Trans health service model workshop

**Report on proceedings**

March 2016

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# Purpose of this report

This is the report of a workshop convened on 11 March 2016 by the Trans Expert Advisory Group to the Health and Human Services Working Group (‘**Working Group**’) of the Victorian Government’s Lesbian, Gay, Bisexual, Trans and Gender Diverse, and Intersex (‘**LGBTI**’) Taskforce. The purpose of the workshop was to identify key health service delivery issues to be addressed and critical elements of good practice at both a system and practitioner level, for trans and gender diverse (‘**TGD**’) people.

# Background

The Victorian Government is committed to equality, decency and fairness for LGBTI Victorians, and has established the LGBTI Taskforce to provide advice to the Minister for Equality, Martin Foley MP.

To assist the Taskforce a Health and Human Services Working Group has been established to advise on current and emerging LGBTI issues in the health portfolio. The Working Group has in turn established Trans and Intersex Expert Advisory Groups.

The Trans Expert Advisory Group convened a workshop. The outcomes of the workshop will inform production of a service planning and development framework, and guidelines and training materials for practitioners.

The workshop was facilitated by Dr Heather Wellington.

The workshop agenda is at **Attachment 1,** the background paper is at **Attachment 2** and a list of attendees is at **Attachment 3**.

# The current service context

## Community perspective

Jeremy Wiggins, Project Manager, Victorian AIDS Council, presented the results of an on-line survey of members of the TGD community. The community survey contained seven questions asking about how important different health services were for TGD people in Victoria and how easy or difficult it was to access these services. The survey also included a number of open ended questions asking about difficulties associated with accessing services, services not available, the support and knowledge of health professionals and how the system could be improved.

117 responses from TGD people and parents were received in one week. They were analysed and reported by the Department of Health and Human Services (‘**Department**’) and a report was circulated to workshop participants in advance of the workshop. A copy of the report is at **Attachment 4**.

As shown in Figure 1, hormone therapy and mental health services were reported to be most important to TGD people, followed by general practitioner, social welfare and endocrinologist/other specialist services. Surgical therapy was reported to be the most difficult to access, followed by hormone therapy, mental health services and social welfare services.

Figure 1 Number of respondents reporting the following services difficult/very difficult to access and very important for trans and gender diverse people in Victoria.

Survey responses highlighted the following key issues:

* Cost was the most commonly identified difficulty in accessing services, followed by health professional’s lack of knowledge, problems with general practitioners and the complexity of the process.
* Mental health services and surgery were the two services that people most commonly reported not currently having access to but wanting, followed by general sexual health services and hormone therapy. A smaller number of people mentioned other services such as general support services, welfare/social services, speech, hair removal and children’s support.
* The majority of respondents (53) reported that they had not found health professionals knowledgeable about TGD issues. 27 reported mixed experiences while 15 had found health professionals knowledgeable.
* Community members experience high level of underemployment and discrimination.
* There is a need for education of and capacity-building in the general and health care communities.

A question asking about ways in which the system could be improved gained a wide range of responses, with education for health professionals by far the most commonly mentioned item, followed by low/no cost surgery and the use of an informed consent model or a similar approach to make hormone access easier.

Quotations extracted from survey responses were tabled at the workshop. They highlighted the many barriers to health and wellbeing experienced by members of the TGD community.

During discussion:

* the importance of a transparent service delivery model that empowers consumers and incorporates clear pathways to equitable and accountable health care was emphasised; and
* poor access to voice feminisation services was highlighted as an issue.

Department staff committed to undertaking more work to analyse the survey data and provide further information to the community.

## Royal Children’s Hospital service

Michelle Telfer, Clinical Lead of Adolescent Medicine at The Royal Children’s Hospital (‘**RCH**’) in Melbourne since 2012, presented a brief report on the current paediatric service system.

Demand and service provision have changed dramatically over time. In 2012, there were 18 referrals to the RCH service. Last year, 170 referrals were received and more than 200 referrals are expected this year.

Staff undertake significant advocacy on behalf of individual clients and the community, in relation to health and other relevant services.

The Victorian Government recently provided a significant new grant of $6 million over four years. New staff have been recruited and are undergoing training. The RCH now has a multidisciplinary team of 16 health care professionals including paediatricians, child and adolescent psychiatrists, clinical psychologists, a clinical nurse consultant, an administrator, a speech pathologist, surgeons who specialise in fertility preservation and fertility preservation counselling. There is also access to legal and bioethics advice.

Service throughout has increased from 1 new patient undergoing multidisciplinary assessment each week to 5 new patients weekly. Establishment of ‘spoke’ centres in Albury-Wodonga, Geelong and the Mornington Peninsula is commencing, on an outreach and shared service delivery model. Waiting time for a first appointment remains approximately 1 year, but without the grant it was 18 months to 2 years, and was expected to increase to 3 years.

It is hoped that within 12 months, the waiting time will be less than six months.

The RCH accepts young people up to the age of 18, but long waiting times have led to a policy of referring 17 year olds to Monash Medical Centre, which offers a state-wide service for adults. The RCH will review that policy when waiting times have reduced to six months or less.

Although a long waiting time is not ideal, young people on the waiting list and their families are now supported to access services including the Safe Schools Coalition, parent support groups and local health services. By the time young people are seen at the RCH they are generally well educated in TGD issues and socially transitioned, and have a clear understanding of medical treatment and legal options. This has improved the efficiency of the service and enabled timely institution of treatment at that point.

The additional funding for the RCH has enabled investment in evaluation and has relieved considerable staff and community anxiety about the harm associated with unmet need.

## The Monash Clinic

Jaco Erasmus is a psychiatrist who was recently appointed as head of the Gender Dysphoria Clinic at Monash Health (‘**Monash** **Clinic**’). The Monash Clinic is funded through Monash Health’s ambulatory care program. He presented a brief report on the service.

The Monash Clinic operates from Moorabbin and is open two days each week. Its budget ($362,239) is significantly smaller budget than that of the RCH service. It is staffed by a psychiatrist 1 afternoon per week, a clinical psychologist 2 days per week, a social worker 2 days per week, a part time receptionist and a project officer 1 day per week. A new clinical psychologist position of 1.5 days per week is being created. The Monash Clinic purchases approximately 1 day per week of speech pathology services and there is a $30,000 budget to assist people with the costs of surgery, which is only offered in the private sector.

Historically, referral numbers had been 75 per year, but in 2010 there was a dramatic increase and on average 20 new referrals per month are now received. Referral rates appear to have plateaued.

When a referral is received clients are advised of the long waiting list and of options to see private practitioners. There is a professional network, supported by the service, of four clinical psychologists and five psychiatrists who will accept private referrals. Three additional clinicians have indicated they wish to join the network. Waiting times for consultations in the private sector range from six weeks to four months, but cost creates an access barrier for many clients.

Assessment takes between three and six appointments depending on clinical need and complexity. These sessions are not psychotherapy sessions (the term used in the background paper). The purpose of assessment is for the clinician to determine three things: whether treatment is appropriate and safe, and whether the TGD person is capable of giving consent to treatment. Client choices are respected and at no stage are people told what to do with their bodies, whether they are trans, or whether they are ‘trans enough’ to qualify for treatment.

A multidisciplinary clinical meeting is held monthly, attended by Monash Clinic staff, an endocrinologist, a surgeon and a speech pathologist. This is a clinical meeting and no consumer representatives are included.

Once an assessment has been completed, Monash clinicians refer TGD people to other clinicians (often general practitioners practising at Northside Clinic (‘**Northside**’) or private endocrinologists) for hormone therapy. Not all clinicians who prescribe hormones are willing to bulk bill, which creates access barriers for some clients. There is also a problem identifying clinicians in rural and outer metropolitan areas who are willing to prescribe hormone therapy, despite active encouragement from Monash Clinic staff.

People are followed up on the basis of clinical need. Rural clients (of which there are many) can be followed up through Medicare-funded telemedicine, although Geelong falls outside the relevant geographic area and was described as a ‘black hole’.

