Are you an individual or making a submission on behalf of an organisation?

Individual

Are you a

Parent and/or caregiver

1. Does the new vision reflect what we all want for children and families?

The vision is strong in principle but incomplete in practice. It cannot truly protect children unless it commits to evidence-based, safeguarding-first policy for all services.

Right now, vulnerable minors are being channelled into gender-affirming pathways within programs intended for child wellbeing, despite no reliable evidence these interventions are safe or effective.
International reviews — the Cass Review (UK 2024), NICE (2020) and US HHS (2025) — all found evidence for puberty blockers and cross-sex hormones to be very low quality.

Australia still relies on the 2018 “Australian Standards of Care”, a document never endorsed by any health authority. The Cass Review scored it very low quality, and the Federal Court’s Strum v Devin (2022) decision showed its circular self-approval: clinicians citing their own practice as proof of evidence.

A vision for families must reject this model and prohibit any medical or social transition for minors within publicly funded services.

Programs should focus on root causes — trauma, autism, anxiety and same-sex attraction — using multidisciplinary, exploratory therapy that lets clinicians practise ethically without fear of breaching “conversion” laws.

Families need services that restore trust, transparency and parental involvement. Only by grounding the FaC vision in evidence, openness and genuine safeguarding can we ensure every child is protected and supported to thrive.

2. Are the two main outcomes what we should be working towards for children and families? Why/Why not? - Outcome 1: Parents and caregivers are empowered to raise healthy, resilient children - Outcome 2: Children are supported to grow into healthy, resilient adults.

The outcomes are sound in principle but incomplete. Parents can't raise resilient children if programs promote unevidenced gender-affirming interventions that carry lifelong risk.

International reviews — Cass (UK 2024), NICE (2020) and US HHS (2025) — found evidence for puberty blockers and cross-sex hormones to be very low quality. Yet Australian clinics still follow the 2018 Australian Standards of Care, never endorsed by NHMRC and rated "very low quality" in Cass. The Strum v Devin (2022) ruling exposed their circular self-approval. These practices don't build resilience — they risk irreversible harm.

To achieve real outcomes, programs must focus on root causes such as trauma, autism, anxiety and same-sex attraction, allowing clinicians to use exploratory therapy free from ideological pressure. Such therapy helps children understand themselves and recover without medicalisation.

True empowerment means parents are informed and involved, and children are protected from experimental treatment.
If "healthy, resilient" means physically intact and emotionally stable, the FaC framework must reject gender-affirming interventions for minors and restore genuine, evidence-based therapeutic care.

3. Will a single national program provide more flexibility for your organisation?

A single national program could improve consistency, but only if it guarantees transparency, accountability, and genuine safeguarding.
At present, families face confusion and harm from inconsistent approaches to gender-related distress in children. Some services automatically affirm; others take a cautious, therapeutic route. National alignment must not mean enforcing a single ideological model of "affirmation" nationwide.

Flexibility should allow clinicians to practise exploratory, evidence-based therapy without fear of breaching "conversion" laws, and empower parents to be involved in all decisions affecting their children. A national framework must also permit state-level oversight and public access to outcome data, so that unsafe practices cannot hide behind bureaucracy.

If structured correctly, a unified program could prevent what occurred at the Women's and Children's Hospital (SA), where clinicians departed from their own Model of Care without proper review. But if the program embeds activist-driven guidelines like the 2018 Australian Standards of Care, it will entrench those same risks across the country.

A single system should strengthen safeguards, not silence clinical judgement. National coordination is worthwhile only if it restores public trust, parental rights, and evidence-based practice—not if it extends the reach of ideology under the banner of “consistency.”

4. Does the service or activity you deliver fit within one of the three funding streams? Do these streams reflect what children and families in your community need now – and what they might need in the future?

While I’m not a service provider, I speak as a parent who has had to navigate these systems for a vulnerable child. The funding streams must reflect the real needs of families, not ideology.
At present, programs dealing with children’s mental health, wellbeing, and family support are being influenced by gender-affirming frameworks that have no credible evidence base and risk causing irreversible harm.

