20 August 2025

Australian Charities and Not-for-Profit Commission

Attention:

Sue Woodward AM, Commissioner

From:

Hon Dr Gary Johns
[redacted] - [redacted] Australian Medical Professionals Society
[redacted] - [redacted] Nurses Professional Association of Australia

Contact:

Hon Dr Gary Johns

Brisbane

[redacted]

Dear Commissioner,

RE: Australian Professional Association for Trans Health (ABN 87632913912)

1. We write to make a formal complaint about the Australian Professional Association for Trans Health ('AusPATH'). In promulgating and advocating for the Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy, AusPATH fails the public benefit requirement imposed on Australian charities because the proven detriment to the public in carrying out its objects outweighs any of its benefits. The detriment arising from AusPATH's activities should be considered to outweigh any benefit that arises. To assist your consideration, this document sets out the raft of evidence that supports this conclusion, including evidence that has been judicially tested on the balance of probabilities, which is the standard the Australian Charities and Not-for-profits Commissioner must apply in determining whether an entity is entitled to charity status, and evidence of leading experts in the field. While it is established above that clear evidence exists of the detriment flowing from the activities of AusPATH in endorsing and advocating for the gender affirming model, no settled evidence may be furnished for a conclusion that the actions are beneficial. In the balance between benefit and detriment, we are left only with clear evidence of detriment.

This document is structured according to the following headings:

AusPATH's Purposes and Activities

2. AusPATH is a Health Promotion Charity and is registered with the Australian Charities and Not-for-profits Commission (ACNC) as a charity with the purposes of advancing education and as an institution whose principal activity is to promote the prevention or control of diseases in human beings (being a Health Promotion Charity). Consequently, it is a deductible gift recipient. AusPATH is a company limited by guarantee. Its objects are as follows:

> The company's principal purpose is to promote the health and well-being of trans, gender diverse and non-binary people by, without limitation:
>
> a) providing education on the health, rights and wellbeing of trans, gender diverse and non-binary people to health professionals;
> b) developing best practices and supportive policies;
> c) sharing information and promoting communication and collaboration amongst health professionals;
> d) encouraging, promoting and disseminating relevant research; and
> e) maintaining a network of supportive and informed professional service providers.

3. AusPATH describes itself as 'Australia's peak body for professionals involved in the health, rights and wellbeing of all trans people – binary and non-binary.'[1] Spencer and Clarke have recently claimed in the journal *Australasian Psychiatry*:

> Within the organisation, trans members have implored AusPATH to see members with lived experience as experts, and for health professionals to acknowledge their position of 'privilege'. AusPATH includes nonmedical members in its leadership team and within policy, research and education subcommittees. The majority of the current AusPATH board of directors are now trans or gender diverse … AusPATH claims [to] be experts, but their membership consists of whomever wishes to join as a clinician or transgender activist.[2]

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[1] AusPATH *Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy* (Version 1, 2024).
[2] Jillian Spencer and Patrick Clarke 'AusPATH: Activism Influencing Health Policy' *Australasian Psychiatry* (2025) 33(2) 273, 273, 276.

They describe AusPATH as 'an influential proponent of the gender affirming model of care used in all paediatric gender clinics in Australia.'[3]

4. Relevant to the issues raised in this complaint, AusPATH recommends the use of the Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents (the ASCTG).[4] As Spencer and Clarke clarify: 'These guidelines were recently appraised by the University of York as part of the Cass Review and given failing grades on Rigour of Development (19/100), Clarity of Presentation (41/100), Applicability (19/100), and Editorial Independence (14/100).'[5] We return to address the Cass Review further below.
5. Associate Professor Michelle Telfer of The Royal Children's Hospital Melbourne (the RCHM) 'wrote the first draft and approved the final draft of the ASCTG'.[6] The RCHM applies the ASCTG in its care of children. That approach was recently scrutinised and subjected to strident critique by the Family Court in *Re: Devin.*[7] Therein, Strum J characterised the approach of the RCHM as follows:

> Key components of gender affirming treatment approach propounded by the RCHM, as identified in the evidence include: acceptance and affirmation of a child's or young person's stated gender identity, without question; facilitation of early childhood social transition; provision of puberty blockers at early puberty to prevent the pubertal changes consistent with biological sex; and possibly the use of cross-sex hormones and, subsequently, surgical interventions in mid-to-late adolescence to align physical characteristics with gender identity.[8]

6. AusPATH affirms the ASCTG.[9] However, in addition to endorsing the ASCTG, AusPATH has promulgated its Guidelines, which it titles the 'Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy'. Those guidelines amplify the affirmative approach to gender identity, emphasising the need to accept the person's truth and setting out frameworks that could be open to the allegation of endorsing the expediting and abbreviating of proper medical assessment. The following statements illustrate the gender affirming approach advocated by AusPATH:

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[3] Ibid 274.
[4] AusPATH (n 2) 9
[5] Ibid.
[6] *Re: Devin* [2025] FedCFamC1F 211 (3 April 2025) [70] (Strum J).
[7] Ibid.
[8] Ibid [138].
[9] AusPATH (n 2) 9.

a) ‘trans patients are the experts of their own lives and the final authority on their own gender.’[10]

b) ‘Informed consent models of hormone prescribing resist the notion that a doctor can determine the validity of a person’s gender, and instead centre the trans person in the decision making process.’[11]

c) ‘Informed consent enables trans people to access hormone therapy with their clinician, without endocrine or mental health specialist consultations where not indicated, thus avoiding the long wait periods.’[12]

d) ‘Informed consent recognises the trans person as the experts of their own needs and experience, while respecting that medical professional(s) can utilise their expertise to enable effective and safe treatment.’[13]

e) ‘A “gender assessment” with a psychiatrist is not required and is not a mandatory requirement prior to commencing medical gender affirmation.’[14]

f) ‘These guidelines and templates offer approaches clinicians can follow to use the informed consent model when commencing and managing gender affirming hormone therapy (GAHT) for their trans patients – binary and non-binar*y. This process may be completed in one or two appointments*, or may require more, depending on patient needs and clinician confidence.’[15]

As will be seen below, various recent medical and legal developments directly challenge these views.

7. With reference to AusPATH’s website, Spencer and Clarke claim:

> The organisation appears to repeatedly provide inaccurate information. Specifically, inter alia: the safety, evidence underpinning, benefits, and role of puberty blockers; low regret rates following adolescent transition; social transition showing evidence of psychological benefit, and psychology being harmful if offered as an alternative to gender affirming interventions.[16]

They express a particular concern with AusPATH’s advocacy for puberty blockers, stating:

> In 2020 and 2024 statements, AusPATH labelled puberty blockers as ‘safe’ without clarifying the meaning of this term, but it infers that children

[10] Ibid 7.
[11] Ibid.
[12] Ibid 10.
[13] Ibid
[14] Ibid.
[15] Ibid 13.
[16] Spencer and Clarke (n 3) 274.

