Best practice models for the assessment, treatment and care of transgender people and people with transsexualism: A discussion paper for Victoria (Australia)

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CONTEXT & BACKGROUND

This paper summarises the literature regarding the treatment, assessment and care of transgender people and people with transsexualism; and outlines possible program enhancements that would contribute to the development of best practice. It was commissioned by the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) with funding from the Victorian Department of Human Services in response to one of the recommendations of *Health and Sexual Diversity: A health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians* (Victorian Government Department of Human Services, 2003). The plan was produced by the MACGLH and adopted by the Minister for Health and the Department of Human Services. The plan drew on the findings of an earlier research publication on the major health issues facing gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians and extensive statewide GLBTI community consultations, including consultations with representatives of transgender and transsexual groups (Victorian Government Department of Human Services, 2002). The consultations highlighted the need for an integrated and comprehensive approach to the treatment, assessment and care of transgender and transsexual people and the report recommended the "develop[ment] of 21st century model of gender identity management combining best practice medical care and social support" (Victorian Government Department of Human Services, 2003, p43).

Definitions & Language

There is considerable debate amongst communities of transgender people and people with transsexualism, and the professionals working in the field regarding the appropriateness of words used to describe transgenderism and transsexualism.

The term ‘transsexualism’ was coined by Harry Benjamin in the 1950’s to describe individuals who wished to live in the ‘opposite’ gender. It was included in the *Diagnostic & Statistical Manual of Mental Disorders* (DSM) to describe individuals who sought gender reassignment surgery to affirm their gender identity and to relieve the associated distress. In 1994, it was removed and replaced with Gender Identity Disorder (GID)(American Psychiatric Association, 1994).

Various professionals have challenged the diagnostic classification systems arguing they are inaccurate, too narrow or unethical and inappropriate (for example, Vitale, 2005; Seil, 2004; Cantor, 2002; Bower, 2001; Cohen-Kettenis, 2001; Kavanaugh & Volkan, 1978-79). Individuals who live in their affirmed gender who do not want surgery and those who live part-time in their affirmed gender have criticised narrow definitions that focus exclusively on the desire or intention to have genital surgery. The term “transgender” was coined to include a broader understanding and definition of gender identity and gender identity issues (Bullough, 2000).

There is growing interest and research into possible biological causes of transsexualism. A number of researchers have explored the sex differences in a specific part of the brain (the volume of the central subdivision of the bed nucleus of the stria terminalis (BTSc)) (Chung et al.2002; Kruijver et al.2000; Zhou et al.1995; Allen & Gorski, 1990). Specifically, Zhou and colleagues (1995) found the BTSc was of female size in six transsexual women (male to female transsexuals). In rodent studies, the BTSc has been shown to influence sexual behaviour; however, there is no clear indication that it has the same impact on human behaviour.

This and other studies have been applied to assert the existence of 'brain sex' – that during foetal development the brain may be hard wired as one sex while the rest of the body develops as the other sex. It has been argued that transsexualism may therefore be akin to an intersex condition (Diamond, 2004). This application can also be used to suggest that those not wanting surgery are more likely to be transgender and not transsexual. There is considerable debate about this approach and disagreement about the implications for transgender people. While research continues to unravel more and more information relevant to understanding transsexual experiences, it should be noted that it is not possible at this time to assess a person's brain sex.

Due to this complexity, there is a great need to be sensitive with language as it is possible to offend members of the communities by using certain words. This is particularly important in health promotion programs and health care service provision.

The phrase 'transgender people and people with transsexualism' will be used throughout to be inclusive of the diversity of people with variation in gender and its expression. Furthermore, the terms 'transgender women' or 'women with transsexualism' are used to indicate male-to-female people and 'transgender men' or 'men with transsexualism' are used to indicate a female-to-male people.

Prevalence & Demand

International estimates vary depending on the study quoted, and amongst those, the definition of transsexualism varies. The DSM-IV quotes international research that suggests 1 in 30 000 adult males and 1 in 100 000 adult females seek sex reassignment surgery/gender affirmation surgery (Meyer et al.2001). This estimate has been challenged as inaccurate and not inclusive of people with gender identity disorder who do not seek surgery. Lynn Conway (2002) suggests this underestimates the true prevalence of transsexualism. Based on 'detective work', Conway makes a number of estimates of prevalence of transsexualism ranging from 1:500 (including those who do not seek surgery) to 1:1000(for those who seek surgery) for male-to-female transsexuals.

Research clearly demonstrates the impact of culture on prevalence rates. Ross et al. compared prevalence estimates from four countries (including Australia) and concluded that prevalence was higher in countries where rigid gender norms were held (Ross et al.1981). Slightly more recent differences are reflected in the results of prevalence studies from the Netherlands and Singapore. In the Netherlands, Eklund et al. (1988) estimated a prevalence of 1:18 000 for male-to-female transsexuals and 1:54 000 for female-to-male transsexuals while Tsoi (1988) estimated 1:2 900 for male-to-female and 1:8 300 for female-to-male in Singapore (aged 15 and above).

The Australian Bureau of Statistics reported 4 644 950 people in Victoria in the 2001 census, consisting of 2 279 061 males and 2 365 889 females (Australian Bureau of Statistics, 2002). Applying the prevalence rates above to this population give estimates ranging between 76 to 786 male-to-female transsexuals and 24 to 285 female-to-male transsexuals in Victoria (at 2001). This is a rough estimate only as it is not age corrected (as prevalence data is not available in such detail).

