Genspect Australia

Response to

MSAC APPLICATION 1754

Natural history, models of care and additional clinical evidence

October 2026

Genspect Australia is a Health Promotion Charity registered with the Australian Charities and Not-for-profits Commission. Our charitable purpose is to promote the prevention and control of psychological and physical harm associated with gender-related health conditions, including harm arising from gender-related medical interventions and from the challenges faced during detransition. We are active across Australia. Our network includes general practitioners, psychiatrists, psychologists, paediatricians, surgeons, allied health professionals, researchers, parents, and people with lived experience.

This response addresses the assessment reports on the natural history of gender incongruence and models of care, and to MSAC's consultation questions on multidisciplinary assessment, team membership and surgical exemplars for economic evaluation.

We understand that MSAC has also sought a more comprehensive assessment of the clinical evidence, which is in progress. We would welcome publication of that assessment, including the studies it relies on and their appraisal, and confirmation of whether the proposal has changed since April 2025, including its population and eligibility criteria.

Executive summary

Genspect Australia opposes public funding for these surgeries. The case for listing assumes that those who seek them have a stable and intrinsic gender incongruence, and that surgery relieves the distress associated with it, and does not make that distress, or the conditions that accompany it, worse. Nothing in the Natural History and Models of Care assessments, or in the other published materials, establishes either assumption. The Natural History assessment treats the course observed under affirmation as the natural history of the condition, and the Models of Care assessment describes only affirming pathways. Yet affirmation may itself change that course, and close off others.

Diagnosis offers no safeguard. It rests on the person's own account, and cannot distinguish distress arising from gender incongruence from distress with other sources, or those whose distress will persist from those in whom it will resolve. It is also increasingly not utilised in practice. Nor can robust evidence be gathered under current models of care, which offer one pathway and rarely follow those who depart from it, including people who stop treatment, disengage from services or detransition. Low recorded rates of regret and detransition therefore cannot be relied on as reassurance.

Publicly funding surgery for distress that may have other sources raises a question for a public health system: whether it should meet a need that its own models of care may have helped to create. Funding would also establish surgery more firmly as the expected response to that distress, and so may itself further alter the natural history of the condition.

Part B responds to MSAC's questions on multidisciplinary assessment, team membership, surgical exemplars and post-surgical management, without prejudice to our position that listing should not be supported. Those questions cannot be answered satisfactorily without independent, evidence-based national standards for adult gender services, covering both hormone treatment and surgery, which existing guidance cannot supply. Optional multidisciplinary review and assessment would leave current practice largely unchanged, in which assessment rests with the treating practitioner and those most in need of assessment are least likely to seek it. Documented failures in Australian services show that a multidisciplinary label is not itself a safeguard.

Economic evaluation is premature: outcome data are short-term, the proposed exemplars may normalise escalating surgery, and the costs of complications could fall outside the proposed items. Post-surgical management should include long-term follow-up and support for people who come to regret surgery.

Part C draws MSAC's attention to developments since our February 2025 submission. Recent large-scale studies using clinical records found continuing or increased psychiatric need after surgery or medical transition, and neither shows that these treatments improve mental health. Overseas, claims by people treated as minors and as adults have succeeded at trial or been settled, raising the same questions of assessment as this response.

WPATH's standards have also been found deficient on independent appraisal, and WPATH itself, defending a US lawsuit, has described its standards as non-binding and its claims about the necessity, safety and effectiveness of treatment for children as opinion. Professional bodies have raised concerns that Australian conversion practices laws constrain exploratory care. While the alternatives remain constrained and unstudied, the comparative safety and effectiveness of surgery cannot be established.

We recommend that MSAC

- not support public funding of the proposed surgeries,
- irrespective of its decision, advise the Minister that an independent authority, such as the Medical Board of Australia together with other National Boards, should establish national standards for adult gender services, developed in accordance with NHMRC standards and covering both hormone treatment and surgery.

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Part A

A1 Natural history: evidential and practical problems

A natural history describes the course a condition takes in the absence of treatment. It is established by observation, on the assumption that observing a condition does not itself alter it. Because it supplies the comparison against which any benefit is judged, it is the basis for assessing and developing treatment.

Establishing the natural history of gender incongruence and gender dysphoria faces several problems:

- Those presenting are not a uniform group: they differ in ways that include when their distress began, their sex and their sexual orientation. The Natural History assessment notes the rise in presentations among young natal females, but does not assess the stability of gender identity separately by sex, age of onset or sexual orientation. In earlier studies, childhood-onset distress usually resolved, often with a gay or bisexual orientation in adulthood. The course of the adolescent-onset presentations that now predominate has not been established, but the available evidence indicates that it too can change (A5-A8).
- Under current models of care, diagnosis leads directly to affirmation of a child's or adult's stated gender, and affirmation may itself change the course the condition takes. With no alternative model in Australia, there is nothing to compare it with (A5). Nor are those who do not proceed to medical interventions followed, so their course remains largely unknown.
- Gender incongruence and gender dysphoria frequently occur with other conditions that have natural histories of their own. These may contribute to the gender distress, while treatment for the gender distress may in turn affect their course, so the two interact and neither can be observed on its own (A3).
- The available data are limited and heterogeneous. Most data come from cohorts unlike the people now presenting (A4).
- As the Natural History assessment acknowledges, key terms such as desistance and detransition are used inconsistently (A8).[1]
- The same data are interpreted in very different ways. The Natural History assessment reads the rise in referrals as reflecting greater awareness and acceptance, while the authors of a study it

[1] MSAC Application 1754, Natural History: Executive Summary, June 2026, p. 2, https://www.msac.gov.au/sites/default/files/2026-06/msac_1754_final_natural_history_-_executive_summary.pdf

cites considered the reasons unknown and identified social and media influences among the possible explanations (A4).[2]

- Much of the evidence is produced and interpreted by clinicians and services that provide the treatments being assessed, and the standards that inform practice have been developed by membership associations whose members include those who provide the treatments. Independence is a standard criterion in appraisals of both evidence and guidelines, and we urge MSAC to give it weight in this assessment (A5, B1, C3).[3]

The limited evidence on natural history can generate hypotheses, but cannot establish what the case for surgery assumes: that gender incongruence is stable and intrinsic.

A2 Diagnosis: what it cannot distinguish and its diminishing role in practice

An application concerning surgery for adults necessarily turns on how those adults came to seek it, and for many the answer begins in adolescence, and for some in childhood. The diagnostic process they underwent then matters, because it set in train a long pathway of social and medical interventions that may culminate in surgery.

The diagnoses on which children, adolescents and adults enter treatment are worded differently, but each rests on the person's account of their gender, and none requires that account to be tested against other explanations for their distress. The childhood criteria show the problem most clearly.

One of the three elements of the ICD-11 definition of Gender Incongruence of Childhood, and 5 of the 8 DSM-5 indicators, concern preferences for clothing, toys, games, make-believe play and playmates typical of the other sex. Stereotyped expectations of each sex are thus built into the definition of a health condition, and children who do not conform to them are brought within its reach.[4]

The second element of the ICD definition, which DSM-5 mirrors, raises a different problem. It requires "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

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[2] 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", Nordic Journal of Psychiatry 2020, https://doi.org/10.1080/08039488.2019.1667429

[3] Brouwers MC, Kho ME, Browman GP et al., "AGREE II: advancing guideline development, reporting and evaluation in health care", Canadian Medical Association Journal 2010;182(18):E839–E842, Domain 6 (editorial independence), https://doi.org/10.1503/cmaj.090449

[4] World Health Organization, ICD-11 for Mortality and Morbidity Statistics, HA61 Gender incongruence of childhood, https://icd.who.int/browse/2025-01/mms/en#344733949 American Psychiatric Association, DSM-5 criteria for gender dysphoria in children
American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th ed., text rev. (DSM-5-TR), 2022, Gender Dysphoria in Children, Gender Dysphoria | Psychiatry Online

experienced gender".[5] A pre-pubertal child has not experienced those characteristics, so what is recorded is an attitude towards changes that have not yet occurred, formed on what the child understands them to be. The criterion does not ask where that attitude comes from, and cannot distinguish whether gender incongruence is a primary condition, or the result of other factors.

A child approaching puberty who is beginning to notice same-sex attraction may have reason to fear the body producing it, especially in a homophobic environment. Similarly, a child with a neurodevelopmental condition may take in information about puberty differently, or find the prospect of bodily change distressing in itself. And as puberty begins, some children develop body dysmorphic disorder, a preoccupation with perceived defects in appearance that most often starts at 12 or 13, can centre on the breasts or genitals, may continue well into adulthood, and can likewise involve a wish to change the body.[6]

In each of these cases, the diagnostic criterion records a strong dislike of the individual's sexual anatomy, so what distinguishes these children from the child the criterion is meant to identify is only the account the child gives. The diagnosis therefore rests on that account, and nothing in the criteria requires it to be tested against these alternative explanations.

The criteria for adolescents and adults no longer rely on play and companions. MSAC has noted that ICD-11 contains no specific diagnostic criteria, including for what constitutes "marked and persistent" incongruence.[7] The Natural History assessment notes that the diagnosis does not require distress, the definition referring instead to incongruence that "often leads to a desire to 'transition'".[8] DSM-5's gender dysphoria diagnosis does require distress, but its indicators are again matters of desire and conviction: a strong desire to be rid of one's sex characteristics, to be another gender or to be treated as one, and a strong conviction that one has the typical feelings and reactions of another gender.[9]

Alternative explanations remain open after puberty. Same-sex attraction, a neurodevelopmental condition, trauma, and mental health issues including body dysmorphic disorder can each produce a strong wish to be rid of sex characteristics, and the criteria exclude none of them. For the population now presenting to adult services, these are not remote possibilities: as A3 and A4 describe, it is younger, increasingly female, and more likely to have prior mental health difficulties, neurodevelopmental

[5] ICD-11, HA61, DSM 5

[6] Phillips KA, Kelly MM, "Body Dysmorphic Disorder: Clinical Overview and Relationship to Obsessive-Compulsive Disorder", Focus 2021;19(4):413–419, https://pmc.ncbi.nlm.nih.gov/articles/PMC9063569/

[7] MSAC, Public Summary Document, Application 1754, April 2025, p. 5, https://www.msac.gov.au/applications/1754

[8] Natural History assessment, pp. 49–51

[9] APA, DSM-5-TR (2022), "Gender Dysphoria in Adolescents and Adults", criteria A and B

conditions or trauma than the populations on which the surgical evidence was based. The adult diagnosis therefore says nothing about how any distress or perceived incongruence arose.