> prescribed them will not be harmed. Such unqualified statements, made by professional organisations seeking to influence health policy, are unusual … Infertility or sterility and lack of sexual function does not appear salient for AusPATH when declaring puberty blockers to be 'safe'.[17]

Spencer and Clarke conclude that '[i]f clinicians are taking note of AusPATH recommendations about puberty blockers, they will be dangerously misguided.'[18]

8. As noted above, both the ASCTG and the practices of the RCHM, including their approach to prescribing puberty blockers, as endorsed by AusPATH, recently came under severe critique in the judgement of Justice Strum. The findings of fact made therein are apposite to your role as Commissioner, which is to be satisfied that AusPATH fulfils the requirement that it be for the 'public benefit' under section 6 of the *Charities Act 2013* (Cth) ('the *Charities Act*'), and which also requires a determination of whether 'detriment' arises from a charity's operations. Before considering the recently accruing evidence relevant to the question of whether AusPATH's purposes lead to detriment, we first outline the applicable requirements that apply to AusPATH's charity endorsement.

The Criteria for Registration as a Charity

9. For an entity to meet the definition of 'charity' in s 5 of the *Charities Act*, its purposes must not just be charitable purposes; they must also be for the public benefit. To meet the definition of 'charity', an entity must:
   (a) be not-for-profit,
   (b) have purposes that are solely charitable purposes (or incidental or ancillary to in furtherance or in aid of such purposes),
   (c) not have a purpose that is a disqualifying purpose[19], and
   (d) not be an individual, political party or government entity.[20]

Section 6 of the *Charities Act* sets out how to determine if a purpose is of public benefit:

> (1) A purpose that an entity has is for the ***public benefit*** if:
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> (a) the achievement of the purpose would be of public benefit; and

[17] Ibid.
[18] Ibid 276.
[19] Section 11 - The purpose of engaging in, or promoting, activities that are unlawful or contrary to public policy or the purpose of promoting or opposing a political party or a candidate for political office.
[20] *Charities Act 2013* (Cth) s 5.

(b) the purpose is directed to a benefit that is available to the members of:

(i) the general public; or

(ii) a sufficient section of the general public.

Achievement of purpose would be of public benefit

(2) For the purposes of paragraph (1)(a), have regard to all relevant matters, including:

(a) benefits (whether tangible or intangible) (other than benefits that are not identifiable); and

(b) any possible, identifiable detriment from the achievement of the purpose to the members of:

(i) the general public; or

(ii) a section of the general public.

10. Whether AusPATH's purposes are directed towards a class in the community sufficient to be regarded as 'public' is not in contention. However, in considering whether the purpose of AusPATH is for the public benefit, the ACNC is required to have regard to the benefits and any possible identifiable detriment from the achievement of its purposes.[21] We draw your attention to the evidence below that, on balance, AusPATH's purpose is not of benefit due to the detriment it causes to the people it seeks to benefit. On the evidence, those detriments are of such a significant nature as to outweigh any identifiable benefit. This evidence grounds the conclusion that AusPATH is not entitled to registration as a charity and, therefore, as a deductible gift recipient.

Determining Public Benefit

11. The law of 'public benefit' is sourced in the judgment of Lord Wright in *National Anti-Vivisection Society v Inland Revenue Commissioners (National Anti-Vivisection)*.[22] Therein, his Lordship held that the determination of whether a trust extends the public benefit requires a decision-maker to 'weigh against each other' detriment and benefit, ensuring that the question 'must be judged as a whole'.[23] His Lordship held:

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[21] Ibid, s 6(2).
[22] [1948] AC 31.
[23] *National Anti-Vivisection Society v Inland Revenue Commissioners* [1948] AC 31, 47-8 (Lord Wright) ('*National Anti-Vivisection*').

> Even societies coming within the first three heads of Lord Macnaghten's classification would not be entitled to rank as legal charities if it was seen that their objects were not for the public benefit. … It cannot be for the public benefit to favour trusts for objects contrary to the law. Again, eleemosynary trusts may as economic ideas and conditions and ideas of social service change cease to be regarded as being for the benefit of the community, and trusts for the advancement of learning or education may fail to secure a place as charities, if it is seen that the learning or education is not of public value. The test of benefit to the community goes through the whole of Lord Macnaghten's classification, though as regards the first three heads, it may be prima facie assumed unless the contrary appears.[24]

12. The House of Lords held that the question whether promoting the abolition of vivisection was a charitable purpose involved a comparison of the benefits of its abolition with the practical benefits which were proved to flow from the practice of vivisection.[25] This approach continues to apply in Australia after the adoption of the *Charities Act*.[26] As lead charity law academic Gino Dal Pont summarises, 'should the proven detriment to the public in carrying out an object outweigh any of its likely benefits, it cannot meet the "benefit to community" requirement.'[27] The public benefit requirement is to be determined by an objective test applied to the specific facts before the ACNC.[28] The proper place for the commencement of that enquiry is with consideration of the articles of its establishment, followed by the nature of its activities.[29] AusPATH's purposes should be ascertained by considering its constituting ordinance as a whole, including both its objects and functions and its activities.

Evidence of Detriment

13. In the following discussion, we set out the evidence that supports the conclusion that the detriment arising from AusPATH's activities should be considered to outweigh any benefit that arises. The question of whether gender affirming treatment may give rise to a detriment to patients is a complicated one, giving rise to a myriad of medical and

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[24] Ibid.
[25] Ibid 47.
[26] *Charities Act 2013* (Cth) s 6(2); *Explanatory Memorandum, Charities Bill* (Cth) [1.62].
[27] GE Dal Pont, *Law of Charity* (LexisNexis Butterworths, 2nd ed, 2017) 257
[28] *St Margaret's Children and Family Care Society* (Scottish Charity Appeal Panel, No SC028551 2014). P. 70, line 2000.
[29] *Common Equity Housing Ltd v Commissioner of State Revenue (Vic)*, 96 ATC 4598 (1996).

scientific considerations. Acknowledging this reality, we have endeavoured to replicate the evidence of experts in their own words. In the following discussion, these resources are grouped under the following headings:

a) Expert evidence relied upon by the Family Court in *Re: Devin;*
b) Evidence found in the view of the Westmead Children's Hospital; and
c) Evidence found in the Cass Review.