If Conway's estimate of 1:1000 people has transsexualism, there would be 2 279 male-to-female people and 2 366 female-to-male people in need of support in Victoria. A further 2 366 males and 2,279 females may experience intense gender dysphoria but not seek assistance.

Past research has indicated that twice as many male-to-female transsexuals present for treatment than female-to-male. Practitioners involved in treatment and care believe this has been changing over the past decade and recent research demonstrates it is now approaching equality (Garrels et al.2000; Landen et al.1996).

Referrals to the Monash Gender Identity Clinic have been increasing to the current level of approximately two referrals per week. Approximately 30-35 sex reassignment surgeries are performed per year (Kennedy, 2005). Comparing this to the estimates calculated above, there may be considerable numbers of transgender people and people with transsexualism accessing hormone treatment through general practitioners and/or self medicating with hormones accessed via the internet.

Accurate epidemiology of transsexualism in Australia is essential to appropriate service planning and development and should be considered a priority need.

International & Local Developments

There has been increasing international and local attention to the accuracy of the diagnosis of transsexualism and the treatment available to people with transsexualism. A number of practitioners and community representatives are advocating for the removal of GID from the next edition of the Diagnostic & Statistical Manual of Mental Disorders or the establishment of a less pathologising alternative (for example, Vitale, 2005; Cantor, 2002; Cohen-Kettenis, 2001).

A small number of people have spoken publicly about their disagreement with their diagnosis and ultimate rejection of their subsequent treatment. In Australia, Alan Finch has spoken about his experience of requesting a sex change and later in life transitioning to his natal sex (Leung, 2004). The 'Alex' case, also in Australia, highlighted the specific needs of adolescents with GID; and the role of the Family Court of Australia in supporting (or potentially denying) young people's access to treatment (Milligan, 2004).

There have been a number of significant legislative changes and applications that recognise the needs and rights of transgender people and people with transsexualism in Australia and in Victoria. The Family Court recognised as lawful the marriage between a transsexual man and his wife; the Victorian *Equal Opportunity Act* (1995) was amended in 2000 to make unlawful any discrimination on the basis of gender identity; and changes to Births, Deaths & Marriages systems in Victoria (and other jurisdictions) now allows birth certificates issued in Victoria to be corrected to reflect the lived gender of transgender people and people with transsexualism (for more information, see http://online.justice.vic.gov.au).

Research into and understandings of transsexualism are changing rapidly. Services and programs need to keep abreast of such changes and respond appropriately.

METHODOLOGY

An advisory committee of the Ministerial Advisory Committee on Gay & Lesbian Health oversaw the development of this research paper. The advisory committee consisted of: Anne Mitchell (Co-Chair, MACGLH), Dr Ruth McNair, Mr Terry Laidler and Ms Lauren Christopher.

Three major sources of information informed this paper:

Community Consultation Submissions (2001)

The Ministerial Advisory Committee on Gay & Lesbian Health provided access to relevant submissions made to it during the community consultation process in 2001. The needs of and issues for transgender people and people with transsexualism noted in the submissions are included in this report.

Literature & Practice Review

There is a growing volume of literature about the health and wellbeing issues of transgender people and people with transsexualism, with an expanding range of professionals involved in providing services and supports. In an attempt to capture as much information as possible, an extensive literature review was undertaken, including peer reviewed journal articles, academic texts, books, reports, presentations and service providers' websites. This information is summarised in the next section (Evidence & Practice in Assessment, Treatment & Care).

Key Informants

Input was invited from key individuals and organisations providing assessment, treatment and support services in Victoria and elsewhere in Australia. This included psychiatrists, psychologists, general practitioners, endocrinologists, surgeons, speech pathologists, child and adolescent service providers, government policy and program managers, community organisations and peer support providers. A list of key informants and those who provided comment is in Appendix I.

EVIDENCE & PRACTICE IN ASSESSMENT, TREATMENT & CARE

Transgender people and people with transsexualism need access to a range of services across the lifespan:

- services for individuals and their families;
- services and supports for communities of transgender people and people with transsexualism; and
- programs working at a societal level providing community awareness and professional development and advocating for adequate policy and program development, and legislative change.

Standards of Care

A number of standards of care have been developed by various organisations and practitioners working in the field to inform the standards and approach of professionals involved in providing treatment and care.

The Harry Benjamin International Gender Dysphoria Association (HBIGDA) produces International Standards of Care for Gender Identity Disorders. The sixth edition (released in 2001) "articulate[s] this international organization's professional consensus about the psychiatric, psychological, medical and surgical management of gender identity disorders" (Meyer et al.2001, p1). The Standards refer to the DSM-IV diagnostic categories and outline the responsibilities of and training and experience needed by professionals involved in the care of people with GID.

These standards have been criticised by some sections of the transgender and transsexual communities and a range of professionals. In particular, the Standard's psychiatric or mental health framework has been challenged with many arguing that transsexualism is a biological condition that needs physical treatment only with little if any need for mental health assessment and/or care (Isay, 1997; Cascio, undated; GID. info, undated). Recently, the HBIGDA has stated that "[T]ranssexualism is a disorder of sexual differentiation, the process of becoming man or woman as we conventionally understand it. Like other people afflicted with errors in the process of sexual differentiation, such as people with intersex conditions, transsexual people need to be medically rehabilitated so that they can live normalized lives as men or women. The only available, successful and appropriate treatment at present for severe gender dysphoria is gender reassignment treatments, i.e. psychiatric assessments followed by hormone treatment, the real life test and in suitable cases, sex reassignment surgery. This has been confirmed by all long-term studies".

