Journal of Paediatrics and Child Health

doi:10.1111/jpc.12994

VIEWPOINT

Transformation of health-care and legal systems for the transgender population: The need for change in Australia

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Caitlyn Jenner's introduction to the world via the cover of Vanity Fair magazine has brought new meaning to 'Keeping up with the Kardashians', the title of the reality television show in which she stars. The international media response has been predominantly positive and supportive, with the immediate adoption of her preferred name and female pronouns, demonstrating a significant move towards acceptance and understanding of transgender individuals. Reporting of events outside of popular culture reflects progressive change too. The suicide of American transgender teenager Leelah Alcorn, whose religious family had enforced reparative psychotherapy on their child rather than support her wish for transition, led to calls to ban this outdated and harmful practice. The proposed 'Leelah's Law' received a positive response from the White House and follows a similar ban on reparative psychotherapy recently enacted in Canada.

Awareness of gender diversity is also growing in Australian society. This is the notion that for some people, their gender identity is other than what was assigned to them at birth as male or female. Individuals who experience significant distress as a result of this incongruence (commonly referred to as gender dysphoria) are at increased risk of harm because of discrimination, social exclusion, bullying, physical assault and even homicide.[1–3] Unacceptably high rates of depression, anxiety, self harm and suicide exist: evidence suggests that up to 50% of young people with gender dysphoria have self harmed, and 28% will attempt suicide.[1] However, despite these statistics, there is evidence that family support and access to medical treatment pathways that are gender affirming will ameliorate these harms and improve mental health outcomes.[4,5]

Population-based studies estimate that 1.2% of adolescents identify as transgender.[6] The combination of rapid changes in social attitudes and the awareness of safe and effective gender affirming treatment has led to a significant increase in demand for trans-medicine worldwide. Trans-medicine for children and adolescents is also developing rapidly following the widespread adoption of international guidelines published by the World Professional Association of Transgender Health (WPATH).[7] Initially developed by a team in Amsterdam, the 'Dutch Protocol' involves a comprehensive, multidisciplinary mental health and medical assessment at the time of presentation. With confirmation of the diagnosis of gender dysphoria and persistence of distress on entering puberty, commencement of puberty-blocking medication via gonadotrophin-releasing hormone (GnRH) analogues can be offered. This intervention, known as 'stage 1 treatment' is entirely reversible. It allows the adolescent to develop emotionally and cognitively without experiencing the distress associated with the development of secondary sexual characteristics of the 'wrong' gender. At the age of 14–16 years, testosterone or oestrogen is offered, initiating 'stage 2 treatment', which induces partially irreversible physical changes of the affirmed gender. Commencement of puberty blocking medication followed by hormone treatment has been shown to decrease anxiety and depression.[4] A recent Dutch follow-up study of transgender adults 15 years post commencement of this regime (with some accessing surgery), demonstrated that quality of life, educational and vocational outcomes of young trans-adults were equivalent to that of the general population of the Netherlands.[4]

At the Royal Children's Hospital (RCH), Melbourne, the multidisciplinary Gender Service has been providing care for transgender children and adolescents since 2003. Referral numbers have grown from one patient every 2 years initially, to 104 new patients being referred in 2014 (see Fig. 1).With more than 200 new referrals expected during 2015, it is likely that the RCH Gender Service will receive more requests for care within 12 months than it has in the previous 12 years of its history combined.

The average age of presentation to this service is 12.3 years, with the vast majority of patients reporting gender concerns from the age of 3 or 4 years. Interestingly, the average age of presentation to the adult Gender Dysphoria Service at Monash Medical Centre in Melbourne is 40 years, with a large number of patients also reporting gender identity concerns from early childhood. It is likely that with ongoing social change we can expect a decrease in the age of presentation, a situation that will have a significant impact on demand for paediatric services into the future.

Governments are beginning to recognise the need to support these programmes, reflected by the recent announcement of funding in the order of $6 million over 4 years to the RCH to provide the necessary resources to meet this demand. The RCH Gender Service will soon consist of specifically funded adolescent physicians, child and adolescent psychiatrists, gynaecologists, an endocrinologist, psychologists and a social worker. Also contributing to the Gender Service is a speech therapy service for voice training and general surgical input for the purpose of conducting fertility preservation procedures in transfemales wishing to commence oestrogen therapy. A clinical evaluation

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Accepted for publication 20 July 2015.