Expert Evidence Relied upon by the Family Court in *Re: Devin*

14. In *Re: Devin* Justice Strum accepted the following evidence (references to various expert witnesses were deidentified in the proceedings):

a) 'The risks posed by medical (and surgical) gender affirming treatment include risks to fertility, sexual function, bone health, brain development, cardiovascular function and carcinogenesis, as well as the risks of being a lifelong medical patient and of later regret.

b) One of the risks of puberty blockers and cross-sex hormones identified by Dr O is because of findings that over 95 per cent (albeit that Dr M, in his report, opines that it is 98 per cent) of children commenced on puberty blockers progress to cross-sex hormones. She opines that it is doubtful that puberty blockers may be best viewed as a "pause button" that merely allows a child more time to consider their options; rather they may "lock-in" a child to ongoing gender dysphoria and progression to cross-sex hormones, by impeding the usual progress of sexual orientation and gender development.

c) Puberty blockers, especially when given at the earliest stages of puberty, which the child in this case has not even reached, followed by oestrogen/cross-sex hormones (which, she opines, would be the likely trajectory), lead to infertility and sexual dysfunction.'[30]

d) Citing the Cass Review (further considered below): '... adolescent sex hormone surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuits underlying executive function (i.e. maturation of the part of the brain concerned with planning, decision making and judgement). If this is the case, brain maturation may be temporarily or permanently disrupted by the use of puberty blockers, which could have a significant impact on the young

[30] *Re: Devin* (n 7) [151].

person's ability to make complex risk-laden decisions, as well as having possible longer-term neuropsychological consequences.'[31]

e) Citing the Cass Review, 'The focus on puberty blockers and beliefs about their efficacy has arguably meant that other treatments (and medications) have not been studied/developed to support this group, doing the children and young people a further disservice.'[32]

f) 'If [the child] desires surgery when older to create a replication of a vagina (a "neovagina"), there will not be enough penile and scrotal tissue to be used for inversion, so a segment of bowel will likely be used. This surgery has high complication rates. In the original Dutch cohort, one of the original 70 patients died following complications of this surgery, due to necrotising fasciitis ...

g) There are also unknowns due to the lack of long-term data on puberty-blocked children when they grow up, but [the child] will be a medical patient for the rest of his [sic] life to manage these knowns and unknowns. No children's gender clinic, including those studying the original Dutch cohort, has produced any long-term data on outcomes of puberty blockade and cross sex hormone treatments. [City K Children's Hospital] Gender Clinic has not produced any long-term data on the patients it has treated.'[33]

15. In *Re: Devin,* the following critiques of the RCHM were made in evidence by 'Dr O', a consultant psychiatrist and psychotherapist, and were accepted by the Court in full:

a) My discussion in preceding sections of this report raises several important points relevant to the answer to this question. First, my observation is that there is a tendency for [RCHM] [sic] clinicians to overstate the certainty of the evidence, to underplay risks and to dismiss the possibility of alternative treatments ... Second, the [RCHM] [sic] has an ideological commitment to [gender affirming treatment], which it single-mindedly promotes. Third, [Dr N's] report, although brief, indicates her clinical practice/discussions with [the child] and parents follows this ethos. All this suggests that [the child] and parents are not receiving/and will be unlikely to receive accurate information

[31] Ibid [163].
[32] Ibid [167].
[33] Ibid [178].

from [RCHM] [sic] clinicians to enable them to make true informed treatment decisions.

b) I hold further concerns. First, with-in clinic [RCHM] [sic] communications encourage social transition and exclusively focus on glowing accounts of youth who have been “empowered” to transition ... Such communications may act as a type of covert pressure on the clinic’s young patients to transition ...

c) Second, in [State S], children, parents and clinicians are subject to powerful messages from the [RCHM] [sic] and a range of other agencies. For example, it is inaccurately implied that if parents do not affirm their child’s stated gender identity or permit [gender affirming treatment] then their child is at high risk of suicide. Claims are made to the effect that parents who do not support their child’s social transition or oppose their child’s attendance at a gender clinic or do not consent to [puberty blockers] are acting violently and putting their child “at risk,” (which implies notification to child protection services may occur), or that they are guilty of illegal conversion practises.

d) The [RCHM] [sic] clinicians describe that their “individualised approach” involves following the child’s lead, but the communications I have just described must make us consider whether, in reality, it is more the case of the child following the [RCHM]’s [sic] lead, both by with-in clinic communications and by the [RCHM]’s [sic] advertising/promotion of [gender affirming treatment] to media, parents, schools, mental health agencies, other health professionals and policy makers.

e) All these types of issues mean that it is important to consider the impact that influence and coercion might have on the capacity of a minor or the parents to give assent/informed consent. This is especially important in a situation which involve vulnerable minors and their families, who might be presumed to be at particular risk of being unduly influenced or coerced by prestigious physicians and powerful institutions, especially where there is a marked power differential, and when such influence and coercive elements extend beyond the clinic (via media, social media, support groups, regulatory agencies, podcasts and various publications).

f) In sum, these issues raise important questions to which, in my opinion, the Court needs to give careful consideration. Given the [RCHM] [sic] ethos, it would seem unlikely that true informed consent, from the parents and assent from [the child] will be able to occur. First, because the [RCHM] [sic], appears

> to not be providing and is not likely to provide the necessary accurate, unbiased, and comprehensive information regarding the uncertainties and the harms of [gender affirming treatment], nor realistic information on possible alternative treatments. Second, because elements such as influence, and coercion are likely to be undermining [the child's] and parents' capacity to provide true informed consent.[34]

About these assertions, Justice Strum held: 'Having regard to the evidence adduced by … Associate Professor [Telfer] and, for example, the ASCTG, I accept the evidence of Dr O and agree with her concerns, which I share.'[35]

16. In the exercise of weighing evidence, Strum J found that evidence led by medical experts called by the mother, intended to support the approach taken in the ASTCG and adopted by the RCHM, proved the detrimental nature of that approach. The following are but two examples:
    a) Dr N ... conceded that … the side-effects of puberty blockers, even when ceased, are not entirely reversible and include ongoing risks to fertility and bone density, which the child, at this age, could not properly understand or appreciate.[36]
    b) In relation to the risks to bone density, Associate Professor [Telfer] conceded that bone density is accumulated during puberty and that, in the absence thereof, the risk of fracturing in later life is increased.[37]
17. Justice Strum also accepted the following conclusions led in evidence by Dr O, which conclusions directly oppose the approach advocated for by AusPATH, especially in respect of AusPATH's endorsing the avoidance of holistic psychological assessment:

> An approach that prioritizes psychological approaches and delays medical/ surgical treatments does not have the adverse risk profile that do medical and surgical treatments, especially when implemented in youth.
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> These possible benefits need to be weighed against the main risk of delayed medical transition, which is undergoing undesired pubertal physical changes and, especially for biological males, the greater difficulties of later achieving, if one wants, the desired cosmetic outcome of a more feminine appearance.[38]

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[34] Ibid [154].
[35] Ibid [155].
[36] Ibid [144].
[37] Ibid [146].
[38] Ibid [153].

