Public invited to share views on puberty blockers (The Vine Review)

The online form is designed to collect clinical viewpoints. That said, for persons who wish to put their lived experience before the review scroll to the end and the last text box, just above the submit button, will accept 500 words of you valuable commentary.

What follows is a response to the online form prepared by Qtrans and authored by F Mulcahy MBBS a retired Gp and transgender woman. We hope it may be of assistance.

Feel free to use or modify these answers as you see fit. When you submit the form it will be your submission.

Actual form link:
https://www.health.qld.gov.au/research-reports/reports/review-investigation/hormone-therapies-review

Headings in bold are heading used in the online form

Text in italics and grey highlight are the online question or prompt text

Plain text used for example answers.

About you

*Are you **

-- Please Select – select from list

If you are a clinician, what category are you? Select from list

If you are a person aged under 18 who is receiving or has sought Stage 1 hormone treatment or Stage 2 hormone treatment (or are a person responding on behalf of such person), at what age did you (or the relevant person) seek Stage 1 and/or Stage 2 hormone treatment and in approximately what year?

Questions

We are going to ask you some questions in relation to each term of reference.

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

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Puberty suppression with gonadotrophin releasing hormone analogues (GnRHa), Oestrogen, Testosterone, testosterone blockade with Spironolactone or Cyproterone acetate. Norethisterone for menstrual suppression in trans masc individuals

As well as the views and preferences of children and adolescents and their families, what other factors do you think a practitioner should consider when deciding whether to prescribe the following:

Factors for no medication or hormone treatments?

If a competent multidisciplinary team has assessed that medication is not in the child's best interest, remembering that withholding medication is not a neutral option. Withholding medication may exacerbate distress and may be associated with an increase in depression, anxiety and suicidality[1] .

([1] Treatment of Adolescents With Gender Dysphoria in the Netherlands
Cohen-Kettenis, Peggy T. et al. Child and Adolescent Psychiatric Clinics, Volume 20, Issue 4, 689 – 700)

Treatment plans require parental consent for children and consent from 'Glick competent" adolescents or the parents of Glick incompetent adolescents. If there is any dispute as to the competence, the diagnosis, or the treatment, between parents and clinicians then court authorisation is required.

Factors for Stage 1 hormone treatment?

See answer above and Additionally

Criteria required for commencing puberty blockers include:
A diagnosis of Gender Dysphoria.
Medical assessment including detailed fertility preservation counselling
Tanner stage 2 puberty has been reached, clinical exam confirmed with luteinising hormone level greater to or equal to 0.5 IU/L
Bone density assessment is recommended[1].

[1]Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D Safer, Vin Tangpricha, Guy G T'Sjoen, Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, *The Journal of Clinical Endocrinology & Metabolism*, Volume 102, Issue 11, 1 November 2017, Pages 3869–3903, https://doi.org/10.1210/jc.2017-01658

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Factors for Stage 2 hormone treatment?

Criteria required for commencing stage two hormone management include:
A diagnosis of Gender Dysphoria.
Medical assessment including detailed fertility preservation counselling

Factors for other treatment options?

Provision of gender affirming medication should always involve ongoing care and assessment by,
mental health professionals.
paediatrician/ adolescent physician /endocrinologist (with access to Andrologist / gynaecologist)
Nurse practitioner
speech pathologist
GP (as a provider of collaborative care to patient and family)

These professionals involved must, as a team, be competent to:

- make the diagnosis of gender incongruence of adolescence (ICD11 HA60) and gender incongruence of childhood (ICD 11 HA 61)
- assess and support the family unit,
- provide assessment of social, educational and vocations function, must understand
- assess coexisting mental health difficulties
- assess for self-harm and suicide risk
- assess adolescent's capacity to consent (in collaboration with medical speciality)
- discuss issues of fertility preservation

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

Concerns for Stage 1 hormone treatment?