The Monash Clinic:

* supports, without discrimination, people who identify as non-binary or genderqueer;
* has no capacity to provide clinician training, however supervision is offered through the private network that has recently been established;
* is a state-wide service but is managed within the mental health program, which is a regional rather than state-wide service, which may create some confusion; and
* undertook a consumer satisfaction survey two years ago, following protocols from the United Kingdom and the United States of America, and published the results. Consumer satisfaction was relatively high, with 88% of people who were able to access the service satisfied, and 90% saying they would recommend the service.

There are significant access barriers. There is a waiting list of 100 people. Waiting times for assessment and treatment are currently increasing, from 12 to 18 months. The Monash Clinic has recently assigned staff to ensure people on the waiting list are supported by a social worker.

While there is support in principle for establishing a reference group to support the service, there is insufficient funded time for clinicians to work effectively with such a group. The idea should be ‘held’ until more resources are available.

Monash Health representatives confirmed that the Board is keen to expand the Monash Clinic. The 2016/17 budget is currently being compiled and representation is being made both internally and to the Department for additional resources.

## Treatment standards and guidelines, and services

Riki Lane works at the Monash Clinic 1 day per week, but attended the workshop as an independent professional rather than as a representative of the Clinic.

Riki presented information about the treatment standards and guidelines that are applied in Australia, referencing a number of Australian-based publications describing the model of care and specific treatment pathways (**Attachment 5**).

The World Professional Association for Transgender Health (‘**WPATH**’) has published standards of care for the health of transsexual, transgender, and gender nonconforming people. These standards require, in most circumstances, a diagnosis by a mental health professional before initiation of treatment. There is an increasing trend for assessment by a clinical psychologist rather than a psychiatrist.

Other standards and guidelines are based on an informed consent model. The Centre of Excellence for Transgender Health has published a range of guidance material.

There are no definitive Australian guidelines for provision of primary care services to TGD people. In some jurisdictions general practitioners play a significant role in trans health, but most Australian general practitioners are not adequately trained in this area. The Monash Clinic receives many calls from general practitioners who have little if any relevant knowledge. He considers there is an urgent need for primary care guideline development in Australia.

The Endocrine Society in the USA has published a clinical practice guideline – *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline* (2009). It recommends diagnosis by a mental health professional. Most hormones are prescribed in accordance with the guideline in Australia.

Riki also presented a summary of currently available services in Victoria and asked participants to provide him with any updated information. Currently in Victoria, expert GPs who prescribe hormones do so only after a full assessment is done by a trans-expert psychiatrist or clinical psychologist who can confirm the diagnosis of gender dysphoria. PBS-subsided prescriptions for testosterone therapy are only possible if the person has been seen at least once by a specialist such as an endocrinologist or sexual health physician.  General practitioners are usually the prescribers and managers of hormone treatment, with or without support from an endocrinologist.

Dr Darren Russell is a Cairns-based sexual health physician and Director of Sexual Health at Cairns Base Hospital. He provides services under an informed consent model without review by a mental health clinician first. He can also prescribe testosterone without referral because he is a sexual health physician. His clinic is the only one of its type in Australia.

# Issues identified by participants

## Pathologising gender dysphoria

The allocation of a diagnostic categorisation to gender dysphoria is a significant concern for TGD people.

The Diagnostic and Statistical Manual of Mental Disorders (‘**DSM**’) is the handbook used by health care professionals in much of the world as the authoritative guide to the diagnosis of mental disorders.  DSM contains descriptions, symptoms, and other criteria for diagnosing mental disorders and classifies gender dysphoria as a mental health disorder.

The World Health Organisation is responsible for developing and disseminating the International Classification of Diseases (‘**ICD**’), which is the standard set of definitions of diseases and health conditions used throughout most of the world. As part of the development of the eleventh revision of the International Classification of Diseases (ICD-11), WHO appointed a Working Group on Sexual Disorders and Sexual Health to recommend changes necessary in the classification of mental and behavioural disorders in ICD-10 that are related to sexuality and gender identity. The Working Group recommended a name change to gender incongruence and strongly recommended that the diagnoses be removed from the section on mental and behavioural disorders.

The TGD community strongly disagrees with labelling variations in gender expression as symptoms of a mental health disorder.

Jaco agreed that gender dysphoria remains a pathologising diagnosis. He confirmed that persistent gender dysphoria as a phenomenon is sufficient for people to access medical care in the Monash Clinic, and a psychiatric diagnosis is not required. In his view, the ICD classification is less stigmatising than the DMS classification – for example pregnancy, which is clearly not a disease, is also a diagnosis under the ICD model. He noted, however, that health care funds have recently changed to a diagnosis funding model and clinicians are obliged to provide them with a diagnosis for insurance purposes. The same applies if clients are seeking access to their superannuation funds, or Centrelink support. Obstacles remain, therefore, to totally eliminating the diagnostic approach.

Many participants expressed very strong view that while access to mental health services is essential for many clients, these services should be offered on a supportive basis and accessed in accordance with individual need rather than on a ‘gate-keeping’ basis. There was a particularly strong view expressed that TGD people should not be required to demonstrate a diagnosis (which is experienced as having to pass a ‘test’) as a precondition of access to hormone prescriptions. It was suggested that if a clinician refuses to commence hormones, they should be required to provide a medical reason in writing, which should be reviewable by a competent review board. Further, there is a view that there should be an accountable requirement for clinicians to refer to another competent provider if they are not willing to provide, or capable of providing, care themselves.

‘Informed consent’ and ‘shared responsibility’ models, both of which are significantly more person-centred than the current model, were discussed. The former vests the decision to embark on treatment solely in the hands of the informed TGD person, does not require people to ‘prove’ their gender dysphoria and recognises the autonomy of the individual to make their own informed decisions about medical care. The latter distributes responsibility for treatment decisions between the TGD person and health and other professionals. There is a collaborative process of working out what is in the person’s best interest. Not all power is vested in health professionals, who are responsible for creating and fostering conditions where shared responsibility can occur.

It was noted, however, that the outcome of a decision about hormone or other transitioning treatment affects only one party to the ‘shared responsibility’ model (i.e. the TGD person).

Clinician participants emphasised their strict legal duty to ensure treatment is both safe and appropriate, which requires a process of assessment in accordance with peer professional opinion[[1]](#footnote-1). They suggested that much of the mental health assessment is directed at excluding potential differential diagnoses, rather than confirming the presence of gender dysphoria, which is usually obvious. Clinicians also need to consider whether the experience the person is having is solely in the context of gender dysphoria or is complicated by other factors.

It was suggested that TGD people who have co-existent mental health or other relevant conditions are discriminated against in access to health care, with the presence of the co-existent mental health condition “used as justification for denying access to hormone therapy or surgery”. Equality of access for people with co-existing mental health conditions needs to be assured.

The question as to whether health funds’, superannuation funds’ and/or Centrelink’s requirement for a diagnosis may offend State and/or Federal antidiscrimination laws or the *Mental Health Act 2014* (Vic) was raised. It was suggested that legal advice is sought.

## Access to services

### Quality primary care

There was consensus that there is inadequate knowledge about and understanding of the needs of TGD people in the Australian primary care sector. All general practitioners should be capable of providing high quality primary health care to TGD people, which includes skills in appropriate communication and the prescription of hormone therapy as appropriate, but most do not have these skills. The services of other skilled primary care professionals including social workers, counsellors and psychologists should be accessible to TGD people in local communities.

There was discussion about the serious long term impacts of early negative interactions with primary care professionals, particularly for young people. TGD people are often placed at significant risk because poor early experiences of help-seeking deter them from seeking further advice and lead to ongoing barriers to communication with health care professionals.

### TGD-specific services

There are compelling reasons to improve access to TGD-specific specialist services. Waiting times for both paediatric and adult services are unacceptable (noting that RCH waiting times are reducing). Some people with very complex mental health conditions require much more specialist multidisciplinary support than they receive while waiting for service access. The significant risk of suicide by TGD people on waiting lists was discussed. The TGD community is concerned about an increasing number of people accessing mental health services in severe distress. Waiting times for voice feminisation services are also excessive, and there is no access to publicly-funded surgery.

Access for TGD people from culturally and linguistically diverse backgrounds was highlighted as especially problematic. Monash Health representatives reported there are 201 languages spoken within its general referral population.

