrician that there was a causal link, was not supported by the study itself.

The impact of transition on suicide risk

252. There is some evidence that gender affirming interventions can lead to improvements in some measures of suicidality in the short-term, but “neither hormones nor surgeries have been showed to reduce suicidality in the long-term.”²⁸⁰ Levine et al point to a 30 year Swedish study which found that adults who underwent surgical transition were 19 times more likely than their age-

²⁷⁴ Biggs, Michael, “Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria” (2020) Archives of Sexual Behaviour 49 2227-2229 [42].

²⁷⁵ Biggs (2020) [42].

²⁷⁶ Biggs (2020) [42].

²⁷⁷ Clayton (2021) [1].

²⁷⁸ Clayton (2021) [2].

²⁷⁹ Turban et al “Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation.” (2020) Pediatrics 145(2) 2019-1725 [7].

²⁸⁰ Levine (2022) [8].

matched peers to die by suicide and the rates for female to male participants, 40 times the expected rate. A 2020 Dutch study found that suicides occur at similar rates along all stages of transition from pre-treatment to follow up.²⁸¹ Biggs' study of GIDS above found no statistical difference in suicide of those on the waitlist and those being treated.²⁸²

253. Levine et al²⁸³ state relevantly:

In our experience in working with trans-identified youth, an adolescent's suicidality can sometimes arise as a response to parental distress, resistance, scepticism, or wish to investigate the forces shaping the new gender identity before social transition and hormone therapy. When mental health professionals or other healthcare providers fail to recognize the legitimacy of parental concerns, or label the parents as transphobic, this only tends to intensify intrafamilial tension. Clinicians would be well-advised that gender transition is not an appropriate response to suicidal intent or threat, as it ignores the larger mental health and social context of the young patient's life—the entire family is often in crisis. Trans-identified adolescents should be screened for self-harm and suicidality, and if suicidal behaviours are present, an appropriate evidence-based suicide prevention plan should be put in place (de Graaf et al., 2020).²⁸⁴

Management of suicide risk

254. There are tools for assessment and management of suicide risk and protocols in hospitals and services.²⁸⁵ If a risk of suicide is asserted, the Court should have information about the assessment of the risk, what steps have been put in place to manage the current and any future risk. Suicide risk of children and young people is managed by treating mental health professionals each day.

Fully reversible?

255. Puberty blockers are generally understood to be a benign intervention that can “buy time” or act as a “pause” to give the young person time to consider their identity and decision to transition and, that they are fully reversible. As the RCHGS says on its website:

“Puberty blockers suppress the development of secondary sex characteristics and are used for adolescents in the early stages of pubertal development. As they are reversible in their effects, should an adolescent wish to stop taking them at any time, their biological puberty will resume.”²⁸⁶

256. The Australian Standards of Care state:

“Puberty suppression typically relieves distress for trans adolescents by halting progression of physical changes such as breast growth in trans males and voice deepening in trans females and is reversible in its effects. Other physical changes such as linear growth and weight gain

²⁸¹ Levine (2022) [8]-[9].

²⁸² Levine (2022) [9].

²⁸³ Dr Julia Mason MS MD FAAP (US), a board-certified paediatrician and Fellow of the American Academy of Pediatrics.

²⁸⁴ Levine (2022) [9].

²⁸⁵ Pettit, Jeremy, Victor Buitron, and Kelly L Green, “Assessment and Management of Suicide Risk in Children and Adolescents” *Cognitive and Behavioural Practice* Vol 25(4) 460-472.

²⁸⁶ The Royal Children's Hospital Melbourne, Adolescent Medicine, Gender Service (Web Page)

<<https://www.rch.org.au/adolescent-medicine/gender-service/>>.

continue to occur whilst on these medications and the adolescent is given time to develop emotionally and cognitively prior to making decisions on gender affirming hormone use which will have some irreversible effects.”²⁸⁷

257. The agreed facts in the case stated in *Re Kelvin* included a statement that the effects of puberty blockade are reversible when used for a limited time for approximately 3-4 years.²⁸⁸

258. In a 2022 family law case the treating paediatrician gave evidence that:

“Puberty blockers have also been used for a longer period of time (more than 50 years) in cis-gender children who have a diagnosis of precocious puberty (ie. Commencement of puberty has occurred earlier than expected) and have required medical intervention for pubertal suppression in this context. No safety concerns have been identified in this patient group.”

As will be discussed below, the problem with this statement is that puberty blockers were only used for a short period of time to address precocious puberty, whereas in transgender medicine they are used for very much longer if administered at Tanner Stage 2.

Age children start on puberty blockers

259. The Dutch clinic that started using puberty blockers in the 2000s developed a protocol for their use, often called the Dutch protocol.²⁸⁹ The authors of the protocol were aware that most children would have a “spontaneous realignment of their gender identity with sex by going through early-to mid-stages of puberty”.²⁹⁰ The average age of administering puberty blockers in the Dutch study was around 15 years. Concerns have been expressed about children being put on puberty blockers at much earlier ages than in the Dutch study, at Tanner Stage 2, that is as early as 8-9 years.²⁹¹

260. The Australian Standards state that children must have achieved Tanner Stage 2 (ages 9-11 years) before commencing puberty blockers.²⁹² However, it recommends males being allowed to go through the early parts of puberty, commencing between Tanner Stage 2 to 3, if surgical options are likely to be considered. This is due to the decreased size of the penis and scrotum to fashion a neo-vagina in vaginoplasty surgery²⁹³ and due to the potential impact on sexual function.

How long do children remain on puberty blockers?

261. When treating central precocious puberty, children normally remain on puberty blockers for up to about 12 months and resume normal puberty at a more appropriate age.²⁹⁴ It does not interfere with puberty at the appropriate age and doesn’t interfere with the child’s normal development. Importantly, children will go through puberty with their peers.

²⁸⁷ Australian Standards of Care [15].

²⁸⁸ *Re Kelvin* [12].

²⁸⁹ *Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 [50].

²⁹⁰ Levine (2022) [13].

²⁹¹ Levine (2022) [13].

²⁹² Australian Standards [23].

²⁹³ Australian Standards [14].

²⁹⁴ An expert witness paediatrician in a 2022 FCFCOA case gave this evidence.

262. In the case of gender dysphoria, children who go from puberty blockers to cross-sex hormones never go through puberty. If children commence puberty blockers at Tanner Stage 2, say around 9-11 years, and cross sex hormones at around 16 years. Children may be on puberty blockers for up to 5-7 years. In a 2023 study from Westmead Hospital, children were on puberty blockers from 8 months up to 5.75 years, depending upon their age of commencement.²⁹⁵
263. The WPATH Standards of Care version 8 (SOC 8) released in 2022 have removed all age limits for the use of puberty blockers and cross-sex hormones. If these guidelines are followed in Australia, it may impact the commencement timing of cross-sex hormones and the length of time a child is on puberty blockers.

Risks of puberty blockers

264. The only risk of puberty blockade referred to in the agreed facts in *Re Kelvin* was bone density.²⁹⁶ There are more risks associated with puberty blockers than were put before the Full Court.

265. The Westmead hospital 2023 study authors say:

“The physical effects of GnRH agonists have long been thought to be fully reversible when ceased, puberty recommences. Recent data suggest a negative impact of long-term puberty suppression on bone mineral density. Far less is known, however, about the effects of puberty suppression on cognitive, psychosocial, and psychosexual development and mental health functioning.”²⁹⁷

Bone density

266. If you block that process of puberty, you are stopping physical maturity - growth stops. One of the recognised impacts is on the natural process of increasing bone mineral density. Puberty is a time of peak bone mineralization. Humans put on about 50% of the naturally increasing bone density that they will have in their lifetime. After 2 years on puberty blockers up to a third of children will have abnormally low bone density, that is bone density in the lowest 2.3% of the population of the same sex and age.²⁹⁸ It is not clear whether this impairment of bone health will result in future osteoporosis.²⁹⁹

267. The graphs below show bone density after 24 months of puberty suppression.³⁰⁰

²⁹⁵ Eldaki (2023) [11].

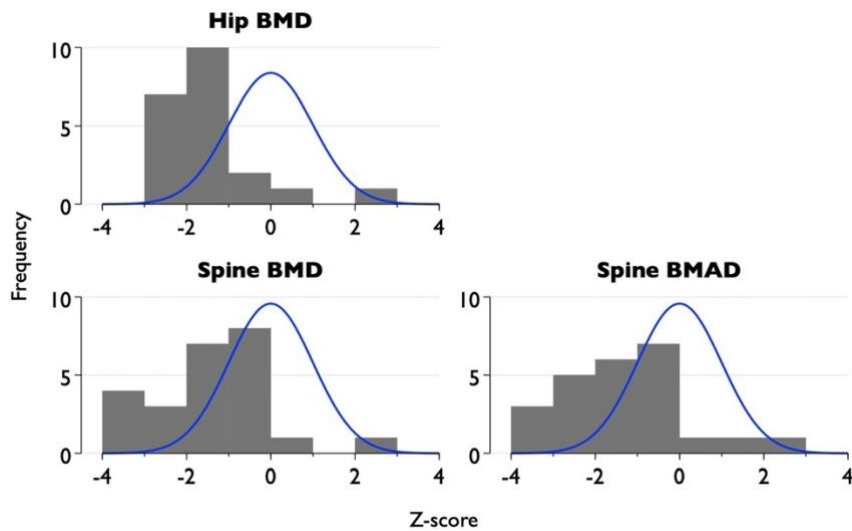
²⁹⁶ *Re Kelvin* [18].

²⁹⁷ Eldaki (2023) [3].

²⁹⁸ Biggs, Michael, “Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria” (2021) *Journal of Paediatric Endocrinology and Metabolism* Vol 34(7) 937-939.

²⁹⁹ Malone, W, “Time to Hit Pause on ‘Pausing’ Puberty in Gender-Dysphoric Youth” (Commentary, 17 September 2021) <<https://www.medscape.com/viewarticle/958742>>.

³⁰⁰ Biggs (2021) [938].



n = 24 for spine, 21 for hip. BMAD, bone mineral apparent density; BMD, bone mineral density.

268. A 2020 study confirmed that the use of puberty blockers during normally timed puberty, on males and females with bone health within normal range before the start of treatment, reduced bone turnover³⁰¹ and prevented normal accrual of bone density. After 2 years of puberty blockers, the children were put on cross-sex hormones for 3 years. This did not result in normalisation of bone density on males treated with estrogen. Females treated with testosterone showed near normalization of bone density. The effects on bone structure and fracture risk remain unknown.³⁰²
269. The process of feminisation and virilisation with cross-sex hormones is not equivalent to puberty, meaning that these children do not actually go through a puberty. The extent of these impacts will not be known for many years.
270. Bone density is a known risk of pubertal suppression.³⁰³ Gender affirming clinicians may offer monitoring of bone density as part of treatment. Monitoring however does not stop the impact. Consideration will need to be given to what will happen if puberty blockers are granted and there is a negative impact on bone density. Gender affirming therapists are likely to recommend an earlier move to cross-sex hormones.³⁰⁴

Risks to fertility

Females

271. For females, puberty causes the uterus to enlarge in length, diameter, and endometrial thickness during each stage of puberty. Without female puberty, a female will not be able to carry a foetus. The young person is unlikely to be able to conceive, as ovum are unlikely to mature without sex hormones.³⁰⁵ If the young person proceeds from puberty blockers to cross-sex hormones, they are likely to be infertile, that is require medical assistance to conceive. There are no proven

³⁰¹ Bone turnover is a natural process of bone replacement with little change in shape and occur's throughout a person's life.

³⁰² Schagen, S, et al, "Bone Development in Transgender Adolescents Treated with GnRH Analogues and Subsequent Gender Affirming Hormones" (2020) Journal of Clinical Endocrinology and Metabolism Vol 105(12) 4252-4263.

³⁰³ The makers of Lupron Depot provide safety warnings that thinning of the bones may occur which may not be completely reversible <www.luprongyn.com>.

³⁰⁴ Australian Standards of Care [14]. SOC 8 [S65]

³⁰⁵ Notoni, L, et al, "Forever young? The ethics of ongoing puberty suppression for non-binary adults" (2020) Journal of Medical Ethics Vol 46 743-752.

methods of fertility preservation.³⁰⁶ If the young person proceeds with surgery to remove ovaries, fallopian tubes, testis they will be rendered sterile.

272. The Australian Standards refer to the child having to receive fertility preservation counselling being a requirement prior to commencing puberty blockade. However, it is unclear what fertility preservation counselling will involve as there are no proven methods to preserve fertility in early pubertal transgender identified adolescents.³⁰⁷ In a 2020 article whose authors included Associate Professor Michelle Telfer, the authors acknowledged the impact on fertility:

“While fertility preservation techniques exist (eg ovarian tissue cryopreservation), these remain experimental, especially for individuals who have not gone through puberty.”³⁰⁸

Males

273. The listed side effects for GnRH agonists on males are decreased libido, decreased haemoglobin, depression, dizziness, oedema, emotional lability, fatigue, flushing / hot flashes, headache, increased serum cholesterol, increased serum triglycerides, insomnia / sleep disorder, infertility, nausea, testicular atrophy, weight changes.³⁰⁹

274. Similarly for males, puberty blockage prevents the maturation of sperm and may preclude gamete maturation. There is evidence that sperm production is also impaired.³¹⁰

275. The Australian Standards state relevantly:

“Should a trans female adolescent be commencing puberty suppression in early adolescence (Tanner Stage 2-3) collection of mature sperm will usually not be possible since mature sperm are produced from mid puberty (Tanner Stage 3-4). Unfortunately, this point in development often coincides with voice deepening, so most adolescents will find waiting for sperm maturation to occur unacceptable in the context of their gender dysphoria.”³¹¹

276. In such a case, the only other option raised by the Australian Standards is “testicular tissue cryopreservation” which is “currently experimental” and with limited availability outside of major capital cities.³¹²

277. The impact of puberty blockers on sexual function and fertility are important to consider, given that almost all children on puberty blockers will continue to cross-sex hormones. This raises questions about a pubescent child being able to comprehend the impact of these decisions. As Dr Clayton, a psychiatrist, says:

³⁰⁶ Clayton, A, “Gender-Affirming Treatment of Gender Dysphoria in Youth: a Perfect Storm Environment for the Placebo Effect – The Implications for Research and Clinical Practice” (2022) Archives of Sexual Behaviour Vol 52(2) 483-494 (Clayton (2022)(c)) [3].

³⁰⁷ Krishna, KB, et al “Use of Gonadotropin-Releasing Hormone Analogs in Children: Update by an International Consortium” (2019) Hormone Research in Pediatrics Vol 91 357-372 [365].

³⁰⁸ Notoni (2020).

³⁰⁹ WPATH SOC8 draft chapter on Eunuchs.

³¹⁰ Australian Standards [13].

³¹¹ Australian Standards [13].

³¹² Australian Standards page [13].

“These impaired fertility and sterility outcomes are important because, firstly, as Cheng et al (2019) reported, the widespread assumption that many transgender people do not want to have biological children is not supported by several recent studies. Secondly, children as young as ten, who do not have the capacity for informed consent, are starting a treatment course that will likely render them infertile or sterile and this raises complex bioethical issues.”³¹³

Sexual function

278. Impaired sexual function is a known potential physical harm of puberty blockers, which may also have psychosocial consequences.³¹⁴ Puberty suppression blocks sex hormones which reduces libido. This is the very reason that they are used in the United States to chemically castrate men with sexual obsessions.³¹⁵

Females

279. Puberty (exposure to estrogen) is responsible for cellular and mucosal changes to the vulva and vagina, including lengthening and thickening of the vagina. Puberty blockade will therefore prevent maturation of the vagina. Prepubertal genitalia will function quite differently from those that have gone through puberty.³¹⁶ A side effect of pubertal suppression is vaginal atrophy, the symptoms of which are thinning of the vaginal wall, dryness and cracking. Ongoing pubertal suppression will create long-term vaginal atrophy which can result in the young person experiencing pain during any vaginal intercourse.³¹⁷

Males

280. Puberty blockers stop the development of the penis and testicles. They are used to decrease sexual desire in sex offenders, so it is not surprising that they decrease libido.

281. In 2021 Dr Marci Bowers MD³¹⁸, surgeon raised concerns about an “overlooked problem”, namely the capacity for later orgasm. Dr Bowers said that if a male whose puberty is blocked, proceeds to cross-sex hormones and then surgery, it will be very difficult to achieve orgasm, if the young person has not achieved orgasm pre-surgery.³¹⁹ While a recent study provided more favourable data, there was no evidence about the Tanner stage at which the children started puberty blockade and capacity for orgasm.³²⁰ This raises serious questions about the long-term implications of the medical pathway for males (noting that there are no studies on female orgasm) and the capacity of children to provide informed consent to risk of later sexual dysfunction.

282. Dr Clayton refers to a recent literature review on sexual outcomes in adults post-vaginoplasty and noted the paucity of high-quality evidence. It reported up to 29% of patients may be diagnosed with a sexual dysfunction “due to associated distress with a sexual function disturbance” and

³¹³ Clayton (2022)(c) [3].

³¹⁴ Notoni (2020) [746].

³¹⁵ Biggs (2022)(b) [6].

³¹⁶ Notoni (2020) [747].

³¹⁷ Notoni (2020) [747].

³¹⁸ Dr Marci Bowers MD is a gynaecologist who has performed over 2,000 vaginoplasties and is the President elect of WPATH.

³¹⁹ Shrier (2021); Clayton (2022)(c).

³²⁰ Clayton (2022)(c) [4].

another systematic review found that 24% of patients post-vaginoplasty were unable to achieve orgasm.³²¹

Brain development

283. In a 2022 Family Law case, the treating paediatrician gave evidence that:

“There are some unknown effects with using GnRHa during early adolescence which include the impact on emotional and cognitive development. Whilst this has not been effectively studied...my own experience and that of my team at the hospital...is that cognitive and emotional development continues as expected during treatment with GnRHa and young people are able to thrive academically and socially when they are not distressed by unwanted pubertal development which is inconsistent with their gender identity.”

284. The treating paediatrician was not concerned that puberty blockade could impact on decision-making, including progression to cross-sex hormones and Gillick competence.

285. The agreed facts in the case stated in *Re Kelvin* similarly that puberty blockade “allows the adolescent time to mature emotionally and cognitively such that they can achieve maturity sufficient to provide informed consent for Stage 2 treatment.”³²²

286. The Dutch longitudinal studies measured IQ at baseline but did not measure it again.³²³ There have been several smaller studies of children treated with puberty blockers for precocious puberty whose IQ dropped 7 points in one study and a gap of 8 points between the treated group and control group in another. Another small study found that males undergoing puberty suppression performed worse in executive functioning than 3 control groups.³²⁴ While there have been concerns for some time, there is a lack of research.

287. In 2017, the Endocrine Society (US) said that more rigorous evaluations of the effectiveness and safety of endocrine and surgical tools were needed. Specifically, there needed to be “careful assessment” of the effects of prolonged delay of puberty in adolescents on the brain including effects on cognitive, emotional, social and sexual development.³²⁵

288. It is not surprising that puberty blockers would have an impact on the brain as it is not just the body that physically matures during puberty, but also the brain. It is likely that puberty “may be a second kind of period for brain organization, when estrogen and testosterone shape neural circuitry in potentially lasting ways.”³²⁶ Researchers from the RCHGS acknowledge that “[a]dolescence is a time where executive functions and abstract thinking develop.”³²⁷

³²¹ Clayton (2022)(c) [4].

³²² *Re Kelvin* [12].

³²³ Biggs (2022)(b) [12].

³²⁴ Biggs (2022)(b) [12].