These conclusions are in direct contrast to the expedited approach advocated by AusPATH, whereby "gender assessment" with a psychiatrist is not required and is not a mandatory requirement prior to commencing medical gender affirmation,[39] as further outlined above.

18. The conclusions reached by Strum J on the question of harm to the child from the gender affirming approach applied by the RCHM under the ASCTG are directly relevant to the Commissioner's application of the *National Anti-Vivisection* test to the purposes of AusPATH:

    a) great caution should be exercised when the treatment proposed by the mother and her experts is potentially life altering and irreversible. In the circumstances, inter-related with the issue of parental responsibility, I consider the injunctions the father seeks preventing continued attendance by the child at the RCHM and administration to the child of Stage 1 and Stage 2 hormonal treatment, to be in the child's best interests.[40]

    b) I … find, that if the mother were to have sole parental responsibility for decisions in relation to the child's gender identity, and to live with her, as I address further below, this would be highly likely to result in the child receiving potentially life-altering and damaging medical intervention for which there may not be a proper underlying basis.[41]

19. Deploying an analysis redolent of Lord Wright's requirement that detriment and benefit be 'weigh[ed] against each other', ensuring that the question 'must be judged as a whole',[42] Justice Strum concluded that the detriment arising from the application of the ASCTG outweighed any potential benefit in light of the evidence before the Court. It is helpful to set out the relevant components of Strum J's reasoning in full. We have italicised the particular comments that are apposite to the assessment of the detriment as opposed to benefit arising from the gender affirming model advocated by AusPATH:

> *I am not satisfied that, given the current levels of symptoms or distress expressed or manifested by the child, even if gender incongruent or dysphoric, the purported benefits of puberty blockers outweigh the identified risks thereof.* I do not accept that the child's desire for puberty blockers can

[39] Ibid.
[40] Ibid [345]-[346].
[41] Ibid [351].
[42] *National Anti-Vivisection* (n 24) 47-8 (Lord Wright).

be determinative, or even of significant weight, given, not only the child's age but, equally so, the concessions by Dr N that the information given to the child thus far was "rose tinted" (Transcript 28 May 2024, p. 51 line 31) and by Associate Professor [Telfer] that this could influence the child's desire for such treatment (Transcript 30 May 2024, p.20 lines 1–5). Further, on the evidence, I do not accept that the child, at this age and pre-pubertal stage in life, can properly understand the implications and potential risks of puberty blockers. The Independent Children's Lawyer submits, and I agree, that the answers given by Associate Professor [Telfer] on this issue were internally flawed and circular. Whilst, in relation to risks to fertility, she conceded that sperm production is reduced by puberty blockers, she dismissed this as being a long-term concern, because ability to produce sperm will return if they are ceased after short-term use. Even if that be the case, *the evidence is that the vast majority of children continue with this treatment and progress to Stage 2, after which sperm production would not recommence.*

I do not accept the evidence of Dr N in the January 2024 report at paragraph 95 that should the child "be denied an opportunity to access treatment with puberty blockers, she [sic] will be at heightened risk of increased gender dysphoria and a decline in her [sic] general mental health". The evidence, including that of Dr O, Dr M and Dr R, which was not substantially undermined in cross-examination by counsel for the mother, is that there are other acceptable, if not more acceptable, avenues open to the child.

In the circumstances, I conclude that, even if, contrary to my findings above, the child were gender incongruent or gender dysphoric, given the evidence regarding the risks, balanced against the alleged benefits, of puberty blockers (as well as Stage 2 treatment, namely, the administration of cross-sex hormones), I would not, as between the parties, permit the child to continue gender affirming treatment at the RCHM (or elsewhere) and, in particular, Stage 1 medical treatment. It is of considerable concern that, notwithstanding the weight of the evidence, including, but not limited to, the Cass Report, the RCHM continues to represent to parents and children that puberty blockers are fully reversible and relatively risk-free and yet, through practitioners such as Dr N and Associate Professor [Telfer], to concede the lack of evidence to support that position.

> I refer, in particular, to the evidence of Dr N that no child or young person who has been diagnosed with gender dysphoria by, and has asked for puberty blockers from, the RCHM, and has supportive parents, has ever been refused. Not dissimilarly, Associate Professor [Telfer] said that almost all such children, if referred to a paediatrician at the RCHM, would be provided with the treatment. Further, the evidence is that, once on puberty blockers, such a child or young person is between 95 and 98 per cent likely to progress to cross-sex hormones. This supports the argument that the RCHM is, in fact, essentially a single medical pathway once Stage 1 hormone treatment commences. *The risks, not only of Stage 1 treatment, but also of future infertility, sexual dysfunction, inability to orgasm or have any sexual pleasure, inherent in Stage 2 treatment, cannot be ignored. I also have regard to the evidence in relation to the likely pain and trauma for the child, as an adult, in the event of a later change of mind and wish to de-transition.* It is inconceivable that the child could, at present, truly comprehend what would be placed at risk and potentially, if not likely, forgone if a decision were made, at this stage, to embark on a medical gender affirming treatment pathway.
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> Rather, I accept the expert opinion of Dr M (at paragraph 63 of his report) that –
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> > ... the most likely best strategy for [the child] would be to give him [sic] time to breathe, to allow life to settle in his [sic] visitation pattern, to not push nor deny any expression, to not seek treatment or information on a condition/state that [the child] may or may not have that may or may not eventuate into something more formative.[43]

20. Notably, his honour clarified that the same outcome would obtain even where the child had been diagnosed with gender dysphoria. Justice Strum concluded his analysis of gender affirming care with the following words:

> To adopt, for illustrative purposes, the mathematical hypothetical propounded by the Full Court in *Isles & Nelissen*, *even if there were only a 33.33 per cent chance of the child being harmed by puberty blockers, I consider that no sensible person would take the risk of putting the child in that situation because, even though the prospect of harm would only be possible, as*

[43] *Re: Devin* (n 7) [187]-[191].

opposed to probable, the risk is too high to tolerate and is, therefore, unacceptable.[44]

These findings directly implicate AusPATH's purposes and activities. Indeed Strum J held that the gender affirming approach advocated by AusPATH could lead to 'psychological (and, indeed, physical) harm' to the child: 'I find that there is a need to protect the child from potential psychological (and, indeed, physical) harm, were the mother to continue (as she seeks to do) in her pursuit of gender affirming treatment for the child, including, in particular, by the administration of puberty blockers to the child'[45] and 'if the mother were to have, as she seeks … sole parental responsibility for the child ... there would hereafter be an unacceptable risk of serious psychological and, indeed, physical harm to the child by her single-minded pursuit of gender affirming treatment, including medically, for the child.'[46] The evidence accepted by the Court, according to the balance of probabilities, which is the standard the ACNC Commissioner must apply in determining whether an entity is entitled to charity status, was not in the domain of the hypothetical or the contingent. It was tested across 20 days of hearing, with at least 15 competing experts being called to the stand for cross-examination by the parties. The findings of Strum J are directly on point. They are of significant probative value for the question as to whether AusPATH satisfies the requirement that its purposes be 'for the public benefit'.