Other frameworks for the care of transgender people and people with transsexualism exist that are not as supportive of the DSM-IV classification of Gender Identity Disorder. For example, Israel & Tarver's book - *Transgender Care: Recommended Guidelines, Practical Information and Personal Accounts* (1997) – provides detailed guidelines for mental health care, hormone administration and surgery; for working specifically with cultural diversity and transgender youth; and for a range of other issues. There is also the *Health Law Standards of Care for Transsexualism adopted at the second International* Conference on Transgender Law and Employment Policy (ICTLEP) in August 1993 in Houston, Texas (USA).

The Transition Process

Practitioners around the world may base their services on any of these standards or on a combination of them. There is, therefore, variation in the steps made by a person to transition to living full-time in their affirmed gender. Generally, an

individual progresses from initial contact with an appropriate health care provider (general practitioner, mental health provider), through assessment (medical, endocrinology, mental health), to hormone treatment, living full time in their affirmed gender (real life experience) for a minimum of 12 months and, if desired, surgery (genital surgery). According to the HBIGDA, this should be done with the consistent support of psychiatric monitoring and therapy. Some people's sequence of treatment may be different, for example, transgender or transsexual men may have chest surgery prior to or during their real life experience; some people may begin hormones and not seek surgery; others may have begun hormones without formal assessment. A major challenge for services and providers is to ensure appropriate assessment is conducted that informs any treatment intervention; and that any treatment provided maximises the physical and psychological well being of people presenting for assistance. This requires direct and active engagement of the person seeking services, and coordination and communication amongst service providers.

Service Types

For the purposes of this paper, services will be divided into assessment, treatment and care categories, with the following broad definitions:

Assessment: the process of physical, psychosocial, psychiatric, endocrinological and other considerations to determine the diagnosis, needs and issues of an individual and/or a family that will inform appropriate interventions and/or treatment.

Treatment: any interventions aimed to address the physical, emotional, psychosocial needs of transgender people and people with transsexualism. Treatment is commonly understood to include hormone therapy, counselling or psychotherapy, real life experience, transition, speech therapy, surgery (sex affirmation surgery), and psychiatric monitoring.

Care: services that support and assist an individual, their family and friends deal with and respond to their gender issues; such services may operate on an individual, community or societal level. On an individual level, care services include primary health care, counselling, welfare and social support, employment support, accommodation, individual advocacy and so on. Examples of care services on a community level include peer support programs; and services operating at a social level include community and professional education, advocacy for legislative reform, policy and service development.

Assessment, treatment and care services and supports need to be accessible to transgender people and people with transsexualism throughout their lives – not only during their transition period. Services need to be accessible, confidential, respectful, and be able to refer clients to other services they may need. Examples of best practice services, practitioners and organisations within Australia and around the world are provided throughout this section (highlighted in boxes).

Assessment

The function of assessment is to accurately identify the issues, conditions, needs and, if appropriate, diagnosis that will inform treatment interventions. Generally, transgender people and people with transsexualism will present to professionals

seeking access to hormonal treatment and potentially surgical affirmation; other treatment may also be needed such as speech therapy and electrolysis.
Treatment should not begin without a comprehensive assessment confirming a diagnosis of Gender Identity Disorder (GID).

Assessment should:

- meet the diagnostic criteria provided in either the International Classification of Diseases (ICD-9) or the Diagnostic and Statistical Manual IV (TR)(American Psychiatric Association, 1994); and
- be conducted according to the HBIGDA Standards of Care (Meyer et al.2001) or other recognised set of standards.

The HBIGDA Standards of Care note that mental health practitioners and physicians involved in assessment and care should have adequate knowledge and training to do so – with adult or child specialities. If practitioners do not have such experience, it is recommended they refer to professionals experienced with GID.

Assessment and diagnostic categories for transsexualism have changed over time in line with changing understandings of gender identity development. There is significant commonality in the criteria offered by the ICD and the DSM-IV.

Essentially four criteria must be met for a diagnosis to be made:

- evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is of the other sex (not simply a desire for the perceived cultural advantages of being the other sex);
- evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex;
- no concurrent intersex condition[1] (though the diagnosis of GID Not Otherwise Specified can be used if an intersex condition is present); and
- evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 1994).

Both the ICD and DSM-IV diagnostic systems require age-related diagnosis to be made and provide specific criteria for the diagnosis of Gender Identity Disorder of Childhood.

Assessing the core gender identity of any individual who presents for treatment can be complex and time consuming. Detailed interviewing and history taking are needed to explore a wide range of issues, such as medical, psychiatric and psychological history, gender identity over lifetime, psychosocial supports, and more (Harte & Bower, 2004). Attention needs to be given to the potential of psychiatric conditions that may also need to be treated. Cultural diversity and its relationship with gender, and social and familial pressures that may impact on an individual's capacity/opportunity to express their gender need to be sensitively included in thorough assessment.
A trusting, open and honest relationship with the client is essential for the accuracy of assessment. Some people with GID are highly suspicious of medical and mental health practitioners and the potential for them to be 'gate keepers'. This suspicion can contribute to clients telling what they think a practitioner 'needs' to hear to confirm them as someone with transsexualism and thus

[1] Intersex conditions include genetic and other developmental conditions that lead to hormonal imbalance and can cause ambiguous genitalia that are obvious from birth and other conditions that may not be noticed til later in life. The incidence is approximately 1:1 000 births.

support their access to treatment. Practitioners therefore need to pay particular attention to the consistency, depth and integrity of what clients disclose over the period of assessment (Lev, 2004; Juran, 1999; Israel & Tarver, 1997; Miller, 1996).