Puberty blockade may be associated with relative loss of bone mineralisation. If patients have reduced bone density consideration of an earlier progression to stage 2 hormones should be considered by the treating team. All patients on GnRHa should be encouraged to have adequate calcium and Vit D intake and regular weight bearing

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exercise. That said recent literature concludes that GnRH agonist treatment is generally safe[1]

[1] van der Loos MATC, Vlot MC, Klink DT, Hannema SE, den Heijer M, Wiepjes CM. Bone Mineral Density in Transgender Adolescents Treated With Puberty Suppression and Subsequent Gender-Affirming Hormones. JAMA Pediatr. 2023;177(12):1332–1341. doi:10.1001/jamapediatrics.2023.4588

Concerns for Stage 2 hormone treatment?

For feminising hormones, breast tissue development is permanent (unless surgically managed). Use for three years will decrease testis size and sperm production the reversibility of this is not known. As noted in answer above fertility counselling is a core activity of a competent team managing gender incongruency in children and adolescents
For masculinising hormone, changes to facial and body hair distribution, after five years are most likely irreversible. Cessation of menses, vaginal atrophy and fertility most likely can recover but can not be guaranteed as reversible. Enlargement of the clitoris due to testosterone to the best of my knowledge has not been studied adequately to comment.
As noted above full and frank discussion of these likely changes their impact on fertility and their time course is part of adequate care.

What are they?

Answered above

Do you have any other concerns about the impacts of Stage 1 and/or Stage 2 hormone treatments for children and adolescents in the short, medium and/or long term?

My concerns relate to the dangers of the cessation of what is current mainstream academically endorsed best practice based on ideologically tainted over valued publications. The wide disparity between transgender and cisgender children vis a vis suicidality is documented in many pieces of research[1].

[1]Brian C. Thoma, Rachel H. Salk, Sophia Choukas-Bradley, Tina R. Goldstein, Michele D. Levine, Michael P. Marshal; Suicidality Disparities Between Transgender and Cisgender Adolescents. *Pediatrics* November 2019; 144 (5): e20191183. 10.1542/peds.2019-1183.

The effectiveness in reduction to suicidality from access to gender affirming medical management is also well documented.[2]

[2] Christensen, J.A., Oh, J., Linder, K. *et al.* Systematic Review of Interventions to Reduce Suicide Risk in Transgender and Gender Diverse Youth. *Child Psychiatry Hum Dev* **56**, 88–100 (2025). https://doi.org/10.1007/s10578-023-01541-w

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Universal denial of gender affirming care is NOT a neutral safe, clinically or morally valid action.

How much information about the short, medium and/or long-term risks and/or benefits of Stage 1 and Stage 2 hormone treatment do you think a treating team should provide to a child or adolescent (and/or their parent or carer) before commencing treatment?

It is incumbent on a treating team to provide detailed and comprehensive explanations of and discussion around the effects of treatment. The use of an outside expert source of information about fertility implications and preservation options is recommended.

How would a treating team know that a child or adolescent (and/or their parent or carer) has understood the information given to them about those risks and/or benefits?

In medical practise we regularly experience situations that were both ethically and clinically complex. The tools we used to improve our certainty that families understand risks and benefits of life changing measures included multiple discussions of the problem at hand between the family and multiple professionals (medical, nursing, social work, chaplain). Time to go away and think over the discussions is important when it was practical. If possible, offering families the time to consult their usual GP as a semi-independent expert also helped. A multidisciplinary team with backup from a family Gp if one exists is ideally suited to getting as much certainty as is possible.

In your view, are there areas of current practice relating to Stage 1 and/or Stage 2 hormone treatment for children and adolescents that lack sufficient evidence?

Long term longitudinal study is needed to follow the bone health status of patients whose are prescribed puberty blockers. Otherwise no.

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

As noted above minimise the time of puberty blockade for children with poor bone mineralisation and support bone health with appropriate diet and exercise.