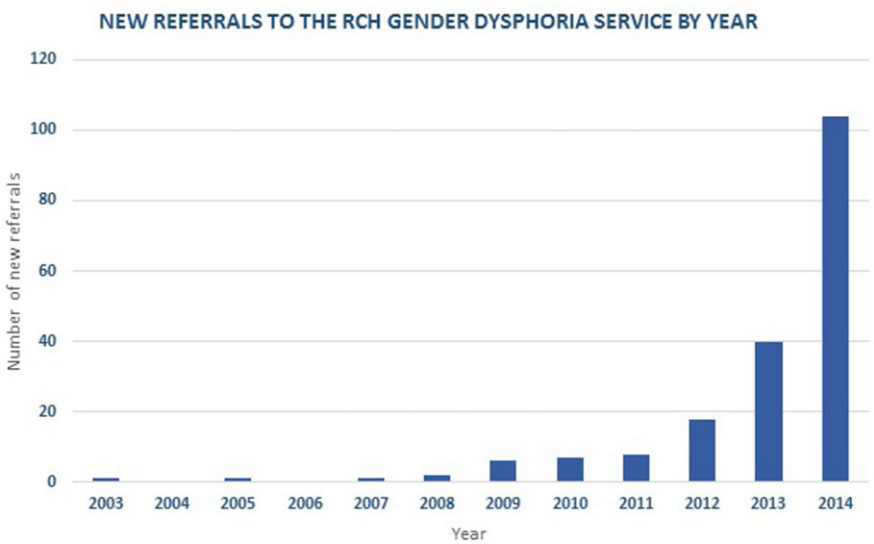

Fig. 1 New referrals to the gender dysphoria service by year.

of the RCH Gender Service is also being developed to assess treatment outcomes and inform evidence based practice into the future.

Although Victoria can soon boast one of the most comprehensive health services for transgender children and adolescents in the world, other states lack sufficient funding to provide necessary care. Compounding this, Australia's unique legal situation imposes a major barrier to treatment access. Based on legal precedent in 2004 following the case of *Re Alex*,[8] stage 1 and stage 2 treatment in adolescents under the age of 18 years were both classified as 'special medical procedures', necessitating approval by the Family Court of Australia. Challenged in 2013 with the case of *Re Jamie*,[9] the full bench of the Family Court removed the need for legal approval for stage 1 treatment and agreed that an adolescent who was 'Gillick' competent could consent to stage 2 treatment. But it determined that it was the Court that must decide whether the young person is competent. With the Court almost exclusively relying on medico-legal reports from the treating specialist team to determine competency, the court's involvement could be considered to be an expensive, time consuming and ultimately unnecessary intrusion into the complex decision making between the patient, their parents and the treating medical team. It is unclear whether this decision from *Re Jamie*[9] extends to other areas of medicine, but as applied only to transgender young people, it is arguably a form of institutional discrimination.

A recent study showed that the greatest risk of attempted suicide occurred between the time that a transgender individual decided to embark on medical care, and the time that he or she was able to access that care.[10] It is clear that if the Australian medical and legal systems cannot shift towards meeting the needs of the transgender population, increasing waiting lists and legal barriers will result in an ongoing rise in morbidity and mortality. With the increasing acceptance of gender diversity being fuelled by social media and popular culture, actively embarking on change to medical and legal systems is required, and urgency exists.

Nationwide, publically funded medical services for the transgender population is required. Equitable access to GnRH analogues, testosterone, oestrogen therapy and the creation of Medicare item numbers for therapeutic gender affirmation surgery in adults is needed. We need to educate medical students, junior doctors, general practitioners, medical specialists and surgeons. We need more research including longitudinal studies embedded in clinical programmes to inform better evidenced based practice in the longer term.

It was only last year that Australia's Human Rights Commissioner Mr Tim Wilson announced that, 'It's time for the transgender talk Australia'. In 2015, the talk is everywhere, and now it is time for action.

Acknowledgements

Not applicable.

References

1 Hillier L, Jones T, Monagle M *et al*. *Writing Themselves in 3: The Third National Study on the Sexual Health and Wellbeing of Same Sex Attracted and Gender Questioning Young People*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University, 2010.
2 Giordano S. *Children with Gender Identity Disorder: A Clinical, Ethical, and Legal Analysis*. Oxon, UK: Routledge, 2013.
3 Couch M, Pitts M, Mulcare H, Croy S, Mitchell A, Patel S. *Tranznation: A Report on the Health and Wellbeing of Transgendered People in Australia and New Zealand*. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University, 2007.
4 de Vries A, McGuire JK, Steensma TD, Wagenaar E, Doreleijers TAH, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics* 2014; **134**: 2013–958.
5 Simons L, Schrager SM, Clark LF, Belzer M, Olson J. Parental support and mental health among transgender adolescents. *J. Adolesc. Health* 2013; **53**: 791–3.

6 Clark TC, Lucassen MFG, Bullen P *et al*. The health and well-being of transgender high school students: results from the New Zealand adolescent health survey (Youth'12). *J. Adolesc. Health* 2014; **55**: 93–9.
7 Coleman E, Bockting W, Botzer M *et al*. Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *Int. J. Transgend.* 2012; **13**: 165–232.
8 Nicholson CJ. *Re Alex* : Hormonal Treatment for Gender Identity Dysphoria. FamCA 297; 2004.
9 Bryant CJ, Finn MM, Strickland JJ. *Re Jamie*. FamCAFC 110; 2013.
10 Bauer GR, Pyne J, Francino MC, Hammond R. Suicidality among trans people in Ontario: implications for social work and social justice. *Serv. Soc.* 2013; **59**: 35–62.

Happy giraffe by Abi Tomlinson (7) from Operation Art 2014.