Some practitioners make use of established psychometric tests (such as the MMPI, the Beck Depression Inventory or mental health state questionnaires) (Miach et al.2000; Lothstein, 1984). Other practitioners, such as Harte & Bower (2004) have developed their own profile/psychiatric assessment form incorporating mental state examination, comprehensive history and gender specific assessment.

The diagnosis of GID requires the possibility of an intersex conditions to be identified, however, chromosome testing and assessment of internal sexual organs may not be carried out as a matter of course. The cost and diagnostic relevance of such investigation has been questioned as it is highly unlikely that known intersex conditions affecting the chromosomes will be found.

Assessment needs to include an exploration of the impact of transitioning and of not transitioning. It is possible that transition may not improve the quality of life of an individual, and/or may cause additional stressors that the individual may not be able to deal with.

Differential diagnosis

To effectively and accurately assess and diagnose GID, a practitioner (and the individual seeking care) need to consider alternative diagnoses - this takes time and skilled assessment. Multidisciplinary teams are involved in assessment in the majority of treatment facilities around the world.

A number of possible alternate diagnoses have been identified: transient stress related cross-dressing, preoccupation with castration, transvestic fetishism with gender dysphoria, homosexuality with internalised homophobia, organic psychosis, intellectual disability, personality disorder (narcissistic, borderline), body dysmorphic disorder, malingering, dissociative identity disorder; schizophrenia, and obsessive compulsive disorder (Harte & Bower, 2004; Brown, 2001; Israel & Tarver, 1997; Hashimoto, 1992). These possibilities need to be excluded.

Personality disorders can be particularly difficult to assess and often require a long-standing relationship between the practitioner and the client to identify and explore patterns of behaviour and response. Questions, doubts and changes in gender identity can be experienced by people with personality disorders (and other mental health issues) – so it is important to fully assess the history of both the personality disorder and the GID (Hartman et al.1997; Bodlund et al.1993; Levine, 1980). While having a personality disorder does not exclude the possibility of having a GID, it does require comprehensive consideration.

Identification of other mental health needs does not necessarily exclude the possibility of a GID diagnosis. However, consideration needs to be given to the potential relationship between the coexisting condition and gender identity. The outcome of transition will be strongly influenced by the presence of negative prognostic features, such as the coexistence of a poorly managed mental health condition.

Special needs of children and young people

Gender identity disorders in children and young people are considered uncommon, however, there is little if any reliable and recent epidemiological data to confirm this (Di Ceglie, 2000). The majority of transsexual adults report feeling as they do since early childhood; and research from the 1980's suggests that the majority of children who have cross gender identification develop a homosexual sexual orientation rather than identify as transsexual (Green, 1987; Green et al 1972). Without adequate prevalence studies, it is difficult to estimate confidently the number of children and young people with transsexualism.

Working with people less than 18 years presents additional challenges and responsibilities for health practitioners. The Royal College of Psychiatrists has developed specific guidelines for the assessment and management of gender identity disorders in children and adolescents (Royal College of Psychiatrists, 1998). These guidelines outline detailed assessment strategies:

- Comprehensive assessment including family evaluation
- Therapy to assist the child/young person in their development (particularly gender identity development)
- Removal of secrecy by recognising and accepting gender identity 'problem'; and
- Decision about the extent to which the child/young person can express themselves in their gender role;

and a staged approach to physical treatment beginning with procedures that are fully reversible and moving through stages over time eventually ending with treatment that is irreversible.

A number of articles outline approaches to assessment and its impact on treatment decisions (Zucker, 2004; Di Ceglie, 2000; Newman, 2000; Cohen-Kettenis, 1998; Sugar, 1995; Zucker et al.1993; Bradley et al.1978,). Children and young people often present for help due to their parents' or carers' concerns. It is critical that family be involved in the assessment process as there are opportunities to educate, inform and assist parents. Assessment usually involves interviews with the individual child with their parent(s)/caregiver(s) and family; with the child alone; and with the parent(s) alone. A detailed developmental history is needed to identify issues that may require treatment or support. Child and family therapy contributes to both assessment of the child and family and treatment too.

Young people can present for assistance without the knowledge or support of their parents; some may find it difficult to identify appropriate services. Young people may be experiencing significant distress dealing with the physical impact of puberty and its impact on their gender identity. Diagnosis can be difficult as assessment needs to consider the impact of physical changes during puberty on the core gender identity of the young person. Internationally, increasing attention is being paid to the potential benefits of treating young people with cross hormones at the age of 16 years. Detailed and accurate assessment is essential for this to occur. These benefits include improved minimisation of the development of secondary sex characteristics of the natal sex and improved development of those characteristics of the affirmed gender; improved mental health; and increased social acceptance.