³²⁵ Hembree, WC, et al, “Endocrine Treatment of Gender-Dysphoric / Gender Incongruent Persons: An Endocrine Society Clinical Practice Guide” (2017) *Journal of Clinical Endocrinology & Metabolism* Vol 102(11) 3869-3903 (Endocrine Guidelines, 2017) [3874].

³²⁶ Hooven (2021) Carole Hooven is a behavioural endocrinologist at Harvard University.

³²⁷ Notoni (2020) [748].

289. There is international concern that the effects of puberty blockers on adolescent brain maturation are unclear.³²⁸ In December 2020 an international interdisciplinary panel reached consensus on how to assess the impact of puberty blockers on the brain and defined an approach for investigation.³²⁹ As of February 2022, the investigation had not commenced³³⁰ and it will presumably be many years and more likely decades before any results are known.

290. In 2022, RCH GS notified that it proposed to commence a study to investigate the impact of puberty blockers on changes in the brain function of adolescents.³³¹ This is in the context of the gender service presumably having referred children for puberty blockade for at least the last 10 years.

291. SOC 8 also recognises the concerns about impact of puberty blockers on brain development.

“Puberty is a time of significant brain and cognitive development. The potential neurodevelopmental impact of extended pubertal suppression in gender diverse youth has been specifically identified as an area in need of continued study.”³³²

292. In February 2022, Professor Hilary Cass summarised the concerns:

“3.32 A closely linked concern is the unknown impacts on development, maturation, and cognition if a child or young person is not exposed to the physical, psychological, physiological, neurochemical and sexual changes that accompany adolescent hormone surges. It is known that adolescence is a period of significant changes in brain structure, function, and connectivity. During this period, the brain strengthens some connections (myelination) and cuts back on others (synaptic pruning). There is maturation and development of frontal lobe functions which control decision making, emotional regulation, judgement, and planning ability. Animal research suggests that this development is partially driven by the pubertal sex hormones, but it is unclear whether the same is true in humans. If pubertal sex hormones are essential to these brain maturation processes, this raises a secondary question of whether there is a critical time window for the processes to take place, or whether catch up is possible when oestrogen or testosterone is later introduced.”³³³

293. In July 2022, Professor Hilary Cass, in her capacity as chair of The Cass Review wrote to the National Director of the National Health Service (NHS) England:

“We do not fully understand the role of adolescent sex hormones in driving the development of both sexuality and gender identity through early teen years, so by extension we cannot be sure about the impact of stopping these hormones on psychosexual and gender maturation. We therefore have no way of knowing whether, rather than buying time to make a decision, puberty blockers may disrupt that decision-making process.”³³⁴

³²⁸ Krishna (2019) [365].

³²⁹ Chen, D et al “Consensus Parameter: Research Methodologies to Evaluate Neurodevelopmental Effects of Pubertal Suppression in Transgender Youth” (2020) *Transgender Health* Vol 5(4).

³³⁰ Cass Review – Interim (2022).

³³¹ Royal Children’s Hospital Gender Service Newsletter, 13 April 2022.

³³² SOC 8 [S65]

³³³ Cass Review - Interim (2022) [38] 3.32.

³³⁴ Cass, Hilary, “Letter to NHS England” (Letter, 19 July 2022) <https://cass.independent-review.uk/publications/> [19]

294. Behavioural endocrinologist, Carole Hooven says changes in the body that occur during puberty “are typically co-ordinated with changes in how we feel about ourselves. And since adolescence is an especially important time for exploring one’s feelings about one’s gender, blocking puberty may also reduce opportunities to get more information as one matures physically, cognitively and emotionally.”³³⁵
295. It is difficult to understand why potential impact on the brain is only being investigated now. The process of physical, mental, and emotional maturation in puberty is recognised in every culture and in our legal system. It is not difficult to imagine that blocking puberty would have an impact on the whole human system, including the brain.

Pause or a single medical pathway?

296. Historically puberty blockers were asserted to provide a “pause” to allow the child to develop and consider his/her options. The Dutch researchers used them as part of their diagnostic process. The notion of puberty blockers giving an adolescent time to mature was an agreed fact in *Re Kelvin*.³³⁶
297. Far from being a pause, puberty blockade is part of a single medical pathway. It is uncontested that almost all of the children who commence on puberty blockers will continue to cross-sex hormones. It is not understood why this is the case.
298. The studies to support this statistic are:
- A. 98% of 333 children in Amsterdam Clinic to end of 2015 (Wiepjes et al 2018);
 - B. 96.5% of 143 children in Netherlands Clinic - Brik (2020)³³⁷;
 - C. 98% of 44 children at GIDS (UK) - Carmichael (2021)
 - D. 98% of 54 children at RCHGS - Tollit (2021)
 - E. 93.9% of 49 children at Westmead Hospital – Elkadi (2023)³³⁸
299. Dr William Malone, endocrinologist, says that halting the physical and psychosocial development of children through blocking puberty negatively impacts on the chances of these children coming to a “stable gender identity consistent with their biological sex”, which is why almost all children who commence puberty blockade continue to cross-sex hormones.³³⁹ This is what Kenneth Zucker, referred to as “treatment that is, in effect, iatrogenic”³⁴⁰ where the treatment causes the condition.
300. Professor Hilary Cass stated in February 2022:

³³⁵ Hooven (2021) [228].

³³⁶ Re Kelvin [12].

³³⁷ Brik, T et al “Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria” (2020) Archives of Sexual Behaviour Vol 49 2611-2618.

³³⁸ Elkadi, 2023 [17]. Noting that the children who commenced on the medical pathway were highly screened.

³³⁹ Gender: A wider lens. Episodes 5 and 6.

³⁴⁰ Elkadi (2023) [17].

“The most difficult question is whether puberty blockers do indeed provide a valuable time for children and young people to consider their options, or whether they effectively lock in children and young people in a treatment pathway which culminates in progression to feminising/ masculinising hormones by impeding the usual process of sexual orientation and gender identity development.”³⁴¹

301. In the 2023 Westmead hospital study of the cohort diagnosed with gender dysphoria, 6.1% desisted from the medical pathway while on puberty blockers. This was consistent with other international studies as set out above. The authors noted concerns in the literature about the high rates of persistence from puberty blockers to cross sex hormones:

“Rather than serving, as intended, as a “pause button” that creates for the child and family a period of reflection and further consideration, these critics have argued that the use of puberty blockers sets children onto a medical treatment pathway that, for better or worse, they are unlikely to step away from – with major consequences for who they are and how they live.”³⁴²

302. The Westmead authors continued:

“Whether our findings reflect a successful screening and assessment process that identifies “exceptional cases”³⁴³, or whether they reflect the dynamic of the self-fulfilling prophecy dynamic alluded to above, cannot be determined at this time. Outcome data many years down the track are needed to clarify this complex question.”³⁴⁴

303. Proponents of a medicalisation model may still insist that a child can cease taking puberty blockers at any time, while that may be true, it is argued that this is a moot point, as they almost never do. If a child ceases puberty blockers, “a slightly altered natal puberty” will begin, namely starting at a later age and it “may not have exactly the same overall effects as a normal puberty.”³⁴⁵

304. The Court may consider that the proposed treatment is a single medical pathway. The almost certainty of a child who has received puberty blockade proceeding to cross-sex hormones should be made clear to the child and parents as part of informed consent. The risks and asserted benefits of cross-sex hormones, in particular the impacts on future fertility, must also be considered at the time of deciding whether to commence puberty blockade.³⁴⁶

Stage 2: Cross-sex hormones

305. Cross-sex hormones are administered orally and cause the development of some of the secondary sex characteristics of the opposite sex. In the case of females, testosterone will cause the voice to deepen, facial and skin changes, head and body hair changes, redistribution of fat and muscle. Many of these changes are irreversible. It is important to understand that taking cross-sex hormones does not cause a child to go through the puberty of the opposite sex.

³⁴¹ Cass Interim Report [38] 3.31.

³⁴² Elkadi (2023) [17].

³⁴³ Elkadi (2023) [4] The Swedish National Board of Health and Welfare says that the risks of puberty blockers and cross-sex hormones currently outweigh the benefits and gender affirming treatments should only be offered in “exceptional cases.”

³⁴⁴ Elkadi (2023) [17].

³⁴⁵ Hooven (2021) [228].

³⁴⁶ Hooven (2021) [228].

306. Hormonal transition requires a lifetime of dependence upon hormones.³⁴⁷ The asserted benefits of cross-sex hormones are that they will make the child's / young person's body more closely align with their subjective transgender identity and will improve mental health.

307. The Dutch studies did not release results on the impact of cross-sex hormones, the outcomes combined the cross-sex hormones and surgical results into a single set of outcomes.³⁴⁸ There is conflation of the cause of any potential benefit. It was for this reason that the National Institute of Clinical Healthcare Excellence (NICE) excluded the Dutch (2014) study in its review of the evidence on cross-sex hormones.

308. A 2022 secondary analysis of a cross-sectional non-representative sample of 27,715 transgender adults in the US concluded that accessing gender affirming hormones (GAH) known also as cross-sex hormones was associated with lower odds of past year suicidal ideation, when compared with people who desired but did not get GAH. Adolescent access to GAH was associated with lower odd of past year suicidal ideation when compared to accessing GAH during adulthood.³⁴⁹ There are significant criticisms of this article and it is currently under review by the publishers. The criticisms include:³⁵⁰

- A. Failure to note in abstract, introduction or conclusion that adults given GAH had higher odds of binge drinking and illegal drug use.
- B. The survey was non-representative and excluded people who no longer identified as transgender, who were the group most likely to be negatively impacted by GAH.
- C. Despite GAH being asserted as a treatment for gender dysphoria, there were no questions in the survey about gender dysphoria.
- D. Estrogen in males was assumed to have the same effect as testosterone in females. In fact, not taking estrogen was associated with better results than taking it in males. Taking testosterone was associated with better outcomes than not taking it in females.
- E. There was no baseline of mental health for the respondents, so reverse causality could apply ie: those with worse mental health were not prescribed GAH and they continued to have worse mental health in later years.
- F. The author's recommendation that GAH be made available for transgender adolescents is without justification.

309. SOC 8 acknowledges that the "long-term effects of gender-affirming treatments initiated in adolescence are not fully known..."³⁵¹ Nor is it known if gender affirming hormone treatment (GAHT) should be reduced in older TGD people.³⁵²

³⁴⁷ Hooven (2021) [228]. SOC 8 [S112].

³⁴⁸ Abbruzzese (2023) [7].

³⁴⁹ Turban, Jack L, at al, "Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults" (2022) PLoS ONE Vol 17(1) e0261039.

³⁵⁰ Turban (2022) – Michael Biggs comments.

³⁵¹ SOC 8 [S65].

³⁵² SOC 8 [S112].

310. In relation to cross-sex hormones the NICE review said:

“This evidence review found limited evidence for the effectiveness and safety of gender-affirming hormones in children and adolescents with gender dysphoria, with all studies being uncontrolled, observational studies, and all outcomes of very low certainty. Any potential benefits of treatment must be weighed against the largely unknown long-term safety profile of these treatments.”³⁵³

311. In the Florida Medicaid Review, Dr Brignardello-Peterson et al, noted the lack of control studies and the inability to determine if people with gender dysphoria who use cross-sex hormones experience better outcomes in relation to gender dysphoria, depression, anxiety, quality of life and suicidality than those with gender dysphoria who do not. The studies included systematic reviews which reported changes in outcomes for patients with gender dysphoria after using cross-sex hormones. The authors concluded that despite these studies: ³⁵⁴

- A. The evidence that suggests that after treatment with cross-sex hormones, people with gender dysphoria experience an improvement in gender dysphoria, depression, anxiety and suicidality is of “low certainty”; and
- B. The evidence that suggests that there are changes in quality of life is of “very low certainty.”

312. Dr Brignardello-Petersen and Wiercioch conclude:

“Due to the important limitations in the body of evidence, there is great uncertainty about the effects of puberty blockers, cross-sex hormones and surgeries in young people with gender dysphoria. This evidence alone is not sufficient to support whether using or not using these treatments. We encourage decision makers to be explicit and transparent about which factors play an important role in their decision, and how they are weighed and traded off.” ³⁵⁵

313. A 2020 Finnish study from their main paediatric gender clinic found that while after treatment with cross-sex hormones, the need for treatment for depression, anxiety and suicidality / self-harm was recorded less frequently, however

“the need for psychiatric treatment overall did not decrease from the level before and during the gender identity assessment to the real-life phase [cross-sex hormones]. New needs had also emerged about as frequently as need for treatment diminished.”³⁵⁶

314. The Finnish study concluded that cross-sex hormones do not have a positive impact on psychiatric co-morbidities at large, and there can be even a deterioration in psychiatric needs and functioning during the first year of cross-sex hormones and treatment.³⁵⁷ They continue:

“Not all psychiatric and psychosocial problems in adolescents displaying gender dysphoria are secondary to gender identity issues and will not be relieved by medical gender reassignment. An

³⁵³ National Institute of Clinical Health Excellence (NICE) “Evidence Review: Gender-affirming hormones for children and adolescents with gender dysphoria” (2020) [50].

³⁵⁴ Brignardello-Peterson (2022) [3].

³⁵⁵ Brignardello-Peterson (2022) [3].

³⁵⁶ Elkadi [18].

³⁵⁷ Kaltiala (2020)(a) [6].

adolescent’s gender identity concerns must not become a reason for failure to address all her/his other relevant problems in the usual way.”³⁵⁸

315. In a 2023 Australian study, 88% (44/50) of young people who had presented with gender distress at Westmead Children’s Hospital Gender Service for diagnostic assessment of gender dysphoria, reported receiving treatment for ongoing mental health concerns 4-9 years after initial presentation.³⁵⁹

Risks of cross-sex hormones (also called Gender Affirming Hormones (GAH))

316. Cross-sex hormones are associated with cardiovascular disease and venous thromboembolism (VTE)(blood clots in the veins) with use of estrogen. In the case of use of testosterone, there is increased cardiovascular risk, increased myocardial infarction (heart attack), increased blood pressure, decreased HDL- cholesterol, excess weight gain and polycythemia (increased red blood cell mass).³⁶⁰ Polycythemia vera is a rare and chronic disorder involving the overproduction of blood cells in the bone marrow. It causes abnormally high number of circulating blood cells within the blood increasing thickness and volume of blood, causing hyper viscosity. It can have a variety of symptoms in adults including: headaches, fatigue, weakness, dizziness or itchy skin; an enlarged spleen, gastrointestinal issues; risk of blood clot formation.³⁶¹ Cross-sex hormones may also increase the risk of certain cancers.³⁶²

Males: trans female identification

317. The Australian Standards list the following physiological effects of oestrogen on males.³⁶³

Effect of oestrogen	Onset	Maximum	Reversibility
Redistribution of body fat	3-6 months	2-3 years	Likely
Decrease in muscle mass and strength	3-6 months	1-2 years	likely
Softening of skin and decreased oiliness	3-6 months	Unknown	Likely
Decreased libido	1-3 months	3-6 months	Likely
Decreased spontaneous erections	1-3 months	3-6 months	Likely
Breast growth	3-6 months	2-3 years	Not possible
Decreased testicular volume	3-6 months	2-3 years	Unknown
Decreased sperm production	Unknown	>3 years	Unknown

³⁵⁸ Kaltiala (2020)(a) [6].

³⁵⁹ Elkadi [18].

³⁶⁰ Clayton (2022)(c) [3]. SOC 8 [S112]. Polycythemia can have a variety of symptoms in adults including: headaches, fatigue, weakness, dizziness or itchy skin; an enlarged spleen, gastrointestinal issues; risk of blood clot formation.

³⁶¹ NORD “Polycythemia Vera” (2020) 18 November 2020, <https://rarediseases.org/rare-diseases/polycythemia-vera/>

³⁶² Clayton (2022)(c) [3].

³⁶³ Australian Standards (2018) [14].

Effect of oestrogen	Onset	Maximum	Reversibility
Decreased terminal hair growth	6-12 months	>3 years	Possible
Scalp hair	Variable		
Voice changes	None		

Sexual function

318. Estrogen use in males is associated with decreased sexual desire and erectile dysfunction.³⁶⁴ If a male has had his puberty blocked, the penis and testes will be smaller than of an adolescent of the same age.

Fertility

319. If a male has had his puberty blocked and proceeds to cross-sex hormones, his chances of producing viable sperm are low.³⁶⁵ See section on fertility under puberty blockers.

320. If a male ceases oestrogen then his natural testosterone will increase and he will go through puberty. However, he will not go through puberty at the same time as his peers and the impacts of the psychosocial and psychological of this are unknown. There appear to be irreversible effects such as breast growth from oestrogen. Other impacts on testicular volume and sperm production, both of which may impact on sexual function and fertility, are not known.

Females: trans male identification

321. The Australian Standards advise of the following physiological effects of testosterone (Australian Standards adapted from the Endocrine Society Guidelines (2017))³⁶⁶

Effect of testosterone	Onset	Maximum	Reversibility
Skin oiliness and acne	1-6 months	1-2 years	Likely
Facial and body hair growth	6-12 months	4-5 years	Unlikely
Scalp hair loss	6-12 months	-	Unlikely
Increased muscle mass and strength	6-12 months	2-5 years	Likely
Fat redistribution	1-6 months	2-5 years	Likely
Cessation of menses	1-6 months	-	Likely
Clitoral enlargement	1-6 months	1-2 years	Unknown

³⁶⁴ Clayton (2022)(c) [3].

³⁶⁵ Hooven (2021) [229].

³⁶⁶ Australian Standards (2018) [14].

Effect of testosterone	Onset	Maximum	Reversibility
Vaginal atrophy	1-6 months	1-2 years	Unknown
Deepening of voice	6-12 months	1-2 years	Not possible

Facial, head and body hair

322. Testosterone will cause increased body and facial hair and male pattern baldness.³⁶⁷ This is irreversible and may make later detransition very difficult.

Voice

323. During male puberty testosterone interacts with the receptor cells in the larynx to elongate and increase the size of the larynx. Inside the larynx are vocal folds, which are “rubber-band like tissues that stretch across it” which control affect the rate of vibration and sound produced. In male puberty testosterone can cause the diameter of the larynx to increase and the vocal folds to thicken and lengthen, which is important to determine the depth of voice.³⁶⁸ Male puberty masculinizes the voice by building up ligaments and muscles in the larynx and growing facial bones to increase the size of nasal and sinus cavities. Testosterone also lowers the position of the larynx in the neck.³⁶⁹

324. When females take testosterone, it can thicken the vocal folds but has limited impact on the larynx, which remains relatively narrow. The smaller size of the larynx, vocal folds, chest and nasal cavity can all constrain the ability to achieve a deep, powerful voice.³⁷⁰

325. The masculinization of the female voice through testosterone can take place at any age. The voice begins to deepen within 2 to 5 months, stabilizing within a year. It may never reach the depth of a male.³⁷¹ Once the changes in the vocal folds are made, they cannot be undone by blocking testosterone or taking estrogen in later life.³⁷²

Fertility

326. As the vagina and uterus require estrogen for normal development, the absence of estrogen and presence of testosterone causes vaginal atrophy. Further, the use of testosterone can suppress ovulation and alter ovarian histology. The effect of hormone therapy on fertility is “potentially reversible, but the extent is unclear.”³⁷³ There are reported examples of trans males becoming pregnant, but this does not provide evidence about the fecundity of this population. Much depends on when they were first medicalised.

³⁶⁷ WPATH SOC 8 [S83].

³⁶⁸ Hooven (2021) [218].

³⁶⁹ Hooven (2021) [218].

³⁷⁰ Hooven (2021) [220].