The lack of access to surgical services is highly problematic. The Monash Clinic offers a small financial subsidy to a limited number of patients for private care. Procedures are often inappropriately viewed as cosmetic.

There are some high quality private medical and surgical services available, but these are not financially accessible to many TGD people, many of whom are under- or un-employed and financially disadvantaged.

The centralised nature of specialist adult services is also problematic, particularly as the clinic is currently located in Moorabin. There is no specialised service in rural Victoria.

Despite a currently supportive political environment, there is concern about the vulnerability of publicly-funded TGD services to political and/or policy change.

For all of these reasons, the service system is not considered either adequate or sustainable. This situation mirrors that in other states and territories, with the possible exception of the Australian Capital Territory.

## Elements of care

### Appropriateness of care

Participants reported aspects of current practice that are inappropriate and lead to poor relationships between TGD people and service providers. Irrelevant and intrusive questions asked on surveys were provided as an example. Providers confirmed the use of such survey tools is not ideal, but without resources to develop and validate new tools they continue to be used so there is a basis for evaluation of outcomes of care.

### Inclusion of non-binary people

Non-binary people were reported to experience particular difficulty accessing appropriate services. It was suggested that they are sometimes forced to mislead providers in order to access care.

### A broader focus on health and wellbeing

Participants expressed a desire for the service system to be designed, and services to be delivered, with a focus on meeting the holistic needs of TGD people. An integrated approach to the provision of health, education, housing, employment and justice services was strongly supported.

### Continuity of care between paediatric and adult services

While the RCH makes efforts to provide a complete service to late adolescents, to avoid the need for them to transfer between paediatric and adult services, an integrated service would be preferred.

### Peer support

Participants reported a very significant deficit in availability of support services for families of TGD people and their families. There were also reports of parents being pathologised.

### Consumer and community engagement

There is a lack of consumer reference or advisory groups to ensure appropriate engagement in service design and performance.

Participants consider there is an opportunity to more broadly disseminate information to TGD people and the wider community about existing specialist services.

### Provider diversity

TGD people seek choice and diversity of provider, with many having a preference for providers who come from their own community.

## Investment in education and research

The Monash Clinic employs a researcher (Riki Lane) 1 day per week. There is no other research investment in the Australian system, although there is a relatively strong international research base. It was suggested that there is a lack of familiarity in Australia with international research, and the Australian health care system has not responded to the evidence base about the significant unmet health care needs of TGD people.

# A lack of resources for education and development of clinicians and communities was also noted. There is currently no avenue for TGD training of primary care clinicians, psychologists and other counsellors, or specialists.

# Comparative systems strengths and weaknesses

Gavi Ansara, Manager Research and Policy, National LGBTI Health Alliance, presented the strengths and weaknesses of comparative systems. His presentation, illustrated with case studies, addressed concepts of:

* disparities between providers and consumers in power and authority;
* the intersection between medical and mental health care, the pathologisation of the gender dysphoria and the problem of mental health gatekeeping in the current system;
* conflicts of interest inherent in the current system;
* lack of knowledge and understanding in the health care provider network;
* reduced legal barriers to changing gender status in Australia, compared to some other systems;
* the illogicality of the assumption that endocrinologists are uniquely qualified to prescribe testosterone;
* the person-directed nature of aged care in Australia and the contrast with care for TGD people;
* the lack of influence of general practitioners and family members in a multidisciplinary approach to care of TGD people, with mental health professionals having the predominant influence;
* the rationale for a system that respects patient autonomy;
* the particular problems of equity and access experienced by non-binary people; and
* the power of consumer and community engagement in the service system.

There was further discussion about the tension between:

* the informed consent model; and
* the medical practitioner’s legal responsibility to provide care that accords with peer professional opinion.

Clinicians emphasised their legal duty to take a thorough history and form a view as to the appropriateness of treatment. Gavi clarified that he was not advocating demand-based care, but the process of agreeing to provide hormone therapy should not need to be more onerous than processes that apply to the prescribing of other medication with similarly significant long term effects. If a doctor does not wish to prescribe treatment, they should be obliged to refer the TGD person to another practitioner. In Gavi’s view, there is an unreasonable fear within the medical profession of long term consequences.

# What would ‘good’ look like?

Participants described a vision for a well designed TGD service system that delivers high quality care.

It was agreed that robust, sustainable services that offer high quality care (including both general health care for TGD people, and TGD-specific health care) should be available as ‘the norm’. In accordance with generally accepted frameworks, high quality care services for TGD people would meet agreed standards of:

* access;
* effectiveness;
* appropriateness;
* safety; and
* acceptability to consumers (including appropriate levels of respect, empathy, privacy etc.).

A well structured and resourced service system would also incorporate adequately funded education and research elements. It would be well-governed, supported by a skilled workforce, transparent, accountable and well-integrated with other relevant service systems including education, employment and justice.

## Primary care

### First point of contact

The first point of contact for TGD people seeking health care advice is often a general practitioner or other primary care provider (e.g. a psychologist, counsellor or social worker).

Participants consider that all primary care providers should be capable of providing high quality primary care services to TGD people, and there is a need for:

* education and training in TGD health to be included in the core curriculum for doctors and general practice trainees;
* a guideline for primary care providers on interacting with and providing care to TGD people; and
* education, training and tools to support its uptake.

Generally, following an initial presentation, it was agreed that 2-3 visits to a general practitioner would normally be required to enable engagement and assessment before a decision could be made to either proceed with hormone treatment in appropriate cases, or refer to a specialist centre. It was noted that many TGD people do not elect to receive hormone treatment.

Participants suggested that all general practitioners should be capable of initiating hormone treatment without further referral unless complicating health factors (e.g. serious mental health issues) are present. Ideally, the service system would be predominantly primary care based, and highly distributed to facilitate local access. However, very few providers in the current service system are willing and/or capable of providing a ‘one stop shop’ as described, instead referring TGD people for an independent specialist mental health assessment and/or initiation of hormone treatment. It was also noted that the Australian and New Zealand Professional Association for Transgender Health (‘**ANZPath**’) Guidelines recommend almost every TGD person seeking care should be referred to a mental health professional.

There was some discussion about the alarmingly high depression and suicide rates in the TGD community, and clinicians expressed some surprise that participants had obviously negative attitudes to involvement of mental health professionals in care. Participants emphasised that in many circumstances depression and suicide are not caused by intrinsic issues but by external reactions to the TGD person’s situation. The TGD community does not question the need for mental health support, but it does object to the notion of mental health services creating an obstacle that must be successfully negotiated before medically-controlled transition therapies can commence.

### Ongoing primary care

Willingness to provide ongoing hormone prescriptions to TGD people varies considerably, presumably based on competence and/or confidence to prescribe, however participants consider this to be a ‘usual’ health service that should be within the scope of practice of most general practitioners.

TGD people have a range of ‘general’ medical and other primary health care needs, which should be able to be met in local communities by general practitioners and other primary health care providers.

The Australian Medical Association and the Royal Australian College of General Practitioners (‘**RACGP**’) are believed to be interested in working with the TGD community and general practitioners to improve the ‘trans friendliness’ of general practice.

### A community-based network

Recognising the current limitations in general practitioner confidence and competence to provide care to TGD people, participants suggested that, as an alternative or interim step to development of a fully distributed primary health care system a tiered approach should be considered, incorporating a state-wide defined network of competent and/or accredited community-based providers. This network would provide peer mentoring for clinicians involved in TGD care. Two possible existing systems could be used- either establishing a community of practice via Primary Health Networks (advantage that these can include any primary care clinician), or a TGD special interest group thorough the RACGP (however this would only include GPs). Analogies were discussed including with current Victorian systems of:

* prescription of methadone and buprenorphine;
* publicly-funded sexual health clinics; and
* ‘section 100’ prescribing.

The sexual health clinic system has the advantage of publicly funded education and training. There is also a RACGP sexual health special interest group that links various GPs with a sexual health interest for peer support. The ‘section 100’ prescribing system is not ideal because there is only an initial training phase, following which there is no further workforce development.