Gender Identity Development Service (England)
http://www.tavi-port.org/patient/tavistock-clinic.html (search for gids)

The Gender Identity Development Service is a national public health service based in London associated with the Department of Paediatric Endocrinology at the Middlesex Hospital, University College London Hospitals. The specialist multi-disciplinary team of child and adolescent psychiatrists, psychologists, social workers, nurses, psychotherapists and paediatricians provide services for children and adolescents (up to 18 years) and their families who have issues with gender identity (Gender Identity Development Service, 2004). The service has strong links with Mermaids – a support group for children and adolescents with gender identity issues, and their families (see example below).

In 2004, the Family Court Australia considered the request for hormonal treatment from 'Alex', a 13 year-old ward of the state and provided approval for puberty blocking treatment (Family Court of Australia, 2004). The ongoing role of the Family Court of Australia in approving treatment for all young people is not confirmed at this point.

Needs of those not provided access to treatment
Little is written about the support and care needs of people who are not given access to treatment (Smith et al.2001; Morgan, 1978). Generally, people would not be given access to treatment when the primary diagnosis is not GID or where there are a considerable number of negative prognostic factors (such as those listed in the *Differential diagnosis* section above). Referral to sensitive and informed mental health services for ongoing support and treatment is critical to an individual's well being. Services for transgender people and people with transsexualism are often overloaded and not able to provide intensive support for those whose mental health needs are greater than their gender identity issues.

Not gaining access to treatment (including surgery) can exacerbate the distress individuals feel and may lead to an increase in risk taking behaviours such as self-harm or mutilation. This can result in contact with emergency services, hospital Accident & Emergency Departments, general practitioners and/or crisis mental health services - which may not be sensitive to or experienced in working with those with gender identity issues. These services/practitioners may need training, secondary consultation and/or supervision.

Treatment

On confirmation of a diagnosis of GID, a number of treatment interventions can be initiated and transition planned. The timing and sequence of treatment is a decision made by the transgender person or person with transsexualism, with input from the treating practitioners. Personal circumstances and supports need to be taken into consideration. Treatment should begin at a time when the individual is most able to deal with the impact of treatment. This may require the treating team or practitioner to provide considerable support and refer to support services. The HBIGDA Standards of Care (Meyer et al.2001) note that access to treatment should not be affected by a person's marital status, sexual orientation, hepatitis or HIV status.

Hormone therapy

The aim of hormone treatment is to acquire the secondary sex characteristics of the affirmed gender (Gooren, 1999). The HBIGDA Standards of Care outline the basic requirements for hormone therapy: being over 18 years of age; have a clear understanding of the impact, limitations and risks associated with hormone treatment; and at least three months of psychotherapy or real life experience (though it is noted that hormones may be provided to individuals who have not met the final requirement in certain circumstances).

There is considerable discussion in the literature about appropriate endocrine care of transgender people and people with transsexualism. Such literature provides guidelines about dosage, methods of delivery, alternatives and more (Dobs & Moore, 2004; Greenman, 2004; T'Sjoen et al. 2004; Moore et al.2003; Basson & Prior, 1998; Prior & Elliot, 1998).

The following issues should be discussed with an individual prior to beginning hormones:

- the effects, limitations and risks associated with hormone treatment. Hormones can also have significant side effects and individuals seeking hormone treatment need to be fully informed of this. Some clinics have developed informed consent forms that clearly outline these considerations and document an individual's consent (for example, Dimensions at the Castro-Mission Health Center in San Francisco and Fenway Community Health Center in Boston, see http://tghealth-critiques.tripod.com; Sherbourne Health Centre, Canada, see www.sherbourne.on.ca/index.html);
- reproductive options prior to beginning hormone therapy. If desired and legally possible, it is recommended that storage of gametes (notably sperm) should be arranged. The future use of these gametes is dependent on local legislation; and
- thorough base line testing needs to be arranged to enable ongoing monitoring and to identify health conditions that may be affected by hormones or that may contraindicate their use.

An experienced endocrinologist works with each individual to tailor the right combination of hormones, antiandrogens and/or other medication to achieve the desired result. Responses to hormones can vary and the endocrinologist needs to monitor their impact. A positive response to hormones should not be used to confirm the diagnosis of GID as hormones are known to have mood-altering effects regardless of the presence of GID (Slabbekoorn et al.2001). Contrary to this advice, some practitioners do use a positive response to hormones as an indicator of GID. Ongoing monitoring of hormone levels and attention to potential side effects (short and long term) should be established and maintained.

Individuals with gender dysphoria can and do access hormonal treatment through alternate sources and may not be medically supervised in their use. This places individuals at risk of potential side effects. General practitioners in particular may be used as a source of prescription hormones though may not have the expertise to fully understand the health implications of hormonal therapy for transgender people and people with transsexualism.

International practice varies from the HBIGDA Standards of Care in relation to hormone therapy. Some international practitioners and services are treating young people with hormones prior to 16 years of age and in Australia, three months of psychotherapy or real life experience prior to hormone administration is difficult to require given lack of access to such services.

Psychiatric monitoring and ongoing assessment
Research into the psychopathology of transgender people and people with transsexualism varies in the degree of pathology identified (for example, Hepp et al. 2005; Giltay et al.2004; Meyer, 2004; Haraldsen & Dahl, 2000; Bodlund, 1993). Psychiatric consultation is advised prior to and for the duration of the real life experience (Meyer et al.2001) which enables both the individual and their mental health provider(s) to monitor progress and to address the implications of moving towards their affirmed gender. Assessment is an ongoing process and this monitoring enables assessment to be reviewed in light of the experience of transition and living full time in the affirmed gender. If an individual is not able to live full time in their affirmed gender, psychiatric monitoring allows the impact of this limitation to be addressed.