Families in my community need trauma-informed, evidence-based supports — not medicalisation of distress or social transition of minors. Programs must prioritise services that explore root causes such as autism, anxiety, eating disorders, or trauma, and provide parents with guidance to respond safely and compassionately.

Future funding should support multidisciplinary, exploratory therapeutic approaches, not interventions based on unproven identity models. Families also need assurance that programs receiving Commonwealth funds operate transparently, with safeguarding and parental inclusion as central principles.

The current funding structure could meet community needs — but only if it stops supporting organisations or programs that promote unevidenced gender-affirming care. What families really need is truthful information, clinical caution, and practical support to help their children grow into healthy, resilient adults without life-altering medical intervention.

5. Are there other changes we could make to the program to help your organisation or community overcome current challenges?

Yes. The most urgent change is restoring evidence-based care and safeguarding across all family and child services.
Parents struggle to find clinicians willing to explore the underlying causes of gender

distress—trauma, autism, anxiety or internalised homophobia—without defaulting to affirmation or medicalisation.

Programs should ensure services:

Provide exploratory, trauma-informed therapy as first-line care.

Prohibit medical or social transition for minors in publicly funded settings.

Include parents in all decisions about their children.

Collect and publish long-term outcome data to monitor safety and efficacy.

Independent oversight and open reporting are vital, given failures such as those at the Women's and Children's Hospital in South Australia.

Current "conversion" laws have created fear among clinicians, discouraging open discussion. The program must affirm that exploratory therapy is not conversion, but ethical, evidence-based care.

Families need practical, honest support—not ideology. By prioritising transparency, parental rights and safeguarding, this reform can protect children and rebuild community trust.

6. Do you agree that the four priorities listed on Page 4 are right areas for investment to improve outcomes for children and families?

The priorities are well-intentioned but incomplete. Investment must focus on safeguarding, evidence-based care, and parental involvement, or the system will continue to fail vulnerable children.

Current services risk serious harm by promoting gender-affirming approaches without credible evidence. International reviews — Cass (UK 2024), NICE (2020) and US HHS (2025) — have all found the research base for puberty blockers and cross-sex hormones to be very low quality. Yet Australian services still follow the 2018 Australian Standards of Care, which were never endorsed by NHMRC and rated "very low quality" by Cass.

Future investment must prioritise:

Exploratory and trauma-informed therapy as first-line support.

Comprehensive assessment addressing autism, trauma, and mental health before any gender-related referral.

Parental inclusion and informed consent as non-negotiable.

Independent evaluation and open data, ensuring programs remain accountable and transparent.

Without these safeguards, public funds risk supporting practices that are unethical and unsupported by evidence.
True investment in children means helping them understand themselves, not medicalising distress.

Australia must follow the international move toward caution and child protection—not double down on failed models.

7. Are there any other priorities or issues you think the department should be focusing on?

Yes. The Department must urgently prioritise child safeguarding, clinical transparency, and the prevention of medical harm in all services working with minors.

Australia remains an outlier internationally in continuing to support gender-affirming models of care for children despite the lack of credible evidence. Reviews by Cass (UK 2024), NICE (2020) and US HHS (2025) all found the evidence for puberty blockers and cross-sex hormones to be very low quality with uncertain benefits and real risks.

The Department should ensure that:

No program for children or families promotes or facilitates medical or social transition for minors.

Clinicians are free to offer exploratory, evidence-based therapy without fear of breaching “conversion” laws.

Parents are included in all decisions about their children’s care.

All services are subject to independent evaluation and required to publish outcome data.

There must also be dedicated support for detransitioners and desisters, who are currently left without care or recognition.
Ignoring this growing group is unethical and inconsistent with a trauma-informed, child-centred approach.

The Department's highest priority should be protecting children from ideologically driven, unproven medical practices.
Families need safe, honest, and compassionate services — not affirmation of distress, but real help to heal and grow.