³⁷¹ Hooven (2021) [219].

³⁷² Hooven (2021) [219].

³⁷³ Cheng, PJ, et al “Fertility Concerns of the transgender patient” (2019) *Translational Andrology and Urology* Vol 8(3) 209-218 [209].

327. If a female has her puberty suppressed and then proceeds to cross-sex hormones, her chance of producing a viable egg is low.³⁷⁴ As stated, there are no proven methods for fertility preservation for this population. See section on fertility under puberty blockers.

Sexual function

328. Trans male identified young people on testosterone report an increase in sex drive. However, there is evidence that testosterone may impact female sexual desire in a bell shape curve, where the high levels may have no impact or even a negative impact on sexual function.³⁷⁵

329. There are no studies on the sexual function of trans boys/men on testosterone who have had their puberty blocked and then continued to cross-sex hormones. The only studies after of trans men who went through female puberty and then took testosterone. The impacts of the combination of puberty blockade and cross-sex hormones on sexual function are not studied.

330. A reported side effect of testosterone is enlargement of the clitoris, which is made of erectile tissue. Enlargement typically occurs within the first years of treatment with maximal growth at 2 years. Studies have found that the clitoris can enlarge up to 3.83 to 4.6cm over 1-2 years of systematic testosterone treatment.³⁷⁶

331. The vagina is an estrogen responsive organ, removal of estrogen causes the tissues to atrophy. Testosterone decreases the resilience of the vaginal tissues and the lubrication which makes the vagina more prone to tearing and micro-abrasions.³⁷⁷ Vaginal atrophy can take months or years to emerge but can cause pain when walking and particularly during sexual activity.³⁷⁸ There are reports of vaginal lacerations.³⁷⁹ Urinary tract infections can be related to or made worse by vaginal atrophy. The urethra is estrogen responsive and therefore taking testosterone increases the risk of urinary tract infections.³⁸⁰

332. The impact of testosterone on the uterus and pelvic muscles is unknown.³⁸¹ Pelvic pain is another reported side effect of testosterone which may be treated by attention to ensure doses of testosterone are even, anti-inflammatory medications and muscle relaxants.³⁸² There are limited studies on this issue, but one study found that 12% of the 211 subjects experienced pain which led to sexual dysfunction.³⁸³

³⁷⁴ Hooven (2021) [229].

³⁷⁵ Clayton (2022)(c) [3].

³⁷⁶ Grimstad, F, et al, "The role of androgens in clitorophallus development and possible applications to transgender patients" (2021) *Andrology* 9 1719-1728 [1724].

³⁷⁷ Land, Emily, MA, "Q&A: Gynecologic and vaginal care for trans men" San Francisco Aids Foundation (Blog, 23 July 2019) <<https://www.sfaf.org/collections/beta/qa-gynecologic-and-vaginal-care-for-trans-men/>>.

³⁷⁸ Land (2019).

³⁷⁹ Reed, Jamie, "I thought I was saving Trans Kids. Now I'm Blowing the Whistle" (Blog, 9 February 2023) <<https://www.thefp.com/p/i-thought-i-was-saving-trans-kids/>>.

³⁸⁰ Land (2019).

³⁸¹ Land (2019).

³⁸² Land (2019).

³⁸³ Mattawanon, N, et al, "Sexual Dysfunction in Transgender People: A Systematic Review" (2021) *Urologic Clinics of North America* Vol 48(4) 437-460 [441].

Persistence and Risk of Regret

Persistence

333. Until recently, it was universally accepted that for the majority of children their gender dysphoria would not persist into adolescence or adulthood. Eleven international research studies indicate a high resolution of gender incongruence in children by late adolescence or early adulthood without medical intervention.³⁸⁴ The persistence studies were recorded prior to the American Academy of Paediatrics endorsing social transition of children and adolescents³⁸⁵ thereby dramatically increasing the number of children who socially transition. The Dutch did not recommend early social transition as they identified it as likely a factor in persistence of childhood gender dysphoria into adolescence.³⁸⁶ WPATH and the Endocrine Guidelines noted this also.³⁸⁷ It is still considered possible that social transition will predispose a young person to persist with their transgender identity long-term.³⁸⁸

334. After criticism of the 11 international studies, data from 4 international studies from 2008 to 2013 of children referred to specialized gender identity clinics was reanalysed and confirmed the following rates of children's gender dysphoria / gender identity not persisting through adolescence into adulthood:

A. Children with a diagnosis of Gender Dysphoria under the DSM 5 - 67.2% did not persist.

B. Children who were sub-threshold for gender dysphoria diagnosis, 92.9% did not persist.³⁸⁹

335. In 2016, GIDS released its service specification which cited studies showing that gender dysphoria persisted into adulthood for 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995), that is 67-94% of children's gender dysphoria did not persist into adulthood. Boys in these studies were more likely to identify as gay in adulthood than as transgender.³⁹⁰ The persistence rate for girls was believed to be 12-27%. The conclusion being that for the majority of children, gender dysphoria desists over time as they enter adolescence. Although the early introduction of puberty blockers "may mask these developmental changes."³⁹¹

336. A 2020 Nordic and UK study reported that:

"Healthy children vary considerably in gender expression. Of children even with a marked incongruence between their sex and experienced gender, about four out of five are known to

³⁸⁴ Levine (2022) [6].

³⁸⁵ Levine (2022) [6].

³⁸⁶ De Vries (2014) [703].

³⁸⁷ Endocrine Guidelines (2017); WPATH Standard of Care (Version 7).

³⁸⁸ Levine (2022) [6].

³⁸⁹ Zucker, K "The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistence' theories about transgender and gender non-conforming children" by Temple Newhook et al" (2018) International Journal of Transgenderism [4]; Data was from Drummond et al. (2008), Singh (2012), Steensma et al. (2013a), and Wallien and Cohen-Kettenis (2008).

³⁹⁰ NHS Standard Service Contract – Gender Identity Development Service - Service Specification (2016) page 4 of 61 citing (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zucker, 1984) (GIDS Service Specification (2016)) [4].

³⁹¹ GIDS Service Specification (2016) pages 4-5, citing Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

develop toward identifying with their biological sex at puberty. Therefore, medical treatments modifying sexual characteristics are not recommended before puberty.”³⁹²

337. In 2022, the DSM-5-TR says that studies from the Netherlands and North America found the persistence rates for gender dysphoria from childhood into adolescence or adulthood are:

A. In males 2% to 39% (that is 61-98% do not persist); and

B. In females 12% to 50% (that is 50-88% do not persist).³⁹³

338. Importantly the DSM-5-TR says that there is only a modest correlation between persistence and the severity of gender dysphoria at time of childhood baseline. Further the DSM itself acknowledges that early social transition may also be a factor in persistence of gender dysphoria in adolescence.³⁹⁴ This is discussed further below.

339. The rates of persistence raise important questions around diagnosis, treatment and informed consent. If there is a significant chance that the young person’s gender dysphoria will not continue into adulthood, why are children being medicated?

Regret

340. In a 2022 family law case, the treating paediatrician gave evidence that:

“Regret of having undertaken the treatment. This is estimated to be 0.3-0.6% which includes regret due to change to gender identification and regret due to social pressure or other external factors.”

341. This percentage comes from a Dutch study by Wiepjes et al (2018) which found that 0.6% of transwomen and 0.3% of transmen in their study were identified as experiencing regret.³⁹⁵ The study included both adults and adolescents treated at the Dutch gender clinic. The patients were subject to the strict requirements of the Dutch protocol. Only those that underwent a gonadectomy (removal of testis or ovaries) (not medication alone and not medication plus mastectomy) – were assessed for regret/detransition. That patients assessed for regret ranged in age from 25 to 54 years at the start of hormone therapy.³⁹⁶ Regret was stringently defined (as recorded by the clinician in the clinical record plus the prescription of hormones consistent with sex).³⁹⁷ Deceased patients were excluded.³⁹⁸ The study only included those patients who continued in follow-up (36% of the study population dropped out of follow up).³⁹⁹ They were followed up at a range of 0.4 to 41.6 years, with the average 6.4 years⁴⁰⁰ but the vast majority had a relatively short follow-up

³⁹² Kaltiala (2020(b)) [40].

³⁹³ DSM-5 TR [516].

³⁹⁴ DSM-5 TR [516].

³⁹⁵ Wiepjes, CM, et al “The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment and Regrets.” (2018) *Journal of Sexual Medicine* Vol 15 582-590 [582].

³⁹⁶ Wiepjes (2018) [585].

³⁹⁷ Wiepjes (2018) [583].

³⁹⁸ Wiepjes (2018) [584].

³⁹⁹ Wiepjes (2018) [589].

⁴⁰⁰ Wiepjes (2018) [585].

period.⁴⁰¹ The average time for regret was about 10 years.⁴⁰² The authors acknowledge that their findings could be an underestimation of regret rates because some patients may choose to go elsewhere for reversal therapy, some may experience regret without pursuing reversal therapy and as the average time to regret was 130 months (just over 10 years), it was too early to examine regret rates in people who started hormone treatment in the past 10 years.⁴⁰³

342. Most contemporary youth gender clinics do not follow the strict Dutch protocol, which limits the applicability of this study. The strict requirements of this study would have excluded detransitioners such as Kiera Bell, who underwent hormone therapy and a bilateral mastectomy but not a gonadectomy.⁴⁰⁴
343. A major difficulty in this area is that there is no diagnostic test for whether a child /young person will persist with their cross-gender identification into adulthood. As can be seen above, having a diagnosis of gender dysphoria is not predictive of future persistence. The previous studies were of children with early childhood onset gender dysphoria. Currently the predominant presentation is adolescent onset gender dysphoria and their trajectories are less clear.⁴⁰⁵

“A growing body of evidence suggests that for many teens and young adults, a post-pubertal onset of transgender identification can be a transient phase of identity exploration, rather than a permanent identity as evidenced by the growing number of detransitioners....in the last several years since gender-affirmative care has become popularized, the rate of detransition appears to be accelerating.”⁴⁰⁶

344. Professor Cass states:

“Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally.”⁴⁰⁷

345. Rates of regret are not accurately known, and records of gender clinics cannot be relied upon as detransitioners may not return to gender clinics, particularly paediatric gender clinics, to inform of their regret/detransition.

346. Despite the lack of data, there is international concern about regret. The Finnish, Swedish, UK guidelines raise concerns about this issue, which are referred to in the 2023 Westmead study.

“The emerging voices of detransitioners have identified important issues. Some have reported that they had come to believe that gender-affirming medical treatment would alleviate their feelings of dysphoria, but it had not. Some have highlighted the potential for adverse outcomes, particularly in relation to interventions whose effects cannot be reversed (ie: cross-sex hormones and gender-affirming surgery). Some have reported that, in hindsight, because of their age or

⁴⁰¹ Clayton, A, “The Gender Affirmative Treatment Model for Youth with Gender Dysphoria: A Medical Advance or Dangerous Medicine” (2022) Archives of Sexual Behaviour Vol 51 691-698 [695] (Clayton (2022)(a)).

⁴⁰² Wiepjes (2018) [589].

⁴⁰³ Wiepjes (2018) [589].

⁴⁰⁴ Clayton (2022)(a) [695].

⁴⁰⁵ Levine (2022) [6].

⁴⁰⁶ Levine (2022) [6].

⁴⁰⁷ Cass Review – Interim (2022) [36] 3.21.

mental health concerns, they were not fit to give consent at the time it was required. Some raise regrets about making decisions about their sexuality before that sexuality-and their understanding of that sexuality – was explored and clarified. Finally, some think – in retrospect – that they were misguided in focusing exclusively on their gender dysphoria: that they should also have considered and addressed some of the concurrent adverse childhood experiences and issues pertaining to peer relationships and emerging sexuality that were contributing to their subjective distress and loss of wellbeing. In this scenario the professionals’ affirmation of the gender dysphoria was seen as simplistic and superficial, reflecting a failure to take a more in-depth approach and to examine what was going on underneath.”⁴⁰⁸

347. As a result of the concerns, Westmead adopted what they describe as a “cautious, carefully considered, individually tailored approach” which involved significant psychological support.⁴⁰⁹ They followed up children between 4 and 9 years after their presentation at the gender service.⁴¹⁰ Of the 68 children with a diagnosis of gender dysphoria, 2 were lost to follow up, 6 desisted and 1 persisted in his transgender identity but ceased medical intervention.⁴¹¹ The rate of desistance for those formally diagnosed with Gender Dysphoria was 9.1% (6/66).⁴¹² Almost 1 out of 10 young people who had held a deep-seated desire for medical transition, desisted. In relation to the whole group who had presented with gender distress, 22.1% (17/77) desisted.⁴¹³ The study shows that even with careful screening, psychiatric assessment, comprehensive biopsychosocial assessment (including family assessments) and holistic therapeutic support, almost 1 in 10 children were at risk of starting or continuing down a medical pathway with significant risks. Westmead conclude that it is “ill-advised to loosen up the requirement for a psychiatric diagnostic (biopsychosocial) assessment for young people with gender related distress seeking medical interventions.”⁴¹⁴ Using their data, if that requirement was removed “one could project that more than a fifth of the sample (17/77, or 22.1%, in our study) could have been exposed to inappropriate medical treatment, future regret and potential harm.”⁴¹⁵

348. A 2022 US study reported on the discontinuation rates of cross-sex hormones in transgender adults and adolescents, with follow-up at 4 years. The 4-year gender affirming hormones discontinuation rate was 25.6% for those who had commenced gender affirming hormones under 18 years.⁴¹⁶

349. A 2021 UK Study from an adult gender clinic found 6.9% of those treated with gender affirmative interventions detransitioned within 16 months of starting treatment and another 3.4% were anticipated to do so, suggesting a detransition rate of over 10%. Another 21.7% disengaged from the service without completing treatment. Another UK study from a primary care facility, found that 12.2% of those who started hormonal treatments either detransitioned or documented regret, while 20% stopped treatment for a variety of reasons.⁴¹⁷

⁴⁰⁸ Elkadi (2023) [7].

⁴⁰⁹ Elkadi (2023) [7].

⁴¹⁰ Elkadi (2023) [12].

⁴¹¹ Elkadi (2023) [13].

⁴¹² Elkadi (2023) [13].

⁴¹³ Elkadi (2023) [12].

⁴¹⁴ Elkadi (2023) [17].

⁴¹⁵ Elkadi (2023) [17].

⁴¹⁶ Roberts, CM, et al “Continuation of Gender-affirming Hormones Among Transgender Adolescents and Adults” (2022) *Journal of Clinical Endocrinology & Metabolism* Vol 107(9) 3937-3943 [3].

⁴¹⁷ Levine (2022) [7].

350. Discontinuance rate does not equate to desistence, however this statistic raises questions about the asserted low rate of regret.

351. The reality is that the rates of regret may not be known for many years, given that the average time to regret appears to be about 10 years.

Detransition

352. It is argued that a significant reason for regret is due to social pressure or other external factors.

353. In 2021, Lisa Littman released a study on 100 detransitioners, who had largely transitioned before 2015.⁴¹⁸ In order to qualify as medically or surgically transitioned the participants had to have one or more of: puberty blockers, cross-sex hormones, anti-androgens or a surgical procedure and then subsequently detransitioned by stopping medications or having had surgery to reverse the changes from transition. 70% of the participants were female, 90% were white, over 80% had college education. 56% had experienced early onset gender dysphoria, 44% post-puberty onset. The female participants were on average 20 years when they sought medical care transition and 24 years old when they decided to detransition. The men were older, average 26 years to seek medical transition and 33 years on average to detransition.

354. What medical treatments had they received:

- a. Cross-sex hormones (96%);
 - i. Females took testosterone on average for 2 years;
 - ii. Males took estrogen on average 5 years and anti-androgen on average 3 years
- b. Surgeries:
 - i. Females:
 1. 33% had mastectomy
 2. 1% had genital surgery
 - ii. Males:
 1. 16% had breast augmentation
 2. 16% had genital surgery

355. In order to detransition, 95% stopped cross-sex hormones and 9% had surgery.

356. The expressed reasons for transition were:

- a. For both sexes 77% said wanting to be perceived as their target gender;
- b. Females:
 - i. Feeling wrong in their bodies (74%);
 - ii. Belief that transition was the only option for feeling better (73%)
 - iii. To reduce gender-related harassment (51%)

⁴¹⁸ Littman, Lisa "Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners." Littman, L (2021) Archives of Sexual Behaviour Vol 50(8) 3353-3369.

c. Males:

- i. They would become their true selves through transition (71%)
- ii. Belief that transition would eliminate their gender dysphoria (71%)
- iii. To reduce gender-related harassment (16%)

357. Importantly:

“Nearly a third (30%) endorsed the response “someone else told me that the feelings I was having meant that I was transgender and I believed them” to describe how they felt about identifying as transgender in the past. Many participants selected social media, online communities, and in-person friend groups as sources that encouraged them to believe that transitioning would help them.”⁴¹⁹

358. The expressed reasons for detransition were:

- a. Both sexes: leading reason was becoming more comfortable with identifying with their sex “due to a change in personal definition of female and male” (female 65% and males 48%)
- b. Females:
 - i. Concerns about medical complications from transitioning (58%);
 - ii. Dissatisfaction with medical results / too much change (51%).
 - iii. Feeling that they were being discriminated against (17%)
- c. Males:
 - i. Dissatisfaction with physical results / too little change (36%)
 - ii. Deteriorating physical health (36%)
 - iii. Continued mental health problems (36%);
 - iv. Feeling that they were being discriminated against (36%)

359. Most respondents (70%) were dissatisfied with their decision to transition and 85% were satisfied with their decision to detransition. 61% had returned to identifying with their birth sex, 14% identified as nonbinary and 8% identified as transgender.

360. The authors at SEGM provide the following takeaway:

“This study describes the experiences of the individuals who transitioned largely before 2015, the year when the landscape of gender care drastically changed. The numbers of young people expressing gender-related distress have sharply risen in 2015 for reasons that remain poorly understood. At the same time, the “gender-affirmative” approach to treating gender dysphoria, which supports the use of hormonal and surgical interventions as first-line treatment, has become widely adopted, while the “informed consent model of care” eliminated the requirement for mental health evaluations. It is likely that the problems highlighted by the study are even more prevalent today, and if not addressed, they may lead to increasing numbers of individuals subjected to inappropriate medical interventions for their gender distress.”⁴²⁰

⁴¹⁹ Littman (2021).

⁴²⁰ Littman (2021).

361. Even though hormonal and surgical treatments have been employed by much of the Western world for some decades, there has been little attempt to follow up past patients.

Stage 3: Surgery

362. Gender affirming surgery is aimed at aligning the young person's body more closely with their gender identity, thereby hoping to improve mental health. Gender affirmation surgery on minors must assume that the young person's gender identity is fixed for life. There is no diagnostic test to determine which children's gender identity will persist into adulthood. Surgeries are not reversible.

363. The surgical options for males in one trans surgery clinic⁴²¹ are described as:

- A. Facial feminization surgery: can include brow lift with bossing, scalp advancement, nose reshaping, blepharoplasty, tracheal shave, cheek implants, lip lift, lip and cheek implants, cheek softening, face and neck lift.
- B. Breast augmentation: breast implants.
- C. Body feminization surgery: trunk liposuction and buttocks augmentation, with the transfer of fat from the trunk to the buttocks area;
- D. Gender confirmation surgery: several procedures resulting in "penile inversion therapy" where the penis is turned inside out to form the inner walls of a "neo vagina". The head of the penis is used to create a clitoris. Outer and inner labia are formed, and the urethra is shortened and repositioned. The result is asserted to be a fully functioning female genitalia allowing penetration, orgasm, and urination.