Psychological and/or pharmacological treatment of concomitant mental health needs is advisable as management of them may impact on the distress caused by the GID (Lev, 2004).

Counselling and psychotherapy
As noted above, professionals and members of the transgender and transsexual communities are working towards the removal of GID as a mental illness. Regardless of how or where GID is defined, the impact of gender identity disorder on mental health and emotional well-being is well recognised and people need access to therapeutic support (Lev, 2004; Nuttbrock et al. 2002; Ettner, 1999; Brown, 1996). Trauma, stress, self-esteem, identity, family and intimate relationships, isolation, social skills, and sexuality are some of the issues that individuals may explore in ongoing counselling or psychotherapy.

The HBIGDA Standards of Care do not require psychotherapy for every person requesting treatment. If a need for psychotherapy is identified, it should be provided or an appropriate referral made (with clear treatment goals). Counselling or psychotherapy is different to psychiatric monitoring that is usually provided by the treating psychiatrist. Access to ongoing counselling and psychotherapy is often limited by cost unless it is provided by a transgender health service. There has been some debate about the therapeutic value of therapy that is ‘required’ for or linked with treatment (Walters, 1997); managing dual roles of therapist and ‘gate keeper’ to treatment requires considerable experience, ongoing supervision, and attention to ethics (Kipnis, 2004; Anderson, 1997). The gatekeeper role is particularly problematic as it may contribute to client’s sense that they need to ‘jump through hoops’ and increase their tendency to report what

is needed to ‘pass the test’ rather than engage in an open relationship with the therapist. The impact of this can be considerable if the individual is not disclosing psychological symptoms or needs. Therapeutic group programs have been developed in numerous locations and appear to have many positive benefits (Lev, 2004; Keller et al. 1982). Confidentiality and privacy, especially in relatively small communities may impact on the effectiveness of this treatment intervention.

The HBIGDA Standards of Care detail the level of training and experience required by mental health professionals providing counselling and psychotherapy – specialist training in gender and related issues is limited in Australia.

Real-life experience

At some point in time, a person on hormone treatment will usually transition to living full time in their affirmed gender; this is called the ‘real-life experience’. The timing of this experience is critical and must be decided on by the individual.

The intent of the real-life experience is to fully address the realities of living in the affirmed gender – maintaining or establishing work, social, economic and legal identification in the affirmed gender. The experience assists both the individual and their mental health provider in assessing the next steps to be taken in the transition process.

It is recognised that the real-life experience may present an individual with considerable challenges. Counselling and social supports can be established to care for a person (and their significant others) through this time.

Ongoing delays in instigating or maintaining the real life experience may reflect ambivalence and should be discussed between the client and their treating practitioner(s). If transition to living full time in the affirmed gender does not happen within a reasonable timeframe, the continued use of hormones should be reviewed.

Facial and unwanted hair removal

Removal of facial and other unwanted hair is provided by private practitioners and does not require medical approval or diagnosis. For the majority of transgender women and women with transsexualism, facial hair removal will be required as hormone therapy will not totally stop hair growth (though it may affect the strength and density of facial hair). This process is expensive, time-consuming (up to two years) and painful (Denny & Mishael, 1998). Laser treatment may be considerably quicker than electrolysis, though it remains expensive and uncomfortable.

Access to this treatment is totally dependent on an individual's financial resources as it is only provided by private practitioners. Individuals may need support and information about other ways to manage facial hair during the real life experience and beyond.

Speech therapy
Speech pathologists focus not only on the voice, they also attend to overall communication skills (known as pragmatics). They provide an important service to people with GID, especially for transgender women and women with transsexualism. Hormone therapy will affect the voice to some degree: testosterone will deepen the voice adequately for transgender men and men with transsexualism, whereas oestrogen will not fully feminize the voice for transgender women and women with transsexualism (Gooren, 1999). For transgender women, speech therapy focuses on improving (feminising) the pitch, articulation, resonance, voice quality, and pragmatics (Oates & Dacakis, 1997; Oates & Dacakis, 1983).

The effectiveness of speech therapy is influenced by a number of factors. Local research (Dacakis, 2000) shows that increase in pitch can be maintained over time. The amount of time needed in speech therapy varies according to the needs of the individual. Some transgender people and people with transsexualism may wish to access speech therapy a number of times during their transition and potentially afterwards. Surgery to increase pitch has been trialled with limited success (Neumann et al. 2002).

Access to speech pathology varies around the world and is not always included in the multidisciplinary teams at dedicated treatment facilities. Private speech pathology services require private payment, which may be beyond the capacity of many transgender people and people with transsexualism.

Surgery
Surgery is seen by some as the ultimate step in gender affirmation or transition. Options exist for breast augmentation, chest reconstruction and various genital surgery. Not all transgender people or people with transsexualism will seek or be able to access surgery. Therefore desire for or completion of genital surgery should not be a definer of transsexualism.

The HBIGDA Standards of Care recommend surgery take place after a minimum of 12 months of continual hormone treatment and a minimum of 12 months of real life experience (Meyer et al. 2001). In Victoria genital surgery is generally not considered prior to 18 months of real life experience, however, breast augmentation and laryngeal surgery is available prior to this (without the need for psychiatric assessment).