8. Do the proposed focus areas – like supporting families at risk of child protection involvement and young parents match the needs or priorities of your service?

Yes, supporting at-risk families and young parents is crucial, but these programs must be grounded in safeguarding, evidence, and transparency. In many cases, families end up under child protection scrutiny not because they are neglectful, but because they question or resist gender-affirming approaches being promoted to their children without proper evidence or consent.

Parents who seek cautious, trauma-informed care are often dismissed as unsupportive, when in fact they are trying to protect their children from irreversible medical harm. This is a failure of the system, not the family.

Programs for vulnerable families should therefore:

Prioritise parental inclusion in all clinical and educational settings.

Provide honest, evidence-based information about the lack of proof for gender-affirming interventions.

Ensure child protection and family services understand the difference between safeguarding and ideological compliance.

Support parents in accessing exploratory, trauma-informed therapy rather than affirmation models.

Focusing on early intervention is valuable — but only if it prevents medical harm, not enables it. Families at risk need real help to rebuild safety, stability, and trust, not pressure to conform to a politicised model of care.

By centring these priorities, the Department can strengthen families rather than alienate them, ensuring all children grow up safe, supported, and free from unnecessary medicalisation.

9. Are there other groups in your community, or different approaches, that you think the department should consider to better support family wellbeing?

Yes. Families need access to clinicians and community supports that focus on root-cause mental-health care, not ideological models.
Many parents are isolated because local services now default to gender affirmation instead of exploring underlying issues such as trauma, autism, anxiety or same-sex attraction. Parents seeking a cautious, evidence-based approach often cannot find help locally and are treated as unsupportive.

The Department should invest in:

Community-based exploratory therapy programs where families can access ethical, trauma-informed care.

Support networks for parents navigating gender distress, helping them stay engaged with schools and mental-health professionals.

Education for clinicians and teachers about desistance rates, the Cass Review's findings, and the importance of open exploration.

Dedicated detransition and desistance services for those harmed by premature medicalisation.

These groups represent a growing and underserved population whose experiences reveal systemic failures in safeguarding.

By supporting community programs grounded in truth, compassion, and transparency, the Department can help families rebuild trust, protect children from unnecessary medicalisation, and ensure wellbeing services reflect real-world evidence rather than ideology.

10. What are other effective ways, beyond co-location, that you've seen work well to connect and coordinate services for families?

The best coordination happens when services share information, accountability, and values based on safeguarding and transparency—not just buildings.
Families fall through the cracks when professionals work in silos or when ideological frameworks replace open, multidisciplinary collaboration.

Effective models include:

Shared assessment frameworks where clinicians, schools, and family services jointly explore the root causes of a child's distress (trauma, autism, anxiety, same-sex attraction) before any referral for gender or identity-related support.

Regular multidisciplinary case reviews focused on evidence and child welfare rather than ideology.

Direct parent participation in all planning meetings to ensure transparency and informed consent.

Cross-agency data reporting and independent oversight so outcomes and safeguarding breaches are openly reviewed.

Families need a coordinated system that prioritises truthful, evidence-based care, not one that reinforces unproven "gender-affirming" models.
When professionals share honest information and respect biological reality, children receive consistent, compassionate, and safe care.

Strong communication, shared ethics, and clinical accountability—more than co-location—are what truly connect services and protect families.

11. What would you highlight in a grant application to demonstrate a service is connected to the community it serves? What should applicants be assessed on?

Services should demonstrate genuine connection by showing trust, transparency, and accountability to the families they support — not by aligning with activist agendas or ideological networks.

Applicants should be assessed on whether they:

Engage openly with parents and carers, ensuring families are informed and involved in all decisions about their children.

Operate from evidence-based principles, not advocacy positions such as automatic gender affirmation.

Provide safe, trauma-informed, exploratory care that addresses underlying causes of distress rather than medicalising children.

Demonstrate independent oversight and willingness to publish outcome data, including adverse events or treatment discontinuation.

Show that they actively protect sex-based rights, safeguarding standards, and parental consent in all programs.