Because the diagnosis rests on the person's account, it matters that the account may itself be shaped by what a person understands assessment requires. Consumer attendees at MSAC's consultation described pre-surgical assessment that can include questions such as "Have you had women's thoughts?", leaving the person feeling "they have to come up with something on the spot to get a box ticked for surgical access." They also noted that some people "may mask their neurodivergence" to avoid additional sessions with a psychologist.[10]

Studies of Dutch services describe the same adaptation. In adolescent care, Oosthoek and colleagues found young people wary of voicing uncertainty. One explained that "you had to be careful what you told them", because expressing doubt could mean waiting longer.[11] In adult services, de Boer and colleagues found that clinicians' preference for accounts of lifelong or early-onset dysphoria can encourage patients to present the history they understand is required, and that negotiating a diagnosis can result in gender dysphoria being "reified into a stable entity that existed in the past and will exist in the future".[12] Where this happens, the diagnosis records an account adapted to obtain a diagnosis, and the history that might point to another explanation is not heard. A diagnosis made in this way cannot confirm stability of identity.

In practice, diagnosis appears to carry increasingly less weight. Clinicians and state and territory representatives told MSAC's consultation that practitioners "have mostly moved away from the historical need for a formal diagnosis of gender dysphoria" to enable access to medical or surgical treatment, and one organisation submitted that no diagnosis should be required.[13]

The reasons for this change are not recorded in the consultation summary. AusPATH's standards for hormone treatment present informed consent as the threshold, an approach they describe as facilitating access "without the additional burden of a formal diagnosis"[14]. ACON, which provides accredited CPD training in gender-affirming practice for GPs (A5), states on its TransHub website that "diagnosis is not strictly required for gender affirming surgery".[15]

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[10] Medical Services Advisory Committee, Consultation meetings with consumers: meeting notes, Application 1754, 8, 11 and 12 May 2026, pp. 10–11, https://www.msac.gov.au/applications/1754

[11] Oosthoek ED, Gerritse K, de Vries MC, Dedding C, de Vries ALC, "The Fiction of Prior Knowledge: Rethinking Informed Consent in Adolescent Gender-Affirming Medical Care", Medical Law International 2026

[12] de Boer W, Molewijk BC, Bremmer MA, Kreukels BPC, Moyer EM, Gerritse K, "Doing and undoing transgender health care: The ordering of 'gender dysphoria' in clinical practice.", Sociology of Health & Illness 2024;46(4):644–663, p. 658

[13] MSAC, Consultation meetings with clinicians and states & territories: Summary of meeting outcomes—Application 1754, 5 and 8 May 2026, p. 5.

[14] AusPATH, Australian Standards of Care for Informed Consent Gender-Affirming Hormone Therapy, Version 2, 2025, p. 13, https://auspath.org.au/wp-content/uploads/2026/05/Standards_of_Care_Digital_Final_30_April_2026.pdf

[15] ACON, TransHub, "Gatekeeping by doctors", https://www.transhub.org.au/medical/gatekeeping-by-doctors

Whatever the reasons, the trend to disregard a need for diagnosis departs from surgical practice generally, in which an operation is performed for an established clinical indication. It also bears on public funding. Medicare benefits are payable only for services "generally accepted in the medical... profession as being necessary for the appropriate treatment of the patient".[16] We urge the MSAC to consider how the necessity would be established, and whether a patient's documented wishes are sufficient.

A3 Co-occurring and underlying conditions

Among the other sources of distress the diagnosis cannot distinguish are the conditions that frequently accompany gender distress, in children and in adults. These include neurodevelopmental conditions such as autism, as well as body dysmorphic disorder, depression, anxiety, eating disorders and the effects of trauma, which can have their own causes in a person's history, such as loss, neglect, abuse or family conflict. Whether these conditions simply occur alongside gender distress or underlie it matters for treatment. If the distress has other sources, treatment directed at gender may leave them untouched, and surgery may permanently alter the person's body without relieving distress.

Finnish evidence bears directly on that question, because it shows how often these conditions come first. Kaltiala-Heino and colleagues, reviewing the first 2 years of an adolescent gender service, found that 75 percent of applicants "had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria when they sought referral".[17] They reported that "severe psychopathology preceding onset of gender dysphoria was common", that these difficulties "could seldom be considered secondary to gender dysphoria", and that it was "not possible to predict" whether the gender dysphoria would "cease with the resolution of wider developmental problems" or consolidate into a lasting trans identity.

Ruuska and colleagues, using Finnish registers to follow people referred to gender identity services before the age of 23, found that the proportion with prior specialist psychiatric treatment roughly doubled between those referred in 1996–2010 and those referred in 2011–2019. They concluded that, for some, "mental health challenges may manifest as concerns related to gender identity", and that "psychiatric needs do not subside after medical gender reassignment".[18]

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[16] Health Insurance Act 1973 (Cth), s 3(1), definition of "clinically relevant service", https://www.legislation.gov.au/C2004A00101/latest/text

[17] Kaltiala-Heino R, Sumia M, Työläjärvi M, Lindberg N, "Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development", Child and Adolescent Psychiatry and Mental Health 2015;9:9,[https://pmc.ncbi.nlm.nih.gov/articles/PMC4396787/

[18] Ruuska S-M, Tuisku K, Holttinen T, Kaltiala R, Acta Paediatrica 2026, https://doi.org/10.1111/apa.70533.
The study linked national records for 2,083 people referred before age 23 and 16,643 matched controls, with follow-up to June 2022.

Elevated rates of suicidality among those presenting to gender services are often cited as a reason for gender-affirming treatment. Using the same national cohort, Ruuska has also compared the mortality of adolescents and young adults referred to gender identity services with that of matched population controls. Suicide mortality was higher in the referred group, but the difference was no longer statistically significant once specialist psychiatric treatment was taken into account. The authors concluded that "clinical gender dysphoria does not appear to be predictive of all-cause nor suicide mortality when psychiatric treatment history is accounted for", and emphasised the importance of identifying and treating mental disorders to prevent suicide.[19] Elevated suicide risk therefore cannot simply be attributed to gender dysphoria without examining the other mental health difficulties of those presenting. Nor does its presence establish that interventions such as gender affirming surgery will reduce it. Indeed, new research suggests that suicidal ideation and psychiatric need may increase after surgery and medical transition, as discussed in C1.

Australian evidence, though more limited, points to substantial comorbidity amongst those with gender dysphoria. Of 57 children and adolescents presenting to the Westmead gender service, almost 90 per cent had a co-occurring psychiatric diagnosis, and most showed high-risk attachment patterns and high rates of unresolved loss or trauma. On these measures they did not differ from children with mixed psychiatric disorders, and the authors concluded that, "akin to children with other forms of psychological distress", these children "present in the context of multiple interacting risk factors".[20]

Taken together, this evidence shows that, for many of those presenting, other conditions precede the gender distress, and that their relationship to it cannot be determined at presentation. Stigma and discrimination may add to distress, but they cannot account for conditions that preceded it.

A4 The changing population and the role of social influences

The most salient question in the natural history of gender incongruence and gender dysphoria among young people is how a presentation that was once rare came, within a few years, to generate a near-exponential rise in referrals across western countries. During the 2010s, that rise was accompanied by a marked change in the adolescent population presenting, with the increasing predominance of natal girls.[21] Explaining the scale and speed of this rise is central to understanding the condition's aetiology and course,

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[19] Ruuska S-M, Tuisku K, Holttinen T, Kaltiala R, "All-cause and suicide mortalities among adolescents and young adults who contacted specialised gender identity services in Finland in 1996–2019: a register study", BMJ Mental Health 2024;27:e300940, doi.org/10.1136/bmjment-2023-300940. This study draws on the same Finnish referral cohort as Ruuska 2026, rather than providing an independent replication. After adjustment for specialist psychiatric treatment, the suicide mortality hazard ratio was 1.8 (95 per cent confidence interval 0.6–4.8).

[20] Kozlowska K, Chudleigh C, McClure G, Maguire AM, Ambler GR, "Attachment Patterns in Children and Adolescents With Gender Dysphoria", Frontiers in Psychology 2021;11:582688, https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2020.582688/full

[21] Kaltiala et al., “Time trends in referrals” (2020)

and how those who may eventually present for surgery came to understand their distress and seek medical intervention.[22]

The Natural History assessment cites Australian prescribing data showing a nearly fivefold rise between 2013 and 2024 in the number of people beginning subsidised cross-sex hormones each year. The source document also shows the increase in testosterone prescribed to natal females clearly (Figure 1).[23] Over this period, natal females initiating testosterone increased from 79 per year to 2095, a 26.5-fold increase, compared with a threefold increase in oestradiol initiations among natal males. The mean age of initiation of hormones decreased in both sexes, but particularly for natal males where it went from 51.1 to 27.0 years. The mean age for females starting treatment in 2024 was 23.8 years old, clearly indicating that this is now a phenomenon of youth. The Natural History assessment reports only the overall rise which it attributes to "increased awareness, acceptance, and access to care rather than true prevalence alone."

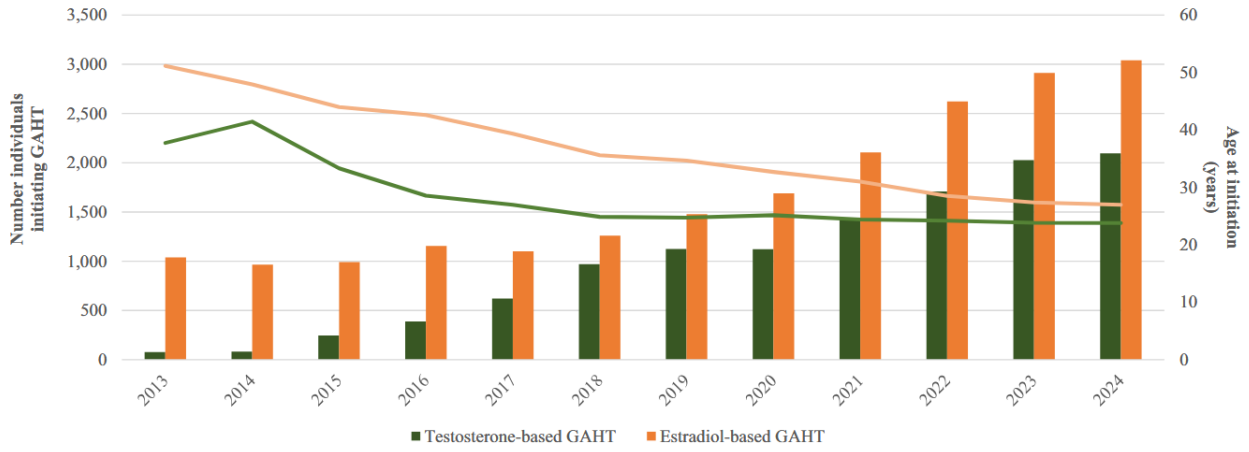


Figure 1. Individuals initiating PBS-subsidised gender-affirming hormone therapy, Australia, 2013–2024, by hormone type, and mean age at initiation. Testosterone-based therapy (green) rose from 79 initiations in 2013 to 2,095 in 2024; oestradiol-based therapy (orange) rose from 1,039 to 3,040.