Participants emphasised the need for a holistic psychosocial approach to care. Multidisciplinary teams of health care professionals (psychologists, counsellors, social workers, speech pathologists) and properly resourced peer support groups for TGD people and their families should be accessible in community settings. Community health centres (e.g. cohealth), specialist services such as the Zoe Belle Gender Centre and specialist youth services such as Frontyard Youth Service in Melbourne and GASP in Geelong were suggested as potentially suitable providers of such services because they are publicly funded, provide a range of complementary health and wellbeing services and are accessible to people with limited financial means. Participating general practitioners could be either co-located or affiliated in some way with such centres.

It was suggested that each of the six Victorian Primary Health Networks (‘**PHNs**’) should be charged with responsibility for ensuring an integrated service is developed within its geographic regions. The orientation and integration of services was highlighted as critically important:

|  |
| --- |
| *We are looking for a holistic centre, not psychiatrically based, also addressing housing, family needs, transition issues, linking people to peer support, helping people meet their educational needs, helping them into employment, a go-to place for all needs ... not a medical gate-keeping centre ... assistance with navigation, social support, Medicare, Centrelink. Many of our community are under-achievers and don’t know where to get help. We want somewhere where that is in place. Do it with us, not to us.”*Workshop participant |

## Secondary/tertiary care

At present, the secondary and tertiary care system is centralised through the RCH and Monash Health. The RCH is establishing ‘spoke’ centres in Albury-Wodonga, Geelong and the Mornington Peninsula. Monash Health does not offer any ‘spoke’ services.

It was agreed that access standards for secondary and tertiary services are required, addressing waiting times, affordability and geography.

It was suggested that a public sector ‘institute’ or Centre of Excellence approach should be adopted with a single health service, actively affiliated with a University, assuming responsibility for system-wide leadership in care, education, training, and research. Ideally, paediatric, adolescent and adult services would be integrated, to eliminate difficulties associated with transition between services.

The institute would provide care to complex clients from across the state. As well, it would lead state-wide service system development, including both provision and leadership of a consistent ‘best practice’ model of care that meets defined quality standards. As far as possible, the model of care would be non-medicalised and would take a holistic approach to wellness. The cancer centre model in Victoria was discussed as a potential exemplar.

The institute would also take a lead role in educating and training the state-wide workforce. It would establish a research program. It would monitor the performance of the service system, identifying service, workforce and research gaps and advocating for them to be addressed. It would be a genuine ‘centre of excellence’ in TGD care, research and education.

Regional service spokes may be appropriate, depending on client need.

Surgical services need to be provided as part of the state-wide service system. Ideally, these would be accessible regionally, although there is a paucity of surgeons with appropriate skills and the service system needs to be developed. It was suggested that if surgery were to occur in the public sector workforce issues would be addressed, as the public sector is the main site of surgical training.

The risks to accountability of establishing a monopoly institute were discussed. It was agreed that the governance of such an institute would be critical to its success and sustainability. True community engagement in governance would be required, in accordance with recognised governance standards in health care. Transparency of performance, including through systematised evaluation processes, was identified as a key element of good governance.

The vision is of a genuine ‘one stop shop’ service system, led by an institute, with integrated service hubs in each PHN region, bringing relevant services together to address the needs of clients over their lifetimes.

There was discussion about how the private sector would integrate with such a system. It was agreed that the vision is for quality care through a planned, distributed and highly accessible community-oriented service system, regardless of the source of funding for particular services. Private sector services should be conceptualised as key elements of an overall system.

# Service development initiatives

Participants reported the following service development initiatives:

* The Victorian AIDS Council is commencing a new community-based service for the TGD community. Dr Pauline Cundill will be providing general practitioner services from the PRONTO! site. The vision is of affirmative practice and a community led model of care. A community advisory group will be established.
* Discussions have commenced with North West PHN about the possibility of piloting a ‘Healthpathways’ project[[2]](#footnote-2) for LGBTI care in its geographic region. There may also be the potential to develop a TGD-specific pathway. The objective would be to encourage general practitioner participation in a pilot project, and then to subsequently apply successful processes in other PHNs.

# Other issues discussed

Some participants raised concerns about the inequity of power between workshop participant, the difficulty in establishing trust between the TGD community and providers and a desire for the TGD community to have its own ‘space’ to deal with the issues discussed at the workshop, without clinicians present.

Clinician participants emphasised their capacity and willingness to assist, and the need for collaborative work between the TGD community and the provider community to achieve a better system of care.

# Recommendations from the workshop

## Preferred directions/principles

Discussion from the workshop identified the following preferred key directions/principles for the development of a new model of service provision for TGD people in Victoria:

* Move away from a pathologising approach to a gender dysphoria diagnosis.
	+ Shift towards a non-gatekeeper participatory system based on the ‘Informed consent’ or ‘shared responsibility’ models.
* Improve access to TGD services:
	+ Improve inclusion of non-binary people.
	+ Improve access to peer support.
	+ Develop skilled and inclusive local primary care services to meet the primary health and wellbeing needs of most TGD people.
	+ Maintain/develop specialist services for system-wide leadership and referral of complex cases.
	+ Reduce waiting times and cost barriers that impair access to specialist services.
* Improve access to and integration with broad health and wellbeing services.
* Ensure continuity of care between paediatric and adult services.
* Develop system-wide research and education capability.

Additional work will be undertaken to refine these directions into a vision and short, medium and long term objectives for the TGD service system.

## Initial ideas for change

Workshop participants contributed the following initial ideas for shifting towards a service system based on the directions/principles above:

### Short term actions

1. Provide extra funding for the Monash Clinic, to reduce waiting times for assessment in the short term to no more than three months.
2. With the RACGP, explore the possibility of incorporating standards for the care of TGD people in the RACGP’s practice accreditation standards (which are currently under revision).
3. Expand and support the existing Monash Health training and supervision network.
4. Expand and support existing peer support groups.

### Medium term actions (1-3 years)

1. Develop and promulgate guidelines for the primary care of TGD people.
	1. This would include work on the requirements for prescribing hormones by GPs. In particular, understanding the perspective of ANZPATH and the medical indemnity organisations on whether they would endorse trans- experienced GPs prescribing hormones after their own assessment rather than after a psychiatrist or clinical psychologist assessment (for people without complex psych issues of course).
2. Establish, distribute and support the uptake of education modules (using a variety of media including video- and internet-based technologies) comprising:
	1. An introduction to the care of TGD people.
	2. Management of hormone therapy for TGD people.
	3. Training for mental health clinicians in TGD care.
	4. A certification program for general practitioners who wish to develop and/or formalise their special skills in the care of TGD people.
	5. An education module for inclusion in the undergraduate medical curriculum.
3. Establish and support a state-wide network of skilled and interested primary care and mental health professionals.
4. Explore possibilities to develop a TGD ‘HealthPathway’, through North West PHN initially and subsequently in all PHNs.
5. Pilot a comprehensive, integrated community-based TGD service.

### Long term actions (3-5 years)

1. Develop a state-wide centre of excellence for TGD care, research and education.

## Other recommendations

Other suggestions emerging from the workshop included:

1. Review and determine whether the requirement of various government and private entities for a diagnosis before TGD people can access entitlements and/or benefits breaches equal opportunity, mental health or other laws.
2. Analyse and report on the standard of care clinicians need to demonstrate when deciding whether to initiate hormone, surgical or other treatment of TGD people, to meet the standard of care for professionals as defined in section 59 of the *Wrongs Act 1958* (Vic).
3. Seek advice as to whether health funds’, superannuation funds’ and/or Centrelink’s requirement for a diagnosis may offend State and/or Federal antidiscrimination laws or the Mental Health Act 2014 (Vic).