The HBIGDA Standards of Care advise surgeons involved in genital reconstruction to be part of a multidisciplinary team involved in the medical and psychological care of individual patients. If this is not possible, the surgeon should obtain documentation from the treating physician and mental health practitioners regarding the person's diagnosis and treatment, and have contact with these practitioners to confirm the accuracy of the information provided. It is also advised that the surgeon ensure that such letters of support are provided by practitioners who have specialised experience with GID.

The decision to undergo genital surgery is a major one. Individuals need to be provided with comprehensive information about the techniques to be used, likely outcomes, length of hospitalisation and recovery, risks, possible complications, costs and post surgical rehabilitation requirements. This requires considerable time and may best be explored with the surgeon and with other practitioners involved in their care.

Breast augmentation and chest reconstruction can be accessed privately in some countries and may not require adherence to the HBIGDA Standards of Care. Post surgical care may be compromised in these situations.

Genital reconstructive surgery is sophisticated, technical and requires considerable training and practice. The technical details are beyond the scope of this paper; however there is considerable literature on various surgical procedures used to affirm gender, factors influencing decision making about surgery and post operative function and satisfaction (for example Collyer & Heal, 2002; Rachlin, 1999; Barrett, 1998).

The HBIGDA Standards of Care (Meyer et al.2001) note that it is unethical to deny surgery on the basis of infection with a blood borne virus (hepatitis B, C or HIV); and guidelines exist for selecting HIV positive patients for genital reconstructive surgery (Kirk, 1999).

Special needs of children and young people
Research demonstrates that transgender adolescents and young people with transsexualism do not necessarily exhibit major psychopathology (Cohen et al. 1997). Given the developmental challenges for children and young people, treatment focuses on counselling and psychotherapeutic intervention with the individual and their parents/family. The aim of treatment with children and young people is to assist development, particularly gender identity development and to minimise distress and impact on learning and functioning (Di Ceglie et al. 2002; Royal College of Psychiatrists, 1998).

It is recommended that hormone treatment is only provided when a GID diagnosis is confirmed and with due consideration of the demands of adolescent development. Both the HBIGDA Standards of Care and the Royal College of Psychiatrists Guidelines recommend that physical intervention begins with wholly reversible procedures such as suppression of hormone production that will delay puberty. In time, treatment can proceed to partially reversible procedures such as cross hormone administration, and then if needed, surgery.

Evidence shows that transgender young people and young people with transsexualism benefit from sex affirmation procedures (Smith et al. 2005; Smith et al. 2002; Cohen-Kettenis et al. 1997).

If a child or young person is transitioning during their time at school, it is important to involve, inform, educate and support the school and the Department of Education. In some jurisdictions, school policies have been developed to protect young people from bullying and discrimination, which can be used to ensure the safety of a young person during transition.

Care
During treatment, the real-life experience and post transition, individuals and their significant others may need to access a variety of support services.

Counselling and psychotherapy
As noted above, there are many possible reasons transgender people and people with transsexualism may seek and benefit from therapy. In the absence of an established and well-resourced service (such as those listed below), accessing effective counselling can be difficult and expensive.

Literature addressing therapeutic work with transgender people and people with transsexualism (and their partners and families) is increasing (Lev, 2004; Raj, 2002; Ettner, 1999; Lothstein, 1977). Research suggests that transgender people and people with transsexualism benefit from working with a therapist who has experience in gender issues (Rachlin, 2002). There are examples of private practitioners specialising in counselling with transgender people and people with transsexualism (for example, Choices Counseling & Consulting in New York - www.choicesconsulting.com/). Publicly funded multidisciplinary teams (such as those noted throughout this paper) usually include counselling services.

Accommodation and social support
Isolation, discrimination, violence, rejection/non-acceptance by family and friends, and financial difficulties may make it difficult to maintain employment and/or a support network. Some transgender people and people with transsexualism may therefore require accommodation assistance and other social support services; however, mainstream services may not be particularly aware of or sensitive to the particular needs of transgender people and people with transsexualism.

> ***The Gender Centre (NSW)***
> ***www.gendercentre.org.au***
> *The Gender Centre is funded by the NSW Department of Community Services and supported by Sydney South West Area Health Service to provide access to medium term accommodation for up to 11 people, and to a range of support services that aim to enhance the well being of people with gender issues. Additional funding is made available from the NSW Department of Health to work with transgender sex workers. This service is proudly managed by transgender people and people with transsexualism. It provides a first point of contact for people with transsexualism, their significant others and professionals working with them.*

Workplace transition education and support
Transitioning at work can be a challenge for the transgender person/person with transsexualism, as well as their colleagues, management and the organisation. Assistance and support may be needed to ensure the process is as smooth as possible. Policy development, mediation, education and training (including information about an employer's legal responsibilities) can be provided by a range of services/agencies (Walworth, 1998). Generally, these services are provided by private practitioners and/or peer based community groups.

Transgender people and people with transsexualism may also need assistance and support in finding employment, changing jobs/careers, and dealing with questions about disclosure, rights and responsibilities.

Transgender clinics, programs, private practitioners and employment organisations offer sensitivity training and other assistance related to an individual transitioning at work (see, for example, www.lisettelahana.com/ and www.tgender.net/taw/). The Victorian advocacy group, TransGender Victoria has recently finalised 'Practical Transitioning Guidelines for Employers' in conjunction with the Victorian Employers Chamber of Commerce (VECCI) and the Seahorse Victoria. These are available online at http://home.vicnet.net.au/~victrans/.