[22] Later reductions in hospital referrals do not establish that the overall population entering treatment has diminished. A Victorian audit suggests that declining tertiary referrals may reflect movement into primary and community-based services: Lum S, Eade D, Colon Cabrera D et al., "A reducing demand for tertiary hospital-based gender affirming care in Victoria, Australia", Internal Medicine Journal 2026;56(1):108–110, published online 13 December 2025 https://pubmed.ncbi.nlm.nih.gov/41388757/. The Queensland Hormone Treatment Review documents private treatment before public-clinic assessment and gaps in information about prescribing outside those clinics: Queensland Health, Independent Review of Stage 1 and Stage 2 Hormone Therapies in Queensland, 2025, Independent Review Advice Report, pp. 63 and 69, https://www.health.qld.gov.au/__data/assets/pdf_file/0035/1478843/Queensland-Hormone-Treatment-Review-Report-and-Annexures.pdf

[23] Natural History summary, pp. 5, 8 and 10, citing Saxby K, Nolan BJ, "Temporal trends in gender-affirming hormone therapy initiation: evidence from whole-of-population Australian administrative data", Internal Medicine Journal 2025;55:2092–2094 https://doi.org/10.1111/imj.70194

In England a similar pattern is seen, with around a quarter of accepted referrals to adult gender services now from people aged 17 to 19, and a rising proportion of natal females. A recent NHS review also reports more neurodevelopmental conditions and a broader range of mental health difficulties, childhood trauma and abuse in this newer, younger population.[24]

The population now presenting is therefore younger, increasingly natal female, predominantly so amongst adolescents, and more likely to have experienced mental health conditions than the populations from which most of the surgical evidence was drawn. MSAC has itself recognised that these changes make it difficult to assess the comparative outcomes reported in the evidence base.[25]

The explanation commonly offered for this rapid rise in presentations assumes that greater awareness, acceptance and access to care have enabled people who were already transgender to recognise and disclose it, and to seek treatment. The Natural History assessment adopts this account, suggesting, as noted above, that the trends likely reflect increased awareness, acceptance and access to care.[26]

That is an untested hypothesis, and the assessment's own evidence does not support adopting it. Greater awareness and acceptance would be expected to enable disclosure across both sexes, yet the increase has been concentrated among young natal females. The assessment's phrase "rather than true prevalence alone" allows that prevalence itself may have risen, but the assessment does not consider why. The assessment cites Kaltiala and colleagues' study of referral trends, which concluded that the reasons for the increase were unknown and expressly identified social and media influences among the possible explanations.[27] The question therefore arises from the assessment's own evidence: do social influences merely enable disclosure, or do they also shape gender identification and distress?

Other explanations cannot be set aside and in fact may explain some of the evidence better. The period of rapid growth in presentations to gender clinics also saw marked changes in other mental health presentations among young people. In Australia, psychological distress among young people rose substantially between 2012 and 2020, most sharply among girls.[28] The same period saw rapidly expanding smartphone use and access to online communities, which contributed to that distress, although the

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[24] NHS England, "Operational and delivery review of NHS adult gender dysphoria clinics in England", 18 December 2025, updated 11 March 2026, paras 13–18 and Table 1. The review reports 198 accepted referrals per month among people aged 17–19 https://www.england.nhs.uk/long-read/operational-and-delivery-review-of-nhs-adult-gender-dysphoria-clinics-in-england

[25] MSAC, PSD, pp.6-7

[26] MSAC, Natural History, p.10

[27] Kaltiala 2020, cited in Natural History summary, p.6

[28] Mission Australia and Black Dog Institute, Psychological Distress in Young People in Australia: Fifth Biennial Youth Mental Health Report, 2012–2020, 2021, p.21, https://www.blackdoginstitute.org.au/wp-content/uploads/2021/09/Youth-Mental-Health-Report-2012-2020.pdf. The proportion reporting psychological distress rose from 22.4 to 34.1 per cent among females and from 12.6 to 15.3 per cent among males.

extent of their contribution is debated.[29] The alternative also fits more readily with the predominance of younger people among presentations: if greater acceptance were enabling increased disclosure, older people might be expected to come forward in comparable numbers.

Even researchers who favour an awareness and disclosure explanation recognise that the scale and speed of change require explanation. Pang and colleagues described the rapid increase in clinical demand as "unusual within medicine", and their study of Melbourne and UK services between 2009 and 2016 found associations between media coverage and referrals within the following 2 weeks. They also discussed young people selecting media content to "explore and construct their identities".[30] Their findings do not distinguish coverage prompting disclosure of pre-existing feelings from coverage helping young people interpret experiences unrelated to gender through a gender framework.

Social influences are not confined to social media and smartphones. They include news media, school programs, the views and responses of peers, and the availability and authority of clinical services, which may shape how a young person frames their mental health or social challenges. A young person already experiencing depression, anxiety, isolation, difficulties associated with autism, emerging sexuality or discomfort with puberty (A3) may find in a transgender identity an explanation for experiences that previously seemed unrelated or incomprehensible. Peers, online communities and now the medical establishment offer gender as both an explanation and a proposed solution.[31]

The Natural History assessment adopts the awareness explanation, but does not test it against the scale and speed of the rise, its concentration among natal females, or the age of those now presenting. Whether social influences, interacting with existing difficulties, help shape gender identification and distress is not a peripheral question. It concerns how the population whose natural history the assessment seeks to describe came to present for treatment, including those who now investigate surgery as adults. Once a gender explanation has been adopted, the model of care that follows reinforces it (A5).

A5 The disruption of natural history by the affirmation model

The affirmation model accepts a gender explanation of distress at the outset and builds each later step on it. Social transition, puberty suppression, hormones and, in time, surgery each reinforce that explanation, and may consolidate the identity and close off other courses.

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[29] Australian Council on Children and the Media, "Aussie Teens and Kids Online", Small Screen, no. 327, reporting ACMA and eSafety research on changes in adolescent internet and smartphone use between 2011 and 2015 https://childrenandmedia.org.au/assets/files/resources/small-screen/ss-327-Feb.pdf

[30] Pang KC, de Graaf NM, Chew D, Hoq M, Keith DR, Carmichael P, Steensma TD, "Association of Media Coverage of Transgender and Gender Diverse Issues With Rates of Referral of Transgender Children and Adolescents to Specialist Gender Clinics in the UK and Australia", JAMA Network Open 2020, https://pubmed.ncbi.nlm.nih.gov/32721030/

[31] Cass H, Independent Review of Gender Identity Services for Children and Young People: Final Report, April 2024, paras 8.55–8.56, https://cass.independent-review.uk/home/publications/final-report/

This matters for care, and most for people whose distress may be a response to other difficulties, including difficulties that have arisen only recently, such as those that accompany puberty or the social pressures that have grown over the past decade. For them, the model may consolidate a gender identity where the distress might otherwise have resolved, or been addressed in other ways.

It also matters for what is known about the condition. Because affirmation is the only course now followed in Australia, it is also the only one observed. What is recorded as the natural history is the course followed under affirmation, not necessarily the course the distress would otherwise have taken.

What the course may be without affirmation is clearest in a study of children diagnosed before affirmation became the norm. Singh, Bradley and Zucker followed boys referred in early childhood to a specialist gender service in Toronto, almost none of whom had socially transitioned before puberty. Nearly 90 per cent were no longer gender dysphoric at follow-up, and nearly two-thirds grew up to be bisexual or gay.[32] The Natural History assessment does not consider sexual orientation, despite its prominence in this, the best-documented childhood course.

Westmead's gender service required young people to be engaged in continuing therapy and assessed them, with their families, before any medical intervention. Of those referred between 2013 and 2018, 22 per cent had desisted by follow-up 4 to 9 years later, some after starting puberty blockers or cross-sex hormones.[33] For at least a substantial minority, gender identity was not stable, and more may change course over time.

The Royal Children's Hospital, by contrast, adopted the affirmation model, which subsequently became dominant in paediatric gender services across Australia, although Queensland and the Northern Territory altered course in 2025. Its standards take the gender identity a child or adolescent expresses as the basis of care, and state that depression, anxiety and psychosis "should not necessarily prevent medical transition".[34] Like other guidelines reviewed internationally, they do not say how co-occurring mental health difficulties should be managed.[35]

The hospital's entry process reflects this. New patients and their parents attend a single 90-minute session with a nurse, who undertakes a biopsychosocial assessment and triages them "based on

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[32] Singh D, Bradley SJ, Zucker KJ, "A Follow-Up Study of Boys With Gender Identity Disorder", Frontiers in Psychiatry 2021;12:632784, https://doi.org/10.3389/fpsyt.2021.632784

[33] Elkadi J et al., "Developmental Pathway Choices of Young People Presenting to a Gender Service with Gender Distress: A Prospective Follow-Up Study" See also, https://www.abc.net.au/news/2023-07-10/transgender-children-westmead-hospital-research-four-corners/102568570

[34] Royal Children's Hospital, Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents, Version 1.4, p. 12, 230242 RCH Gender Standards Booklet 1.4_Nov 2023_WEB.pdf

[35] Taylor J et al., "Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of recommendations (part 2)", Archives of Disease in Childhood 2024;109(Suppl 2), https://adc.bmj.com/content/109/Suppl_2/s73

pubertal assessment and their hopes for medical transition". Those in early puberty are "fast tracked" to multidisciplinary assessment "for a medical pathway within 2 months", so that "those patients who will benefit most from puberty-blocking treatment" can "access treatment as required".[36] Of the first 194 patients, more than 90 per cent went on to multidisciplinary assessment for a medical pathway.

