Dear Commissioners

Thank you for the opportunity to contribute to the Productivity Commission's Review of the National Mental Health and Suicide Prevention Agreement (the Agreement).

Genspect Australia is a non-partisan, interdisciplinary organisation committed to promoting a healthy, evidence-based approach to sex and gender. Our membership includes clinical professionals working in mental health care, as well as parents and families of young people experiencing gender dysphoria or gender incongruence.

Our submission focuses primarily on LGBTQIA+SB populations, but also addresses issues relevant to other priority groups under the Agreement, including children and young people and people living with disability, reflecting the overlap between these communities.

Recommendation 1:

> Base suicide prevention strategies on reliable, transparent data, adopting a precautionary approach where data is lacking.

Public discourse around young people with gender-distress in Australia frequently invokes a stark "transition or suicide" narrative. Ministers, health departments, gender clinics, and advocacy organisations frequently claim interventions like puberty blockers, cross-sex hormones, and surgeries are "life-saving".

There is no doubt that young people experiencing gender dysphoria are among the most vulnerable in our society and are deserving of the greatest possible compassion, care, and support. It is precisely because of this vulnerability that clinical practice and public policy must be grounded in robust, rational, and reliable evidence. But for all its influence, the "transition or suicide" narrative rests on an uncertain and limited evidence base.

Although enrolments at pediatric gender clinics have grown rapidly in recent years, Australian clinical researchers are yet to produce the longitudinal data that would support the efficacy of gender-related medical interventions - particularly in relation to suicidality and suicide within LGBTQIA+SB communities. Gender clinics rarely publish detailed clinical data, and very few conduct follow-up studies of sufficient duration that might speak to the efficacy of their treatments. The Trans20 study at Melbourne's Royal Children's Hospital has the capacity to provide insight but despite collecting data since 2017 and calls for the release of its findings, it is yet to publish results that are informative on mental health and quality of life outcomes.

In the absence of robust clinical data, advocacy groups and governments have relied on three community surveys: *Trans Pathways* (2017) a Telethon Kids Institute study exploring mental health and suicidal thoughts and behaviours among transgender and gender-diverse young people aged 14–25; *Private Lives* (most recently 2020) which documents the self-reported experiences of LGBTQIA+ adults; and *Writing Themselves In* (2021), a survey of LGBTQIA+ youth aged 14-21.

Although these surveys offer insight into LGBTQIA+SB community concerns, all three suffer the same key methodological limitations: small, self-selected samples; sampling and response bias that is inherent in anonymous online surveys, and, most critically, a lack of longitudinal follow up. As single-point, cross-sectional snapshots, they are unable to show how mental health or suicidality changes over time, or whether specific interventions are helpful or harmful. They are also unlikely to capture whole sub-populations—such as detransitioners—who, research suggests, often disengage with the LGBTQIA+SB community. Studies using actual clinical populations show lower estimates of suicidality than community-based online surveys, suggesting that the latter may overestimate suicidality. (Comparable critiques have been made of community surveys in the US and UK, citing flawed design, sampling bias and misinterpretation of findings.)

At the same time, international studies based on clinical and administrative data—rather than snapshot-in-time, community-based surveys—directly challenge the "transition or suicide" narrative. A Swedish cohort study for example reported a nearly 19-fold higher suicide rate among people who had undergone sex re-assignment surgery compared to matched controls from the general population. A Californian study of 869 vaginoplasty patients monitored for an average of two years pre- and post-surgery found that suicide attempts doubled post-surgery. Similarly, a separate 2024 US study reported a five- to twelve-fold increase in suicide attempts and self-harm among patients after gender-affirming surgeries compared to control groups. Lastly, a 2025 US study drawing data from more than 107,000 individuals diagnosed with gender dysphoria found that for those who had no prior mental health diagnosis, undergoing gender affirming surgery very significantly increased the risk of subsequent diagnosis with depression, anxiety, suicidal ideation and substance use disorder, compared to matched controls with gender dysphoria but without surgery.

However, completed suicide among adolescents referred to gender clinics remains—thankfully—rare. NHS data from the UK's Tavistock clinic identified four suicide deaths among approximately 15,000 adolescents referred between 2010 and 2020 - equivalent to 30,000 patient-years, given an average engagement of two years. Two of these individuals were receiving treatment and two were on the waiting list. A 2024 Finnish registry study also indicates that youth referred for gender-related care experience suicide rates similar to peers with conditions like autism, anorexia, or depressive disorders.