Evidence Furnished by the Westmead Children's Hospital

21. The Westmead Children's Gender Service has recently raised the following concerns with the gender affirmative model of care, as advocated by AusPATH:

> To provide adequate care, clinicians need to understand and confront the complexity of the clinical presentations. They need, in particular, to use a broad, holistic, systemic (i.e., biopsychosocial) framework that takes into account the full range of interacting factors— social, economic, relational, family, psychological, and biological—that have defined the life circumstances of the child and the family seeking care for gender dysphoria." "Some families—but also some clinicians—function within a non-holistic (non-biopsychosocial) framework where the child's developmental experiences are disconnected from their clinical presentation. This

[44] Ibid [201] (emphasis added).
[45] Ibid [305].
[46] Ibid [327].

non-holistic framework is likely to promote a healthcare delivery model that dehumanizes the child (by not examining the child's and family's lived experience) and that promotes medical solutions (correcting the identity/body mismatch) for a problem that is much more complex. Third, as noted earlier, our experience suggests that, insofar as the gender affirmative model is taken as equivalent to medical intervention, clinicians (including ourselves) who work in gender services are coming under increasing pressure to put aside their own holistic (biopsychosocial) model of care, and to compromise their own ethical standards, by engaging in a tick-the-box treatment process. Such an approach does not adequately address a broad range of psychological, family, and social issues and puts patients at risk of adverse future outcomes.[47]

In *Re: Devin* Strum J cited the view of The Westmead Children's Gender Service, replicated in the evidence of Dr O, and stated 'I accept the evidence of Dr O and agree with her concerns, which I share'.[48] As noted above, in its guidelines, AusPATH endorses a single assessment model, stating: '*This process may be completed in one or two appointments …*'[49]

Evidence Furnished by The Cass Review

Brief Summary of the History of the Cass Report

22. The 'Independent Review of Gender Identity Services for Children and Young People' (the 'Cass Review') was commissioned in 2020 by NHS England.[50] It was led by Dr. Hilary Cass, a retired consultant paediatrician and former President of the Royal College of Paediatrics and Child Health. The review sought to comprehensively analyse the provision of gender-affirming care to children and young people in England and Wales. To provide an evidence base upon which to make its recommendations, the Review commissioned the University of York to conduct a series of independent systematic reviews of existing evidence and new qualitative and quantitative research to build on the evidence base.

23. In 2022, the Cass Review released its interim report ('Interim Report'). The NHS

[47] Cited in ibid [153].
[48] Ibid [155].
[49] AusPATH (n 2) 13.
[50] "NHS commissioning » Independent review into gender identity services for children and young people". *www.england.nhs.uk*. Retrieved 9 April 2024.

acted upon some of the findings in the Interim Report.[51] Notable changes implemented by the NHS in response to the Interim Report included:

i. bringing about the managed closure of the Gender Identity Development Service at the Tavistock Clinic; and

ii. taking a clear position that access to puberty blockers is no longer routinely available as part of the NHS children and young people's gender service.

Overview of the Key Findings of the Final Report

24. The Final Report was published on 10 April 2024 (the 'Cass Report' or the 'Report'). It raised many concerns regarding the methodology underlying the gender-affirming care model. It subjects the approach adopted by AusPATH to direct critique. The broad areas of concern included:

(a) **Lack of Longitudinal Data -** One issue highlighted by the review was the scarcity of longitudinal data on the outcomes of gender-affirming interventions for transgender youth. Without robust long-term data, it was challenging to evaluate the efficacy and potential risks associated with various treatments, such as puberty blockers and hormone therapy.

(b) **Age-Appropriate Assessment and Consent -** The review underscored the importance of ensuring that assessments for gender-affirming interventions are conducted in an age-appropriate manner and with due consideration for the capacity of children and young persons to provide informed consent. Concerns were raised about the impact that a lack of evidence to support gender-affirming care may have on the ability of children, young persons, and parents to give informed consent.

(c) **Limited Evidence Base -** The review noted the limited evidence base informing the development of gender-affirming care guidelines and protocols. While some interventions were supported by evidence, others lacked robust scientific data to support their efficacy and safety, leading to uncertainty and variability in clinical practice. The Report variously describes the evidence base attending the various relevant matters of medical inquiry as 'poor',[52]

[51] 'Implementing Advice from the Cass Review' NHS England https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/implementing-advice-from-the-cass-review/.

[52] Cass, Hilary 'Independent Review of Gender Identity Services for Children and Young People: Final Report', April 2024. https://cass.independent-review.uk/?page_id=936. ('Cass Report') 34, 130.

'weak',[53] 'inadequate',[54] 'very limited',[55] as exhibiting 'troubling' 'gaps'[56] or as completely lacking[57] or as 'not adequately supporting claims'.[58] Further, the Report states that 'attempts to improve the evidence base have been thwarted by a lack of cooperation from the adult gender services.'[59]

(d) **Psychological Support and Mental Health Screening -** Another area of concern highlighted by the review was the need for mental health screening for young persons seeking and undergoing gender-affirming interventions. The review emphasized the importance of addressing underlying mental health issues, such as depression and anxiety, and providing ongoing support throughout the transition process.