Any account of the natural history must therefore examine the extent to which treatment itself shapes it. The point was raised in the Australian debate over the Trans20 study at the Royal Children's Hospital in 2019–2020. The study's protocol stated an aim to "document the natural history of gender diversity presenting in children". D'Angelo and colleagues responded that it would "not be able to document the natural history of gender dysphoria in young people as this natural history is being altered by gender-affirming interventions", among which they included psychosocial as well as medical steps.[37]

The Natural History assessment illustrates the problem. It reports that approximately 90–93 per cent of socially transitioned children showed no retransition over a median follow-up of 5 years, extending only into early adolescence, and in cohorts for which complete social transition was a condition of entry.[38] But persistence within an environment that affirms the child's identification cannot show what would have happened outside it, and follow-up that ends in early adolescence stops at the point at which, in earlier studies, most childhood dysphoria resolved (A1).

Puberty suppression

Puberty suppression, to which the RCH's triage is directed, interrupts the natural history at its most consequential point, on the basis of an unproven rationale, and with known and unknown consequences for health, including possible effects on cognitive development.[39] Puberty blockers were introduced in the Netherlands for young people whose childhood gender dysphoria persisted into early puberty, with the rationale that delaying puberty would "buy time to think".[40] Yet in the Toronto study, most children diagnosed in childhood were no longer dysphoric when followed up at an average age of 20 years.

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[36] Eade DM, Telfer MM, Tollit MA, "Implementing a Single-Session Nurse-Led Assessment Clinic into a Gender Service", Transgender Health 2018;3(1):45–47, https://doi.org/10.1089/trgh.2017.0050

[37] D'Angelo R et al., "What constitutes informed consent in the treatment of childhood gender dysphoria? Some comments on the Trans20 study", and subsequent correspondence in 2019–2020, responding to Tollit MA et al., "What are the health outcomes of trans and gender diverse young people in Australia? Study protocol for the Trans20 longitudinal cohort study", BMJ Open 2019;9(11):e032151, https://bmjopen.bmj.com/content/9/11/e032151.responses

[38] Natural History summary, p. 7, citing the Trans Youth Project cohorts, including Olson KR et al., "Gender Identity 5 Years After Social Transition", Pediatrics 2022, https://pubmed.ncbi.nlm.nih.gov/35505568/

[39] Baxendale S. "The impact of suppressing puberty on neuropsychological function: A review." *Acta Paediatrica*. 2024;113(6):1156–1167. https://doi.org/10.1111/apa.17150.

[40] Cass Review, Summary and recommendations, para 80

Suppression may therefore intervene at the point at which childhood dysphoria would otherwise have resolved, and cannot be assumed merely to pause development, or to be neutral to the natural history.

Follow-up studies in the Netherlands and England found that the great majority of adolescents prescribed puberty blockers went on to cross-sex hormones.[41] Had blockers provided time to think, some divergence in outcomes might have been expected. The Cass Review drew that inference from the same studies, finding that given this progression "there is no evidence that puberty blockers buy time to think", and "some concern that they may change the trajectory of psychosexual and gender identity development".[42]

Continuation is nonetheless commonly treated as evidence that the condition is stable, and that the gender explanation adopted at the outset was correct. The Natural History assessment reasons the same way for adults: in the studies it reviewed, stability was typically measured by whether people detransitioned or discontinued care.[43] But the reported rates of continuation do not establish stability, and large losses to follow-up leave the rate of detransition unknown. Westmead's experience shows that some change course well after treatment has begun. Continuation also occurs within a pathway in which a person's identification is affirmed at each stage, and it is what such a pathway would be expected to produce, whether or not the condition would otherwise have persisted. The near-universal progression from suppression to cross-sex hormones is therefore consistent with suppression, and the affirmation that accompanies it, foreclosing the resolution that might otherwise have occurred.

Adult affirmation

Affirmation now shapes adult care in the same way, and the position hardened when AusPATH issued its own standards. The 2019 position statement on hormone treatment, which AusPATH endorsed alongside the Endocrine Society of Australia and the RACP, recommended a comprehensive mental health review, noting that mental health professionals can "exclude less common conditions such as psychosis, dissociative identity disorder or body dysmorphic disorder".[44] AusPATH's current standards state instead that mental health conditions, "including eating disorders and neurodiversity, are not contraindications for initiating GAHT under the informed consent model, provided they do not currently impair the individual's capacity to

[41] Brik T, Vrouenraets LJJJ, de Vries MC, Hannema SE, "Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria", Archives of Sexual Behavior 2020;49:2611–2618, https://doi.org/10.1007/s10508-020-01660-8: of 143 adolescents, "125 (87%) started gender-affirming hormones". 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", PLoS ONE 2021;16(2):e0243894, https://doi.org/10.1371/journal.pone.0243894: "43 (98%) elected to start cross-sex hormones".

[42] Cass Review, summary and recommendations

[43] MSAC, Natural History, p.7

[44] Cheung AS, Wynne K, Erasmus J, Murray S, Zajac JD, "Position statement on the hormonal management of adult transgender and gender diverse individuals", Medical Journal of Australia 2019;211(3):127–133, https://pubmed.ncbi.nlm.nih.gov/31271465/

consent".[45] Even conditions that may impair capacity, "such as acute psychosis, intellectual disability, or dementia", are not excluded. The standards advise that they "should be stabilised and/or the appropriateness of GAHT should be assessed in a multidisciplinary team setting".

Before surgery, MSAC's consultation heard that "the individual surgeon will then determine if the person would benefit from a mental health assessment to determine their readiness for surgery", and participants later warned that mandatory diagnostic processes "may introduce delays and barriers that currently don't exist for patients".[46] WPATH asks clinicians to "identify and exclude other possible causes of apparent gender incongruence", but describes such causes as rare and leaves their identification to clinician judgement.[47] Other conditions are treated as bearing on capacity or readiness, not as possible sources of the distress. For adults, as for children, other courses are foreclosed for those whose distress has other sources, and what is recorded as the natural history is again the course followed under affirmation.

Why the alternatives remain closed

Legal and professional pressures have narrowed the alternatives further. The RACGP told MSAC's consultation that an exploratory approach is "less common now because of concerns it may be interpreted as coercive conversion practice".[48] In submissions to the Victorian Law Reform Commission's review of the state's conversion practices law, RACGP Victoria reported practitioners' fears about exploratory questioning and referral for neutral, non-judgmental therapy, and AMA Victoria identified continuing uncertainty around exploratory discussion.[49] An alternative that clinicians are reluctant to offer, or families are frightened to consider, may not be meaningfully available (C4).

Nor is it being studied. The Australian programs funded by the NHMRC and MRFF study or support the affirmation pathway, but do not compare it with appropriate psychological care offered in its place.[50]

Public messaging and clinical training point the same way. ACON's TransHub website describes requiring patients to prove that they "really want or need access to medically affirming care" as gatekeeping, and

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[45] AusPATH 2025, pp. 19-20

[46] MSAC Clinician Consultation, pp. 4-6

[47] Coleman E, Radix AE, Bouman WP et al., "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8", International Journal of Transgender Health 2022;23(sup1):S1–S259, doi:10.1080/26895269.2022.2100644 ("SOC-8")

[48] MSAC clinician consultation, p. 4

[49] Royal Australian College of General Practitioners, Victoria Faculty, submission 196 to the Victorian Law Reform Commission's review of the Change or Suppression (Conversion) Practices Prohibition Act 2021, 2026, pp. 2–4 https://media.lawreform.vic.gov.au/wp-content/uploads/2026/05/Sub_196_RACGP_Victoria_Redacted.pdf; Australian Medical Association Victoria, submission 121 Sub_121_Australian_Medical_Association_Victoria_Reviewed.pdf

[50] Trans20 longitudinal cohort, NHMRC grant GNT2006529 (NHMRC disclosure log); "Ensuring Safe and Effective Puberty Suppression for Transgender Adolescents", NHMRC Investigator Grant GNT2027186 (NHMRC funding outcomes); Australian Research Consortium for Trans Youth and Children (ARCTYC), MRFF grant MRF2032119; TAG TEAM, MRFF grant MRF2029506 (ARCTYC funding information)

advises people who experience it that they can find another practitioner.[51] ACON also provides CPD training in gender-affirming practice for GPs and other clinicians, including a series developed with a Commonwealth-funded Primary Health Network and accredited by the RACGP and ACRRM.[52] We are concerned that, in this environment, examining whether an intervention is appropriate may itself be characterised as gatekeeping, making it harder for clinicians and patients to raise doubt.

Claims about suicide prevention add to that pressure. Elevated suicide risk cannot simply be attributed to gender dysphoria (A3), yet where affirmation and medical intervention are presented as necessary to protect a young person's life, parents are placed under pressure to agree, and the young person may come to regard intervention as their only prospect of relief. Australian psychiatrist Alison Clayton has drawn attention to the possibility that exaggerated suicide narratives may themselves heighten distress and strengthen expectations of benefit.[53]

Where alternatives are neither offered nor studied, the course followed under affirmation is the only one that can be observed.

A6 Surgery as part of the pathway from the outset

Under the affirmation model, surgery is not a separate question that arises only in adulthood. It is part of the pathway from the outset, as a step to which the others may lead.