Heather Wellington
31 March 2016

# ATTACHMENTS

# Attachment 1 – Workshop agenda

|  |  |
| --- | --- |
| Time and date | 9.00am – 1:00pm Friday 11 March 2016  |
| Facilitator | Heather Wellington |
| Location | Leichardt Room – Dialouge, 27-29 Lt Lonsdale St (formerly Urban Workshop conference centre) |

|  |  |  |  |
| --- | --- | --- | --- |
| Item | Time | Description | Presenter |
|  | 9:00-9:15 | Welcome and aims | Rowena AllenHeather Wellington |
|  | 9.15-9.40 | Context:* Community perspective
* RCH
* Monash Gender Clinic
* Current Victorian/Australian TGD practice
 | Jeremy WigginsMichelle TelferJaco ErasmusRiki Lane |
|  | 9:40-10:30 | Issues with the current system | All |
|  | 10:30-10:45 | Comparative systems strengths and weaknesses  | Gavi Ansara |
|  | 10:45-11:00 | Break |  |
|  | 11:00-11:50 | Principles to create an ideal system  | All |
|  | 11:50-12:20 | Support and guidance for workers |  |
|  | 11:20-12:50 | Pathway and products required for change  | All |
|  | 12:50-1:00 | Close | Heather Wellington |

# Attachment 2 – Background paper

Trans health service model workshop
**Background - Models of care and pathways for adults**

### Context

There is increasing demand for both adult and child trans health services in Victoria. Demand for the Monash Health Gender Dysphoria Program services has been trending up since 2011-12 and is expected to continue to increase. The clinic currently has an average waiting period of nine months.

### Systems design and pathways.

An important issue, which is currently contested, is the appropriate pathway for the commencement of medical treatment for trans people.

Currently the most widely followed guideline on this issue is the Standards of Care (SOC) produced by the World Professional Association for Transgender Health (WPATH). The current version (v7) of the SOC was produced in 2011 and is intended to reflect available science and expert professional consensus, but acknowledges that most of the research and experience comes from a North American and Western European perspective.

The SOC are intended to provide guidance relating to a wide range of assistance that may be required, including primary care, gynaecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counselling, psychotherapy), and hormonal and surgical treatments.

They are intended to be flexible guidelines:

The SOC are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender-nonconforming people. Clinical departures from the SOC may come about because of a patient’s unique anatomic, social, or psychological situation; an experienced health professional’s evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm-reduction strategies (p.2).

### Commencing hormone treatment

The SOC state that hormone therapy can be initiated by a physician with a referral from a qualified mental health professional, but that alternatively this may be done by a health professional who is appropriately trained in behavioural health and competent in the assessment of gender dysphoria.

The criteria for the initiation of hormone therapy are:

1. Persistent, well-documented gender dysphoria (Gender dysphoria defined as discomfort or distress caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth)
2. Capacity to make a fully informed decision and to consent for treatment
3. Age of majority in a given country
4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

Appropriate qualifications for a mental health professional are defined broadly as a master’s degree or equivalent in psychology, psychiatry, social work, mental health counselling, marriage and family therapy, nursing, or family medicine with specific training in behavioural health and counselling. They recommended that mental health professionals develop and maintain cultural competence to facilitate their work with trans and gender diverse people.

Although a mental health screening and/or assessment is required in the SOC for referral to hormonal and surgical treatments, psychotherapy, although highly recommended, is not a requirement. The SOC do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery, however this is still common practice.

An alternative approach that is being used in some community health centres in the United States is known as the “informed consent” model. This approach has developed protocols under which the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary environment, rather than diagnosis or treatment of gender dysphoria. A psychosocial assessment is undertaken but there is no requirement for psychotherapy/counselling unless the patient requests it or significant mental health concerns are identified.

There is support for the Informed Consent approach among many trans people and advocacy organisations (including the National LGBTI Health Alliance) based on the argument that trans people should not be required to attend therapy to prove a desire to change their gender and then be granted permission to change their bodies. Rather individuals should be able to self-determine, with therapy as an option not a requirement. This would be consistent with other medical procedures such as cosmetic plastic surgery, vasectomy, tubal ligation, and abortion.

The SOC note informed consent models as being consistent with that guideline, but describe the differences between approaches as follows:

The difference between the Informed Consent Model and SOC, Version 7, is that the SOC puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription (p.36).

However, as mentioned above, in addition to alleviating gender dysphoria, informed consent approaches do not require gender dysphoria to either be present or diagnosed, as a precondition for initiating hormone therapy.

### Informed consent in practice

A recent US study examined the use of an informed consent model at 12 unique sites representing a total of 1,944 patients that had been treated for an average of 3.13 years.[[3]](#footnote-3) One-quarter of these clinics were primarily LGBT focused, 75% were community/non-profit and the same proportion urban. As the following table shoes, seventeen known cases of regret were reported across all sites (0.8%), with three cases of regret (0.1%) leading to reversal of gender transition.

**Site details and cases of regret**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Site** | **Total patients treated** | **Years offering IC model** | **Average yrs patients under care** | **Number of known cases of regret** | **Transition reversal** | **Legal filings** |
| *ALL* | *1944* | *6.96 avg* | *3.13 avg* | *17 (0.8%)* | *3(0.15%)* | *0* |
| 1 | 800 | 20 | 9 | 2 | 0 | 0 |
| 2 | 35 | 0.5 |  | 0 | 0 | 0 |
| 3 | 8 | 3 | 3 | 0 | 0 | 0 |
| 4 | 400 | 4 | 3 | 2 | 1 | 0 |
| 5 | 6 | 0.5 | 1 | 0 | 0 | 0 |
| 6 | 150 | 1.5 | 1.5 | 10 | 0 | 0 |
| 7 | 300 | 32 | 5 | 1 | 0 | 0 |
| 8 | 120 | 8 | 3 | 2 | 2 | 0 |
| 9 | 12 | 5 | 3 | 0 | 0 | 0 |
| 10 | 75 | 5 | 3 | 0 | 0 | 0 |
| 11 | 13 | 1 | 1 | 0 | 0 | 0 |
| 12 | 25 | 3 | 2 | 0 | 0 | 0 |

As per the table below, five sites required a minimum number of visits (1 or 2) prior to beginning treatment), and three sites required a waiting period prior to beginning treatment (average 19 days, with one clinic reporting the widest range of 0 to 30 days). Nine of the 12 sites used pre-printed materials as part of the consent process.

**Characteristics of informed consent processes**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Site | Total intake time with any mental health provider | Total intake time with any medical provider | Minimum number of visits prior to initial? (Y/N) | Number of required visits | Required waiting period? | Period (days) | Pre-printed materials used? |
| ALL | 2.36 hr avg | 1.1 hr avg | 5/12 | 1.5 avg | 3/12 | 19 avg | 9/12 |
| 1 | 2 | 1 | Y | N/A |  |  |  |
| 2 | 0 | 1 |  |  |  |  | Y |
| 3 | 0.5 | 0.5 |  |  |  |  | Y |
| 4 | 0 | 1 | Y | 0-2 | Y | 0-30 | Y |
| 5 | 2 | 1 | Y | 2 | Y | 14 | Y |
| 6 | 2 | 2 |  |  |  |  | Y |
| 7 | 3 | N/A |  |  |  |  | Y |
| 8 | 0 | 0.75 | Y | 2 | Y | 28 |  |
| 9 | 0 | 0.25 |  |  |  |  |  |
| 10 | 1 | 1.5 | Y | 2 |  |  | Y |
| 11 | 6 | 2 |  |  |  |  | Y |
| 12 | 0 | 2 |  |  |  |  | Y |

Only four of the 12 sites required any contact with a mental health provider prior to initiation of hormone treatment, with one of these using a psychiatrist, the other three using a psychologist and/or caseworker/counsellor.

**Staff types with direct face-to-face patient contact during the informed consent intake process**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Site | Physician (nonpsychiatrist) | Nurse practitioner or physician assistant | Nurse | Psychologist | Psychiatrist | Counsellor or caseworker |
| ALL | 11/12 | 3/12 | 3/12 | 2/12 | 1/12 | 2/12 |
| 1 | 1 |  |  |  |  |  |
| 2 | 1 |  | Y |  |  |  |
| 3 | 1 |  | Y |  |  | Y |
| 4 | 1 | Y |  |  |  |  |
| 5 |  |  |  | Y |  |  |
| 6 | 1 | Y | Y | Y |  | Y |
| 7 | 1 |  |  |  | Y |  |
| 8 | 1 |  |  |  |  |  |
| 9 | 1 |  |  |  |  |  |
| 10 | 1 |  |  |  |  |  |
| 11 | 1 | Y |  |  |  |  |
| 12 | 1 |  |  |  |  |  |

The authors suggest that the low use of mental health professionals during intake indicates that basic medical needs of transgender patients are in some settings effectively met with minimal or no involvement of a mental health provider. They propose that a properly trained hormone provider who is able to initiate hormone therapy without a mental health referral may lead to more constructive and multifaceted connections with patients, which can then remove burden of gatekeeping from the mental health provider who is free to establish a more trusting, supportive, and facilitative relationship with patients.