364. Despite the descriptions in a US study in 2019, transwomen reported having genital surgery at rates between 5-13%, meaning that 87-95% retain their genitals.⁴²² The difficulty with statistics on rates of surgery is that they are likely to be impacted by the extent to which the costs of surgeries are covered by the State or medical insurance.

365. Surgical options for females are less appealing generally to transmen themselves. In a 2015 US study, about 36% of transmen have a double mastectomy called "top surgery", while about 61% want it. In contrast about 3% have phalloplasty and only about 13% desire it.⁴²³

366. In 2019, Associate Professor Michelle Telfer from the RCHGS and President of AusPath, sought funding for chest masculinization surgery (double mastectomies) for young people under 18 years of age describing it as "an integral part of transition process for trans males". Further, Telfer asserted that international research demonstrates high satisfaction with surgical outcomes, low levels of surgical complications and improved mental health outcomes with lowered rates of anxiety and depression.⁴²⁴ This contrasted with the conclusions of Brignardello-Petersen from the Florida-review below. Telfer cited 3 studies, one of which was a study from 2017 of 14 patients,

⁴²¹ The Transcenter <<https://www.thetranscenter.com/>>.

⁴²² Nolan, I, C Kuhner, and G Dy, "Demographic and temporal trends in transgender identities and gender confirming surgery" (2019) *Translational Andrology and Urology* Vol 8(3) 184–190.

⁴²³ Shrier [176]-[177].

⁴²⁴ Witness Statement Associate Professor Michelle Telfer – Royal Commission into Victoria's Mental Health System 1 July 2019 [17] and [82].

with some data only on 10 patients. The study itself, while listing self-reported satisfaction as a benefit, noted the study's limitations as: small number of subjects, relatively short follow up, lack of objective comprehensive measure of the subjects' satisfaction and/or change in psychological status before and after the procedure.⁴²⁵

367. According to John Hopkins Hospital phalloplasty is a multi-staged procedure (likely 3 stages) which involves a donor site, taking "skins flaps" to create a penis from one of the radial forearms, anterolateral thigh flap (leg) or musculocutaneous latissimus dorsi flap (side). These "skin flaps" are in fact the skin, fat, nerves and arteries of the arm from the wrist to halfway up the forearm or similar length from the other sites.⁴²⁶

368. There are significant implications arising from these surgical interventions. The implications for boys who have taken puberty blockers are significant, as male genitalia may not have increased in size sufficiently for more standard surgical interventions. Jazz Jennings an American male to female transsexual had insufficient genital material to fashion a neo-vagina, the surgeons used a skin graft and tissue from her abdominal lining to complete the surgery. The surgery had complications.⁴²⁷

369. In relation to surgeries Brignardello-Petersen and Wiercioch concluded:

"There were no systematic reviews and studies reporting on gender dysphoria, depression, anxiety and suicidality. There, the effects of surgeries on these outcomes (when compared to a group of patients with gender dysphoria who did not undergo surgery), or the changes in these outcomes (improvements or deterioration) among patients who undergo any gender-affirming surgery is unknown. Because of the lack of comparable studies, it is also unknown whether people with gender dysphoria who undergo surgeries experience more improvement in quality of life or less regret than those with gender dysphoria who do not undergo surgery. There is low certainty evidence suggesting that a low percentage of participants expressed regret, and very low certainty evidence about changes in quality of life after surgery."⁴²⁸

370. Brignardello-Petersen and Wiercioch summarise their findings in relation to stages 1, 2 and 3:

"Due to the important limitations in the body of evidence, there is great uncertainty about the effects of puberty blockers, cross-sex hormones and surgeries in young people with gender dysphoria. This evidence alone is not sufficient to support whether using or not using these treatments. We encourage decision makers to be explicit and transparent about which factors play an important role in their decision, and how they are weighed and traded off."⁴²⁹

371. The foundational Dutch studies did not study the impact of surgery separately from cross-sex hormones and psychotherapy.

⁴²⁵ Marinkovic, M., Newfiled, R.S., "Chest Reconstructive surgeries in transmasculine youth: experience from one pediatric center" (2017) *International Journal of Transgenderism* Vol 18(4) [381]. Telfer relied upon de Vries (2014) which did not distinguish between outcomes for cross-sex hormones and surgery.

⁴²⁶ John Hopkins Medicine, The Centre for Transgender Health FAQ Phalloplasty.

⁴²⁷ Muldowney et al, "Transgender teen and 'I Am Jazz' star Jazz Jennings on sharing the final steps of her transition journey: her gender confirmation surgery" (ABCNews, 16 October 2018) <<https://abcnews.go.com/Health/transgender-teen-jazz-star-jazz-jennings-sharing-final/story?id=58513271>>.

⁴²⁸ Brignardello-Petersen (2022) [3].

⁴²⁹ Brignardello-Petersen (2022) [3].

Fertility

372. Genital surgery renders males infertile. If females have their reproductive system interfered with, they will also be sterilised. Impaired fertility and sterility are important as while it is generally assumed that transgender people do not want to have biological children, several studies have shown that not to be the case with one study showing over 50% of transmen and transwomen wanting to have children.⁴³⁰

Breastfeeding

373. Further, double mastectomies will mean that a female will be unable to breast feed, should she later cease taking testosterone and be able to conceive. This has implications for the mother's mental health and the child's attachment and nutrition and may not currently be part of the informed consent process.⁴³¹

Sexual function

374. If a male has had his puberty suppressed, continues to cross-sex hormones and then surgery, there is unlikely to be sufficient genital material to fashion a neo-vagina. Abdominal tissue may be used. Such surgery is more complicated and there are significant risks to the capacity for orgasm as set out above.

375. Regardless of the surgical technique, the transwoman will need to use a vaginal dilator to maintain the size and shape of the vaginal canal and to keep it open. This will need to be done for the rest of the transwoman's life. Failing to dilate adequately and consistently will mean that the skin inside the vagina will shrink and contract, ultimately leading to irreversible shortening and narrowing of the canal, or stenosis.⁴³²

376. Recommendations as to how many times a day it will need to be done vary, however dilation reduces in frequency over time.

E *The Current State of the Law in Australia*

377. In 2013, the Full Court in *Re Jamie*⁴³³ held that prescription of puberty blockers (stage 1) for the treatment of childhood gender identity disorder does not require the consent of the FCFCOA if the parents, the child, and the treating professionals are in agreement. However, it held that Court approval was required for stage 2 treatment, cross-sex hormones. Bryant CJ held relevantly in relation to puberty blockade (stage one):

[108] ...stage one treatment of childhood gender identity disorder is reversible, is not attended by grave risk if a wrong decision is made, and is for the treatment of a malfunction or disease, being a psychological rather than physiological disease. As such, absent controversy, it falls within the

⁴³⁰ Cheng (2019) [210].

⁴³¹ Gribble, K.D, Bewley, S., Dahlen, H.G "Breastfeeding grief after chest masculinisation mastectomy and detransition: A case report with lessons about unanticipated harm" (2023) *Frontiers in Global Womens' Health* 03 Vol 4.

⁴³² Inglefield, C, "How does dilation work after gender confirmation surgery?" *The London Transgender Clinic* (Blog, 26 January 2022) <<https://www.thelondontransgenderclinic.uk/general/how-does-dilation-work-after-gender-confirmation-surgery/>>.

⁴³³ *Re Jamie* (2013) 278 FLR 155.

wide ambit of parentally responsibility reposing in parents when a child is not yet able to make his or her own decisions about treatment.”

378. In 2017, the Full Court in *Re Kelvin*⁴³⁴ held that the prescription of cross-sex hormones to adolescents did not require the approval of the Court if the parents, the child, and the treating practitioners agree. The majority of the Full Court opined that while *Re Jamie* may have been the proper application of *Re Marion* at the time it was decided, “but since then, the science had moved on, changing the factual basis upon which the decision in *Re Jamie* had rested. The therapeutic benefits of the treatment had been shown to outweigh the risks. This justified departure from its recent and carefully considered earlier judgment.”⁴³⁵

379. *Re Kelvin* was a case stated to the Full Court without the benefit of findings of fact from a judge. The Court was reliant upon an agreed set of facts provided by the parties and there was no proper contradictor. The majority of the Full Court in *Re Kelvin* based their decision upon a number of facts as set out in the case stated which are challenged by more recent scientific studies and reviews:

- A. WPATH Standards of Care and Endocrine Society Treatment guidelines are the basis of treatment protocols internationally, including throughout Australia.⁴³⁶
- B. Stage 1 puberty blocking treatment and the effects of treatment are reversible when used for a limited time for approximately 3 – 4 years.⁴³⁷
- C. Puberty blocking acts as a pause, allowing children to “mature emotionally and cognitively such that they can achieve maturity sufficient to provide consent for stage 2 treatment.”⁴³⁸
- D. Stage 1 treatment is ideally commenced in the early stages of puberty (Tanner Stage 2) which can occur from approximately 9 – 12 years of age.⁴³⁹
- E. Stage 2 treatment does not necessarily cause long term infertility, however options regarding the young person’s future ability to have biological children are explored prior to commencement of stage 2.⁴⁴⁰
- F. Individuals with gender dysphoria who commence cross-sex hormones “generally report improvements in psychological well-being.”⁴⁴¹

380. The majority held at [162]:

“The consensus of the applicant, the ICL and all but one of the intervenors, is that the development in the treatment of and the understanding of Gender Dysphoria allows this Court to depart from the decision in *Re Jamie*. In other words, the risks involved and the consequences

⁴³⁴ *Re Kelvin* (2017) 327 FLR 15.

⁴³⁵ Parkinson, Patrick, “Reconsidering Kelvin: Cross-sex hormone treatment as a response to adolescent gender dysphoria.” (2022) *Australian Journal of Family Law* 35 [162].

⁴³⁶ *Re Kelvin* [8].

⁴³⁷ *Re Kelvin* [12].

⁴³⁸ *Re Kelvin* [12].

⁴³⁹ *Re Kelvin* [12].

⁴⁴⁰ *Re Kelvin* [15].

⁴⁴¹ *Re Kelvin* [20].

which arise out of the treatment being at least in some respects reversible, can no longer be said to outweigh the therapeutic benefits of the treatment, and court authorisation is not required. This is so, of course, only where the diagnosis has been made by proper assessment and where the treatment to be administered is in accordance with the best practice guidelines described in the case stated.”

381. The majority held that the reasons for the departure from *Re Jamie* was due to legally relevant factual differences... “those differences relate to the advances in medical science regarding the purpose for which the treatment is provided, the nature of the treatment, and the risks involved in undergoing, withholding or delaying treatment.”⁴⁴²
382. Professor Patrick Parkinson argues that the decision in *Re Kelvin* does not provide an authoritative determination of the issues which it purported to settle as the majority “had no evidential basis for their conclusion that new developments in the medical and scientific understanding of gender dysphoria justified a different decision than was reached in *Re Jamie*.” This is because the Court did not admit any such evidence and the propositions in the case stated were not tested by a contradictor.⁴⁴³
383. Watts J in *Re Imogen* [No. 6] [2020] FamCA 761 held that Court approval is required if either parent or treating clinicians dispute the Gillick competence of the young person, the diagnosis or proposed treatment.⁴⁴⁴ If an application is made to the Court about an adolescent being Gillick competent and that is the only dispute, the Court should determine that dispute by way of a declaration under s34(1) of the Act. If the adolescent is found to be Gillick competent, then the court is not required to make a determination about the proposed treatment on best interest principles. Rather the adolescent is left to determine their treatment without court authorisation.⁴⁴⁵
384. However, His Honour held that notwithstanding a finding of Gillick competence, if there is a dispute about diagnosis or treatment, the court should:
- A. Determine the diagnosis;
 - B. Determine whether treatment is appropriate, having regard to the adolescent’s best interests as the paramount consideration; and
 - C. Make an order authorising or not authorising treatment pursuant to s.67ZC of the Act on best interests considerations.
385. Importantly, Watts J held, that if a parent or legal guardian does not consent to an adolescent’s treatment for gender dysphoria, a medical practitioner, who is willing to do so, should not administer treatment to an adolescent who wishes it, without court authorisation.⁴⁴⁶

⁴⁴² *Re Kelvin* [175].

⁴⁴³ Parkinson (2022).

⁴⁴⁴ *Re Imogen* (No.6) [2020] FamCA 761.

⁴⁴⁵ *Re Imogen* (No.6) [35].

⁴⁴⁶ *Re Imogen* (No.6) [35(d)].

386. His Honour confirmed that the same principles apply to Stage 3 treatment, following the decision of Her Honour Justice Rees in *Re Matthew* (2018).⁴⁴⁷ Rees J found a double mastectomy was a therapeutic treatment for Matthew's gender dysphoria.⁴⁴⁸

Determining what is appropriate in an evolving medical debate

387. A 2023 study from Westmead hospital says relevantly:

“In the last five years, however, the gender-affirming medical model has been questioned by both clinicians (who have highlighted the current lack of a solid evidence base) and detransitioners (who have highlighted the potential for adverse outcomes. The current evidence suggests the need for a much more nuanced and complex approach. As research data pertaining to long-term outcomes continues to accumulate, “the best way to proceed” is likely to be seen as ranging over a much more diverse range of treatment options and pathways, with each supported by a stronger evidence base than is currently available.”⁴⁴⁹

388. Given more recent questioning of the medical affirmation model through the High Court in *Bell v Tavistock*,⁴⁵⁰ the Cass Review in the United Kingdom, the reviews and changes of approach in Sweden, Finland and Florida, United States, as Professor Parkinson opines:

“Exploration of any of these three areas of dispute [Gillick competence, diagnosis and / or treatment] in contested proceedings will require courts to reconsider some of the issues which, it is argued, were not properly examined by the Court in *Re Kelvin*. This is likely to necessitate a more nuanced and balanced examination of the state of the medical and scientific evidence and the issues of controversy and uncertainty which surround the question of whether the benefits of treatment are likely to outweigh the risks in any given case.”⁴⁵¹

Applications to Court

389. Most children attending gender services have no contact with the Family Law system. Both parents sign authorities and informed consent documents for their children to receive puberty blockers and / or cross-sex hormones.

390. Gender dysphoria issues are dealt with pursuant to the FCFCOA Rules on Medical procedure proceedings, rule 1.11.

1.11 Medical procedure proceedings

(1) This rule applies to applications:

- (a) for an order authorising a major medical procedure for a child that is not for the purpose of treating a bodily malfunction or disease; or
- (b) where there is a dispute about the Gillick competence of, or the diagnosis or treatment of a child for gender dysphoria as defined in the Diagnostic and Statistical

⁴⁴⁷ *Re Matthew* [2018] FamCA 161. Matthew a female who identified as a trans male sought the removal of her breasts, known as chest masculinisation surgery or top surgery. She was 15 years of age at the time of the hearing.

⁴⁴⁸ *Re Matthew* [46].

⁴⁴⁹ *Elkdi* (2023) [20].

⁴⁵⁰ *Bell v Tavistock* [2020] [Admin].

⁴⁵¹ *Parkinson* (2022) [13].

Manual of Mental Disorders (DSM-5) at 302.85 or any subsequent or similar definition.

391. An application can be made by a parent, someone with a parenting order, the child, an independent children’s lawyer, or a person concerned with the child’s care, welfare and development.⁴⁵²
392. The Applicant must produce evidence that satisfies the Court that the proposed medical procedure is in the best interests of the child.⁴⁵³

Rule 1.11(5) sets out the required evidence:

- (5) The evidence must include evidence from a medical, psychological or other relevant expert witness that establishes the following:
- (a) the exact nature and purpose of the proposed medical procedure;
 - (b) the particular condition of the child for which the procedure is required;
 - (c) the likely long-term physical, social and psychological effects on the child:
 - (i) if the procedure is carried out; and
 - (ii) if the procedure is not carried out;
 - (d) the nature and degree of any risk to the child from the procedure;
 - (e) if alternative and less invasive treatment is available—the reason the procedure is recommended instead of the alternative treatments;
 - (f) that the procedure is necessary for the welfare of the child;
 - (g) if the child is capable of making an informed decision about the procedure—whether the child agrees to the procedure;
 - (h) if the child is incapable of making an informed decision about the procedure—that the child:
 - (i) is currently incapable of making an informed decision; and
 - (ii) is unlikely to develop sufficiently to be able to make an informed decision within the time in which the procedure should be carried out, or within the foreseeable future;
 - (i) whether the child’s parents or carer agree to the procedure.
- (6) The evidence in support of an application under this rule may be given:
- (a) in the form of an affidavit; or
 - (b) with the court’s permission, orally.
- (7) An application to which this rule applies and any document filed with it must be served on the prescribed child welfare authority.

393. There is also a Family Law Practice Direction – Medical procedure proceedings dated 28 November 2022. This practice direction applies to cases brought after September 2021 and requires any application to be served on the relevant child welfare authority.⁴⁵⁴

⁴⁵² Federal Circuit and Family Court of Australia (Family Law) Rules 2021 (FCFCOA Rules) 1.11(2).

⁴⁵³ FCFCOA Rules 1.11(4).

⁴⁵⁴ Family Law Practice Direction – Medical procedure proceedings [2.12]-[2.13].

Expert evidence

394. Normally the Applicant will be relying upon the opinion of the child / young person's treating practitioners, most likely paediatrician, psychologist, psychiatrist and perhaps endocrinologist as is permissible under the Rules without the Court's permission.⁴⁵⁵

395. Under the FCFCOA rules a single expert would normally be appointed, perhaps to reassess the child and give an expert opinion.

7.02 Purpose of Part 7.1

The purpose of this Part is as follows:

- (a) to ensure that parties obtain expert evidence only in relation to a significant issue in dispute;
- (b) to restrict expert evidence to that which is necessary to resolve or determine a proceeding;
- (c) to ensure that, if practicable and without compromising the interests of justice, expert evidence is given on an issue by a single expert witness;
- (d) to avoid unnecessary costs arising from the appointment of more than one expert witness;
- (e) to enable a party to apply for permission to tender a report or adduce evidence from an expert witness appointed by that party, if that is necessary in the interests of justice.

396. Given the heavily polarised debate, not just in Australia but internationally, it would be very difficult to find a single expert, practising in gender medicine who would be able to present the Court with a neutral view. It could be argued that it is in the interests of justice to allow the party opposing medicalisation to call their own expert witnesses. This is the very area where justice is better served by having experts who can set out the differences of medical opinion, medical evidence, benefits, risks, and nature and extent of the informed consent for the Court.

7.11 Application for permission for expert witness

- (1) A party may seek permission to tender a report or adduce evidence from an expert witness by filing an Application in a Proceeding.
- (2) The affidavit filed with the application must state the following:
 - (a) whether the party has attempted to agree on the appointment of a single expert witness with the other party and, if not, why not;
 - (b) the name of the expert witness;
 - (c) the issue about which the expert witness's evidence is to be given;
 - (d) the reason the expert evidence is necessary in relation to that issue;
 - (e) the field in which the expert witness is expert;
 - (f) the expert witness's training, study or experience that qualifies the expert witness as having specialised knowledge on the issue;
 - (g) whether there is any previous connection between the expert witness and the party.
- (3) When considering whether to permit a party to tender a report or adduce evidence from an expert witness, the court may take into account the following:

⁴⁵⁵ FCFCOA Rules 7.01(1).

- (a) the purpose of this Part (see rule 7.02);
- (b) the impact of the appointment of an expert witness on the costs of the proceeding;
- (c) the likelihood of the appointment expediting or delaying the proceeding;
- (d) the complexity of the issues in the proceeding;
- (e) whether the evidence should be given by a single expert witness rather than an expert witness appointed by one party only;
- (f) whether the expert witness has specialised knowledge, based on the person's training, study or experience:
 - (i) relevant to the issue on which evidence is to be given; and
 - (ii) appropriate to the value, complexity and importance of the proceeding.