Australian services also make provision for surgical referral during adolescence. The Perth Children's Hospital Gender Diversity Service's 2021 model of care provided that, where a young person wished to arrange "top surgery" while still in its care, the service would supply details of private surgeons and documentation of diagnosis and treatment history to accompany a GP referral.[54] In 2024, Victoria's Health Minister confirmed that Royal Children's Hospital clinicians could refer adolescents to private specialists to consider surgery where clinical need was determined, and that this had been the hospital's consistent approach.[55] South Australia's model of care also provides for young people under 18 to be referred for

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[51] TransHub, “Gatekeeping by doctors”

[52] For example see ACON, "Trans Vitality: Trans-Affirming Practice eLearning"; Healthy North Coast https://www.pridetraining.org.au/collections/for-gps/products/lgbtq-inclusive-practice-for-aged-care-services-elearning-copy, https://hnc.org.au/news/gender-affirming-education-series-now-open-for-registrations/

[53] 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", Archives of Sexual Behavior 2023;52:483–494, https://doi.org/10.1007/s10508-022-02472-8

[54] Child and Adolescent Health Service, Gender Diversity Service Model of Care, 16 September 2021, p. 10, tabled in the Legislative Council of Western Australia. tp-764.pdf

[55] Victorian Parliament, Legislative Council, question on notice 1476, “Surgical treatments for gender affirmation”, asked by Moira Deeming on 18 April 2024; answer by Mary-Anne Thomas, Minister for Health, recorded 16 July 2024. Question 1476 - Surgical treatments for gender affirmation (Questions on Notice) - Parliament of Victoria

surgical assessment.[56] These arrangements place consideration of surgery within the adolescent pathway, rather than leaving it to a later adult assessment.[57]

A request for surgery in adulthood may therefore follow years in which one explanation of distress has been affirmed, physical intervention has been presented as the appropriate response, and expectations have developed around its continuation. Some may seek surgery as soon as they reach adulthood, with the decision already formed within the adolescent pathway. If the pathway includes young people whose distress would otherwise have resolved, or had other sources, some of those adults may be among them, and nothing in the current evidence identifies who they are. We urge MSAC to distinguish a request for surgery formed in this way from evidence that surgery is needed.

A7 Eligible age: what would an age limit secure?

MSAC has said that eligible age "needs to be addressed and resolved," noting that the applicant whose members would perform the procedures indicated a willingness to restrict the items to people aged 18 and over.[58] We are not aware of any published outcome of the further consultation MSAC sought on the question, and neither the Natural History nor the Models of Care assessment appears to address it.[59]

In our view, the limited evidence available points to greater risk among young adults, and nothing presented to MSAC establishes that 18 is a safe threshold. ESC noted initial research suggesting that a higher proportion of people who detransition had transitioned before the age of 25. A related study by the same Finnish research group discussed in A3 is consistent with that concern, finding that the risk of discontinuing established hormone treatment was almost 3 times as high among those who first contacted gender identity services in 2013–19 as among those who did so in 1996–2005, and that discontinuation was occurring earlier.[60] While the study did not compare age groups, its later cohorts reflect the changing population described in A4.

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[56] SA Health, Statewide Gender Diversity Model of Care, Version 1.2, July 2023, s 8.9.3, p. 40. Model of care_Gender Diversity_Jul2023_FINAL_FOR PUBLICATION.pdf

[57] In a study of US surgeons' experiences and attitudes towards vaginoplasty in minors, Milrod and Karasic described adolescents receiving puberty blockers and then cross-sex hormones, "with vaginoplasty as the presumed final step in their physical transition". Milrod C, Karasic DH, “Age Is Just a Number: WPATH-Affiliated Surgeons’ Experiences and Attitudes Toward Vaginoplasty in Transgender Females Under 18 Years of Age in the United States”, Journal of Sexual Medicine 2017;14(4):624–634, https://doi.org/10.1016/j.jsxm.2017.02.007.

[58] MSAC, PSD, p. 6. The applicant, whose members would perform the procedures, indicated a willingness to restrict the items to people aged 18 and over, while several healthcare professionals suggested 25 and over.

[59] MSAC PSD., p.10

[60] Kaltiala R, Helminen M, Holttinen T, Tuisku K, "Discontinuing hormonal gender reassignment: a nationwide register study", BMC Psychiatry 2024;24:566 The hazard ratio was 2.7. doi.org/10.1186/s12888-024-06005-6

National hospital statistics in Germany show that, since about 2015, genital surgery has been most common relative to population among those aged 18 to 25.[61] We are not aware of any published Australian data on the age of those undergoing these procedures, although hospital morbidity data may allow it to be estimated. If the German pattern holds here, surgery would be concentrated among young adults, the group in which presentations have risen most rapidly, prior mental health difficulties have become more common, and social influences may shape how distress comes to be understood. They are also the least likely to have had the opportunity to weigh the loss of fertility and sexual function.

Age alone cannot therefore answer MSAC's question. Because the pathway begins well before the request, what matters at any age is whether it has examined other explanations for the person's distress, and whether the explanation adopted at the outset still holds (A2 to A6). An age limit cannot supply that examination, but it can reduce the risk where the evidence suggests it is greatest.

Our position remains that listing should not be supported. If MSAC nonetheless considers it further, the first safeguard should be independent standards that require other explanations for the person's distress, and contraindications to surgery such as body dysmorphic disorder, to be assessed and addressed before surgery at any age (B1). Within those standards, we urge MSAC to consider recommending a minimum age of 25 for these surgeries, as several healthcare professionals suggested in consultation.

A8 Persistence, regret and detransition: what do the reported rates establish?

The Natural History assessment concludes that gender identity was largely stable, especially in adults, that detransition was uncommon and that most people continued treatment during follow-up. We are concerned that gaps in who is followed and what is recorded mean these conclusions cannot be relied on. Even if the reported rates accurately described persistence, continuation and detransition, they would not establish that treatment had relieved distress, improved functioning or avoided lasting harm.

MSAC has itself identified a critical need for long-term data, including on regret and detransition, and accepted that the commonly cited regret rate of 1 per cent may be an underestimate.[62] Its reasons, that many underlying studies involved more restrictive criteria than now apply and that less satisfied patients

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[61] Statistisches Bundesamt, DRG statistics (Fallpauschalenbezogene Krankenhausstatistik), OPS 5-646, as analysed by Athena Forum, "Germany has the data: a 2,700% rise in genital surgeries and a shift towards younger patients",

[62] MSAC, PSD, p8, citing Bustos VP et al., “Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence", Plastic and Reconstructive Surgery Global Open 2021;9(3):e3477, https://doi.org/10.1097/GOX.0000000000003477 We also draw MSAC’s attention to expert response to the 1% claim. Expósito-Campos and D'Angelo have noted that 23 of the 27 Bustos et al included studies were at moderate to high risk of bias, that only five studies (3 per cent of participants) were of higher quality and even these had loss to follow-up of 28 to more than 40 per cent, that many studies followed participants for only one or two years although regret is estimated to take eight to 8.5 years to emerge, and that the sample for the largest included study had been inflated from 2,627 to 4,863: Expósito-Campos P, D'Angelo R, "Letter to the Editor: Regret after Gender-affirmation Surgery", Plastic and Reconstructive Surgery Global Open 2021;9(11):e3951, https://pmc.ncbi.nlm.nih.gov/articles/PMC8751779/

are less likely to respond to follow-up, apply with particular force to the changing population described in A4. Those who provide and support these treatments acknowledge the same gaps. Participants at the applicant's 2023 roundtable described outcome measurement as "not often done well or at all"[63], and AusPATH also recognises that "capturing the precise rates of hormone discontinuation is difficult due to limited longitudinal follow-up and dropout".[64] In England, a review of NHS adult gender clinics found "no robust data on treatment and outcomes other than the reasons patients are discharged".[65] The question is therefore not only how long people are followed, but whether the information collected describes what happened to the distress, functioning and health of those treated.[66]

There are structural reasons why regret and changes of course may not be captured. Studies restricted to people who continue attending a gender clinic or still identify as trans can exclude those whose subsequent experience differs from the expected pathway. The Natural History assessment's definition of detransition has a similar effect: because it counts only re-identification with birth-registered sex, it would not capture someone who regrets surgery while continuing to identify as trans, or someone whose identity moves from binary to non-binary, which the assessment treats as "a distinct gender identity rather than a transitional state."[67] Counting requests for reversal misses people who regret treatment but for whom reversal is impossible or impractical, while reliance on spontaneous disclosure assumes that people will return and tell the service that treated them.

Disclosure may also carry social costs. A Canadian qualitative study documented rejection and loss of support from trans and LGBTQ+ peers and community spaces following detransition, alongside accounts of selectively disclosing or concealing a changed identity.[68] In Littman's survey of 100 people who had detransitioned, only 24 per cent had informed their treating clinicians.[69] In Vandenbussche's survey of 237 people who had detransitioned, only 29 per cent received support for their detransition from the professionals who had treated them, while online groups were the most common source of help (65 per

[63] Australian Society of Plastic Surgeons and Australian Collaborative on Access to Gender Affirming Medical Care, The Australian Roundtable on Gender Affirming Surgery 2023, Sydney, 2024, p. 9

[64] AusPATH, 2025, p.47

[65] NHS, footnote 24 above

[66] Cohn J, "The Detransition Rate Is Unknown", Archives of Sexual Behavior 2023;52:1937–1952. https://link.springer.com/article/10.1007/s10508-023-02623-5

[67] MSAC 1754 Natural History assessment, executive summary, p. 2

[68] MacKinnon KR, Gould WA, Ashley F, Enxuga G, Kia H, Ross LE, "(De)Transphobia: Examining the Socio-Politically Driven Gender Minority Stressors Experienced by People Who Detransitioned", Bulletin of Applied Transgender Studies 2022;1(3–4):235–259.

[69] Littman L, "Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners", Archives of Sexual Behavior 2021;50:3353–3369.

cent). Respondents described doctors who "did not believe them, did not listen to them, refused them services", or lacked the knowledge to help.[70]

Australian recording arrangements also make it difficult to follow people across services. The Queensland hormone-treatment review could not obtain comprehensive information about private practitioners treating young people and identified the absence of a central database and reporting requirements.[71] An audit of Victorian tertiary gender clinics suggested that reduced referrals might reflect a shift towards primary and community services, which clinic-based follow-up does not reach.[72] PBS dispensing records provide another source of information, but identifying testosterone prescribed for gender affirmation has required researchers to infer its purpose from prescribing and recorded sex or gender markers.[73] These sources can describe aspects of treatment, but do not by themselves provide a continuous account of the original presentation, subsequent interventions and outcomes.

The Models of Care assessment does not address this. It distinguishes people who stop treatment, reverse earlier interventions or re-identify with their birth-registered sex, but describes only care pathways towards gender-affirming care, the gender affirmation model having informed "almost all" of the pathways it identified.[74] Services with no pathway for those who reconsider are unlikely to record what happens to them. NHS England, following a recommendation of the Cass Review, has begun developing a national service specification for adults who wish to detransition, expressly recognising that some would prefer support outside their previous or current gender clinic.[75] The United States has introduced a diagnostic code, effective 1 October 2026, for a personal history of gender detransition.[76] We urge MSAC to consider how Australian services respond to people who reconsider treatment, because it bears directly on whether their course is recorded.