In this regard they cite a small retrospective survey of Finnish trans people that found that a majority of respondents lied to psychiatrists “in order to meet the expectations of the psychiatrist and sought hormone therapy on their own when the psychiatrist was denying or delaying it”. This has also been reported anecdotally in the Victorian context.

### Surgical intervention

For surgical intervention as either breast/chest or genital surgeries the SOC requires documentation of persistent gender dysphoria by a qualified mental health professional, with some surgeries having additional criteria including feminising/masculinising hormone therapy and one year of continuous living in a gender role congruent with one’s gender identity. These criteria are as follows:

Breast/chest surgery criteria:

1. Persistent, well-documented gender dysphoria – one referral from MH professional
2. Capacity to make a fully informed decision and to consent for treatment
3. Age of majority in a given country
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is NOT a requirement for FtM surgery, but recommended for 12 months for MtF.

Genital surgery criteria:

1. Persistent, well-documented gender dysphoria – TWO referrals from MH professional
2. Capacity to make a fully informed decision and to consent for treatment
3. Age of majority in a given country
4. If significant medical or mental health concerns are present, they must be reasonably well controlled
5. 12 continuous months of hormone therapy as appropriate to the patient’s gender goals (unless hormones are not clinically indicated for the individual).
6. For metoidioplasty or phalloplasty, 12 continuous months of living in a gender role that is congruent with their gender identity.

### Australian application

The WPATH Standards of Care, have been endorsed by the Australia and New Zealand Professional Association for Transgender Health (ANZPATH). The Standards are currently enacted narrowly in Victoria and generally require that a psychosocial assessment and psychotherapy is undertaken by a psychiatrist, who then makes an assessment and if judged appropriate provides a letter of support to be taken to a GP for the provision of a prescription.

Other than psychiatrists at the Monash Gender Dysphoria Clinic there are only four clinical psychologists and no other mental health professionals that undertake assessments (possibly due to a lack of training opportunities). This results in substantial delays in accessing hormone treatment and places additional pressure on the state funded Monash Gender Clinic. The cost of these sessions to patients can be an additional barrier to access.

### Requirement for specialist care

The role of endocrinologists in hormone treatment for trans people is another area of concern and subject to some difference of opinion amongst consumers.

Under recent changes by the Commonwealth Government designed to curb the perceived over prescribing of testosterone, GPs now have to consult with a specialist paediatric endocrinologist, urologist, endocrinologist or registered member of the Australasian Chapter of Sexual Health Medicine before they can prescribe testosterone for a patient. This authorisation is only required at the start of treatment, or for patients already taking testosterone, it will be required for their next prescription.

This requirement may be seen as inconsistent with the WPATH Standards of Care which state that screening and management of long-term hormone use fall more uniformly within the scope of primary care rather than specialist care.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners, physician assistants, and primary care physicians. Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved. Many of the screening tasks and management of comorbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (p.41).

They indicate that an “experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder”. Lack of formal training in transgender medicine for both primary health professionals and endocrinologists can impede their effectiveness in delivering hormone therapy.

The new requirement for involvement of a specialist causes concern to some trans men who have previously initiated testosterone treatment and who may now face additional costs and delays due to being required to see an endocrinologist when seeking new prescriptions. The National LGBTI Health Alliance has written to the Commonwealth Health Minister recommending that the testosterone prescribing rights of GPs be retained, without the requirement to consult with other specialists. They argue (consistent with the Standards of Care) that GPs are most appropriately placed to initiate and manage hormone therapy for all but a small group of patients with complex medical needs.

Notwithstanding this issue, access to endocrinologists remains important to some trans people due to specific medical needs (such as coexisting metabolic/endocrine disorders or difficulty achieving appropriately balanced hormone levels), or a lack of adequately trained GPs. Some individuals may have a preference for seeing an endocrinologist due to a belief that they provide superior care, although evidence indicates GPs are actually well placed to provide this.

In this context, it is problematic that there are few endocrinologists willing to undertake assessments and management of trans patients, apparently due to liability concerns and/or because this treatment is seen as experimental. It is widely reported that there are only two willing practitioners in the Victorian public system. There do not appear to be any specific state policy related impediments to their involvement.

Integration of broader psychosocial support services and the appropriate way to achieve this is another area of concern.

### World Medical Association statement on transgender people

In October 2015 the World Medical Association (WMA), an international and independent confederation of free professional medical associations representing 102 national medical associations, released a Statement on Transgender People.

The preamble acknowledges that being transgender does not in itself imply any mental impairment, and that transgender people are often denied access to appropriate and affordable transgender healthcare (e.g. sex hormones, surgeries, mental healthcare) due to, among other things, the policies of health insurers and national social security benefit schemes, or to a lack of relevant clinical and cultural competence among healthcare providers. Transgender persons may be more likely to forego healthcare due to fear of discrimination.

The statement makes a number of recommendations as follows:

1. The WMA emphasises that everyone has the right to determine one’s own gender and recognises the diversity of possibilities in this respect. The WMA calls for physicians to uphold each individual’s right to self-identification with regards to gender.
2. The WMA asserts that gender incongruence is not in itself a mental disorder; however it can lead to discomfort or distress, which is referred to as gender dysphoria (DSM-5).
3. The WMA affirms that, in general, any health-related procedure or treatment related to an individual’s transgender status, e.g. surgical interventions, hormone therapy or psychotherapy, requires the freely given informed and explicit consent of the patient.
4. The WMA urges that every effort be made to make individualised, multi-professional, interdisciplinary and affordable transgender healthcare (including speech therapy, hormonal treatment, surgical interventions and mental healthcare) available to all people who experience gender incongruence in order to reduce or to prevent pronounced gender dysphoria.
5. The WMA explicitly rejects any form of coercive treatment or forced behaviour modification. Transgender healthcare aims to enable transgender people to have the best possible quality of life. National Medical Associations should take action to identify and combat barriers to care.
6. The WMA calls for the provision of appropriate expert training for physicians at all stages of their career to enable them to recognise and avoid discriminatory practises, and to provide appropriate and sensitive transgender healthcare.
7. The WMA condemns all forms of discrimination, stigmatisation and violence against transgender people and calls for appropriate legal measures to protect their equal civil rights. As role models, individual physicians should use their medical knowledge to combat prejudice in this respect.
8. The WMA reaffirms its position that no person, regardless of gender, ethnicity, socio-economic status, medical condition or disability, should be subjected to forced or coerced permanent sterilisation (WMA Statement on Forced and Coerced Sterilisation). This also includes sterilisation as a condition for rectifying the recorded sex on official documents following gender reassignment.
9. The WMA recommends that national governments maintain continued interest in the healthcare rights of transgender people by conducting health services research at the national level and using these results in the development of health and medical policies. The objective should be a responsive healthcare system that works with each transgender person to identify the best treatment options for that individual.