25. Additionally, the Report expressed serious concerns regarding the quality of two international clinical guidelines that are highly influential in the field of transgender medicine, namely:

a) Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline (Endocrine Society Guideline);[60] and

b) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 ('WPATH 8').[61]

This is of direct relevance to the purposes and activities of AusPATH. AusPATH endorses the Endocrine Society Guidelines, directing its supporters to a link that provides those Guidelines with the statement that it is a document 'supporting gender affirming approaches that refer[s] to work with trans people of all ages.'[62] Most concerningly for the approach adopted by AusPATH, the Cass Review described

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[53] Ibid 22.
[54] Ibid 132.
[55] Ibid 179.
[56] Ibid 40.
[57] Ibid, see eg, 31, 33, 164, 179, 194.
[58] Ibid 187.
[59] Ibid 20.
[60] W.C Hembree et al, 'Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline' (2017) 102(11) *The Journal of Clinical Endocrinology & Metabolism* pp. 3869-3903. https://doi.org/10.1210/jc.2017-01658.
[61] 'Standards of Care for the Health of Transgender and Gender Diverse People Version 8' (2022) *International Journal of Transgender Health* 23 (sup1): S1-S259. https://doi.org/10.1080/26895269.2022.2100644.
[62] https://auspath.org.au/2021/06/26/auspath-public-statement-on-gender-affirming-healthcare-including-for-trans-youth/

WPATH 8 as 'overstat[ing] the strength of the evidence'.[63] The authors of the ASCTG, endorsed by AusPATH, state that those Guidelines are 'based primarily' on the preceding version of the international guidelines (WPATH 7). The reliance by AusPATH on the Endocrine Society Guideline and the GPTAH 7 (through its endorsement of the ASCTG) contradicts the argument that is currently being made by proponents of gender-affirming care that the Cass Report is not relevant to the Australian clinical context.[64]

26. The Report noted the worrying trend that the two guidelines, WPATH 8 and the Endocrine Society Guideline, tend to be self-reinforcing, with each using the other to justify its recommendations. The Report stated:

> These two guidelines are also closely interlinked, with WPATH adopting Endocrine Society recommendations, and acting as a co-sponsor and providing input to drafts of the Endocrine Society guideline. WPATH 8 cited many of the other national and regional guidelines to support some of its recommendations, despite these guidelines having been considerably influenced by WPATH 7 … The circularity of this approach may explain why there has been an apparent consensus on key areas of practice despite the evidence being poor.[65]

27. The Report was particularly critical of WPATH 8, stating:

> The WPATH 8 narrative on gender-affirming medical treatment for adolescents does not reference its own systematic review …[66]
>
> Within the narrative account the guideline authors cite some of the studies that were already deemed as low quality, with short follow-up periods and variable outcomes, as well as a selected account of detransition rates … Clinical consensus is a valid approach to guideline recommendations where the research evidence is inadequate. However, instead of stating that some of its recommendations are based on clinical consensus, WPATH 8 overstates the strength of the evidence in making these recommendations.[67]

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[63] Ibid 132.
[64] 'Cass Review out-of-line with medical consensus and lacks relevance in Australian context', Equality Australia, April 10 2024. https://equalityaustralia.org.au/cass-review-out-of-line-with-medical-consensus-and-lacks-relevance-in-australian-context/.
[65] Cass Report 130.
[66] Ibid 131.
[67] Ibid 132.

The above findings of the Report about Endocrine Society Guideline and WPATH 8 cast serious doubt on the ongoing use of these guidelines as recommended by AusPATH, through its affirmation of the ASCTG.

28. Notably, the Final Report made the following specific recommendations that are relevant to whether the purposes activities of AusPATH are of public benefit or otherwise lead to detriment:

    (a) there is no clear evidence that social transition in childhood has positive or negative mental health outcomes;[68]

    (b) there is no evidence that puberty blockers improve body image or dysphoria;[69]

    (c) the Review found that 'evidence is weak' and clinicians report that 'they are unable to determine with any certainty which children and young people will go on to have an enduring trans identity';[70]

    (d) there is no evidence that access to hormone treatment reduces the risk of suicide;[71]

    (e) outcomes for children and adolescents who experience discomfort with their gender identity are best if 'they are in a supportive relationship with their family'; and[72]

    (f) In the interests of the child or young person, parents should be actively involved in decision-making, unless 'there are strong grounds to believe that this may put the child or young person at risk.[73]

Each of these conclusions receives support from the more recent findings of Justice Strum in *Re: Devin.* I now turn to set out the comments of the Report relating to each of these issues.

Lack of Evidence to Support Social Transitioning

29. The Report noted the lack of robust evidence to support social transitioning, stating:

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[68] Cass Report, 31, 164.
[69] Ibid 179.
[70] Ibid 22.
[71] Ibid 33.
[72] Ibid 164.
[73] Ibid.

> … there is no clear evidence that social transition in childhood has positive or negative mental health outcomes. There is relatively weak evidence for any effect in adolescence. However, sex of rearing seems to have some influence on eventual gender outcome, and it is possible that social transition in childhood may change the trajectory of gender identity development for children with early gender incongruence. For this reason, a more cautious approach needs to be taken for children than for adolescents.[74]

Lack of Evidence to Support the use of Puberty Blockers

30. The Report noted the lack of robust evidence to support the use of puberty blockers, particularly concerning their long-term effects and outcomes:

> The University of York systematic review found no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes, which without a control group could be due to placebo effect or concomitant psychological support.
>
> It is important not to lose sight of the fact that hormonal surges are a normal part of puberty and are known to lead to mood fluctuations and depression, the latter particularly in girls.
>
> It is not unexpected that blocking these surges may dampen distress and improve psychological functioning in the short-term in some young people, but this may not be an appropriate response to pubertal discomfort.[75]

Lack of Clinical Certainty regarding the Stability of 'transgender' Identity

31. The Report noted observations by clinicians concerning their ability to predict which young people will continue to identify as transgender into the future. The Report stated:

> There remains diversity of opinion as to how best to treat these children and young people. The evidence is weak and clinicians have told us they are unable to determine with any certainty which children and young people will go on to have an enduring trans identity.[76]

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[74] Ibid.
[75] Ibid 179.
[76] Ibid 22.

Lack of Evidence that Access to Hormone Treatment Reduces the Risk of Suicide

32. The Report noted that parents and clinicians may feel pressured to allow gender-affirming care due to widespread claims that denying access to such treatment increases the risk of suicide in young persons with gender identity issues:

> The Review has heard that the widespread claims that puberty blockers reduce the risk of death by suicide in this population may place pressure on families to obtain private treatment.[77]
>
> Some clinicians feel under pressure to support a medical pathway based on widespread reporting that gender-affirming treatment reduces suicide risk.