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[70] Vandenbussche E, "Detransition-Related Needs and Support: A Cross-Sectional Online Survey", Journal of Homosexuality 2022; Corrected 2026

[71] Queensland Health, Independent Review Advice Report: Advice and evidence base regarding policy options for the use of puberty suppression (Stage 1) and gender affirming (Stage 2) hormones for children and adolescents with gender dysphoria in Queensland's public hospital system (28 November 2025), p. 69, paras 247–248.https://www.health.qld.gov.au/research-reports/reports/review-investigation/hormone-therapies-review

[72] Lum et al., "A reducing demand for tertiary hospital-based gender affirming care" (2026; published online 2025)

[73] Nolan BJ, Zwickl S, Zajac JD, Cheung AS, "Gender affirmation testosterone therapy, Australia, 2021–22: a review of PBS dispensing data", Medical Journal of Australia 2024;221(9):491–492, doi:10.5694/mja2.52415. The authors describe use of an androgen-deficiency authority indication and acknowledge that the data do not provide a specific count of people using testosterone for gender affirmation. A subsequent linked-data analysis identified likely testosterone-based gender-affirming treatment through prescribing records and current or previous female markers, while acknowledging exclusions and possible misclassification: Saxby and Nolan, "Temporal trends in gender-affirming hormone therapy initiation" (2025)

[74] MSAC 1754, Models of Care assessment, executive summary, pp. 2-3, 10-11

[75] NHS England, "Call for evidence: a clinical pathway for adults who have previously undergone a gender transition and who wish to detransition", 30 October 2025.

[76] Centers for Disease Control and Prevention, National Center for Health Statistics, *ICD-10-CM FY 2027 code descriptions and addenda*, code Z87.893, "Personal history of gender detransition", effective 1 October 2026.

Where subsequent outcomes are unknown, the absence of a recorded adverse outcome cannot provide reassurance that none occurred, and a commitment to future monitoring would not resolve the uncertainty in the evidence presently relied on.

Where reconsideration is recorded, it often reflects a different understanding of the original distress. These accounts are also part of the natural history. They describe courses other than persistence, and reasons for distress that a stable and intrinsic gender incongruence would not explain. The Natural History assessment records reinterpretation of dysphoria, and concerns about insufficient earlier psychological assessment, among the reported reasons for discontinuing treatment. In Vandenbussche's survey, 70 per cent reported realising that their gender dysphoria was related to other issues, and 45 per cent had found alternatives for dealing with it. In Littman's survey, some participants came to understand their dysphoria in relation to trauma, abuse or a mental health condition, while others described homophobia or difficulty accepting themselves as lesbian, gay or bisexual as part of why they had transitioned (A3, A5).

A9 Beyond the record: what families and clinicians tell us

Our network includes parents, young people and clinicians whose experiences are not reflected in the published data. We set out what they report to us because it concerns matters that clinical records and published studies rarely capture (A8). Their accounts of services are discussed in Part B (B3).

Aetiology

Parents' accounts of how their child's distress arose follow a common pattern. Almost all the parents who contact us report that their child was not notably gender non-conforming in early childhood and did not express discomfort with their sex, and that distress began between puberty and young adulthood. Most children had one or more pre-existing difficulties: suspected or diagnosed autism or ADHD; same-sex attraction; trauma, such as sexual assault, family breakdown or the death of a loved one; mental health conditions, including depression, anxiety, eating disorders, self-harm and psychosis; serious medical illness; early puberty; and intense or consuming interests. Several of these, particularly neurodivergence, brought social isolation or bullying in childhood. In adolescence or early adulthood, while identity was still forming and the young person was seeking acceptance, transgender identity was presented as the explanation for always having felt different and the solution to their difficulties.

The declaration of a transgender identity typically followed involvement with social media, including Tumblr, Reddit and YouTube influencers, online gaming communities in which older gamers encouraged boys and young men especially to identify as transgender, peer groups in which several young people identified as transgender at around the same time, school support for social transition, media portrayals of thriving transgender people, and pornography. Parents of daughters describe distress at the sexualised and often violent depictions of women their child had encountered, and parents of sons describe pornography presenting feminisation or transition as an erotic theme.

These accounts are consistent with the adolescent-onset presentations and social influences discussed in A4. Parents also hold the developmental history against which a young person's own account would ordinarily be assessed. Some report young people coming to recount a childhood history of gender non-conformity that was not observed at the time. Where diagnosis rests on the person's own account (A2), such a history may be relied on without corroboration.

Desistance and detransition outside the record

Parents in our support groups increasingly report young people whose gender distress eased or resolved in young adulthood without medical treatment, often after five or more years of identification. Some had been assessed by a gender service and left without further contact; others never attended one. Neither group is likely to be recorded as having desisted: the first because services do not follow people once they leave, and the second because they never entered the record. Some families in our network also include young adults who have detransitioned after hormone treatment or surgery and who, as far as they are aware, have not been followed up or had their detransition recorded by the services that treated them.

Clinicians in our network, particularly general practitioners who continue to see patients after they leave gender services, describe the same courses: patients whose distress has resolved without treatment, patients who have detransitioned, and patients whose distress has continued after treatment. The services that treated these patients are unlikely to know of them.

Few parents speak publicly, for fear of damaging their relationship with their child, and so their experience is largely absent from the published record. These accounts show that courses other than persistence occur in Australia, often outside clinical oversight and beyond the reach of the evidence on which the application relies. We urge MSAC to take them into account when weighing the recorded rates of persistence, regret and detransition.

A10 Conclusion: an unmet need for surgery?

At the first stage, MSAC acknowledged "an unmet clinical need for gender affirming surgeries for people with gender incongruence". The distress of those seeking surgery is real and warrants a clinical response, but its existence and severity do not establish that surgery is the appropriate response, or that the distress has the stable and intrinsic source the case for listing assumes. Where the request for surgery may itself have been shaped by the pathway that precedes it (A5, A6), the need cannot be measured by the demand, and funding would raise a wider question for a public health system: whether it should meet a need that its own models of care may have helped to create.

MSAC has acknowledged the need for more evidence, including on the magnitude of benefit and on regret, and has commissioned a more complete evaluation. We urge MSAC to keep these uncertainties central to its assessment, and to support independent standards irrespective of the outcome of this application.

Part B: Multidisciplinary Teams and Surgical exemplars for economic evaluation

This part responds to MSAC's consultation questions on multidisciplinary assessment, team membership and surgical exemplars for economic evaluation. We address them without prejudice to our position that listing should not be supported.

B1 Multidisciplinary assessment

Standards come first

MSAC's questions about MDT arrangements cannot be answered satisfactorily without independent, evidence-based national standards for adult gender services. Those standards would determine what assessment is required, and therefore what an MDT is for, who should be on it and what it is responsible for deciding. Bringing several disciplines together does not by itself resolve the questions identified about diagnosis, the sources of distress or whether surgery would address them (A2 to A4).

Existing guidance cannot supply those standards. Australian clinicians treating adults draw on guidance issued by AusPATH and WPATH, organisations that combine clinical guidance with advocacy for the affirmation model. AusPATH's standards are written to "provide clear practical guidance for GPs and other primary care clinicians", yet the RACGP's view, recorded in MSAC's consultation, is that AusPATH documents "do not meet RACGP standards for clinical guidelines" and are "recognised (not endorsed)" as a resource.[77]

MSAC has itself recognised the need for Australian evidence-based guidelines for adults with gender incongruence and gender dysphoria, including for surgical intervention[78] (A3,A6). We recognise that developing or mandating such guidelines is outside MSAC's remit. We nevertheless urge MSAC to recommend that an independent authority, such as the Medical Board of Australia, together with other National Boards, establish them, developed to NHMRC standards, including systematic evidence review, assessment of benefits and harms, and transparent recommendations using GRADE.[79] They should cover both hormone treatment and surgery, as a necessary safeguard for the care already provided to adults through general practice, specialist clinics and private surgical services.

MSAC's own consultation records both broad support for allowing GPs, nurse practitioners and other practitioners to diagnose and refer patients for surgery, and a lack of evidence-based guidelines "on when

[77] MSAC, Clinician Consultation p.4

[78] MSAC, PSD, pp.3,7

[79] National Health and Medical Research Council, Procedures and requirements for meeting the NHMRC standards for clinical practice guidelines.

surgery is indicated".[80] Widening referral before such guidelines exist would leave the decision to each referrer's judgement, without a common standard against which it could be assessed.

The cosmetic surgery precedent

Australia's experience with cosmetic surgery shows the cost of waiting. Standards there were set largely within the field until concerns about harm to patients prompted an independent review in 2022, after which the Medical Board introduced new guidelines.[81] We urge MSAC to consider that experience: the case for acting first is stronger still for these surgeries, which are often more extensive and less reversible, and which are sought by a population that has changed rapidly, whose distress is often accompanied by other mental-health difficulties. (A3, A6).

Under the cosmetic surgery guidelines, an adult's consent is necessary but not sufficient. Practitioners must assess the patient's reasons for seeking surgery and whether their expectations are realistic, and must assess them for "underlying psychological conditions such as body dysmorphic disorder" that may make them unsuitable for surgery, with independent evaluation where such conditions are indicated. They must also discuss the option of not having surgery, and must decline to operate if surgery is not in the patient's best interests. The requirement for independent evaluation recognises that assessing psychological suitability calls for skills a surgeon may not have. These safeguards protect people who may seek surgery for reasons surgery cannot address.

Informed consent

Informed consent also depends on the information the patient receives from those treating them. In gender surgery, that information is often gathered elsewhere. Consumer attendees reported that most people "rely on internet forums or word of mouth to learn about their care options, which is unregulated and risks misinformation", and that feeling sufficiently informed before surgery "can depend on one's own research rather than on information provided by the surgeon".[82] National standards should ensure that patients receive this information from those treating them. They should also give effect to ongoing consent, so that earlier consent is not treated as agreement to later interventions, and changes in circumstances or response to treatment prompt renewed discussion of the proposed treatment, its risks and alternatives.[83]

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[80] MSAC, Clinician Consultations, pp. 5,7

[81] Ahpra and Medical Board of Australia, Guidelines for registered medical practitioners who perform cosmetic surgery and procedures, effective 1 July 2023.

