Professor Ruth Vine

At the October 2023 Liberal National Party Council resolution 66 was passed. The policy of this political party in opposition at the time, included that: “all puberty blockers, hormone treatment and surgical intervention be suspended for children under 18 until the review is completed”
This was a political ideological position taken to cease the currently acknowledged best clinical practice for gender dysphoric children and their families and untenable overreach into clinical decision-making that prevents clinicians from holistically treating patients within a multidisciplinary team.

This ideologically driven policy was put into practice by the current Qld Government. It is our position that the Health Minister’s actions in this regard are immoral and unethical.

As an Association dedicated to the welfare of gender diverse persons we support all and any research that endeavours to expand the knowledge base around care of gender diverse persons and the risk/benefit profiles of all and any treatment. To that end we try to keep ourselves informed.

There has been a great deal of ideologically motivated reporting in the media to suggest or at least imply that gender affirming care of children does not have an adequate research base. This simply not true.

There have been numerous reports worldwide into the evidence base that underpins both the WPATH and AusPATH guidelines for children. We draw your attention to a comprehensive report on gender affirming medical treatments for paediatric patients with gender dysphoria prepared by the College of Pharmacy University of UTAH[1] August 2024.

An extract for 1.6.0 Conclusions reads:” The conventional wisdom among non-experts has long been that there are limited data on the use of GAHT in paediatric patients with GD. However, results from our exhaustive literature searches have led us to the opposite conclusion. We found more than 277 individual, full-text citations that met eligibility for study design, population, and treatments of interest, including N=230 primary clinical studies reporting on the patient-level experience of at least N=28,056 paediatric GD patients all over the world. We provide in this report extracted findings and ROB assessments for N=89 English-language clinical studies that included high-priority comparisons and outcomes (listed below).” (pg 90)

[1] GENDER-AFFIRMING MEDICAL TREATMENTS FOR PEDIATRIC PATIENTS WITH GENDER DYSPHORIA Joanne LaFleur, PharmD, MSPH Director, Drug Regimen Review Center Associate Professor, Department of Pharmacotherapy University of Utah, College of Pharmacy University of Utah College of Pharmacy, Drug Regimen Review Center. Copyright © 2024 by University of Utah College of Pharmacy, Salt Lake City, Utah https://www.transvitae.com/wp-content/uploads/2025/05/report.pdf

Another ideologically motivated over valued idea is that regret and desistance are a common and tragic companion to GA medical and surgical care.

From the University of Utah[1] report; “We found 32 studies that addressed persistence, desistance, and/or regret. Findings from these studies that relate to rates of persistence and desistance are summarized in Table I.26 (pg 81) ……”With regards to any misgivings that stakeholders may have about allowing paediatric patients to receive pharmacologic (and frequently surgical) treatments over concerns about future regret, we found (based on the N=32 studies that addressed it) that there is virtually no regret associated with receiving the treatments, even in the very small percentages of patients who ultimately discontinued them. Reasons for discontinuing GAHT are varied, but changed minds about gender identities is only a very minor proportion overall.” (pg 89)..

While evidence is supporting the current WPATH and AusPATH guidelines as effective and safe additional recent systematic reviews throw light on the value of medical care from interdisciplinary gender clinic in reducing suicide -related thoughts and behaviours.[2] .

Recent publications are educating us as to the harm done by the United Kingdom decision to cease stage 1 and 2 medical management of gender dysphoria.[3] “This research paper centres the voices of the victims of the ban and compares their experiences to those who were fortunate enough to escape the ban by virtue of the date of their first prescription.” It is a harrowing read and given the absence of any lived experience voices on your panel we desperately request you do consider it.

[2]. Christensen JA, Oh J, Linder K, Imhof RL, Croarkin PE, Bostwick JM, McKean AJS. Systematic Review of Interventions to Reduce Suicide Risk in Transgender and Gender Diverse Youth. Child Psychiatry Hum Dev. 2025 Feb;56(1):88-100. doi: 10.1007/s10578-023-01541-w. Epub 2023 May 10. PMID: 37162659.

[3] Natacha Kennedy (17 Jun 2025): Harming children: the effects of the UK puberty blocker ban, Journal of Gender Studies, DOI: 10.1080/09589236.2025.2521699

The Cass report has been heavily criticised in many publications most recently by Noone et al[4]

“Using the ROBIS tool, we identified a high risk of bias in each of the systematic reviews driven by unexplained protocol deviations, ambiguous eligibility criteria, inadequate study identification, and the failure to integrate consideration of these limitations into the conclusions derived from the evidence syntheses. We also identified methodological flaws and unsubstantiated claims in the primary research that suggest a double standard in the quality of evidence produced for the Cass report compared to quality appraisal in the systematic reviews.”

There is a belief within much of academia whereby research that gathers qualitative data is given a much lower validity status. Clearly it is unethical to perform double blind control trials when the placebo group will suffer distinct damage from the absence of treatment. The medical profession uses treatments for pain, depression and numerous other subjective experiences based on large scale qualitative data collection and assessment. Only a commentator who viewed gender as exclusively a binary reality would be prepared to dismiss the abundance of qualitative data that inform current best practise.

Ideology and politics must not be allowed to set clinical narratives.

From the University of Utah[1] “Based on the reviewed evidence included in this report, it is our expert opinion that policies to prevent access to and use of GAHT for treatment of GD in paediatric patients cannot be justified based on the quantity or quality of medical science findings or concerns about potential regret in the future, and that high-quality guidelines are available to guide qualified providers in treating paediatric patients who meet diagnostic criteria.”(pg 91).

Sincerely the Management Board Queensland Transgender, Gender Diverse and Non-Binary Assoc. Inc.(QTrans)

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[4] Noone, C., Southgate, A., Ashman, A. *et al.* Critically appraising the cass report: methodological flaws and unsupported claims. *BMC Med Res Methodol* **25**, 128 (2025). https://doi.org/10.1186/s12874-025-02581-7