Community connection should mean listening to parents — especially those raising concerns about harmful practices — and responding with honesty and evidence.

A truly connected service is one that the community can trust: it protects children, works collaboratively with families, and remains transparent about what works and what doesn't.

12. Beyond locational disadvantage, what other factors should the department consider to make sure funding reflects the needs of communities?

The Department must consider ideological capture, service transparency, and safeguarding capacity as key risk factors when allocating funding.
Location is only one barrier—many families in urban and regional areas face equal or greater harm because local services have adopted gender-affirming models that lack evidence and exclude parents from decision-making.

Funding decisions should assess:

Whether a service is evidence-based or guided by ideology.

Its safeguarding record, including how it handles children with trauma, autism, eating disorders, or same-sex attraction.

Parental trust and community confidence in the organisation.

Outcome transparency, including willingness to collect and publish long-term follow-up data.

The presence of independent oversight and mechanisms for complaint and review.

Disadvantage is not only economic—it is also informational and institutional. Families who question medicalised gender practices often lose access to care or support, effectively discriminated against for protecting their children.

To reflect true community need, funding must prioritise services that provide honest, trauma-informed, and exploratory support, not those promoting irreversible medical pathways for minors.

Ensuring fairness means investing in programs grounded in truth, ethics, and child safeguarding—the foundations of genuine wellbeing for all families, regardless of postcode.

13. What's the best way for organisations to show in grant applications, that their service is genuinely meeting the needs of the community?

Organisations should demonstrate community connection through transparency, accountability, and genuine engagement with families, not by aligning with advocacy or ideological positions.

Applicants should be assessed on whether they:

Provide evidence-based care and publish clear data on outcomes and adverse events.

Include parents and carers in all decisions affecting children.

Demonstrate a commitment to safeguarding, ensuring programs do not promote unproven or harmful interventions such as medical or social transition for minors.

Operate under independent oversight and welcome open review of their practices.

Show strong community trust, particularly among families who feel excluded or dismissed by current gender-affirming systems.

A genuinely connected service listens to families' real experiences — including those harmed by premature or ideological approaches — and adjusts practice accordingly.

The best indicator of community connection is trust built through honesty, clinical integrity, and transparency.

Applicants should be rewarded for serving the whole community, including parents raising safeguarding concerns, rather than only those who align with fashionable narratives.

14. How could the grant process be designed to support and increase the number of ACCOs delivering services to children and families?

The grant process should strengthen community-led, culturally grounded services while ensuring all organisations — including ACCOs — are supported to deliver evidence-based, child-safe, and trauma-informed care.

Aboriginal Community Controlled Organisations (ACCOs) play a vital role in building trust, connection, and culturally respectful support for families. However, they must not be pressured to adopt externally imposed frameworks such as gender affirmation or other ideological models that may conflict with cultural values, evidence, or community priorities.

To build capacity and increase participation, the Department should:

Provide dedicated funding and training for ACCOs in trauma-informed, family-based and exploratory therapeutic care.

Simplify grant and reporting requirements while maintaining transparency and accountability.

Offer research and data support so ACCOs can collect and publish outcome data without reliance on external advocacy groups.

Ensure freedom of practice — allowing ACCOs to uphold cultural, biological, and family-based understandings of child development without ideological interference.

Supporting ACCOs means empowering them to deliver care that reflects their communities' values and evidence-based standards.
True cultural safety must include safeguarding from harm, respect for family authority, and protection of children's physical and psychological wellbeing.

15. What else should be built into the program design to help improve outcomes for Aboriginal and Torres Strait Islander children and families?

Programs must protect cultural integrity, family connection, and child safeguarding equally. Aboriginal and Torres Strait Islander children deserve access to care that is both culturally grounded and evidence-based, ensuring they are not exposed to ideological or experimental practices such as gender affirmation for minors.

Program design should:

Prioritise family- and community-led approaches, recognising parents and elders as central to children's wellbeing.

Embed trauma-informed, exploratory therapy that helps young people understand distress within their social, developmental and cultural contexts.