(4) If the court grants a party permission to tender a report or adduce evidence from an expert witness, the permission is limited to the expert witness named, and the field of expertise stated, in the order.

397. The additional evidence will inevitably extend the trial, however it is difficult to see how the Court can determine the appropriateness of the treatment in the individual case, where a child or young person has been diagnosed with gender dysphoria, and whether the treatment is proportionate to its purpose.⁴⁵⁶

F Key issues for consideration

398. The key issues therefore which the Court is required to determine regarding the proposed medical pathway are:

- a. The nature and purpose of the proposed treatment.
- b. Thoroughness and reliability of the diagnostic process.
- c. Consideration (if any) given to alternative less invasive treatments.
- d. Consent and risks (how informed is the consent of each of the parent and the child).

399. Even if the child is not Gillick competent, often the gender service medical experts refer to the child's understanding of the diagnosis of Gender Dysphoria and the proposed medical pathway as a factor in support of medicalisation, consideration of the child's understanding is important.

400. If the child is asserted to be Gillick competent by the treating medical practitioners, consideration of the information provided to the child/ young person and consideration of his/her capacity to understand the implications of the decision will vary with the risks and benefits.

I. Nature and purpose of the proposed treatment

401. The Australian Guidelines set out a medical pathway in 3 stages:⁴⁵⁷

Stage 1: Puberty blockade with a GnRHa administered via injection.

Stage 2: Gender affirming hormone treatment – using either oestrogen to feminize the body of a male, or testosterone to masculinize the body of a female.

⁴⁵⁶ Parkinson (2022) [18].

⁴⁵⁷ Re Kelvin [11]-[16].

Stage 3: Surgical interventions – chest reconstructive surgery (called top surgery), phalloplasty, hysterectomy, bilateral salpingectomy (removal of both fallopian tubes), creation of a neo vagina, vaginoplasty.⁴⁵⁸

402. The asserted risks and benefits of the medical pathway is set out above.

403. There is significant international medical and scientific debate about the purpose and impact of treatment. What is being treated and what evidence is there to support that the proposed treatment is effective? As set out above, there is no consensus as to whether a child or young person's gender identity, upon which the gender dysphoria is based, is likely to be permanent. Are these children and young people juvenile trans adults, whose identity is fixed? For some, could their gender dysphoria be explained by something else, which they might grow out of on their own or with the assistance of therapy?⁴⁵⁹ How does a clinician determine whether a young person's dislike of their genitalia is due to trauma from sexual abuse or gender dysphoria? What is the difference between body dysmorphia about a limb or a nose and body dysmorphia about genitals or breasts that causes the conditions to be treated so differently?

404. Further, what is the evidence base to support medical intervention? Why would a child's identity be medicalised if it is not permanent? Two recent studies from the United Kingdom and Florida, USA have raised significant concerns about the quality of the evidence to support the medicalisation of children with gender dysphoria.⁴⁶⁰ New guidelines from Finland, France, Sweden and the United Kingdom have moved away from a medicalisation model and recommend the need for research:

“..including, in particular, the collection of short- and long-term outcome measures that examine the impact of gender-affirming medical treatment on the felt sense of gender dysphoria, mental health, quality of life, and physical well-being, including the treatment's risks, regarding bone health, metabolic outcomes, sexual function, fertility, cognitive and emotional development and other health outcomes.

A key problem at present is that data from outcomes studies are sparse, inconsistent and low in terms of evidence-based gradings – especially with regard to children and adolescents. Another major concern is the lack of longitudinal studies that document the developmental trajectories and physical and mental health outcomes of all participants, including those that continue along a GD pathway and those that do not. Concerns pertaining to consent have also been raised.”⁴⁶¹

405. In Australia similar concerns have been raised by researchers and clinicians from Westmead Children's Hospital gender service which is part of the Sydney Children's Hospital network.

⁴⁵⁸ Re Kelvin [16].

⁴⁵⁹ Barnes, Hannah “Time to Think”: The Inside Story of the Collapse of the Tavistock's Gender Service for Children” Swift (2023) [65].

⁴⁶⁰ Brignardello-Petersen (2022); SEGM, “New Systematic Reviews of Puberty Blockers and Cross-Sex Hormones Published by NICE: weighing potential benefits against profound long-term uncertainties” (Blog, 31 March 2021) <https://segm.org/NICE_gender_medicine_systematic_review_finds_poor_quality_evidence>.

⁴⁶¹ Elkadi (2023) [7].

Grading of evidence

406. In order to more fully understand the debate, it is important to understand the quality of the evidence available.
407. Evidence is graded in a hierarchical system which relates to the quality and reliability of the study design. The gradings are illustrated by a pyramid, which indicates the quality and quantity of the evidence, the higher up the better the quality of the evidence.⁴⁶² OpenMD defines the evidence levels as follows going from 1st tier quality down. Systematic reviews and meta analyses rely upon filtered information. The balance rely on unfiltered information.

Systematic Review and Meta-Analysis

A systematic review synthesizes the results from all available studies of a particular health topic, answering a specific research question by collecting and evaluating all research evidence that fits the reviewer's selection criteria.³

Systematic reviews can include meta-analyses in which statistical methods are applied to evaluate and synthesize quantitative results from multiple studies.

Randomized Controlled Trial (RCT)

A randomized controlled trial is a prospective study that measures the efficacy of an intervention or treatment. Subjects are randomly assigned to either an experimental group or a control group; the control group receives a placebo or sham intervention, while the experimental group receives the intervention being studied. Randomizing subjects is effective at removing bias, thus increasing the validity of the research. RCTs are frequently blinded so that neither the subjects (single blind), nor the clinicians (double blind), nor the researchers (triple blind) know in which group the subjects are placed.⁴

Cohort Study

A cohort study is a type of observational study, meaning that no intervention is taken among the subjects. It is also a type of longitudinal study in which research subjects are followed over a period of time.⁵ A cohort study can be either prospective, which collects new data over time, or retrospective, which uses previously acquired data or medical records. This type of study examines a group of people who share a common trait or exposure and are assessed based on whether they develop an outcome of interest. An example of a prospective cohort study is a study that determines which subjects smoke and then many years later assesses the incidence of lung cancer in both smokers and non-smokers.

Case-Control Study

A case-control study is another type of observational study. It is also a type of retrospective study that looks backwards in time to assess information. A case-control study compares people who have the specified condition or outcome being studied (known as "cases") with people who do not have the condition or outcome (known as "controls").⁶ An example of a case-control study is a study that assesses the lifetime smoking exposure of patients with and without lung cancer.

⁴⁶² Cass Review – Interim (2022) [62] 5.19; OpenMD, "New Evidence in Medical Research" (2021).

Case Series and Reports

A case report is a detailed report of the presentation, diagnosis, treatment, treatment response, and follow-up after treatment of an individual patient. A case series is a group of case reports involving patients who share similar characteristics. A case series is observational and can be conducted either retrospectively or prospectively.

Cross-Sectional Study

Also called a prevalence study, a cross-sectional study examines subjects at a single point in time. By definition, a cross-sectional study is only observational.⁷ An example of a cross-sectional study is a survey of a population to determine the prevalence of lung cancer.”⁴⁶³

408. The lowest level of evidence is expert opinion / clinical consensus.

II. Thoroughness and reliability of the diagnostic process

Diagnostic & Statistical Manual of Mental Disorders, 5th Edition (DSM-5-TR)

409. In Australia, in the authorities of Re Jamie, Re Kelvin and Re Imogen as set out above, a diagnosis of gender dysphoria was required before the child / young person is eligible for medical treatment for gender transition, whether it be stage 1 or 2. Part of the rationale was to balance the advised risks against the asserted benefit of amelioration of clinically significant distress.

410. The diagnosis is made pursuant to the criteria for gender dysphoria in childhood or the criteria for gender dysphoria in adolescence and adulthood. Once a young person has commenced puberty, they are able to be diagnosed under the adolescent criteria.

411. Professor Cass says relevantly:

“When it comes to gender dysphoria, there are no blood tests or other laboratory tests, so assessment and diagnosis in children and young people with gender-related distress is reliant on the judgments of experienced clinicians. Because medical, and subsequently possibly surgical treatments will follow, it may be argued that a highly sensitive and specific assessment process is required. The assessment should be able to accurately identify those children or young people for whom physical intervention is going to be the best course of action, but it is equally important that it identifies those who need an alternative pathway or treatment.”⁴⁶⁴

412. Services and clinicians may have divergent opinions around sex, gender identity and causes of the cause of the dysphoria which will likely influence the nature and extent of the diagnostic process. It will likely influence what might be considered relevant in the child’s and family’s history and whether, or the extent to which, there is consideration of any factors which might have led the child to the conclusion about his/her gender identity.

413. Even if the child / young person has a diagnosis of gender dysphoria, what do the clinicians opine is the likelihood of lifetime persistence of the gender identity? Again, the clinicians’ underlying

⁴⁶³ OpenMD (2021) Referred to in Cass Review – Interim (2022) [62].

⁴⁶⁴ Cass Review – Interim (2022) [60] 5.14.

belief about the extent to which a child / young person's gender identity is likely to persist will significantly influence the pathway.

414. Under the gender affirming treatment model, the child is said to “know who they are, and what they need.” The child's stated gender identity is not to be challenged or investigated, other than to perhaps confirm how long the child has felt like this. The DSM-5 requires the child to have met criterion A1 for at least 6 months. The duration of the cross-gender identity does not need to be observed by the clinician, it can be established by the history given by the child and or family. Under the narrow GAT model, the clinician's job is to assist the child move down the pathway of medical transition at the child's pace.
415. A more cautious model, such as seen at Westmead Hospital, has a longer assessment and diagnostic process and considers what may have led the child / young person to their conclusion about their gender identity. Considers broader mental health and neurodiversity issues and how they may be addressed.
416. Professor Cass says that a diagnostic framework is important for gender dysphoria because clinicians will need to determine:
- A. The stability of the child's gender identity, and whether there might be other causes for gender related distress.
 - B. Are there other issues or diagnoses that might have an impact on the child / young person's mental health. The Dutch approach suggesting these should be addressed prior to or alongside initiation of any medical treatments.
 - C. That any life altering treatments are administered on an appropriate decision-making process.⁴⁶⁵
417. The developmental model similarly adopts a biopsychosocial model, with a greater focus on therapeutic intervention and avoidance of medical intervention until adulthood if at all possible. This is due to the poor evidence base or benefits and the increasing and significant concerns about risks.⁴⁶⁶

DSM-5-TR Gender Dysphoria in childhood

Gender Dysphoria in childhood

418. Gender dysphoria is diagnosed under the DSM-5-TR.⁴⁶⁷ The two main elements are incongruence and clinically significant distress.
- A. A marked incongruence between one's experienced / expressed gender and assigned gender of at least 6 months duration, manifested by at least 6 out of 8 criteria (one must be A1):
 - 1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender from one's assigned gender).

⁴⁶⁵ Cass Review - Interim (2022) [59] 5.12.

⁴⁶⁶ Gender Exploratory Therapy Association (GETA), “GETA Membership Statement” (Web Page) <<https://www.gendexploratory.com/statement/>>.

⁴⁶⁷ DSM-5-TR was published in 2022. There are significant changes in the commentary with DSM-5.

2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to wearing typical feminine clothing.
 3. A strong preference for cross-gender roles in make-believe play or fantasy play.
 4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
 5. A strong preference for playmates of the other gender.
 6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
 7. A strong dislike of one's sexual anatomy.
 8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
- B. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

DSM-5-TR Gender Dysphoria in Adolescents and Adults

GD in Adolescents and Adults

419. The DSM-5-TR provides:

- A. A marked incongruence between one's experienced / expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
 1. A marked incongruence between one's experienced / expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced / expressed gender (or in young adolescents, a desire to prevent the development of anticipated secondary sex characteristics).
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

420. As Professor Hilary Cass stated there are two problems associated with the use of the DSM-5:

“Firstly, several of the criteria are based on gender stereotyping which may not be deemed relevant in current society, although the core criteria remain valid.

Secondly, and more importantly, these criteria give a basis on which to make a diagnosis that a young person is clinically distressed by the incongruence between their birth-registered and their experienced gender, but they do not help in determining which factors may have led to this distress and how they might be resolved.”⁴⁶⁸

Sex stereotyping

421. The criteria for childhood are behaviour based and rely upon rigid sex stereotypes. In a recent family law case the diagnosing psychologist gave evidence that activities, toys, and sports are divided notionally into masculine and feminine with the classification based on the clinician’s assessment of historical stereotypes. The 10-year-old female playing basketball, surfing, watching Dr Who and the movie Antman was considered to meet criteria A4 as these interests “aligned more closely to those of same-aged male peers.” The child’s reasons for the interests were not explored. The child having a close friend of the opposite sex was said to meet A5, despite no investigation as to the context of the relationship. Her having short hair and wearing shorts and jeans and avoiding skirts and dresses met A2.

422. The adolescent criteria are also reliant upon gender stereotyping. What does it mean to wish to be treated as the other gender and, what are the typical feelings and reactions of men and women? Where are there objective standards to say that a clinician or young person’s interpretation is correct. In a 2022 family law case the young adolescent’s treating paediatrician gave evidence that:

“He has a strong conviction that he has always had the typical feelings and reactions of someone who is male. This is not necessarily consistent with “stereotypical male feelings”, but he demonstrates thoughtfulness, empathy, compassion for others and a desire to protect his mother and sister, which is consistent with typical feelings of many men in today’s society.”

423. Could it be said that the feelings expressed are sufficiently male to meet the criteria under A6? What are the typical feelings of a non-binary person or eunuch?

ICD 11

424. Not all countries require a diagnosis of gender dysphoria before gender affirming medical treatment can be provided.⁴⁶⁹ The World Health Organization uses the International Statistical Classification of Diseases and Related Health Problems (ICD) currently ICD-11 which came into

⁴⁶⁸ Cass Review - Interim (2022) [60] 5.15.

⁴⁶⁹ WPATH SOC-8 [S7]; ICD-11.

effect in January 2022.⁴⁷⁰ Gender incongruence is classified under “conditions related to sexual health.”

425. Gender incongruence of childhood (HA61) is characterised by:

“..a marked incongruence between an individual’s experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child’s part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.”

426. Gender incongruence of adolescence or adulthood (HA60) is characterised by:

“..a marked and persistent incongruence between an individual’s experienced gender and the assigned sex, which often leads to a desire to ‘transition’, in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual’s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.”

427. Many of the terms such as “marked incongruence”, “strong desire” and “strong dislike” are not defined. Diagnosis relies upon stereotyped behaviour for children and is unclear as to how many criteria must be met. There is no specific guidance on differences in age-of-onset, severity levels, pervasiveness across contexts, or sociocultural factors. Experience and expressed gender as combined as if they are the same. The most important element is the absence of clinically significant distress, which is required under the DSM 5 TR criterion B.⁴⁷¹

428. If Australia was to change the diagnostic criteria from a diagnosis of gender dysphoria pursuant to the DSM 5 TR to childhood or adolescent gender incongruence under ICD 11, a significant rationale for medicalisation would evaporate. The arguments for medical transition of the child or young person would be presumably constructed around notions of self-actualisation and wishes. Given the outcomes of the 2023 Westmead study, one would expect that the risks of a child or young person being incorrectly placed on the medical pathway would increase significantly. The Westmead study participants’ rate of desistance from the group diagnosed with gender dysphoria under the DSM 5 which went through their stepped process was 9.1% and for the whole group including those that did not meet all of the diagnostic criteria, the desistance was 22.1%. Noting that these children / young people’s follow up was between 4 and 9 years after first contact with the service.

⁴⁷⁰ World Health Organisation, “International Classification of Diseases 11th Revision” (Web Page, May 2019) <<https://www.who.int/standards/classifications/classification-of-diseases>>.

⁴⁷¹ Analysis provided by Dr John Blythe, clinical psychologist.

Impact of Complex Presentation on Diagnostic Process

429. Many children presenting at gender clinics around the country (and around the western world), have complex presentations. Westmead Children's Hospital appears representative: high levels of distress (including dysphoria about gender), suicidal ideation (41.8%), self-harm (16.3%) and suicide attempts (10.1%), high rates of co-morbid mental health disorders including anxiety (63.3%), depression (62%), and behavioural disorders (35.4%) and autism (13.9%)⁴⁷². High rates of adverse childhood experiences, family conflict (65.8%), parental mental illness (63.3%), loss of important figures via separation (59.5%), bullying (54.5%), and maltreatment (39.2%).⁴⁷³
430. The gender affirmative model views "serious psychiatric comorbidity" as caused by discrimination, social exclusion, bullying etc. It is asserted that gender affirming care will ameliorate harm and improve mental health outcomes.⁴⁷⁴ This is contested.
431. The developmental model and the Westmead model employ a biopsychosocial assessment to identify and address the multiple potential causes of the poor mental health and loss of well-being of the child / adolescent, including gender dysphoria. The model relies upon psychotherapy work for the child and family to be in a better position to reflectively consider their approach to the child's gender dysphoria.⁴⁷⁵ Both of these models allow the possibility of the child's cross-gender identification and gender dysphoria as being caused or influenced by other factors which need to be explored. The model requires access to multi-disciplinary services.

Autism

432. The co-occurrence of gender dysphoria and autism is well known in the currently presenting cohort of children. However, there has been little research on the reasons.
433. In 2018 there was a consensus statement issued from multiple experts providing guidelines for co-occurring ASD and gender dysphoria. They are known as the Strang Guidelines and are referred to in the Australian Standards.⁴⁷⁶
434. The Strang guidelines explain the complexity of ASD in the context of gender dysphoria:
- ASD is often a debilitating disorder, with studies reporting generally poor long-term (adult) outcomes in terms of independence and meaningful employment. Even for individuals with average or above average intelligence, estimates indicate that only 9% reach full adult functional independence. Deficits in social skills and communication, and the presence of repetitive behaviours / overfocused interests characterize the diagnosis. Children and adolescents with ASD often show profoundly underdeveloped adaptive/independence skills, which are related to problems with executive function skills. Typical ASD executive function profiles include problems with cognitive and behavioural flexibility, as well as with organisation and planning (eg setting and completing goals.)

⁴⁷² Autism diagnosis in the community is under 3%. The over-representation of children and adolescents with diagnoses of ASD is not well understood.

⁴⁷³ Kozłowska (2021)(b) [71].

⁴⁷⁴ Australian Guidelines version 1.3 [1]; WPATH SOC-8 [S6]-[7].

⁴⁷⁵ Kozłowska (2021)(b) [73].

⁴⁷⁶ Australian Standards of Care [9].