[82] MSAC Consumer Consultations, pp.12-13

[83] Australian Commission on Safety and Quality in Health Care, Informed consent—practical guidance for clinicians, 2026. The guidance includes prescription medicines and identifies multidisciplinary responsibility for recognising when consent needs clarification or reconsideration. The Medical Board's cosmetic-surgery guidelines additionally require consent to be obtained in advance and reconfirmed on the day of surgery.

Optional or compulsory assessment

MSAC's consultation recorded "near consensus among stakeholders who attended the meetings" that MDTs should be available but not compulsory. Even the Australian Psychological Society and the RANZCP, whose members are "well placed to help" people make decisions about surgery, considered that psychological or psychiatric assessment should be an option, not a requirement.[84] The summary does not record how these positions were developed or whether members were consulted.

These positions are difficult to reconcile with the consultation's account of current practice. In most adult services, the prescribing doctor, not a mental health professional, assesses gender incongruence and capacity, and an independent assessment occurs only if the treating practitioner seeks one.[85] Consumer attendees reported that "providers generally work in progression (i.e. referring a patient) rather than as a team", and that people "tend to undertake their own research to decide what they want and focus on finding a surgeon with whom they are comfortable". Care described in this way is directed largely by the patient, with each practitioner acting on the step before. An MDT that is available but not required would leave that unchanged, and optional assessment is least likely to reach those who need it most, because a person whose distress has other sources may have no reason to seek it (A3, A5).

Once these standards are in place, assessment by an MDT operating under them should be compulsory for adults considering the proposed surgeries. The team's membership and responsibilities should be determined by those standards. Neither MDT approval nor the adoption of standards would itself establish the safety or effectiveness of the proposed surgeries.

B2 MDT governance failures

Reviews of gender services

The existence of a multidisciplinary team, or a requirement for multidisciplinary assessment, does not establish that safeguards operate in practice. Reviews of gender services have identified failures to document clinical reasoning, undertake required assessments, obtain consent and act on concerns, despite multidisciplinary arrangements or requirements.

In 2008, a review of the Monash Gender Dysphoria Clinic, which assessed and referred adults for sex reassignment surgery, found that key recommendations from an earlier Chief Psychiatrist review remained inadequately implemented despite monthly clinical review meetings. Professor Louise Newman's file audit identified inadequate responses to patients' mental-health needs and no documented reconsideration of suitability for surgery in light of significant psychiatric difficulties. She recommended

[84] MSAC, Clinician Consultations, p.6

[85] MSAC, Clinician Consultations, p.3

independent review of treatment and surgical approvals and regular audits of clinical practice and outcomes, in addition to the clinic's existing multidisciplinary review arrangements.[86]

Two recent paediatric examples show required assessment being omitted within multidisciplinary services. At South Australia's Women's and Children's Hospital, 22 children were treated in 2023–2024 without the prior psychiatric assessment required by SA Health guidelines. The review that followed was internal, conducted with the service's own multidisciplinary team, and only a summary of its recommendations has been published, in August 2026. It found that the service provided care consistent with its own model of care, but recommended as its first priority "a single operational governance structure with operational leadership spanning the mental health and paediatric medical teams".[87] In Cairns, the absence of required multidisciplinary consultation prompted an investigation that found wider failures in consent, clinical documentation, incident reporting, risk management and audit, and described a "negative patient safety culture."[88]

These examples expose different failures: inadequate scrutiny within existing multidisciplinary arrangements, omission of a required specialist assessment, and failure to obtain required multidisciplinary consultation. Two arose in children's services, but each shows how multidisciplinary safeguards can fail in practice, and specifying team membership would prevent none of them. An MDT requirement in the item descriptors would not by itself provide a safeguard, and neither the MDT label nor a collective recommendation should substitute for an accountable clinical judgement.

Raising concerns

Safeguards also depend on clinicians being able to raise concerns. Standards should protect good-faith clinical disagreement and provide independent routes for escalating concerns, including for clinicians outside the team. In settling its dispute with a child psychiatrist, Children's Health Queensland recognised in July 2026 that there is legitimate professional debate about treatment for children experiencing gender dysphoria.[89]

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[86] Louise Newman, Final Report: Review of Gender Dysphoria Clinic, Southern Health Mental Health Program, March 2008, pp. 3, 6, 18–21.

[87] SA Health, Gender Services: opportunities for improvement, August 2026, p. 1, https://cdn.wchn.sa.gov.au/downloads/WCH/children/adolescents/Gender-Services-Review-2026-opportunities-for-improvement.pdf

[88] Queensland Government, "Investigation into Paediatric gender health services provided in Cairns", 28 January 2025, identifying concerns about missing multidisciplinary consultation; ABC News, "Children prescribed puberty blockers without proper assessment at Cairns health service, review finds", 12 February 2026.

[89] Statement from Children's Health Queensland Hospital and Health Service, regarding Dr Jillian Spencer) https://www.childrens.health.qld.gov.au/about-us/news/media-releases/statement-from-childrens-health-queensland-hospital-and-health-service

B3 Assessment in practice: what parents and clinicians report

MSAC has asked what role multidisciplinary care should play for people considering surgery, and whether MDT assessment should be required. The accounts of parents and clinicians in our network bear on both questions, because they show how assessment currently operates in practice.

Children's services

The experiences of parents in our network who attended children's gender services with their child are deeply concerning, and show the same gap between a multidisciplinary structure and its function as the reviews in B2. Affirmation began at the reception desk, where the child's new name and pronouns were recorded. Diagnosis relied on the child's account, other explanations for the child's distress were not seriously explored, and co-occurring conditions were treated as secondary to gender and rarely addressed. The affirmation model left little room for investigation across the team's disciplines, and psychologists and psychiatrists appeared to see their role as securing parental consent.

Parents' knowledge of their child was not valued, and some were given inaccurate information about the law on parental consent. Parents report being told that their child faced a high risk of suicide if they did not consent to medical treatment, and clinicians in our network report the same advice being given. A number of parents told us that psychologists had advised their child to cut off contact with them. Some general mental health services were reluctant to treat once a gender identity was disclosed, preferring to refer to a gender specialist, while gender services did not treat the presenting condition, such as self-harm or suicidality. Young people can be left without treatment for that condition by either service.

Adult services

Many young people are assessed and treated as adults without any history being sought from their parents, although depression, anxiety and other difficulties were evident to them. Adult services need the person's consent to contact family, but a history from parents can be sought with that consent, and it rarely is. Clinicians describe gender clinics that do not seek input from primary care, or do not act on serious concerns raised by long-term general practitioners about a patient's mental health. They also describe assessments that are perfunctory or omitted, hormones prescribed to young adults after one or two consultations under informed consent, and rapid referrals for hormones or surgery without consideration of co-occurring conditions, including trauma.

We are also aware of instances in which online gender services obtained signed consent documentation many months after hormones had been prescribed. Where informed consent is itself the threshold for treatment, consent recorded after prescribing provides no safeguard. Parents also describe young people who disengaged from clinics and now obtain hormones online, and others who have bypassed clinical care altogether. For them, assessment before surgery may be the first assessment they receive.

Surgery

The same gaps extend to surgery. Parents report surgeons proceeding with mastectomy after being made aware of a complex mental health history. Clinicians in our network also report multiple instances when mastectomy for minors was approved after a single psychiatric appointment.

Raising concerns

Clinicians in our network are reluctant to raise these concerns publicly, citing the risk of complaints to Ahpra from people other than their patients, and uncertainty about whether conventional exploratory psychotherapy could expose them to liability, including criminal liability, under conversion practices laws (C4).

The accounts of parents and clinicians in this section bear directly on the consultation's near consensus that MDT assessment should be available but not compulsory (B1). They show that where assessment is optional, brief or conducted by the treating practitioner, conditions that may explain a person's distress can go unexamined at every stage, from first presentation to surgery. In answer to MSAC's questions, the role of the MDT should be independent assessment, and that assessment should be required, under national standards.

B4 MDT membership, training and peer support

MSAC has asked which clinicians should participate in an MDT, and which should be mandatory given the MBS requirement for at least three providers. Membership cannot be settled in advance of the national standards proposed in B1, because it depends on what the team is required to assess. The required membership should follow from the assessment responsibilities defined in those standards, with additional expertise according to the person's circumstances and the proposed procedure.

The team should include an independent clinical assessment by a practitioner who is not involved in providing the proposed surgery and has no financial interest in it. Independence should also permit examination of the diagnosis and earlier treatment decisions, rather than treating them as settled.

Training should prepare practitioners to apply those standards, including differential diagnosis, contraindications, assessment of expectations, informed consent and reassessment after treatment and during follow-up. Competence in these functions should be demonstrated through supervised practice and review of clinical decisions, not inferred from membership of an organisation or completion of a course in gender-affirming practice (A5). Training should include recognising when intervention is inappropriate and supporting patients who decide against, discontinue or regret treatment.

Any lived-experience role requires clear limits and careful selection. A person’s experience of transition does not establish what is appropriate for someone else. Peer support should help patients consider their options without promoting the course the peer worker has followed. Patients offered such support should

have access to accounts of regret, continuing distress and decisions against further treatment, not only accounts of successful transition.[90] Lived experience alone should not confer responsibility for diagnosis or decisions about surgery.

B5 Surgical exemplars for economic evaluation

Clinical questions first

We do not consider that the application should proceed to economic evaluation while the clinical questions identified in this response remain unresolved. Selecting representative combinations of procedures cannot establish that those procedures are an appropriate response to the distress of the people seeking them.

Outcome evidence

The outcome evidence is also poorly suited to economic modelling. Most studies reported outcomes over 6 to 12 months,[91] and short-term improvements in health-related quality of life do not establish that benefits will persist over the time horizon of an economic evaluation, which for permanent procedures may extend over the patient's lifetime. Projecting those improvements forward risks treating an untested assumption as an established benefit. A score recorded shortly after a hysterectomy cannot capture how the permanent loss of fertility may affect a young woman's later life. Studies using different quality-of-life instruments or procedure-specific measures also do not produce interchangeable results.[92] If those findings are used to compare surgical combinations, the assessment should explain how they have been translated into a common measure and whether that method is valid for these populations and procedures.