Ensure freedom from ideological pressure, allowing ACCOs and practitioners to deliver care consistent with cultural values and the best available evidence.

Include independent oversight and transparent reporting so all services remain accountable for safety and outcomes.

Support education and workforce development in culturally sensitive, evidence-based child and adolescent mental-health care.

True cultural safety means protecting children's minds and bodies from harm — including medicalisation of distress — and upholding the authority of families and communities.
By combining cultural strength with clinical integrity, the Department can ensure Aboriginal and Torres Strait Islander children grow up safe, supported, and proud of who they are.

16. What types of data would help your organisation better understand its impact and continuously improve its services?

To ensure services are genuinely helping families, the Department must require collection and publication of transparent, long-term outcome data.
Too often, programs involving children — especially those linked to gender-affirming models — operate without follow-up or accountability. Without reliable data, harmful interventions remain hidden, and families lose trust.

Services should collect and report:

Long-term physical and mental health outcomes for any child referred for gender-related care or identity-based interventions.

Rates of desistance, detransition, and regret, which are currently ignored in most reporting.

Comorbid conditions such as autism, trauma, eating disorders and anxiety to understand root causes of distress.

Parent satisfaction and engagement metrics, measuring whether families feel informed, respected, and included in decisions.

Adverse events and complications from medical or psychosocial interventions.

All outcome data must be publicly available, independently reviewed, and disaggregated by age, sex, and diagnosis to identify risk patterns.

Transparency is not punitive — it's the foundation of improvement.
Families deserve honest information about what works and what harms.
Requiring consistent, evidence-based data collection will help restore public trust, protect children, and ensure that services evolve responsibly and ethically over time.

17. What kinds of data or information would be most valuable for you to share, to show how your service is positively impacting children and families?

The most valuable data is that which demonstrates real-world safety, wellbeing, and long-term outcomes for children and families.
Services should be required to share transparent, evidence-based information that reflects both success and harm — not promotional metrics.

Meaningful measures include:

Long-term physical and psychological health outcomes, particularly for children exposed to gender-related interventions.

Rates of desistance and detransition, showing whether early "gender-affirming" approaches were truly beneficial or premature.

Improvements in mental health, family stability, and school engagement following trauma-informed or exploratory therapy.

Parent and caregiver satisfaction, indicating whether families feel heard, respected, and supported.

Independent audits and peer-reviewed evaluations to ensure accuracy and credibility.

Positive impact is not measured by the number of children who transition — it's measured by how many children recover, thrive, and remain connected to their families.
Transparent, long-term data collection helps identify which interventions genuinely improve wellbeing and which cause harm.

By prioritising truthful, outcome-based reporting, the Department can ensure programs protect children, strengthen families, and continually improve through honest reflection rather than ideology.

18. If your organisation currently reports in the Data Exchange (DEX), what SCORE Circumstances domain is most relevant to the service you deliver?

While I am responding as a parent and advocate rather than a service provider, the most relevant SCORE Circumstances domains for the issues raised would be:

Family functioning and relationships – reflecting the need to strengthen trust and communication between parents, children, and services.

Mental health, wellbeing and self-esteem – especially where trauma, autism, anxiety or internalised homophobia are present.

Personal and family safety – ensuring that all interventions protect children from physical, psychological, or medical harm.

These domains align with an evidence-based, safeguarding-first approach focused on supporting children and families through open exploration, trauma-informed care, and parental inclusion — not through unproven or irreversible medical pathways.

If reporting frameworks like DEX are to be meaningful, they must track long-term outcomes, including harm, regret, or desistance rates, and ensure data transparency so families and policymakers can make informed decisions.

19. What kinds of templates or guidance would help you prepare strong case studies that show the impact of your service?

Case study templates should prioritise honesty, evidence, and long-term outcomes — not advocacy or ideological framing. Families and practitioners need tools that capture both positive results and lessons learned, especially where interventions may have caused harm.

Useful guidance would include prompts for:

Baseline assessment data, including comorbidities such as autism, trauma, anxiety, and eating disorders.