The co-occurrence of ASD and GNC/ND in adolescents presents significant diagnostic and treatment challenges given the social, adaptive, self-awareness, communication, and executive function complexities of youth with ASD.⁴⁷⁷

435. ASD has the potential to complicate issues in the diagnosis and treatment of process for gender dysphoria:

- A. Gender dysphoria symptoms may appear to stem from ASD symptoms and may be dismissed as a trait of ASD, and ASD can be missed if clinicians view a child's social difficulties as stemming from gender dysphoria related challenges.⁴⁷⁸
- B. ASD communication deficits can result in unclear, tangential communications which can make it difficult to know how an adolescent truly feels about their gender.⁴⁷⁹
- C. ASD related executive function deficits may result in concrete thinking and struggle with ambiguity, making it difficult to under the long-term implications of gender transition / medical treatment.
- D. A tendency to interpret language in a literal way and more black and white thinking style will mean that information will need to be presented in carefully and clearly.
- E. ASD-related symptoms can sometimes create or intensify an identification with gender dysphoria. Rigid, overly concrete thinking in adolescents with ASD and milder gender concerns may lead some children/adolescents to assume that their gender non-conforming interests/traits imply full gender dysphoria and a need for transition.⁴⁸⁰
- F. Adolescents with ASD may struggle to consider an "in between", being a feminine male etc. They may also assume that their same sex attraction means that they must be a different gender.⁴⁸¹

436. Given the high incidence of ASD in adolescents presenting with gender dysphoria, gender dysphoric and gender non-confirming adolescents should be screened for ASD.⁴⁸² The Strang guidelines state relevantly when an ASD diagnosis is suspected:

"When an ASD diagnosis is suspected, it is important for an autism specialist to confirm the diagnosis, if a diagnosis has not been established. Whenever possible, a neuropsychological/autism evaluation should be conducted to evaluate the impact of ASD on an adolescent's ability to understand and report GD symptoms as well as engage in therapy/treatments. Evaluations should include assessment of general cognitive skills, executive function skills (impulse control, flexibility, planning, future thinking), communication skills,

⁴⁷⁷ Strang, JF, et al "Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adults." (2018) Journal of Clinical Child & Adolescent Psychology Vol 47(1) 105-115 [106]-[107]

⁴⁷⁸ Strang (2018) [109]

⁴⁷⁹ Strang (2018) [110]

⁴⁸⁰ Strang (2018) [110]

⁴⁸¹ Strang (2018) [110]

⁴⁸² Strang (2018) [109]

emotional functioning, self-awareness/social cognition, and capacity for self-advocacy. Knowledge of the young person's capacities will inform the GD diagnosis process."⁴⁸³

437. Adolescents with ASD who are in an exploratory phase of gender (with unclear or inconsistent signs of gender dysphoria) should be encouraged to explore their identity over time before being considered for irreversible medical treatments.⁴⁸⁴

Clinical work may help adolescents explore whether they might be more comfortable with their body than they originally assert and/or whether they might feel comfortable identifying somewhere outside of the gender binary (i.e., "gender spectrum"). A focus on comorbid symptoms may be helpful during this phase, such as treatments targeting executive function (e.g., flexibility/big picture thinking), communication, social cognition, and so on. By providing concrete psychoeducation about how gender for some people can be fluid, not just binary and physical, and concurrent intervention targeting flexible thinking and self-awareness, some individuals with less urgent gender presentations may realize that full gender transition does not fit them. These young people may become more comfortable with a less binary solution, such as maintaining a female body while expressing some male-typical interests/behaviors.⁴⁸⁵

438. Strang suggests that more caution should be taken with the ASD population before deciding on medical treatments that might have irreversible effects.

Because it is often harder for an adolescent with ASD to comprehend the long-term risks and implications of gender-related medical interventions, consenting for treatment may be more complex in this population.⁴⁸⁶

439. There was no consensus on the exact criteria for commencing medical treatments in this population.⁴⁸⁷

Differential diagnosis

440. A differential diagnosis is standard clinical practice in other areas of medicine. Professor Cass argues that it is equally applicable here. A differential diagnosis involves:

"summarising the main point of the clinical assessment, the most likely diagnosis, other possible diagnoses and the reasons for including or excluding them, as well as any further assessments that may be required to clarify the diagnosis and the treatment option and plan. This is important when a medical intervention is being provided on the basis of the assessment, so the process is robust, explicit and reproducible."⁴⁸⁸

441. The DSM-5 TR also refers to consideration being given to differential diagnoses of:

- A. Non-conformity to gender roles
- B. Transvestic disorder

⁴⁸³ Strang (2018) [109] Figure 1 Assessment protocol.

⁴⁸⁴ Strang (2018) [111]

⁴⁸⁵ Strang (2018) [111]

⁴⁸⁶ Strang (2018) [111]

⁴⁸⁷ Strang (2018) [111]

⁴⁸⁸ Cass Review - Interim (2022) [61] 5.18

- C. Body dysmorphic disorder
- D. Autism Spectrum disorder
- E. Schizophrenia and other psychotic disorders
- F. Other clinical presentations⁴⁸⁹

Formulation

442. A standard form of clinical practice in mental health is the use of a formulation:

“a diagnostic or psychological formulation... is a holistic summary of how the patient is feeling and why, and how to make sense of it, and a plan for moving forward with management and treatment.”⁴⁹⁰

443. The formulation will change over time as more information is gathered. Formulations are likely to be an important source of information for the Court, correspondingly an absence of formulations should raise concerns about the nature and extent of the diagnostic process.

Iatrogenic causation

444. A concern about the gender affirming model is that it risks iatrogenically causing the gender dysphoria. That is, the child's gender dysphoria being caused by the treatment. By way of example, if a child's current gender identification is continuously affirmed by medical professionals, there is a risk that it may reinforce an otherwise transient identity. Encouragement to socially transition may also impact how strongly the identity is held and how difficult it may be for a child or young person to step back from the identity. Concerns have also been raised about a child being educated under this model that the only pathway to authenticity and psychological health and well-being is through medical transition, rather than exploring possibilities for an authentic transgender identity without medicalisation. The child may have been told that it is simply a matter of time before treatment can be commenced, regardless of lack of consent of a parent. A challenge to the child's ability to obtain puberty blockers and / cross-sex hormones is likely to be perceived as a threat to self-actualisation and may impact negatively on their mental health and cause distress.

445. It is important for the Court to understand if there has ever been a Plan B, or any preparation of the child for not getting access to the medical pathway. It must surely be best practice for gender affirming therapists to prepare a child with multiple options, particularly in circumstances where consent of both parents may be an issue.

III. Consideration of alternative less invasive treatments

446. Alternative treatments, like medicalisation, are subject to scientific limitations. There is insufficient research supporting these interventions, there are no control groups and nor has there been systematic follow up of patients at pre-determined intervals with predetermined means of

⁴⁸⁹ DSM 5-TR [519]-[520]

⁴⁹⁰ Cass Review - Interim (2022) [61] 5.18

measurement.⁴⁹¹ However, in the case of alternative therapeutic interventions, there are no irreversible impacts.

Harm minimization under the Australian Standards

447. The Australian Standards do not offer alternative treatment options. The discussion of harm minimisation and alternatives in the Australian Standards is limited to avoiding harm by not withholding treatment. It says relevantly as follows:

“Avoiding harm is an important ethical consideration for health professionals when considering different options for medical and surgical intervention. Withholding of gender affirming treatment is not considered a neutral option and may exacerbate distress in a number of ways including increasing depression, anxiety and suicidality, social withdrawal, as well as possibly increasing chances of young people illegally accessing medications. In the past, psychological practices attempting to change a person’s gender identity to be more aligned with their sex assigned at birth were used. Such practices, typically known as conversion or reparative therapies, lack efficacy, are considered unethical and may cause lasting damage to a child or adolescent’s social and emotional health and wellbeing.”⁴⁹²

Is psychotherapy gender suppression?

448. Proponents of the gender affirmative model assert that the first line treatment for gender dysphoria is the medical pathway. The alternatives posited by the Australian Standards are to follow a medical pathway (puberty blockers / cross sex hormones) or not receive puberty blockers and cross-sex hormones. There are simply no alternative treatments to address a child or young person’s gender dysphoria and to question the subjectively held belief and to try and relieve distress is characterised as “conversion practice”.

449. The assertion that anything other than psychotherapy that positively affirms the child’s current transgender identity is conversion therapy is contested. Critics say that there is a wide range of ethical and agenda-free psychotherapeutic options which are not conversion therapy.⁴⁹³ To equate psychotherapy with conversion therapy is said to misunderstand the complexity of psychotherapy.⁴⁹⁴

450. Since the Standards of Care have been released many states have enacted Change or Suppression legislation,⁴⁹⁵ which makes attempts to suppress or change a person’s gender identity subject to criminal or civil consequences.

451. In February 2021, Victoria introduced the Change or Suppression (Conversion) Practices Prohibition Act 2021 (Vic). Under the Act, change or suppression practices are prohibited. Victoria

⁴⁹¹ Levine (2022) [5]

⁴⁹² Australian Standards of Care [5]; Cantor, James, “American Academy of Pediatrics policy and trans-kids: Fact-checking” (2018) *BJPsych Bulletin* 45(5) 315–316 - Dr James Cantor states in 2018 there were no studies on conversion practices on transgender identity, there are only studies of conversion practices on adults in relation to sexual orientation.

⁴⁹³ D’Angelo, Roberto et al “One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria” (2021) *Archives of Sexual Behaviour* Vol 50 7–16 [1]

⁴⁹⁴ D’Angelo (2020) [1]

⁴⁹⁵ Change or Suppression (Conversion) Practices Prohibition Act 2021 (Vic); amendments to the Public Health Act 2005 (QLD); Sexuality and Gender Identity Conversion Practices Act 2020 (ACT); and changes promised by premiers in New South Wales, Tasmania and Western Australia.

has adopted a gender self-identification model, regardless of medical intervention. In Victoria the Equal Opportunity Act 2010 (Vic) includes a definition of “gender identity” meaning a person's gender-related identity, which may or may not correspond with their designated sex at birth, and includes the personal sense of the body (whether this involves medical intervention or not) and other expressions of gender, including dress, speech, mannerisms, names and personal references.

452. The Victorian Equal Opportunity and Human Rights Commission describes prohibited practices as:

Change or suppression practices can involve people receiving subtle and repeated messages, that with faith and effort, they can change or hide their sexual orientation or gender identity. Change or suppression practices are not just religious or faith based and can also include counselling, psychotherapy and support groups.⁴⁹⁶

453. It is not clear how this will be interpreted by clinicians, police and Human Rights organisations in Victoria and other States and Territories. Will there be a reluctance to treat gender questioning children or young people, or if treatment is provided, a concern about challenging the child or young person's own view of themselves and the reason for transgender identification and distress?

454. It seems that there is evidence supporting these concerns coming out of the UK. In March 2022, Professor Cass stated that during her review some clinicians reported feeling

“unable to undertake the process of assessment and differential diagnosis that would be the norm in their clinical practice because they perceived that there is an expectation of an unquestioning affirmative approach. They felt that this was at odds with a more open holistic evaluation of the factors underpinning the young person's presentation, and consideration of the full range of possible support and treatment options.”⁴⁹⁷

455. The impact of this reluctance is clinicians referring children and young people to the GIDS where the waiting list as of March 2022 exceeded 2 ½ years.⁴⁹⁸ While on the waiting list these young people, who statistically have significant comorbidities with mental health as well as a neurodiverse profile, are not being provided with the same level of care and support as other children and young people with significant distress.

456. The assertion of lack of alternatives to medicalisation is contested internationally and within Australia. In a 2023 article, Westmead Children's Hospital refer to children who may be diagnosed with Gender Dysphoria being potentially eligible for “a range of treatment options yielding different developmental pathways and choices.”⁴⁹⁹ In recent years, some countries are returning to implementing therapeutic processes as first line treatment, as seen in for example Finland, Sweden and United Kingdom.

⁴⁹⁶ <<https://www.humanrights.vic.gov.au/>>.

⁴⁹⁷ Cass BJM (2022).

⁴⁹⁸ Cass BJM (2022).

⁴⁹⁹ Elkadi (2023) [1].

Gender exploratory therapy

457. Gender exploratory therapy which holds a neutral attitude towards the outcome of the child / young person's trans identity. The approach treats identity development as "a complex, gradual process that can be influenced by a variety of factors and mental health issues." Identity exploration is normal for young people and the therapy offers exploration of identity, including gender identity.⁵⁰⁰
458. The National Association of Practising Psychiatrists in NSW recommends individualised psychosocial interventions (eg: psychoeducation, individual therapy, school-home liaison, family therapy) as first-line treatments for young people with gender dysphoria or incongruence and that these treatments should be undertaken before any experimental puberty-blocking drugs and other medical interventions (cross-sex hormones, sex reassignment surgery) should be considered.⁵⁰¹
459. As stated above, the National Health Service (NHS) England, Sweden and Finland have moved to therapy as first line treatment. In 2022 the NHS released a guidance:
- "A significant proportion of children and young people who are concerned about or distressed by issues of gender incongruence, experience co-existing mental health, neurodevelopmental and/or family or social complexities in their lives.
- The relationship between these aspects and gender incongruence may not be readily apparent and will often require careful exploration.
- The primary intervention for children and young people who are assessed as suitable for The Service is psychosocial (including psychoeducation) and psychological support and intervention; the main objective is to alleviate distress associated with gender dysphoria and promote the individual's global functioning and wellbeing."⁵⁰²
460. In a 2020 Nordic and UK study, reference is made to the potential for adolescents with gender dysphoria who "may benefit from psychotherapeutic work in order to explore gender identity, alleviate distress and tack psychosocial problems and comorbid disorders...".⁵⁰³ The report notes that they may also wish to proceed to medical transition. The importance is that psychotherapeutic work appears to be one of a range of options.

Social transition / affirmation

461. Social transition refers to a change of name, pronouns, clothing, and hairstyle, of a child or young person and is often seen as a benign intervention. This may not be the case.
462. The Australian Standards of Care discusses social transition in positive terms. First stating that social transition should be led by the child and that it has a positive impact and little if any risk.
- "social transition can reduce a child's distress and improve their emotional functioning. Evidence suggests that trans children who have socially transitioned demonstrate rates of depression,

⁵⁰⁰ GETA (no date).

⁵⁰¹ Elkadi (2023) [5].

⁵⁰² NHS (2022).

⁵⁰³ Kaltialo, 2020(b) [40].

anxiety and self-worth comparable to their cisgender peers. The number of children in Australia who later socially transition back to their gender assigned at birth is not known, but anecdotally appears to be low and no current evidence of harm in doing so exists.”⁵⁰⁴

463. AusPath says that social transition “has been shown to provide benefits to the health and well-being of many trans people, especially trans youth.”⁵⁰⁵

464. A 2021 German study says:

“To this date, the possible benefits or disadvantages of an “early” social transition for a child’s future development are among the most controversially discussed topics in Transgender Health Care.”⁵⁰⁶

Increased social transition

465. The social transition of children and young people has increased over the last few decades, with little research on the impacts. In the Netherlands, between 2000 and 2004, only 3.3% of the 121 pre-pubertal children presenting at the Dutch gender clinic had completely socially transitioned (clothing, hairstyle, change of name and pronouns) when they were referred. 19% were living in a preferred gender role (clothing and hairstyle) but did not want a change of name or pronoun. The percentages increased in 2005 to 8.9% totally socially transitioned to 33.3% partial social transition.⁵⁰⁷

466. Associate Professor Diane Ehrensaft, developmental and clinical psychologist, who is a founding member of the Child and Adolescent Gender Centre in San Francisco, has observed that the socially transitioned children are now making up about 90% of the children on puberty blockers in her studies. The puberty blockers are not to pause for time but rather to “ward off an unwanted puberty”. Blockers are seen to provide continuity of affirmative care.⁵⁰⁸

467. We do not know the percentage of children presenting to the various gender centres in Australia who are socially transitioned. We do know that it is encouraged as a first step. The RCHGS has a program called “First Assessment Single-Session Triage” (FASST) to reduce waiting times. The FASST model has the child/young person and their family attend a 90-minute face to face session with a clinical nurse consultant or medical fellow. The sessions involve “initial assessment and triage” while delivering information to the young person and their family about things like how to socially transition at home or at school.⁵⁰⁹ Noting that this is pre- assessment and diagnosis of gender dysphoria.

⁵⁰⁴ Australian Standards of Care - The Standards refer to studies Olson, K et al “Mental health of transgender children who are supported in their identities.” *Pediatrics* 2016;137(3);320153223 and Durwood et al “Mental Health and self-worth in socially transitioned transgender youth.” *J Am Acad Child Adolesc Psychiatry* 2017;56(2):116-123 e112.

⁵⁰⁵ AusPATH (2022) [4].

⁵⁰⁶ Sievert (2021) [80].

⁵⁰⁷ GIDS (2016) [5].

⁵⁰⁸ Ehrensaft, Diane PhD, “Fertility Issues for Transgender and Non-binary Youth” (UC San Francisco Child and Adolescent Gender Center, 2021).

⁵⁰⁹ University of Melbourne, “Transgender health outcomes” (Blog, no date)

<[104](https://medicine.unimelb.edu.au/engage/alumni/chiron/transgender-health-outcomes#:~:text=A%20recent%20community%2Dbased%20survey,72%20per%20cent%20with%20anxiety>.”</p></div><div data-bbox=)

468. A 2023 Melbourne study revealed that many children are socially transitioning prior to attending gender clinics, from 2017-2020 36% of 6–12-year-olds were fully socially transitioned at baseline, 54% were partially transitioned and only 10% not transitioned. For the 13-17 year olds, 42% were fully transitioned, 53% were partially transitioned and only 5% were not socially transitioned either at baseline or after attending FASST.⁵¹⁰

Risks and concerns about social transition

469. Dr Cass released an interim report in March 2022 in which she said about social transition:

“Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes.”⁵¹¹

470. In 2012 the Dutch researchers advised that young children should not make complete social transition before the age of puberty, “because most gender dysphoric children will not remain gender dysphoric through adolescence.”⁵¹² The authors were concerned about children with non-persisting gender dysphoria having to make a complex change back to the role of the gender associated with their sex. Some children who have socially transitioned “barely realise that they are the other natal sex”, making it hard for them to accept the multiple and protracted treatments that they will need, and they may have unrealistic expectations of what medical intervention can realistically deliver.⁵¹³ This can impact on their ability to give informed consent. Parents were advised to:

- A. Encourage their child to stay in contact with child and adult role models of their sex.
- B. Encourage a wider range of interests in objects and activities that go with their sex.
- C. Not prohibit gender variant behaviour.

471. The Dutch researchers encouraged parents to find

“a sensible middle of the road approach between accepting and supportive attitude towards their child’s gender dysphoria, while at the same time protecting their child against negative reactions from other and remaining realistic about the situation. If they speak about their natal son as being a girl with a penis, we stress that they have a male child who very much wants to be a girl, but will need invasive treatment to align his body with his identity if this desire does not remit.”⁵¹⁴

472. Once a child has socially transitioned, arguably it will be difficult for them to return to identifying with their sex; their identity and how people interact with them is as a member of the opposite

⁵¹⁰ Engel (2023) [8].

⁵¹¹ Cass Review [62].

⁵¹² De Vries, ALC and PT Cohen-Kettenis, “Clinical Management of Gender Dysphoria: The Dutch Approach” (2012) *Journal of Homosexuality* Vol 59(3) 301-20 [308].

⁵¹³ De Vries (2012) [308].

⁵¹⁴ De Vries (2012) [308].

gender.⁵¹⁵ Social transition may therefore play a role in consolidating a child's otherwise transient transgender identity.