# Attachment 3 – List of attendees

|  |  |
| --- | --- |
| **Name** | **Agency** |
| **Community Members** |  |
| Rowena Allen | LGBTI Commissioner |
| Jeremy Wiggins | Victorian Aids Council |
| Ruth McNair | Dept of General Practice, University of Melbourne |
| Sally Goldner | Transgender Victoria |
| Sam Lillit | Y-Gender |
| Zoe Birkenshaw | Zoe Belle Gender Collective |
| Andrew Eckland | FTM Shed |
| Joe Latham | Val's Café |
| Cannon O'Saurus | Cobaw Community Health |
| Riki Lane | Monash |
| Brenda Appleton | Transgender Victoria |
| Kai Clancy | trans Aboriginal communities - Sistergirls and Brotherboys. |
| Margot Fink | Minus-18 |
|  |  |
| **Professional Members** |  |
| Dr Jaco Erasmus | Monash Gender Dysphoria Clinic |
| George Osman  | Monash Health |
| Georgia Dacakis | Speech pathologist/LecturerLa Trobe Communication ClinicLa Trobe University |
| Donna Eade (nurse) | Gender clinic RCH |
| Dr Nick Brayshaw | GP at Kardinia Health in Geelong |
| Meagan Bartle | Peninsula Pride in Frankston |
| Ben Callegari | Privte psychologist |
| Anna Brown | Human Rights Law Centre |
| **Departmental staff** |  |
| Martin Turnbull | DHHS |
| Daniel Perkins | DHHS |
| David Wain | DPC |
|  |  |
|  |  |

# Attachment 4 – Community survey report

|  |
| --- |
| Trans health service model workshop |
| Community survey results summary |

The online trans community survey contained seven questions (See appendix) asking about how important different health services were for trans and gender diverse people in Victoria, how easy or difficult they personally had found these to access and then a number of open ended questions asking about the types of difficulties faced accessing services, services not available, support and knowledge of health professionals, and how the system could be improved.

The survey was promoted via community networks and received 117 responses, 81 per cent of whom were trans or gender diverse themselves, with the remainder being parents, partners of family members of trans or gender diverse people.

Figure 1: Respondents by status (percentage) (n-113)

The first two questions asked how important selected services were for trans or gender diverse people in Victoria and how difficult people had found these to access personally.

As Figures 2 and 3 show, services that were reported to be most important to trans or gender diverse people were hormone therapy and mental health services followed by GPs, social welfare and endocrinologists/other specialists.

Figure 2: Number of respondents reporting the following services very difficult to access and very important for trans and gender diverse people in Victoria.

Figure 3: Number of respondents reporting the following services difficult/very difficult to access and important/very important for trans and gender diverse people in Victoria.

Surgical therapy was reported as the most difficult to access, followed by hormone therapy, mental health services and social welfare.

Figure 4: Respondents reporting it difficult/very difficult to access the following types of transition related services in Victoria

Cost was the most commonly identified difficulty in accessing services, followed by health professional’s lack of knowledge, problems with GPs and the complexity of the process.

Figure 4: Difficulties reported accessing services (n=94)

The two services that people most commonly reported not currently having access to but wanting were mental health services and surgery, followed by general sexual health and hormone therapy. A smaller number of people mentioned other services such as general support services, welfare/social services, speech, hair removal and children’s support.

Figure 6: Are there any services you would like to have access to, but currently do not? (n=83)

The bulk of respondents (53) reported that they had not found health professionals knowledgeable, 27 reported mixed experiences and 15 that they have found them knowledgeable.

Figure 7: Have you found health professionals to be knowledgeable and supportive? (n=95)

The question asking about ways in which the system could be improved gained a wide range of responses, with education for health professionals clearly the most commonly mentioned item, followed by low/no cost surgery, and the use of an informed consent or similar approach to make hormone access easier. Better information and resources about services and pathways was the fourth most commonly mentioned item and included suggestions for a website, a database/registry of services, and information about navigating the system.

Figure 8: What would you most like to see changed to create a better system for supporting trans and gender diverse people in Victoria? (n=103)

### Appendix - Questions

1. Are you a?
	* Trans or gender diverse person
	* A parent of a trans or gender diverse person
	* Other:
2. How important are the following services for trans and gender diverse people in Victoria? (Very important, Important, Somewhat important, Not very important, Not at all important)
* GPs
* Mental health services (e.g., assessment, counselling, psychotherapy)
* Hormonal treatment
* Surgical treatment
* Gynecologic and urologic care
* Reproductive options
* Voice and communication therapy
* Endocrinologists or other specialists
* Social or welfare services
1. Personally, how easy or difficult have you found it to access the following types of transition related services in Victoria? (Very easy, Easy, Neither easy or difficult, Difficult, Very difficult, N/A)
* GPs
* Mental health services (e.g., assessment, counselling, psychotherapy)
* Hormonal treatment
* Surgical treatment
* Gynecologic and urologic care
* Reproductive options
* Voice and communication therapy
* Endocrinologists or other specialists
* Social or welfare services
1. Please tell us about any difficulties you have experienced accessing these services:

1. Are there any services you would like to have access to, but currently do not?

1. Have you found health professionals to be knowledgeable and supportive? If not how has this been lacking?

1. What would you most like to see changed to create a better system for supporting trans and gender diverse people in Victoria?

# Attachment 5 – Practices and guidelines for Australian primary care physicians working with trans and gender diverse people

1 International guidelines and other documents

2 Brief outline of current Victorian/Australian situation

3 Brief summary of existing Australian guidelines Bearman/Northside/Atkinson

4 “informed consent models” and how they are situated in the Australian situation

## Purpose of the document

This document has been prepared to inform the development of a best practice consensus guide for the care of trans and gender diverse (TGD) people in Australia.

Internationally, primary care clinicians are increasingly providing care for TGD people, either as shared care providers with TGD expert clinicians, or as primary providers of hormone therapy and psychosocial care. To date, there has been no guide for GPs and other primary care clinicians in Australia, who are also beginning to enter this area. This document sets out the current practices and guidelines available to inform this work.

It has been developed by Dr Riki Lane, with input from TGD expert clinicians involved in the Australian and New Zealand Professional Association for Transgender Health (ANZPATH).

ANZPATH has the following aims:

* To promote within professional training programs, the subjects of the health, rights and well-being of people who experience difference in sexual formation and/or gender expression.
* To serve as a forum for and promote communication and collaboration amongst professionals involved in the health, rights and well-being of people who experience difference in sexual formation and/or gender expression.
* To encourage, promote and share research in the fields of the health, rights and well-being of people who experience difference in sexual formation and/or gender expression.
* To develop best practices and supportive policies which promote the health, rights and well-being of people who experience difference in sexual formation and/or gender expression.
* To establish a known network of professional service providers in the fields of the health, rights and well-being of people who experience difference in sexual formation and/or gender expression.

## 1 Key international protocols

**WPATH Standards of Care (SOC) 2011**

The World Professional Association for Transgender Health (WPATH) is the only international professional association specifically around transgender health. The Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People Version 7 2011 (SOC) is the key international document providing clinical guidance for all medical professionals in transgender health care. It aims to gather the best evidence, and recognises the US/Western European research bias; thus requiring adaptation for other contexts.

Compared to previous versions of the SOC, v7 is more flexible and advocates a collaborative approach with clients to achieve the best outcome. They “acknowledge the role of making informed choices and the value of harm reduction approaches [and] recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments.”

The guidelines support flexibility in order to meet the diverse health care needs of TGD people: “criteria … for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them” – such departures should be recognized, explained and documented.

**Endocrine Society 2009**

Hembree 2009 Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline JCEM 94(9):3132-54

Evidence-based guideline developed in a consensus process including US and European general and Paediatric Endocrinology societies and WPATH. Recommends: “a safe, effective hormone regimen that will 1) suppress endogenous hormone secretion … 2) maintain sex hormone levels within the normal range for the person’s desired gender. A mental health professional (MHP) must recommend endocrine treatment and participate in ongoing care … The endocrinologist must confirm the diagnostic criteria the MHP used … we do not recommend endocrine treatment of pre-pubertal children. We recommend treating transsexual adolescents (Tanner stage 2) by suppressing puberty with GnRH analogues until age 16 years old, after which cross-sex hormones may be given.”

**Center of Excellence for Transgender Health University of California San Francisco (UCSF) 2011**

Website at <http://transhealth.ucsf.edu/protocols> - widely referenced by relevant health professionals

***Useful recent publications***

**American Psychological Association (APA) 2015 psychology practice guidelines** (not treatment)

**UK NHS GP trans 2008 Guidance** **for GPs, other clinicians and health professionals on the care of gender variant people. Transgender wellbeing and healthcare**

**Various Informed Consent models:**

**Tom Waddell 2013 Protocols** **for Hormonal Reassignment of Gender**: This clinic is the originator of the “Informed consent” approach.

**Sherbourne 2015 Guidelines And Protocols** **For Hormone Therapy**, **Raj 2015** – both work on a “Collaborative care and informed consent model”. They maintain the need for differential diagnosis, but where it is clear cut, they shift that responsibility from psychiatry to primary care.