Type and duration of intervention, distinguishing between exploratory therapy and medical or social transition.

Short- and long-term outcomes, including wellbeing, family connection, and any regret or adverse effects.

Parent and child reflections, ensuring family voices are central.

Independent review or peer validation, to confirm accuracy and reduce bias.

Templates should also allow reporting of detransition and desistance experiences, which are currently absent from most program evaluations but essential for understanding real outcomes.

Strong case studies are those that tell the truth — where data, not ideology, defines success.
By guiding services to document both benefits and harms transparently, the Department can ensure programs evolve responsibly and genuinely improve the lives of children and families.

20. What does a relational contracting approach mean to you in practice? What criteria would you like to see included in a relational contract?

A relational contracting approach should mean building mutual trust, accountability, and shared safeguarding responsibility between government, service providers, and families.
In practice, this means relationships grounded in transparency, honesty, and evidence — not ideological conformity or fear of speaking out.

Too often, services prioritise compliance with activist-driven frameworks (such as gender affirmation) over genuine partnership with families.
Relational contracts must protect the ability of clinicians and parents to ask difficult questions, explore causes of distress, and make decisions based on the child's best interests, not institutional pressure.

Key criteria should include:

Evidence-based practice as a non-negotiable standard.

Safeguarding and child safety as the highest priority in every funding agreement.

Parental inclusion and informed consent as essential to service delivery.

Independent oversight and transparent outcome reporting to maintain public trust.

Freedom of conscience for clinicians, ensuring they can provide exploratory therapy without breaching conversion-law fears.

A true relational contract values integrity over ideology.
It should empower services to collaborate openly with families, collect honest data, and protect children from harm — even when that means challenging prevailing narratives.

Only through transparency and shared ethical responsibility can "relational" partnerships genuinely improve outcomes.

21. What's the best way for the department to decide which organisations should be offered a relational contract?

The Department should prioritise organisations that demonstrate trustworthiness, transparency, and a proven commitment to safeguarding and evidence-based care.
Relational contracts should only be offered to services that act with integrity — not those driven by ideology or advocacy.

Selection should be based on clear criteria, including:

Evidence-based practice: programs must rely on independent research, not activist-produced "standards" such as the 2018 Australian Guidelines for Gender

Diverse Youth, which were never endorsed by NHMRC.

Transparency: willingness to collect and publish outcome data, including harm, regret, or desistance rates.

Safeguarding compliance: proven record of protecting children from psychological and physical harm.

Parental engagement: families must be included in all major decisions about their children’s care.

Clinical independence: freedom for practitioners to provide exploratory therapy without coercion or fear of breaching conversion laws.

Cultural and community respect: particularly for Aboriginal and Torres Strait Islander families, recognising family and community as central to child wellbeing.

Organisations that suppress dissent, withhold outcome data, or align with ideological advocacy should not receive relational contracts.

Partnerships built on trust, transparency, and evidence — not ideology — will create genuine relationships that protect children, empower families, and strengthen community confidence in pu

23. Is there anything else you think the department should understand or consider about this proposed approach?

Yes. Above all, the Department must recognise that safeguarding and evidence-based practice are the foundation of every child and family service.
Without these, the entire framework risks repeating the failures now exposed in youth gender medicine — where ideology overtook clinical judgement, parental involvement was sidelined, and children were harmed.

The Department must ensure:

Transparency and accountability in all funded programs, with outcome data published and independently reviewed.

Freedom for clinicians to use exploratory, trauma-informed approaches without fear of breaching “conversion” laws.

Protection of parental rights as an essential safeguard, not a barrier to care.

Independent oversight to prevent ideological capture within services or research.

Public trust depends on openness and honesty. Families deserve confidence that programs will not medicalise distress or conceal harm.

The goal of this reform should be simple: to build a national framework that protects children from unproven interventions, supports parents, and restores clinical integrity.
If the Department gets this right, Australia can lead the world in genuine child safeguarding and responsible family policy — grounded in evidence, compassion, and truth.