473. In 2013, Dutch researchers identified social transition as a significant indicator of adolescent persistence with gender dysphoria:

"Childhood social transitions were important predictors of persistence, especially among natal boys. Social transitions were associated with more intense GD in childhood but have never been independently studied regarding the possible impact of the social transition itself on cognitive representation of gender identity or persistence."⁵¹⁶

474. Steensma identified that the number of socially transitioning children was increasing which could result in a larger proportion of children having to transition back to the gender role associated with their sex accompanied with a possible struggle, "or it may, with the hypothesized link between social transitioning and the cognitive representation of the self, influence the future rates of persistence."⁵¹⁷

475. Due to the lack of studies and knowledge about the impact of social transition on persistence, professionals were advised to provide information to help parents "weigh the potential benefits and challenges of particular choices..."⁵¹⁸

476. In a 2019 study, researchers assessed the impact of childhood social gender transition (SGT) as a means of reducing psychological distress and improving wellbeing. The children who socially transitioned had a change of name, pronouns and were living as the opposite sex. They were compared with children who remained in their gender role while being allowed to express gender non-conformity. The researchers found no difference in any of the Child Behaviour Checklist domains between the two groups. The domains included internalising and externalising behaviours: anxious, depressed, somatic complaints, social problems, thought problems, attention problems, rule breaking behaviour and aggressive behaviour. The authors instead finding that the only predictor of challenges was poor peer relations rather than transition status.⁵¹⁹

477. In 2021, a German study concluded that the impact of family functioning and quality of peer relationships, rather than social transition, were identified as key factors benefitting psychological functioning.⁵²⁰

478. In March 2022, Dr Cass stated:

"Social transition – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their

⁵¹⁵ De Vries (2012) [308].

⁵¹⁶ Steensma, TD, et al "Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study" (2013) *Journal of the American Academy of Child & Adolescent Psychiatry* Vol 52(6) [589].

⁵¹⁷ Steensma (2013) [589].

⁵¹⁸ Steensma (2013) [589] citing the WPATH Standards of Care at the time.

⁵¹⁹ SEGM analysis of Wong et al (2019) "Childhood social gender transition and psychological well-being: A comparison to cisgender variant children." <<http://segm.org/studies>>; Wong, WI, et al, "Childhood social gender transition and psychological well-being: A comparison to cisgender variant children" (2019) *Clinical Practice in Pediatric Psychology* Vol 7(3) 241-253.

⁵²⁰ Sievert (2021) [92].

psychological functioning. There are different views on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes.”⁵²¹

479. In 2022, a 5-year study of the gender-identity trajectory of transgender-identified children who underwent early social gender transition (SGT) was released.⁵²² The children were on average 6-7 years old (mean 6.5 years) at the time of SGT. They were on average 8.1 years at the time of recruitment for the study. 5 years after social transition, at average age of 11-12 years, 97.5% continued to identify as transgender (with 3.5% identifying as non-binary) and only 2.5% desisting. 1.3% retransitioned to their natal gender and back to binary trans identities.⁵²³ Further, 29% had started puberty blockers and 31% cross-sex hormones by the end of the study.⁵²⁴

480. Criticisms of the study are that a low rate of desistence is in sharp contrast to earlier research demonstrating that most cases of childhood onset gender dysphoria tend to resolve sometime during adolescence and before reaching mature adulthood. ⁵²⁵ Also, that there are serious concerns about many aspects of the 5 year study, but conclude that there are 3 matters that can be drawn from the study: ⁵²⁶

- A. Little is known about the trajectories of children who undergo early social gender transition;
- B. Children in the study who underwent early social transition appear to be persisting in their transgender identity at very high rates; and
- C. Most of the early socially transitioned children in the study proceeded to medical transition, and the rest will likely do so also.

481. The study is argued to support the proposition that “children who claim a transgender identity and undergo early social transition rarely change their minds, at least into their early teen years.” ⁵²⁷

IV. Informed consent of parent(s) and child

482. Whether a young person is Gillick competent requires an assessment of whether s/he has gained sufficient intelligence and maturity to understand the nature and consequences of the particular medical treatment.⁵²⁸ In the absence of Gillick competence, parents are normally charged with the decision making and if there is disagreement, Division 1 of the Federal Circuit and Family Court of Australia.

⁵²¹ Cass BMJ (2022).

⁵²² Olson, KR, Durwood MS, et al “Gender Identity 5 years after Social Transition” (2022) Pediatrics Vol 150(2).

⁵²³ Olson (2022) [3].

⁵²⁴ Olson (2022) [4] Table 3.

⁵²⁵ Society for Evidence-based Gender Medicine (SEGM), “Early Social Gender Transition in Children is Associated with High Rates of Transgender Identity in Early Adolescence” (Blog, 6 May 2022) <<https://segm.org/early-social-gender-transition-persistence>>.

⁵²⁶ SEGM (2022).

⁵²⁷ SEGM (2022).

⁵²⁸ Gillick v West Norfolk and Wisbech Health Authority [1986] AC 112; Dept of Health and Community Services (NT) v JWB and SMB (Marion’s case) (1992) 175 CLR 218 [237] (Mason CJ, Dawson, Toohey and Gaurdon JJ) and [294] (Deane J).

Gillick competence

483. In *Re Lincoln (No 2)* [2016] FamCA 1071,⁵²⁹ Johnston J set out the following list of indicia to assist in determining whether a young person is Gillick competent:

- A. able to comprehend and retain both existing and new information regarding proposed treatment;
- B. able to provide a full explanation, in terms appropriate to the child's level of maturity and education, of the nature of treatment;
- C. able to describe the advantages of the treatment;
- D. able to describe the disadvantages of the treatment;
- E. able to weigh the advantages and disadvantages in the balance, and arrive at an informed decision about whether and when they should proceed with the treatment;
- F. able to understand that the treatment will not necessarily address all or any of the psychological and social difficulties that the child had before the commencement of treatment; and
- G. being free to the greatest extent possible from temporary factors that could impair judgment in providing consent to the procedure.

484. In *Re Imogen* [No 6] (2020), Watts J made reference to one additional indicium, whether the young person is able to understand that "the decision to proceed with the treatment could have consequences that cannot be entirely foreseen at the time of the decision".⁵³⁰

485. Some States also have their own legislative provisions on age of consent for medical treatment for minors. In Queensland there is also case law from the Supreme Court on this issue.

New South Wales

486. Under the Children and Young Persons (Care and Protection) Act 1998 (NSW), a person must not carry out any medical treatment on a person under 16 years⁵³¹ that is intended or reasonably likely to have the effect of causing permanent infertility.⁵³² Otherwise medical treatment consent is addressed under the Minor (Property and Contracts) Act 1970, which provides a defence against a claim of assault or batter for medical procedures to be carried out on a 14 year old and older with his/her prior consent.⁵³³

South Australia

487. A young person over 16 years can consent to medical procedures under the Consent to Medical Treatment and Palliative Care Act 1995. If parental consent is not available or withheld, a person under 16 years can consent if medical practitioner is of the opinion that "the patient is capable of

⁵²⁹ [2016] FamCA 1071 [49]; see also *Re Elliott* [2017] FamCA 1008 [22] Tree J.

⁵³⁰ *Re Imogen* [2020] 61 Fam LR 344 at [181].

⁵³¹ Children and Young Persons (Care and Protection) Act 1998 (NSW) s3: child defined as person under 16 years.

⁵³² Children and Young Persons (Care and Protection) Act 1998 (NSW) s175.

⁵³³ Minor (Property and Contracts) Act 1979 (NSW) s49.

understanding the nature, consequence and risks of the treatment and the treatments is in the best interests of the health and well-being of the child.” This opinion must be corroborated in writing by at least one other medical practitioner who has personally examined the child before the procedure was commenced.⁵³⁴

Queensland

488. In *Re A* (2022) QSC 159, Boddice J held under the *parens patriae* jurisdiction that a 16 year and 10 month old was able to consent to stage 2 hormones in an undefended proceeding. There were affidavits from 6 expert witnesses including psychiatrists who confirmed the diagnosis of gender dysphoria and the informed consent of the young person.

United Kingdom

489. A 2016 UK article considered the question of Gillick competence in the context of vaccinations. It provides some useful commentary. Unsurprising, the gravity of the decision determines the degree of maturity and intelligence needed. Gillick competence is said to be a functional ability to make a decision. It is task specific so more complex procedures require greater levels of competence.⁵³⁵

“Assessment of Gillick competence requires an examination of how the child deals with the process of making a decision based on an analysis of the child’s ability to understand and assess risks. It is a high test of competence that is more difficult to satisfy the more complex the treatment and its outcomes become. To date no court has found a child in need of life sustaining treatment competent to refuse that treatment.

Sufficient time for the assessment must be allowed by the health professional who needs to be satisfied that a child has fully understood the nature and consequences of the proposed immunization and is mature enough to take account of broader health and social factors when making their decision.”⁵³⁶

490. Gender transition has significant implications for broader health and social factors, including impacting current and future relationships. There are significant concerns the capacity of children and young people to appropriately comprehend the long-term impacts of treatment on sexual function and fertility.

491. The issue of Gillick competence raised very publicly in England where there is a single centralised gender identity service, called the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust.⁵³⁷ In 2020 in *Bell v Tavistock* the UK High Court considered the question of an under 18-year old’s capacity to consent to puberty blockers for the treatment of gender dysphoria. Judge Alison Burt has written an excellent summary of the judgment and its

⁵³⁴ Consent to Medical Treatment and Palliative Care Act 1995 (SA) s12(b)

⁵³⁵ Griffiths, R., “What is Gillick competence?” (2016) *Human Vaccines & Immunotherapeutics* Vol 12(1) 244-247 [245].

⁵³⁶ Griffiths (2016).

⁵³⁷ Cass BMJ (2022).

implications in Australian Family Lawyer.⁵³⁸ The High Court received extensive expert evidence about the treatments and their implications. As Her Honour points out, there are themes in the judgement about the High Court's concern about the lack of research underpinning the model of treatment provided and the uncertainty around the impacts of the treatment.⁵³⁹ The High Court in Bell and Tavistock granted 3 declarations which Her Honour Judge Burt⁵⁴⁰ helpfully summarised as follows:

- A. A child under 16 may only consent to the use of medication intended to suppress puberty where he or she is competent to understand the nature of the treatment, including an understanding of its potentially long term and life changing consequences, and the limited evidence base supporting it;
- B. It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers;
- C. It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risk and consequences of the administration of puberty blockers.
- D. For children aged 16 and over, there is a presumption that they have the ability to consent. However, given the significance of the treatment proposed the court recognised that clinicians may also regard these as cases where the authorisation of the court should be sought prior to commencing stage 1 treatment.

492. GIDS appealed against the decision and the decision of the Court of Appeal was delivered on 17 September 2021.⁵⁴¹ The Court of Appeal reversed the High Court's decision in relation to the declarations above and the guidance given by the High Court on the question of consent. As the Court of Appeal made clear the High Court was not required to consider whether treatment for gender dysphoria is a "wise or unwise course", that is a legal issue and therefore question is for policy makers. The claim advanced by claimants was that the sanction of the court should always be obtained before puberty blocker were prescribed.⁵⁴² The Court of Appeal was critical of the High Court's factual findings, essentially because that was not the Court's role to decide the benefits or disbenefits of treating children with gender dysphoria with puberty blockers and the Court of Appeal determined the High Court was not equipped to make such findings.⁵⁴³

493. As Professor Parkinson says, to the extent that the High Court's judicial guidance to doctors was based on contested facts, the Court of Appeal said it should not have provided the guidance. Once the Court determined that the Tavistock's treatment process was lawful, the question of Gillick competence was a medical decision.⁵⁴⁴ However, there are strong words of caution emanating from the Court of Appeal:

⁵³⁸ Burt, Alison, "Caught in the middle: trans-identified adolescents' consent to treatment and the implications of Bell v Tavistock & Portman NHS Foundation Trust" (2021) Australian Family Lawyer Vol 30(1).

⁵³⁹ Burt (2021) [29].

⁵⁴⁰ Burt (2021).

⁵⁴¹ Bell v Tavistock [2021] EWCA Civ 1363.

⁵⁴² Bell v Tavistock [2021] [3].

⁵⁴³ Bell v Tavistock [2021] [65].

⁵⁴⁴ Parkinson, 2022.

92. We should not finish this judgment without recognising the difficulties and complexities associated with the question of whether children are competent to consent to the prescription of puberty blockers and cross-sex hormones. They raise all the deep issues identified in Gillick, and more. Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment. Great care is needed to ensure that the necessary consents are properly obtained. As Gillick itself made clear, clinicians will be alive to the possibility of regulatory or civil action where, in individual cases, the issue can be tested.⁵⁴⁵

494. The Court of Appeal continued:

Those clinicians must satisfy themselves that the child and parents appreciate the short and long-term implications of the treatment upon which the child is embarking. So much is uncontroversial. But it is for the clinicians to exercise their judgement knowing how important it is that consent is properly obtained according to the particular individual circumstances, as envisaged by Gillick itself, and by reference to developing understanding in this difficult and controversial area.⁵⁴⁶

495. At the present time the impact of puberty blockers on brain including cognition and decision-making is not known. In Finland, there is recognition of lack of maturity and the enormity of the impact of decisions. In 2020,

“Finnish guidelines warn of the uncertainty of providing any irreversible “gender-affirming” interventions for those 25 and under, due to the lack of neurological maturity. The guidelines also raise the concern that puberty blockers may negatively impact brain maturity and impair the young person’s ability to provide informed consent to the subsequent and more irreversible parts of the Dutch protocol: cross-sex hormones and surgeries.”⁵⁴⁷

496. Professor Parkinson notes relevantly, that there are questions around the impact of co-morbid mental health and neurodiversity issues on a young person’s decision-making capacity.⁵⁴⁸ The Court may require more detailed evidence about the impact of neurodiversity or mental health issues on the child’s decision-making capacity.

Levine model of informed consent

497. A 2022 multidisciplinary article by Dr Levine, psychiatrist and others comprehensively addressed the issue of informed consent.⁵⁴⁹ The authors set out the particular issues for gender dysphoria and proposed treatment:

⁵⁴⁵ Parkinson, 2022 [31] citing Bell v Tavistock [2021] [92].

⁵⁴⁶ Parkinson (2022) [31] citing Bell v Tavistock [2021] [93].

⁵⁴⁷ Society for Evidence-based Gender Medicine (SEGM), “One Year Since Finland Broke with WPATH ‘Standards of Care’” (Blog, 2 July 2021) <https://segm.org/Finland_deviates_from_WPATH_prioritizing_psychotherapy_no_surgery_for_minors>.

⁵⁴⁸ Parkinson (2022) [32].

⁵⁴⁹ Levine (2022). Levine is from Department of Psychiatry, Case Western Reserve University, Cleveland OH, USA, Abbruzzese from SEGM Mason Calcagno Pediatrics, Gresham OR, USA.

Social transition, hormonal interventions, and surgery have profound implications for the course of the lives of young patients and their families. It is incumbent upon professionals that these consequences be thoroughly, patiently clarified over time prior to undertaking any element of transition. The informed consent process does not preclude transition; it merely educates the family about the state of the science underpinning the decision to transition. Social transition, hormones, and surgeries are unproven in a strict scientific sense, and as such, to be ethical, require a thorough and fully informed consent process.⁵⁵⁰

498. Levine proposes a model for children, adolescents and young people for all gender affirming therapies (social intervention, puberty blockade, cross-sex hormones and surgery), whether diagnosed under DSM-5 or ICD 11 as involving:⁵⁵¹

- A. Careful and thorough evaluation
- B. Assessment of capacity
- C. Involvement of parents
- D. Full disclosure of the long-term risks and benefits
- E. Discussion of the full range of alternative treatment options
- F. Disclosure of the weak evidence base for these interventions
- G. Slow and thoughtful process culminating in signed consent forms.

499. Levine et al identify 3 main elements of the informed consent process:

- A. A disclosure of information about the nature of the condition and the proposed treatment and its alternatives.
- B. An assessment of patient and caregiver understanding of the information and capacity for medical decision-making; and
- C. Obtaining signatures to signify that informed consent has been obtained.⁵⁵²

500. Levine identifies ethical concerns about inadequate informed consent for trans-identified youth as having several potentially problematic sources, including:

- A. Erroneous assumptions held by professionals.
- B. Poor quality of the evaluation process.
- C. Incomplete and inaccurate information that the patient, parents and family members are given.⁵⁵³

501. There is no established standard for evaluation and further no consensus about the requisite elements of an evaluation. There is not agreement about how the process of obtaining informed

⁵⁵⁰ Levine (2022) [2].

⁵⁵¹ Clayton, A, "Commentary on Levine et al: A Tale of Two Informed Consent Processes" (2022) *Journal of Sex & Marital Therapy* Vol 49(1) 88-95 [2] (Clayton (2022)(b)).

⁵⁵² Levine (2022) [2].

⁵⁵³ Levine (2022) [2].

consent should be conducted. All of this results in inconsistency between practitioners, services and countries.⁵⁵⁴

502. Levine et al opine that the above concerns are amplified by the dramatic growth in demand for gender transition for young people, which has led to a perfunctory informed consent process.⁵⁵⁵ As they say:

“A rushed process does not allow for a proper discussion of not only the benefits, but the profound risks and uncertainties associated with gender transition, especially when gender transition is undertaken before mature adulthood.”⁵⁵⁶

Erroneous assumptions

503. Levine identifies the erroneous assumptions held by professionals, many of which are dealt with above, as follows:⁵⁵⁷

- A. That children and teens know best what they need to be productive and happy.
- B. Minority stress theory: That frequently co-occurring psychiatric symptoms of gender-dysphoric people are because of discrimination and prejudice brought on by gender non-conformity and gender transition will ameliorate these symptoms; even within the gender affirming medical community this is being questioned in light of mental health issues frequently predating the onset of GD.⁵⁵⁸
- C. Lack of awareness of alternatives: watchful waiting or gender exploratory psychotherapy.
- D. Belief that gender affirmative interventions are a standard of care.
- E. That the child or young person has been born in the wrong body.
- F. That atypical genders are created by biology. This ignores the importance that developmental biology places on psychosocial factors and culture generating behaviour.

Quality of evaluations

504. In relation to poor evaluations Levine says frequently evaluations of children and young people may only ascertain a diagnosis of gender dysphoria and screen for conspicuous mental illness. There is no exploration of the forces that may have influenced the young person’s gender identity.⁵⁵⁹

“Confirming the young person’s self-diagnosis of gender dysphoria or gender incongruence is easy. Clarifying the developmental forces that have influenced it and determining an appropriate intervention are not. Contextualizing these forces involves an understanding of child and adolescent developmental processes, childhood adversity, co-existing physical and cognitive

⁵⁵⁴ Levine (2022) [2].

⁵⁵⁵ Levine (2022) [2].

⁵⁵⁶ Levine (2022) [2].

⁵⁵⁷ Levine (2022) [3].

⁵⁵⁸ Levine (2022) [3] Even within the gender affirming medical community this is being questioned in light of mental health issues frequently predating the onset of GD.

⁵⁵⁹ Levine (2022) [5].

disadvantages, unfortunate parental or family circumstances as well as the role of social influence.”⁵⁶⁰

505. There is growing recognition that rapid evaluations which disregard factors contributing to the development of gender dysphoria in youth are problematic, even amongst two leaders of WPATH. It has certainly been an issue for parents, as dozens of support groups for concerned parents have spread in USA, Europe, Australia and New Zealand.⁵⁶¹ Many parents report difficulties in finding professionals who doesn't recommend immediate affirmation.

“The plight of the families unable to find specialists capable of conducting thorough evaluations draws attention to the widespread acceptance of medical interventions for gender-dysphoric youth as the first line of treatment. The problem is that such care has been established through precedent rather than their treatment plan.”⁵⁶²

506. These concerns have been echoed by people who have detransitioned⁵⁶³, who have expressed having felt rushed to medical gender affirmation interventions without appropriate (and in some circumstances any) psychological intervention.⁵⁶⁴

AusPath model for informed consent

507. In 2022, AusPATH released Standards of Care in relation to informed consent. The AusPath informed consent document cites the Australian Commission on Safety and Quality in Healthcare (2020) which defines informed consent as follows:

“Informed consent is a person's decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention that is made:

- Following provision of accurate and relevant information about the healthcare intervention and alternate options available; and
- With adequate knowledge and understanding of the benefits and material risks of the proposed intervention relevant to the person who would be having the treatment, procedure or other intervention.”