These findings thus suggest alternative clinical and policy directives to those indicated by low quality online surveys. As the UK Cass Review concluded:

> The evidence does not adequately support the claim that gender-affirming treatment reduces suicide risk. However, the distress is real for these children and young people, some of whom hold strong beliefs about the efficacy of both puberty blockers and masculinising/feminising hormones.

This conclusion is echoed within the gender-affirming clinical community itself. Dr Laura Edwards-Leeper, founding psychologist of the first paediatric gender clinic in the United States, has noted explicitly:

> As far as I know, there are no studies that say if we don't start these kids immediately on hormones when they say they want them, that they are going to commit suicide. So that is misguided.

In the Australian context, suicide prevention strategies must move beyond assumptions about the protective effects of medical transition and instead focus on the actual drivers of distress—an imperative underscored by the limitations of survey data discussed above, and evidence of clinical data overseas. Suicide prevention strategies should offer targeted psychological support for individuals contemplating or recovering from surgical interventions. For gender-distressed young people, programs must prioritise comprehensive mental health care, family support, and treatment of co-occurring conditions—rather than relying on the unproven assumption that medical transition mitigates suicide risk.

A failure to act with caution not only risks ineffective policy but may also contribute to the very harms—self-harm and suicide—that such strategies are intended to prevent.

Recommendation 2:

> Amend the Agreement to include a commitment to encourage safe and responsible discussion of suicide, including suicide statistics, trends and causes - across all sectors—government, media, health services, gender clinics, and advocacy organisations, and develop an information framework to this end.

Public discourse around suicide in the context of gender-related distress has played a powerful role in shaping health policy, clinical practice, and personal decision-making. When such discourse is poorly grounded in evidence, it risks doing real harm—contributing to policy missteps, pressuring parents into decisions made under duress, and potentially increasing psychological vulnerability in already distressed young people. These are not abstract concerns; they carry real human and economic costs.

Genspect Australia does not seek to curtail responsible public discussion of suicide. Rather, we advocate for the development of a national framework to guide such discussion—serving a similar function to the guidelines established by the World Health Organization

and Australia's Mindframe initiative for responsible media reporting. While those guidelines are aimed at reducing the risk of social contagion arising from media reporting of individual suicides and clusters, a broader framework is needed to ensure that other public discussion of suicide statistics, trends, and causal explanations—particularly in the context of gender-related care—does not itself become a vector for increased suicidality.

While the framework will require careful and transparent development, at a minimum it should include the following commitments by Parties to the Agreement:

- **Routine collection and publication of clinical outcome data**
  Commit to regular, timely publication of clinical data on gender-related care, including mental health and quality of life measures. Data should be collected using consistent parameters—such as sex at birth, comorbidities, treatment pathway, timepoints, and rates of loss to follow-up—to ensure comparability. Public hospitals and agencies already holding such data, including the Royal Children's Hospital and the AIHW, should publish their existing data.
- **Transparent use and explanation of evidence**
  When governments and health authorities use low-quality data —particularly anonymous, self-reported online surveys—limitations must be clearly acknowledged. These include selection bias, lack of control groups, and absence of longitudinal follow-up.
- **Avoid simplistic explanations of suicide and suicidality.** The Royal Children's Hospital Melbourne attributes higher rates of depression, anxiety, self-harm, and attempted suicide among trans and gender diverse youth to experiences of stigma, discrimination, and social exclusion — a framing that risks oversimplifying the complex drivers of mental distress including comorbidities, trauma and social contagion.
- **Calling out emotionally manipulative messaging**
  Avoid fear-based suicide narratives in discussion of medical treatments. A brochure from the Queensland Children's Gender Service, that was available on their website until early 2025, quotes a father of a ten year old child saying: *"The real concern was the statistics on suicide... I didn't want my son to be one, so I supported him in the decisions ahead…"*. Many parents have similarly reported to Genspect that clinicians asked them whether they wanted "a live son or a dead daughter." This type of messaging intensifies distress in families and young people, leading to decisions made under emotional pressure rather than through informed consent.