What questions do you think further research should address?

Children and adolescents simply do not have an adult appreciation of the role of fertility and family building as part of a whole life. Those young people presenting with gender incongruence and dysphoria all just want the distress to go, and the way forward they see, is to engage with the health system so that their bodies align with their identity. Clearly the patient needs to survive into adulthood to develop adult appreciations. I believe if would be wrong to risk a child's life because they may not be satisfied with an element of life as a surviving adult. That said, research that asks transgender people about the value they give their fertility over the years is needed. It will assist the effort gender clinics make to obtain fully informed consent. Even a teenager who is single-

mindedly asking for relief of their dysphoria, might, listen to the voices of those who have lived as transgender adults. I am not suggesting that such aged wisdom will dissuade patients who are gender diverse from engaging with the health system, rather, that they might take more seriously the conversations already offered to them, (in a competent service) about fertility.

Do you think this area of care has appropriate:

clinical oversight?
I do

governance oversight?
I do

regulatory oversight?

I do

Why / why not?

When I listen to consumers of gender affirming medical care the complaint I hear is that the process goes too slowly. These consumers want their or their child's distress to be instantly alleviated and the parents do sometimes fear the child's distress is so overwhelming that it may lead to self-harm. The complaint that the multidisciplinary team process moves too slowly is an endorsement that the assessment of the child and family is being done well.

I am well acquainted with health care professionals working in this field. As a group they are focused on patient centred care. Thay have the welfare of the child forefront in their minds. These are not professionals ideologically driven to say yes to any and every request for medical interference. As a group they would see provision of treatment without full and careful evaluation and full and frank disclosure of costs and benefits anathema.

Lastly regulator oversite occurs in layers. The layers with the lightest and most caring touch are provided by health care professionals themselves. Self-regulation by attending to current best practice supported by good empirical evidence. Less gentle is the application to doctors of limits and expectations by indemnity insurers. Most restrictive is the limitations of medical care by government. In the modern era where a "free and fair" public service has been substantially politicised any governmental regulation will be or risk delivering a political message. The NHMRC "statement on sex, gender, variations of sex characteristics and sexual orientation in health and medical research" acknowledges that transgender people exist. If political whim that is based on

an unscientific exclusive binary view of gender enforces health care policy then quite simply human rights violations will occur.

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

Answered above

Is there anything else that you would like to raise about the current evidence base and ethical considerations for the use of Stage 1 and Stage 2 hormone treatments for children and adolescents?

I believe the action of the Qld government to suspend gender affirming care for patients at the children's gender service (unless they are continuing an active treatment plan) to be ethically reprehensible. Any genuine concerns about clinical standards could have been addressed while the service continued to provide best practice care as confirmed in the recent review. I believe the governmental action to be ideology masked as concern.

I note that the Cass Review has been subject to many critical appraisals, most recently by a paper in *BMC Medical Research Methodology* [1](an open access journal publishing original peer-reviewed research articles in methodological approaches to healthcare research).

[1]Critically appraising the Cass Report: methodological flaws and unsupported claims Chris Noone1*, Alex Southgate2, Alex Ashman3, Éle Quinn4, David Comer1, Duncan Shrewsbury5, Florence Ashley6, Jo Hartland7, Joanna Paschedag8, John Gilmore9, Natacha Kennedy10, Thomas E. Woolley11, Rachel Heath12, Ryan Goulding13, Victoria Simpson14, Ed Kiely15, Sibéal Coll16, Margaret White17, D. M. Grijseels18, Maxence Ouafik19 and Quinnehtukqut McLamore20

"**Results** 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."

I would like the review to consider the recent published paper detailing the harm done to UK children following implementation of Cass.

"The data presented here questions the entire rationale and ethical basis for the puberty blocker ban, providing hard evidence that it is both dangerous and unjustified given the significant level of harm it is causing."[1]

[1] 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

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