Escalating surgery

The proposed exemplars also risk establishing pathways of escalating surgery. For females, the combinations progress from mastectomy alone to mastectomy with hysterectomy and removal of the ovaries, then to those procedures with phalloplasty or metoidioplasty. Presenting increasingly extensive combinations as representative packages may normalise successive operations as an expected course of treatment before the clinical justification for that progression has been established. The ESC also noted "some evidence that people who undergo all of the procedures they sought have better outcomes", but this rests on a small volume of cross-sectional evidence that the ESC elsewhere described as

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[90] Hakeem A, "Psychotherapy for gender identity disorders", Advances in Psychiatric Treatment 2012;18:17–24, doi:10.1192/apt.bp.111.009431. Hakeem describes clinically facilitated groups including people considering surgery, people who had undergone it, including some who regretted it, and people not seeking it.

[91] MSAC PSD, pp. 24 and 33

[92] MSAC PSD, p.33

confounded.[93] Continuing to further surgery is not itself evidence of benefit. People may stop because they have come to see surgery as a mistake, or continue because each procedure has failed to bring the relief expected, a pattern familiar from cosmetic surgery, where repeated procedures can signal distress that surgery does not address (B1). Such evidence should not be used to favour more extensive combinations of procedures.

Costs beyond the proposed items

The financial consequences would extend beyond expenditure on the proposed surgical items. The evidence assessed for MSAC reported high complication and revision rates for genital surgery, mostly over very short follow-up, and in a large population-based study more than half of phalloplasty patients later returned to hospital, emergency or day-surgery care with complications.[94] Treatment of such complications may generate additional expenditure under existing MBS items or through public hospital services, rather than appear against the item funding the original operation.[95] We ask MSAC to clarify how subsequent repairs would be funded and to ensure that these costs are included in its assessment. MSAC's consultation also heard that people receiving gender-affirming care "may require more assistance than is currently available on the MBS" for mental health.[96] Any claim that surgery would offset its costs through reduced mental-health spending should be treated with caution, for the reasons given in C1.

Clinicians in our network report that complications of vaginoplasty present regularly to public hospital emergency departments, where their costs fall outside the proposed items.

Short-term outcome data, escalating combinations of procedures and costs beyond the proposed items each limit what an economic evaluation could show. None of them can be resolved by the choice of exemplars, and each returns to the prior question of whether the clinical evidence justifies proceeding with the application.

B6 Post-surgical management

MSAC has also asked how patients should be managed after surgery. Post-surgical management should extend beyond surgical recovery to long-term follow-up of distress, functioning and complications, including for people who no longer attend the surgeon or service that treated them (A8). It should provide

[93] MSAC PSD, pp.42, 45 and 53

[94] MSAC, PSD, p. 30. Reported complication rates were 31.5 to 43.8 per cent for phalloplasty and 11.1 to 32.1 per cent for vaginoplasty, with a revision rate of 43.3 per cent in one study of phalloplasty with penile prosthesis. Zhang TR, Harel D, Rivera A et al., "Incidence, complications, and long-term outcomes of gender-affirming phalloplasty: analysis of a large statewide population-based dataset", Urology 2024.

[95] MSAC, PSD, pp.15-16,noting that the Urological Society of Australia and New Zealand advised that the proposed items did not "allow for revisions due to adverse events" and suggested further procedures, including "genitourinary fistula repair after previous genital gender affirmation surgery."

[96] MSAC, Clinicians Consultations, p.7

clear routes to psychological and medical support, including for people who come to regret surgery, without requiring them to adopt a particular identity label or describe the previous treatment as a mistake.

Part C: Comparative safety and effectiveness of surgeries

In our February 2025 submission, we raised concerns about the evidence of benefit from these surgeries, their complications and irreversible consequences, and the harms reported by people who subsequently regretted treatment. We draw MSAC's attention to additional research, legal proceedings and developments concerning professional standards since that submission.

C1 Mental health outcomes

A US study published in 2025, using medical records of clinical diagnoses rather than self-report or surveys, suggests that surgery may be followed by deterioration in mental health. Lewis and colleagues compared about 6,000 adults diagnosed with gender dysphoria who underwent surgery with a matched group, also with gender dysphoria, who did not. None had a recorded mental health diagnosis before the index date. Within two years, those who had surgery were more likely to be diagnosed with depression, anxiety and substance use disorder. Among those documented as female, suicidal ideation was diagnosed in 19.8 per cent after surgery compared with 8.4 per cent without.[97]

A Finnish national register study published in 2026 followed 2,083 people referred to specialised gender identity services before the age of 23 between 1996 and 2019, together with 16,643 matched controls, using specialist psychiatric treatment as a measure of severe psychiatric morbidity. Among those who went on to medical gender reassignment, meaning hormone treatment with or without later surgery, the proportion receiving specialist psychiatric treatment rose from 9.8 to 60.7 per cent for feminising treatment and from 21.6 to 54.5 per cent for masculinising treatment. The authors concluded that this "does not support the suggested improvement in mental health after medical GR", and that "in some individuals, medical GR appears to be linked to deterioration in mental health".[98]

C2 Litigation and institutional responses to harm

Our February 2025 submission identified litigation arising from the Monash gender clinic, more recent cases underway in Australia, and proceedings overseas. Since then, a US detransitioner's medical malpractice claim has proceeded to a jury verdict, resulting in an award of US$2 million to the claimant.

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[97] Lewis JE et al., “Examining gender-specific mental health risks after gender-affirming surgery: a national database study”, Journal of Sexual Medicine 2025 doi.org/10.1093/jsxmed/qdaf026

[98] Ruuska et al, 2026

Reporting on the verdict and other pending cases, The Economist noted predictions that combined damages could run into hundreds of millions of dollars.[99]

In the United States, multiple claims by individuals treated as adults have been settled, including days before trial, and similar claims are being pursued in Canada and the United Kingdom. These claims raise the same questions as A2, A3 and B1: whether the person's distress was assessed against other explanations before irreversible intervention, or whether their own account was accepted as sufficient.

Separately, following US government investigations, several US hospitals have committed to funding detransition or restorative treatment.[100]

These cases and commitments concern harms that the published outcome evidence rarely captures. Australian claims are typically settled confidentially, so their outcomes add nothing to the record on which MSAC must rely (A8).[101]

C3 Contested standards of care

Our February 2025 submission raised concerns about WPATH's development of its Standards of Care and their use as a basis for Australian practice. Subsequent legal proceedings and independent appraisal have added to those concerns.

An independent appraisal published in February 2026 examined six SOC-8 chapters, including surgery, hormone therapy and mental health, using the AGREE II guideline-appraisal instrument.[102] It identified weaknesses in rigour of development, applicability and editorial independence. Only two of eight assessors recommended using the chapters without modification; three recommended modification and three recommended against their use.

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[99] "Lawsuits over transgender medicine for minors could be huge", The Economist, 6 February 2026.

[100] US Department of Justice, announcements concerning Texas Children's Hospital, 15 May 2026; Cleveland Clinic, 5 June 2026; and Mount Sinai Health System, 4 September 2026. The agreements included commitments to fund detransition or restorative treatment, with Texas Children's Hospital also undertaking to establish a dedicated clinic.

[101] Patrick Parkinson, "Will the Lawyers Sort Out the Problem of 'Gender-Affirming Care'?", paper for the Gender Healthcare Summit, Adelaide, 2026, p.1. Discussing Australian claims involving people first treated as young adults, Parkinson observes: "We are unlikely to hear about the outcome of the great majority of such cases, because typically, such personal injury claims are settled and the terms of the settlement are confidential."

[102] Zhang Y, Januś D, Kaltiala R, Karvonen M, Ptak JJ, Yepes-Nuñez JJ, "Quality of the World Professional Association for Transgender Health Guideline Standards of Care 8: An Appraisal Using the AGREE II Instrument","https://doi.org/10.1007/s10508-025-03399-6", Archives of Sexual Behavior 2026;55:1845–1857, published online 19 February 2026. Six clinicians and two guideline methodologists independently assessed the chapters on adolescents, children, hormone therapy, mental health, primary care and surgery. Across chapters, domain scores ranged from 39–47 per cent for rigour of development, 28–40 per cent for applicability and 43 to 44 per cent for editorial independence.

In February 2026, the American Society of Plastic Surgeons published a Position Statement that it did not endorse external guidelines for treating children and adolescents with gender dysphoria. It concluded that there was insufficient evidence demonstrating a favourable risk–benefit ratio for the pathway of endocrine and surgical interventions.[103]

In June 2026, the US Federal Trade Commission and four states sued WPATH, alleging deceptive or unsubstantiated claims about the necessity, safety and effectiveness of medical interventions for children.[104] In seeking dismissal, WPATH characterised the challenged statements as "non-actionable opinions about subjects on which there is 'medical and scientific uncertainty.'"[105] It also noted that doctors "bear independent responsibility for their own advice".

This characterisation is difficult to reconcile with treating SOC-8 as authoritative evidence of medical necessity, safety or effectiveness, and, in our view, strengthens the case for the independent Australian national standards for adults.

C4 The "no surgery" comparator and the chilling of alternatives

Our February 2025 submission accepted "no surgical procedure" as an appropriate comparator, but asked that psychotherapy also be considered, because addressing the sources of distress may change a person's wish for surgery. Since then, concern about the effect of conversion practices legislation on such care has grown, including among Australian medical bodies. The RACGP told MSAC's consultation that an exploratory approach is now less common because of concerns that it may be interpreted as conversion practice. RACGP Victoria and AMA Victoria have reported similar uncertainty to the Victorian Law Reform Commission (A5).

Where alternatives to the gender affirmation model are constrained, the comparative safety and effectiveness of surgery cannot be established.

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[103] American Society of Plastic Surgeons, Position Statement on Gender Surgery for Children and Adolescents, 3 February 2026, pp. 1–3. The statement reiterates its August 2024 position on external guideline endorsement and recommends delaying the specified surgeries until at least age 19.

[104] Federal Trade Commission, "FTC, States Sue World Professional Association for Transgender Health Over Deceptive Claims Regarding the Treatment of Children", June 2026. The plaintiffs are the FTC and Alaska, Iowa, Nebraska and Texas. The complaint's assertions are allegations, not findings of liability. FTC announcement.

[105] WPATH, Memorandum in Support of Its Motion to Dismiss, Federal Trade Commission et al. v World Professional Association for Transgender Health, Inc. et al., US District Court, Northern District of Texas, case 4:26-cv-00748-O, Document 53, filed 28 July 2026, printed pp. 1, 10, 15–16 and 33. WPATH memorandum.