Recommendation 3

> Review state and territory laws on 'conversion practices' to ensure they do not inhibit ethical therapeutic care, with possible unintended consequences for suicide prevention.

Genspect Australia unequivocally supports the prohibition of coercive practices in mental health care, including those historically used to suppress same-sex attraction. We acknowledge past harms caused by discredited psychiatric treatments in Australia and strongly support their rejection.

However, it is essential to distinguish those unethical practices from ethical, non-coercive exploratory therapies for individuals experiencing gender dysphoria or gender incongruence—especially where suicidality or complex mental health issues are present. Such therapy does not seek to change identity, but to explore underlying distress, promote psychological well being, and support informed consent.

While most state and territory laws banning "conversion practices" include exemptions for registered health professionals with responsible practice, their vague and ambiguous legislative provisions are creating a chilling effect among counsellors, psychotherapists, and clinicians, many of whom now avoid working with gender-questioning clients—even when therapy is clinically indicated.

Parents of distressed children have found that these carve-outs are not adequately communicated on relevant websites, adding to the stress of finding a qualified therapist. Detransitioners also report that unresolved internalised homophobia contributed to the development of a transgender identity, and this was not addressed by therapists and clinicians. This raises the concern that these laws—rather than protecting LGB people —may prevent them from receiving appropriate therapy geared towards understanding or accepting their same-sex attraction. The distress experienced by some detransitioners' resulting from regret over body modifications, loss of fertility and sexual function, may itself become a driver of suicidality.

Genspect supports a national review of these laws and recommends that any future framework be guided by principles of clinical integrity, professional oversight, and patient autonomy — trusting qualified practitioners to act ethically, without undue legal risk as members of their professional bodies.

Recommendation 4

> Ensure impartiality in government agencies implementing the Agreement, particularly in relation to LGBTQIA+SB mental health policy.

Genspect is concerned that institutions responsible for implementing elements of the National Mental Health and Suicide Prevention Agreement — including the Department of Health and Aged Care (DOHAC), the Australian Health Practitioner Regulation Agency (Ahpra), along with a number of state and territory health departments — have aligned themselves with advocacy-led programs that promote the gender-affirming model of treatment, including the claim that it prevents suicide.

For example, through their enrolment in the Australian Workplace Equality Index (AWEI) — a benchmarking tool administered by ACON, a key advocate for medicalised gender affirmation and its promotion as a suicide prevention strategy — these agencies have created uncertainty as to whether health policy decisions are being shaped by impartial evidence or by incentives embedded in these advocacy-led schemes. Similar concerns led key agencies, including the UK Department of Heath and Social Care, the Equalities and Human Rights Commission and the Treasury to exit the Stonewall scheme in the UK, upon which AWEI is based.

Likewise, by pursuing accreditation under the Rainbow Tick scheme — administered by Rainbow Health Australia, a prominent advocate of gender-affirming treatments, including as a form of suicide prevention — Ahpra gives rise to the impression that it too endorses these interventions. This is concerning as public safety and ethical healthcare require regulators to remain open to evolving evidence rather than aligned with any particular model of treatment.

Recommendation 5

> Make suicide prevention a standing item on the agenda at Health Ministers' Meetings

The National Mental Health and Suicide Prevention Agreement should be supported by a commitment to include suicide prevention and related policies as a standing item on the agenda of regular meetings of Commonwealth, state and territory Health Ministers. This would help ensure that suicide prevention remains a coordinated national priority and that

policies in adjacent areas of health — such as clinical guidelines, public health messaging, and funding decisions — are routinely assessed for their potential impact on suicide risk and prevention outcomes.

Certain high-impact policy processes highlight the need for this oversight. For example, the Medical Services Advisory Committee's consideration of Application 1754 — an application from the Australian Society of Plastic Surgeons Inc for public funding of "gender affirming surgeries" has involved public and professional commentary citing suicide prevention as a justification, despite uncertainty about the evidentiary basis for such claims. Similarly, the development by the NHMRC of new clinical guidelines for transgender and gender diverse children and adolescents is a critical process particularly given the widespread but contested claims about suicide risk and the role of medical intervention. While respecting the NHMRC's independence, appropriate ministerial oversight and engagement may strengthen the process, including by reinforcing its transparency and helping ensure that its outcomes are well understood and effectively integrated into broader health policy frameworks.

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