However, the Report found that 'the evidence does not adequately support the claim that gender-affirming hormone treatment reduces suicide risk'.[78]

The Importance of Family for Young People Struggling with Gender Identity Issues

33. The Report underscored the significance of family involvement and support in decisions related to the care of individuals with gender identity issues. It stated:

> Outcomes for children and adolescents are best if they are in a supportive relationship with their family. For this reason parents should be actively involved in decision making unless there are strong grounds to believe that this may put the child or young person at risk.[79]

Lack of Cooperation from Gender Clinics with the Cass Review

34. The Report openly acknowledged challenges stemming from a lack of cooperation from some gender clinics in the study, which hindered access to comprehensive data and perspectives within the field of gender-affirming care. While striving to provide a comprehensive analysis, the report noted that limited cooperation from specific clinics restricted the breadth and depth of information available for review and analysis. The Report stated:

> The University of York's programme of work has shown that there continues to be a lack of high-quality evidence in this area and disappointingly, as will become clear in this report, attempts to improve the evidence base have been thwarted by a lack of cooperation from the adult gender services.[80]

[77] Ibid 179.
[78] Ibid 187.
[79] Ibid 164.
[80] Ibid 20.

Dr Cass has been reported as stating that this lack of cooperation was 'coordinated and ideologically driven'.[81] In the aftermath of the Report, the UK Health Secretary was scathing of this lack of cooperation with the Cass Review on the part of gender clinics, stating that the refusal by the clinics to cooperate was 'deplorable' and 'a dereliction of professional duty'.[82] This lack of cooperation underscores broader issues related to transparency, accountability, and data sharing within the field of transgender healthcare more generally. Similar concerns about the lack of cooperation from Australian gender clinics have been reported in the wake of the Cass Report.[83]

Lack of Longitudinal Data

35. One of the key findings of the Report was the scarcity of longitudinal research investigating the effects of gender-affirming treatments, such as hormone therapy and gender-affirming surgeries, on various aspects of physical and mental health. There remains a lack of evidence of the long-term consequences of such interventions. The Report highlighted the implications of this lack of longitudinal data:

> When clinicians talk to patients about what interventions may be best for them, they usually refer to the longer-term benefits and risks of different options, based on outcome data from other people who have been through a similar care pathway. This information is not currently available for interventions in children and young people with gender incongruence or gender dysphoria, so young people and their families have to make decisions without an adequate picture of the potential impacts and outcomes.[84]

Concerns about Lack of Age-Appropriate Assessment and Consent

36. Similar to the judgement in *Re: Devin*, the Report highlighted the necessity of holistic assessment processes that consider a range of factors, including gender dysphoria, mental health, social support, and the influence of puberty on identity development. The report emphasised the involvement of multidisciplinary teams to ensure a

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[81] 'Adult transgender clinics in England face inquiry into patient care', *Guardian*, 11 April 2024. https://www.theguardian.com/society/2024/apr/10/adult-transgender-clinics-in-england-face-inquiry-into-patient-care.

[82] 'Health Secretary vows to close loopholes for private and online gender providers', *Braintree & Witham Times*, 16 April 2024. https://www.braintreeandwithamtimes.co.uk/news/national/24255240.health-secretary-vows-close-loopholes-private-online-gender-providers/.

[83] 'Doctors blast opaqueness of gender clinics', *The Australian*, 12 April 2024. https://www.theaustralian.com.au/nation/doctors-blast-opaqueness-of-gender-clinics/news-story/09e329da4a537afde2af0fc3101348de.

[84] Ibid 33.

comprehensive understanding of the needs of the individual child or young person.[85] Again, this is in direct contrast to the expedited approach advocated by AusPATH, whereby a '"gender assessment" with a psychiatrist is not required and is not a mandatory requirement prior to commencing medical gender affirmation',[86] as further outlined above.

37. As noted above, the Report emphasised the implications of a lack of longitudinal data on the ability of families and young people to give informed consent to aspects of gender-affirming care.[87] The Report stated:

> In considering endocrine interventions, the large number of unknowns regarding the risk/benefits in any one individual and the lack of robust information to help them make decisions present a major problem in obtaining informed consent.[88]

On the issue of whether minors are able to consent to the application of a gender affirming approach, the Report states:

> consent is more than just capacity and competence. It requires clinicians to ensure that the proposed intervention is clinically indicated as they have a duty to offer appropriate treatment. It also requires the patient to be provided with appropriate and sufficient information about the risks, benefits and expected outcomes of the treatment.
>
> Assessing whether a hormone pathway is indicated is challenging. A formal diagnosis of gender dysphoria is frequently cited as a prerequisite for accessing hormone treatment. However, it is not reliably predictive of whether that young person will have longstanding gender incongruence in the future, or whether medical intervention will be the best option for them.
>
> In addition, the poor evidence base makes it difficult to provide adequate information on which a young person and their family can make an informed choice.
>
> A trusted source of information is needed on all aspects of medical care, but in particular it is important to defuse/manage expectations that have been built up by claims about the efficacy of puberty blockers.[89]

[85] Ibid 35, 37, 39, 84, 139.
[86] Ibid.
[87] Ibid 194-195.
[88] Ibid 196.
[89] Ibid 34.

38. The Report further stated that any approach relying solely on informed consent would not be 'an approach that would be compatible with GMC guidance with regard to the responsibilities of prescribers (GMC, 2021) or for the safeguarding of minors (GMC, 2018).' This statement is made in response to the following observations:

> Some commentators suggest that since there is no evidence that gender assessments can reliably predict or prevent detransition/ regret better than self-reported gender identity and embodiment goals, services should adopt an 'informed consent' model of care. In this context, this means de-emphasising gender assessments in favour of offering gender-affirming interventions based primarily or solely on the person's informed decision (Ashley et al., 2023). This would also be in line with the views of some service users who see the assessment process as intrusive and 'gatekeeping'.[90]

Concerns about Lack of Evidence Base for Gender-affirming Care

39. The Report raised significant concerns about the absence of a robust evidence base for gender-affirming care.[91] The Report states:

> The gaps in the evidence base regarding all aspects of gender care for children and young people have been highlighted, from epidemiology through to assessment, diagnosis, therapeutic support and treatment.
>
> It is troubling that so little is known about this cohort and their outcomes. An ongoing programme of work is required if the new case-mix of children and young people and their needs are to be fully understood, as well as the short-, medium- and longer-term impacts of all clinical interventions.[92]

40. The Report identifies the following damning rationale for this development:

> It often takes many years before strongly positive research findings are incorporated into practice. There are many reasons for this. One is that doctors can be cautious in implementing new findings, particularly when their own clinical experience is telling them the current approach they have used over many years is the right one for their patients. Quite the reverse happened in the field of gender care for children. Based on a single Dutch study, which suggested that puberty blockers may improve psychological wellbeing for a narrowly defined group of children with gender incongruence,

[90] Ibid 194.
[91] Ibid 197, 202, 215.
[92] Ibid 40.