## 2 Outline of current Victorian/Australian TGD health care

There are no agreed Australian consensus guidelines for transgender health care. ANZPATH refers to the WPATH SOC and the Endocrine Society guidelines. Specialist clinics, such as at Monash Health **Gender Dysphoria Clinic** and the **Gender Clinic** at the Royal Children’s Hospital Melbourne, have their own guidelines. Similarly, some primary health care clinics with a large TGD clientele have developed formal guidelines.

In Victoria, the key services for trans health are:

**TGD community support groups** – Transgender Victoria, Y-Gender, and several other groups play a crucial role in supporting TGD people. The Safe Schools Coalition provides considerable support for TGD young people in schools. Various SSAGD youth groups support TGD young people in rural and urban areas.

**Primary Health Care** – Northside Clinic and Prahran Market Clinic have been the key providers. The Victorian AIDS Council Centre Clinic in St Kilda has also been important, and has now established a new trans clinic in Fitzroy. Other TGD people see a variety of GPs, with differing levels of expertise.

**Mental health counselling** – private psychologists, psychiatrists, some public services such as Drummond Street Services

**Psychiatrists**: Public specialist Clinics – RCH, Monash GDC; private providers

**Other specialists**: endocrinologists, surgery. Public RCH, financial support from GDC; private providers for adults

**Other allied health**: social work – private or public GDC/RCH, speech pathology – private or Latrobe University

Many of the relevant health professionals are listed on the ANZPATH site

<http://www.anzpath.org/about/service-providers/victoria/>

## 3 Existing Australian Primary Care guidelines

**Please note that this is a preliminary summary, which will be fed back to the relevant clinics and other health professionals for refinement.**

Many primary care physicians in Australia work without written protocols: instead referring to WPATH SOC and Endocrine Society guidelines.

The most formalised guidelines appear to be: Northside Clinic North Fitzroy (Ruth McNair); Brisbane Gender Clinic (Gale Bearman). (Websites slightly out of date; up to date presentations provided). There is also a useful overview of general approach for GPs in Atkinson & Russell 2015. Australian Family Physician Vol.44, No.11. This summary is drawn from that material, and only considers assessment, not hormone protocols.

**Assessment**

The general practitioner (GP) or other primary health clinician (including nurse or other community health provider) is often the first contact point with the health system. They will often be the prescriber and manager of hormone treatments after the initial specialist assessment. Transgender health care involves “shared responsibility: patient, generalist hormone prescriber, mental health professional, other professionals (e.g. Endocrinologist or Gynaecologist).” (Bearman)

Care is taken to use preferred names and pronouns in establishing the relationship with the TGD person. (Atkinson)

Management for TGD adults may involve the following steps:

1 An initial evaluation that includes discussion of a patient’s physical transition goals and expectations, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss expected effects of feminizing/masculinizing medications and possible adverse health effects and reproductive options

3. Confirm capacity to understand risks and benefits of treatment and to make an informed decision.

4. Provide ongoing medical monitoring, including hormone effectiveness and side effects.

5. Communicate as needed with a patient’s regular GP, mental health professional (MHP), and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. (Northside)

The GP will do an initial assessment to determine a diagnosis of gender dysphoria. They will usually refer to a psychiatrist or clinical psychologist to confirm their diagnosis and to assess any psychiatric conditions. Most clinicians require that step (Northside, Prahran, VAC) but some (Bearman, Russell) will rely on their own mental health assessment when necessary – e.g. if an MHP is not available.

The client would be recommended to have counselling with a psychologist for assistance with transition and to address with any other mental health issues. The degree of counselling, physical examinations, and laboratory evaluations should be individualized to a client’s needs. Where clients are seeing the Monash Health GDC, the GP will act in line with their protocols (Northside).

A checklist for assessment by a GP with mental health skills or by a MHP would include the initial evaluation plus:

* Gender History – Identity, Expression, disclosures, body transformations
* Gender literacy – level of knowledge, perceptions of what would help, expectations
* Psychiatric history, trauma, current distress, anxiety, depression, personality vulnerability, self-harm
* Substances
* Medical history including medication
* Surgical history
* Family History – Medical, Psychiatric, Social
* Relationships, sexual history, fertility concerns
* Vocational history, employment, financial and insurance issues. (Bearman)

Orange flags that require the GP to seek advice or referral include:

* Complex trauma, dissociation, severe self-harm, poorly-functioning Borderline Personality
* Complex history on Autistic Spectrum
* Complete lack of all social support
* Intellectual Disability or multiple specific learning disabilities
* Personal history of stroke, pulmonary embolism, breast cancer. (Bearman)

After mental health assessment is complete, and assuming that the client is seeking hormone treatment, they will be given a consent form to carefully consider, and sign.

**Management**

After assessment, the GP’s role is to:

* Commence & monitor hormones;
* Co-Referral for surgery no earlier than 12 months after commencing hormone treatment, or earlier if the surgeon/psychiatrist agree (MHP referrals also required for surgery- 1 for ‘top’ surgery, 2 (including 1 psychiatrist) for ‘bottom’ surgery.
* Provide general practice care (standard physical/mental health care) to the patient or share care patient with their usual GP.
* Prescribing GPs should be familiar with the latest version of the WPATH Standards of Care and abide by these standards wherever possible. (Northside)

## 4 Gate-keeping and assessment for gender affirmation hormones and surgery

There appear to be no Australian GPs following an “informed consent” model in the sense it is used in the USA (e.g. Waddell 2013). All primary care physicians require a mental health assessment to rule out differential diagnoses. There are some PC physicians who will start hormones without an *external* *MHP* assessment – this is where they consider themselves competent due to extensive experience, and often where appropriate MHPs are not available in any reasonable timeframe

Unlike many other jurisdictions, GPs in Australia gate-keep access to specialists and to prescriptions. In general PHC research, it is questioned whether GPs have adequate skills for gate-keeping MH. In some other jurisdictions (e.g. Netherlands, Switzerland, UK), there is a shift to GPs playing a larger role in MH generally. In Australia, whilst some play an important counselling role, many are prescribers and referrers. Few GPs have the skills for differential diagnosis with TGD People.

GPs gate-keep access to estrogens without government requirement to get other opinions. In practice, almost all TGD experienced GPs want an MHP to do a mental health assessment. Access to testosterone is gate-kept by GPs, with recent government requirement for an appointment with a specific endocrinologist. Again, the endocrinologists want an MHP assessment.

It appears that it is increasingly clinical psychologists rather than psychiatrists who are doing the mental health assessments.

At least two areas that health professionals are concerned about for TGD people seeking access to hormones; 1 where there could be a differential diagnosis to GD (e.g. DID, Psychosis, body-dysmorphic disorder, Borderline personality disorder) – that could represent an alternate cause and management approach; 2 evident mental health, substance abuse or social problems that could obstruct readiness to transition. Where neither of these are present, assessment is relatively quick – usually three visits to an MHP or other qualified clinician. Where one or both is present, assessment can take much longer, as differential diagnoses need to be ruled out, and other problems may need to be dealt with prior to or alongside transition.

Northside require assessment by MHP: either RCH/Monash GDC or a private MHP. They have TGD-experienced psychologists on site.

Brisbane Gender clinic: Gale Bearman assesses herself as qualified to do the MH assessment, but prefers to have an MHP involved to gain another perspective and potentially save time. She dislikes the counter position of WPATH SOC and Informed Consent and prefer to speak of a “Shared Responsibility” model.

Pauline Cundill at VAC (and other GPs at Northside, Prahran market etc.) would also be considered to be qualified to perform the MH assessment, but refer to MHPs.

1. Section 59, *Wrongs Act 1958* (Vic). [↑](#footnote-ref-1)
2. A ‘health pathway’ refers to an agreed approach to managing a person’s medical condition. [↑](#footnote-ref-2)
3. Deutsch, M B 2011, 'Use of the Informed Consent Model in the Provision of Cross-Sex Hormone Therapy: A Survey of the Practices of Selected Clinics', *International Journal of Transgenderism*, vol.13, no. 3, pp.140-146. [↑](#footnote-ref-3)