508. An additional element is that consent must be given voluntarily, and it is important in the context of gender dysphoria to note the influence or potential influence on a child or young person of family, friends, peers and even medical professionals.

509. AusPATH under the gender affirming model, promotes the patient-led process:

“Informed consent recognises the trans person as the experts of their own needs and experience, while respecting that medical professional(s) can utilise their experience to enable effective and

⁵⁶⁰ Levine (2022) [5].

⁵⁶¹ Levine (2022) [5].

⁵⁶² Levine (2022) [6].

⁵⁶³ Detransition is generally understood as when a person initially transitions their gender to their target gender identity and subsequently attempts to undo what they have done and return to identify with their sex.

⁵⁶⁴ Levine (2022) [7]. Note that one of the studies is Littman (2021) to which I refer below.

safe treatment. Together, they can optimise the health and wellbeing of the person requiring access to gender affirming treatment in a timely manner.”⁵⁶⁵

510. AusPath making clear that the child or young person’s self-described identity and desire for medical treatment is not to be challenged. Medical professionals’ role appears to be to facilitate.

511. The information to be provided is influenced by assumptions about the underlying evidence base supporting the treatment pathway. AusPath states:

- A. Gender affirming healthcare is the widely accepted standard in the field.
- B. There is a significant and growing body of evidence to show that medical affirmation leads to improved quality of life and better mental health outcomes.⁵⁶⁶

512. AusPath says discussions with patients about cross-sex hormones should include:⁵⁶⁷

- A. Likely effects and potential side effects of hormones
- B. Limitations of hormones (things that will not change e: voice, face and neck structure, balding patterns from endogenous testosterone at puberty, height)
- C. Likely timeline of expected changes
- D. Potential irreversible changes with hormone therapy: balding, deep voice with testosterone, breast growth, loss of fertility with estrogen
- E. Contraception needs
 - i. Fertility preservation options
 - ii. Estrogen may lead to permanent loss of fertility
 - iii. Referral to sperm analysis and freezing

513. AusPath’s informed consent process can take place in 1 or 2 appointments or possibly more depending upon patient or clinician confidence.⁵⁶⁸

Comparison of models: AusPath and Levine

514. Dr Clayton, a psychiatrist, analyses the difference between the two informed consent processes as follows:

- A. Levine requires a discussion of the limitation of the evidence base for gender affirming therapy, AusPath does not mention this.
- B. Speed of process: AusPath say it could be as quickly as 1 session, whereas Levine recommends a slow process.
- C. Risk of regret and detransition: Levine requires patients being informed of it, AusPath does not.

⁵⁶⁵ AusPath Informed Consent Standards (2022) [8].

⁵⁶⁶ AusPath Informed Consent Standards (2022) [4].

⁵⁶⁷ AusPath Informed Consent Standards (2022) [12].

⁵⁶⁸ AusPath Informed Consent Standards (2022) [9].

- D. Alternative treatment options: Levine requires as discussion of the full range of alternative treatment options. AusPath does not.⁵⁶⁹

Information provided

515. The information provided in an informed consent process and the timelines for doing so appear to be influenced by differences of opinion on issues including the underlying evidence base and the existence of alternatives. The above paper summarises of what is known at the present time. It is complex and evolving and yet the evidence base supporting medicalisation remains sparse.
516. It will be a matter for the Court to determine whether the information provided to patients and parents about asserted benefits and risks is sufficient. In the absence of medical evidence setting out a complete picture of the current evidence base, it will be difficult for the Court to evaluate whether there has been informed consent. It is hoped that this paper provides a basis for that assessment.

Conclusion

517. It has not been easy to find, read, and understand all of this information. While there is easy access to information which promotes gender affirming medicalisation, it is difficult to find information about contrary views. This paper would not have been possible without the website operated by the Society for Evidence Based Gender Medicine (SEGM). In a 2022 Family Law case, a treating paediatrician was critical of SEGM. I note the comments of the Westmead Hospital researchers about the politicisation of information in this area:

“The fifth challenge pertained to the issue of research. In this context, we had set up research as part of the clinic’s routine activity, enabling us to contribute to the evidence base regarding children who present with gender dysphoria. In the process of writing up data from our clinic, we became aware that the process of knowledge development—ours and that of other researchers—was at risk of being thwarted by ideology (Singal, 2020). In 2019, in response to this issue, the Society for Evidence-Based Gender Medicine was founded “to promote safe, compassionate, ethical and evidence-informed healthcare for children, adolescents, and young adults with gender dysphoria” (Society for Evidence-Based Gender, 2020).”⁵⁷⁰

518. Unfortunately for children and young people, and families who are trying to work through complex issues around identity during a time of distress, this is a highly politicised area. Polarisation and the inability to fully discuss these issues comes at a cost, to young people and their families.
519. As the Westmead researchers conclude:

“One of the biggest challenges for clinicians working with children who present for assessment of gender dysphoria is the effect of polarized socio-political discourses on their daily clinical practice. Polarization happens when people become divided in this case with reference to their views about gender dysphoria in children into sharply opposing groups. Complex phenomena are then often simplified along a single dimension that disregards other dimensions, that dismisses the lived experience of others, and that closes off questioning, hypothesizing, and consideration of, and engagement with, opposing viewpoints. We have

⁵⁶⁹ Clayton (2022)(b) [2]-[3].

⁵⁷⁰ Kazłowska (2021) [88].

seen these processes at work throughout our clinical practice, as described in the present article. Polarized views are unhelpful to clinicians who are at the front line trying to provide holistic clinical care to a distressed group of children and such views are just as unhelpful to the children and families themselves. To provide adequate care, clinicians need to understand and confront the complexity of the clinical presentations. They need, in particular, to use a broad, holistic, systemic (i.e., biopsychosocial) framework that takes into account the full range of interacting factors social, economic, relational, family, psychological, and biological that have defined the life circumstances of the child and the family seeking care for gender dysphoria.”⁵⁷¹

520. The area is complex, and it is important to ensure that the child / young person, parents and the Court have all relevant information.

521. There are 3 immediate questions for the Australian family courts to consider:

- A. Given the above, what is the status of *Re Kelvin* (2017) is it time for reconsideration?
- B. How does the Court address keeping updated about evolving medical evidence in an adversarial system?
- C. What is the obligation of treating medical professionals to bring alternate views and contrary evidence to the Court’s attention?

522. The long-term implications for young people are profound. During the case of *Bell v Tavistock*, Kiera Bell, said:

“It is only until recently that I have started to think about having children and if that is ever a possibility, I have to live with the fact that I will not be able to breastfeed my children. I still do not believe that I have fully processed the surgical procedure that I had to remove my breasts and how major it really was. I made a brash decision as a teenager, (as a lot of teenagers do) trying to find confidence and happiness, except now the rest of my life will be negatively affected. I cannot reverse any of the physical, mental or legal changes that I went through. Transition was a very temporary, superficial fix for a very complex identity issue.”⁵⁷²

⁵⁷¹ Kazłowska (2021) [92]-[93].

⁵⁷² *Bell v Tavistock* [83].

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C. Legislation

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Public Health Act 2005 (QLD)
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D. Statutory Rules/Guidelines

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Appendix A: What are the 72 other genders?

Allarakha, Shaziya (MD) "What Are the 72 Other Genders?" Medicine Net. Medically reviewed 2/2/2022

Besides male and female, there are 72 other genders, which include the following:

1. Agender: A person who does not identify themselves with or experience any gender. Agender people are also called null-gender, genderless, gendervoid, or neutral gender.
2. Abimegender: Associated with being profound, deep, and infinite. The term abimegender may be used alone or in combination with other genders.
3. Adamas gender: A gender that is indefinable or indomitable. People identifying with this gender refuse to be categorized in any particular gender identity.
4. Aerogender: Also called evaisgender, this gender identity changes according to one's surroundings.
5. Aesthetigender: Also called aesthetgender, it is a type of gender identity derived from aesthetics.
6. Affectugender: This is based on the person's mood swings or fluctuations.
7. Agenderflux: A person with this gender identity is mostly agender with brief shifts of belonging to other gender types.
8. Alexigender: The person has a fluid gender identity between more than one type of gender although they cannot name the genders they feel fluid in.
9. Aliusgender: This gender identity stands apart from existing social gender constructs. It means having a strong specific gender identity that is neither male nor female.
10. Amaregender: Having a gender identity that changes depending on the person one is emotionally attached to.
11. Ambigender: Having two specific gender identities simultaneously without any fluidity or fluctuations.
12. Ambonec: The person identifies themselves as both man and woman and yet does not belong to either.
13. Amicagender: A gender-fluid identity where a person changes their gender depending on the friends they have.
14. Androgyne: A person feels a combination of feminine and masculine genders.
15. Anesigender: The person feels close to a specific type of gender despite being more comfortable in closely identifying themselves with another gender.
16. Angenital: The person desires to be without any primary sexual characteristics although they do not identify themselves as genderless.

17. Anogender: The gender identity fades in and out in intensity but always comes back to the same gendered feeling.
18. Anongender: The person has a gender identity but does not label it or would prefer to not have a label.
19. Antegender: A protean gender that can be anything but is formless and motionless.
20. Anxiender: This gender identity has anxiety as its prominent characteristic.
21. Apagender: The person has apathy or a lack of feelings toward one's gender identity.
22. Apconsugender: It means knowing what are not the characteristics of gender but not knowing what are its characteristics. Thus, a person hides its primary characteristics from the individual.
23. Astergender: The person has a bright and celestial gender identity.
24. Astral gender: Having a gender identity that feels to be related to space.
25. Autigender: Having a gender identity that feels to be closely related to being autistic.
26. Autogender: Having a gender experience that is deeply connected and personal to oneself.
27. Axigender: A gender identity that is between the two extremes of agender and any other type of gender. Both the genders are experienced one at a time without any overlapping. The two genders are described as on the opposite ends of an axis.
28. Bigender: Having two gender identities at the same or different times.
29. Biogender: Having a gender that is closely related to nature.
30. Blurgender: Also called gender fuss, blurgender means having more than one gender identities that blur into each other so that no particular type of gender identity is clear.
31. Boyflux: The person identifies themselves as male, but they experience varying degrees of male identity. This may range from feeling agender to completely male.
32. Burstgender: Frequent bursts of intense feelings quickly move to the initial calm stage.
33. Caelgender: This gender identity shares the qualities or aesthetics of outer space.
34. Cassgender: It is associated with the feelings of considering the gender irrelevant or unimportant.
35. Cassflux: There is a fluctuating intensity of irrelevance toward gender.
36. Cavusgender: The person feels close to one gender when depressed and to another when not depressed.
37. Cendgender: The gender identity changes from one gender to its opposite.
38. Ceterogender: It is a nonbinary gender where the person has a specific masculine, feminine or neutral feelings.

39. Ceterofluid: Although the person is a ceterogender, their identity keeps fluctuating between different genders.
40. Cisgender: Being closely related to the gender assigned at birth during the entire life.
41. Cloudgender: The person's gender cannot be comprehended or understood due to depersonalization and derealization disorder.
42. Collgender: Various genders are present at the same time in the individual.
43. Colorgender: In this category, colors are used to describe gender, for example, pink gender or black gender.
44. Commogender: The person knows that they are not cisgender yet continues to identify as one for a while.
45. Condigender: The person feels their gender only under specific circumstances.
46. Deliciagender: Associated with the feeling of having multiple genders but preferring one over the other.
47. Demifluid: Having multiple genders, some fluid while others are static.
48. Demiflux: A combination of multiple genders with some genders static, whereas others fluctuating in intensity.
49. Demigender: The individual has partial traits of one gender and the rest of the other gender.
50. Domgender: The individual has multiple genders with one dominating over the rest.
51. Duragender: Having more than one gender with one lasting longer than the others.
52. Egogender: It is a personal type of gender identified by the individual alone. It is based on the person's experience within the self.
53. Epicene: It is associated with a strong feeling of not being able to relate to any of the two genders of the binary gender or both of the binary gender characteristics.
54. Esspigender: The individual relates their gender identity with spirits.
55. Exgender: The denial to identify with any gender on the gender spectrum.
56. Existigender: The person's gender identity exists only when they make conscious efforts to realize it.
57. Femfluid: The person is fluid or fluctuating regarding the feminine genders.
58. Femgender: A nonbinary gender identity that is feminine.
59. Fluidflux: It means to be fluid between two or more genders with a fluctuation in the intensity of those genders.

60. Gemigender: The person has two genders that are opposite yet they flux and work together.
61. Genderblank: It is closely related to a blank space.
62. Genderflow: The gender identity is fluid between infinite feelings.
63. Genderfluid: The person does not consistently adhere to one fixed gender and may have many genders.
64. Genderfuzz: More than one gender is blurred together.
65. Genderflux: The gender fluctuates in intensity.
66. Genderpuck: The person resists to fit in societal norms concerning genders.
67. Genderqueer: The individual blurs the preconceived boundaries of gender in relation to the gender binary or having just one gender type.
68. Gender witched: The person is inclined toward the notion of having one gender but does not know which.
69. Girlflux: The individual identifies themselves as a female but with varying intensities of female identities.
70. Healgender: A gender identity that gives the person peace, calm, and positivity.
71. Mirrorgender: Changing one's gender type based on the people surrounding.
72. Omnigender: Having or experiencing all genders.

Appendix B: Possible directions

Transfer to Division 1

1. Pursuant to section 149 of the Federal Circuit and Family Court of Australia Act 2021 (Cth), this proceeding is transferred to the Federal Circuit Court of Australia (Division 1), noting that the following criteria are identified:
 - (a) Medical procedure being gender dysphoria treatment.

Service Child Welfare authority

1. By no later than __, the Applicant _____ serve upon the Respondent _____ and the relevant Child Welfare Authority (as required pursuant to paragraph 2.12 and paragraph 2.13 of the Family Law Practice Direction – Medical proceedings), in accordance with Part 2.6 or Part 2.7 (as appropriate) of the Federal Circuit & Family Court of Australia (Family Law) Rules 2021, copies of the following documents:
 - a. XXX
2. Not later than _____ the Applicant shall file and serve an Affidavit of Service confirming compliance with Order 1 above.

Filing of Applications

1. Not later than 4.00pm on _____, the Applicant file and serve:
 - a. An Amended Initiating Application (Family Law) setting out with precisions the final and interim orders sought;
 - b. A supporting Affidavit noting the provisions of Rules 5.04 and 5.08 of the Federal Circuit and Family Court of Australia (Family Law) Rules 2021 together with the Federal Circuit and Family Court of Australia Central Practice Directions 2021.
2. Not later than 4.00pm on _____, the Respondent file and serve:
 - a. An Amended Response to Initiating Application setting out with precisions the final and interim orders sought;
 - b. A supporting Affidavit noting the provisions of Rules 2.20 and 5.08 of the Federal Circuit and Family Court of Australia (Family Law) Rules 2021 together with the Federal Circuit and Family Court of Australia Central Practice Directions 2021.

Summary of Experts Evidence

3. That on or before _____, the Respondent _____ practitioners file and serve a “Summary of Experts’ Evidence” document which cross-references the __ expert reports filed _____ to the appropriate sub-sections of rule 1.11(5).

Assessment of the child

4. The parties do all acts required to facilitate the child's attendance upon a psychiatrist as agreed between the parties and in the absence of agreement as nominated by the Independent Children's Lawyer for the purpose of an assessment, with the parents to each meet the costs of the assessment equally.
5. The psychiatric report to address the following issues in the context of the application before the Court for the child to commence medical intervention for the treatment of gender dysphoria:
 - a. Whether the child currently meets the criteria for a diagnosis of Gender Dysphoria under the DSM5-TR? What is the basis of the opinion?
 - b. What are the risks / benefits of the proposed treatment?
 - c. Are there any alternative interventions?
 - d. What is the child's understanding of the proposed treatment, risks benefits and alternatives?
 - e. Any recommendations?
 - f. Any other matters which the expert considers relevant.

Subpoenaed material to be provided to Respondent's experts:

[This is for the hospital / clinic records and file for the child]

6. The documents produced in response to the Respondent's subpoena filed dd/mm/yyyy be released to the ICL for forwarding to the experts for the Respondent in these proceedings, cc the parent's practitioners subject to:
 - a. Each recipient acknowledging that the material is:
 - i. Not to be distributed to any other person;
 - ii. To be destroyed at the conclusion of the proceedings (such destruction to be confirmed in writing).
 - b. The legal practitioners receiving material for inspection only;
 - c. The parents not being provided with the material.
7. The ICL provide a copy of these orders to any recipient of the subpoenaed material.

THE COURT NOTES THAT:

- A. These orders are made on the basis that all experts will be made aware by the parties' practitioners as to:
 - a. Section 121 Family Law Act 1975 (Cth);
 - b. The implied undertaking as to use of documents.

Conference of Experts

8. The practitioners ensure that a conference of experts is convened on or before _____ in an attempt to identify:

- a. Areas of agreement; and
- b. Areas of disagreement and reasons for disagreement.

Appendix C: Possible questions for the experts

Diagnosis

1. Do we agree that X currently meets the criteria for Childhood Gender Dysphoria (DSM-5 TR)? On what basis?
2. Do we agree that X currently meets the criteria for Adolescent Gender Dysphoria (DSM-5 TR?) On what basis?
3. Do we agree that X met the criteria for Childhood / Adolescent Gender Dysphoria (DSM-5 TR) at the time of diagnosis in the report dated dd/mm/yyyy?

Persistence

4. Do we agree there is substantial scientific evidence that Gender Dysphoria in childhood is in the majority persistent?

Medical pathway

5. Do we agree there are conflicting clinical position statements relating to the most appropriate evidence-based supports and interventions for Gender Dysphoria / Gender Incongruent children and adolescents?
6. Do we agree the scientific evidence indicates that puberty blockers are an effective treatment proven to reduce:
 - a. distress
 - b. depression
 - c. suicidalityfor Gender Dysphoric children and adolescents?
7. Do we agree the scientific evidence indicates that cross-sex hormones are an effective treatment proven to reduce:
 - a. distress
 - b. depression
 - c. suicidalityfor Gender Dysphoric children and adolescents?
8. Do we agree that if X follows the suggested medical affirmative pathway, then X is a risk of impacts on bone health?
9. Do we agree that the impacts of the suggested medical affirmation pathway on brain function is not yet known?
10. Do we agree that if X follows the suggested medical affirmative pathway started at the requested age then x will be an infertile adult?
11. Do we agree that if X follows the suggested medical affirmative pathway started at the requested age then X will have sexual dysfunction?

Alternatives

12. Do we agree Do we agree that X has received psychoeducation related to the full diversity of sexual orientations?
13. Do we agree that X has expressed an understanding of his/her sexual orientation?
14. Do we agree that X has received psychoeducation related to the full diversity of gender identity and expression (gender spectrum work?)
15. Do we agree there are alternative management and/or affirmation pathways other than medical interventions for X?

Addressing co-morbid issues

16. Do we agree that X has received appropriate evidence-based intervention for (ASD? ADHD? Mental health issues)
17. Do we agree that X has not completed an Adaptive Behaviour Assessment?
18. Do we agree that the family's history of trauma (ACE's), ASD (Level X), ADHD, eating disorder, school refusal and mental health conditions have been adequately considered in the case formulation and been a focus of psychotherapy, skills training and intervention planning?

Informed consent:

19. Do we agree that X and his/her parent(s) have received comprehensive medical information on the possible adverse effects of puberty blockers and cross sex hormones on the following:
 - a. Later sexual function
 - b. Fertility
 - c. Brain development
 - d. Cardiovascular health
 - e. Increased cancer risk
 - f. Bone development
 - g. Regret?