> the practice spread at pace to other countries. This was closely followed by a greater readiness to start masculinising/feminising hormones in mid-teens, and the extension of this approach to a wider group of adolescents who would not have met the inclusion criteria for the original Dutch study. Some practitioners abandoned normal clinical approaches to holistic assessment, which has meant that this group of young people have been exceptionalised compared to other young people with similarly complex presentations. They deserve very much better.[93]

Inadequacy of Mental Health Screening

41. The Report noted a lack of standardized protocols for mental health screening and support within gender-affirming care settings. It stated:

> Despite the agreement within the international guidelines on the need for a multi-disciplinary team, and some commonalities between them in the areas explored during the assessment process, the most striking problem is the lack of any consensus on the purpose of the assessment process.

The report highlighted the rising coincidence of gender identity issues with mental health issues:

> The Review has spoken to clinicians working in child and adolescent mental health and in paediatric services. They report seeing an increase in children and young people presenting with issues around gender identity alongside mental health difficulties, suggesting young people are seeking and accessing care across a broader range of NHS services.

42. The Report made the following recommendation concerning the need to identify the presence of other medical conditions that can correlate with gender dysphoria:

> Clinicians should apply the assessment framework developed by the Review's Clinical Expert Group, to ensure children/young people referred to NHS gender services receive a holistic assessment of their needs to inform an individualised care plan.
>
> This should include screening for neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment. The framework should be kept under review and evolve to reflect emerging evidence.

[93] Ibid 13.

Concluding Remarks on Cass Review

43. The Cass Report has been well-received by stakeholders (except proponents of gender-affirming care). The NHS has signalled that it will action the key recommendations of the Report,[94] including further restricting access to puberty blockers and hormone treatments. The Report has received support from both the UK Health Secretary and the Shadow Health Secretary.[95] Moreover, the Report raises issues of importance to the ACNC's consideration as to whether AusPATH exists for the public benefit, and whether its purposes, when effected, actually give rise to detriment. In particular, the Report highlights the lack of a strong basis in evidence for clinical practices that are advocated by AusPATH, such as social transitioning and the prescribing of puberty blockers and cross-sex hormones. The report calls into question the gender-affirming care model itself, and it is highly critical of two influential clinical guidelines that are currently recommended for use by AusPATH. AusPATH is advocating to make it easier for children and young people to access medical interventions such as puberty blockers and cross-sex hormones when the findings of the Report suggest that such access should be curtailed.

Application of the Evidence to AusPATH

44. As noted above, the requirements of Lord Wright's 'balancing' exercise are, first, the determination of the scope of public benefit, followed by the determination of the scope of any detriment, then the analysis of *net* benefit.[96] It is trite law to assert that the 'question of whether a purpose will or may operate for the public benefit is to be answered by the court forming an opinion on the evidence before it'.[97] In the case of AusPATH, the question commanding attention within Lord Wright's 'balancing' exercise is whether the activities of AusPATH entail any form of detriment, and,

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[94] 'Implementing advice from the Cass Review', NHS https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/implementing-advice-from-the-cass-review/.

[95] 'Victoria Atkins tells MPs Cass report shows how 'fashionable cultural values' led to gender clinic children being harmed', *Guardian*, 16 April 2024. https://www.theguardian.com/politics/live/2024/apr/15/david-cameron-tories-election-rishi-sunak-rwanda-uk-politics-live?filterKeyEvents=true&page=with:block-661d54ca8f086f43339e91bb#block-661d54ca8f086f43339e91bb;'Cass review must be used as 'watershed moment' for NHS gender services, says Streeting', *Guardian*, 13 April 2024. https://www.theguardian.com/society/2024/apr/12/cass-review-watershed-moment-nhs-gender-services-wes-streeting-young-trans-people.

[96] Debra Morris, Anne Morris, and Jennifer Sigafoos, "Adopting (In)equality in the UK," *Journal of Social Welfare and Family Law* 38, no. 1 (2016). 30.

[97] *McGovern v Attorney General* [1982] Ch 321, 333 see also *National Anti-Vivisection* (n 24) 44.

further, if they do, whether that detriment 'outweighs' the public benefit entailed in its other operations?

45. Even with the presumption of public benefit,[98] the Commission must take account of probative evidence of detriment. Where such evidence exists, the presumption may be displaced. Referring to a 2013 decision five years ago, Justice Slade asserted that there has been 'proliferation of academic and other writings since [2013] and the emergence of alternative thinking about treatment and questions arising from the state of knowledge in respect of the long-term implications of current medical treatment for Gender Dysphoria'.[99] As demonstrated in this document, proliferation has proceeded apace since Justice Slade's 2018 decision.
46. We have adduced evidence not only that detriment is present, but that *net* benefit is not present. The purposes and activities of AusPATH fail to exhibit public benefit; however, clear evidence of harm or detriment has been furnished. Such is sufficient to justify interference with what would otherwise be charitable.[100] The level of detriment found in the evidence above is enough to provide reasons as to why the presumption of public benefit should be displaced. While it is established above that clear evidence exists of the detriment flowing from the activities of AusPATH in endorsing and advocating for the gender affirming model, both the judgement in *Re: Devin* and the Cass Report established that no probative and settled evidence may be furnished for a conclusion that the actions are beneficial. In the balance between benefit and detriment, we are left only with clear evidence of detriment.

Conclusion

47. As Spencer and Clarke summarise, '[t]he field of gender medicine has been regarded by some as part of the "culture wars"; however, the long-term consequences of the gender affirming pathway for children and adolescents are profound. If clinicians are taking note of AusPATH recommendations about puberty blockers, they will be dangerously misguided.'[101] This complaint is not made to contribute to the 'culture wars'. It conveys evidence tested in the impartiality of the Australian judicial process and furnished by highly respected clinicians. That evidence leads to the conclusion that the approach advocated by AusPATH is harmful to children. The identifiable

[98] *Charities Act 2013* (Cth) s 7; *National Anti-Vivisection*, 65 (Lord Simonds); *McGovern v Attorney General*, Ch 321 333-4.
[99] *Re Imogen* [57] (No 6) [2020] FamCA 761; (2020) 61 Fam LR 344.
[100] J Warburton 'Charities and Public Benefit – from Confusion to Light?' (2008) 10(3) *Charity Law & Practice Review* 1.
[101] Spencer and Clarke (n 3) 276.

detriment from the achievement of AusPATH's purpose is harm to the very people the AusPATH claims its purpose will benefit. This detriment outweighs any benefit that the achievement of the purpose would confer on either the public or a section or class of the public. As such, the Commissioner should not accept that AusPATH's purposes are for the public benefit. As AusPATH's purposes are not for the public benefit, it does not meet the definition of charity under section 5 of the *Charities Act*. This means that, based on the information currently available, AusPATH would not be entitled to registration as a charity or as a deductible gift recipient.