Primary health care

Research findings loudly indicate that many transgender people and people with transsexualism do not access primary health care services, even though they may have needs to be addressed (Garbo, 2000; Lee, 2000). A number of jurisdictions around the world have used various strategies to address this dilemma including the development of GLBT sensitive primary health care services (Clark, 2001); and generalist services specifically targeting GLBT communities (Craft & Mulvey, 2001). Garbo (2000) identified the need for physicians treating people with gender identity issues to be adequately skilled and trained to deal with these broader health care needs (and not only gender issues).

Tom Waddell Health Center (USA)
www.dph.sf.ca.us/chn/HlthCtrs/transgender.htm
The Tom Waddell Health Center offers a Transgender Clinic that promotes care for the whole person (primary health care) not only their gender issues. It is staffed by a multidisciplinary team including medical, mental health and social service personnel; and has strong referral links with community organisations. The Clinic was established in 1993 and is supported by the San Francisco Department of Public Health. It operates 6 days per week and is available after hours. The intake process for new clients is clearly defined – people drop in during certain hours to meet with a social worker; their next appointment will be with a member of the psychosocial team; and their third with a physician (a second appointment with the doctor may also be needed). Hormones are then prescribed and there is capacity to refer to counselling and peer support on site.

Peer support

Many transgender people and people with transsexualism experience significant isolation and some are rejected by partners, family or friends. Contact with peers can be safe, meaningful and supportive. A number of models of peer support exist around the world, including independent and unfunded services (such as the FTMA Network noted below), therapeutic support provided by professional workers who are also transgender or transsexual identified (such as Rupert Raj at Sherbourne Health Centre, Canada [www.sherbourne.on.ca/]) and internet-based networks such as FTM International.

FTMA Network
www.ftmaustralia.org or *www.ftma.net*
FTMA Network is a peer support group based in Sydney that provides information, contact, support, referral and resources to transgender men (FTM) and men with transsexualism; their partners, family and friends; professionals who work with them; and employers. Support is provided at monthly meetings, via phone, email, a bi-monthly newsletter Torque and via their website Currently FTMA receives no direct funding; however it is supported by the Men's Health Information and Resource Centre (MHIRC) and the Physical Disability Council of NSW.

Partner, parent and family support
The needs of partners, parents, family members and significant others has been given little attention in the literature; however, their needs are great. The impact of disclosure and transition is considerable and partners, parents and families often need to access support – with or without the person who is transitioning. Various forms of support may be needed, including couple and family therapy, peer support, access to information and education, assistance and support with further disclosure.

Partner Support Group (Victoria, Australia)
A 12-week support group for partners of people who identified as transgender or transsexual was trialled in Melbourne in 2003. The group met weekly and was facilitated by a psychologist and psychiatrist (Sinnott & Harte, 2004). Members had the opportunity to explore the implications of their partner's gender identity on them, their relationship, their family and friends. Feedback from participants was very positive and the group continued to meet for another 12 months (Sinnott, 2004)

Websites such as TransFamily (http://www.transfamily.org/) and organisations such as P-FLAG (Parents & Friends of Lesbians and Gays; see www.pflag.org/) provide internet and in-person access to parents and family members who have a child (or children) who are transgender or transsexual. Personal stories, such as *He's My Daughter – A Mother's Journey to Acceptance* (Langley, 2002) can also be of great solace and value. The need to meet another person in the same situation is sometimes very high.

Mermaids (UK) *www.mermaids.freeuk.com/*
Mermaids is a self-help group in the UK that aims to support children and teenagers (up to age 19) and their families, who are trying to cope with gender identity issues. They provide support via telephone, email and usual mail, the website, and group meetings; training and assistance to professionals involved in the care of children and young people; and direct support to individual young people. Mermaids has strong links and supports from the Gender Identity Development Service (Portman Trust).

Minimising the Risk of Misdiagnosis & Inappropriate Treatment

Given the physical, emotional and social significance of transition and gender affirmation, it is important that professionals involved in the process minimise the potential for misdiagnosis and/or inappropriate treatment. As noted above, adequate time and consideration is needed for appropriate assessment and monitoring during treatment (hormones and the real life experience). This needs to be balanced with the potential devastating effect of delayed treatment on individuals seeking help. It is important to note that the rate of regret in individuals who have transitioned is very low where comprehensive assessment has occurred – it is estimated to be between one and two percent (Smith, 2005; Bockting et al. 2004; Lawrence, 2003; Kuiper & Cohen-Kettenis, 1998; Cohen-Kettenis et al. 1997).

Individual practitioners and services can employ a range of strategies to minimise the risk of misdiagnosis and treatment, including:

- Operate within a multidisciplinary team involved in assessment, treatment and care. If this is not possible, establish links with other mental health professionals to enable consultation about individual clients.
- Provide adequate time for thorough assessment – both in terms of length of session and duration of assessment (one session may not be adequate). Ensure additional appointments are made and followed-up if missed.
- Maintain thorough documentation in line with professional best practice standards.
- Critically and thoughtfully apply the criteria for diagnosis, adhere to the HBIGDA Standards of Care (or other standards of care), and seek a second opinion.
- Offer referral and encourage participation in therapeutic counselling/therapy. If co-existing mental health conditions are identified, ensure effective referral and treatment.
- Develop and document a treatment plan in conjunction with the individual.
- Pay attention to the potential for and the capacity to address malingering, deceit or 'standard' responses that do not seem genuine (though this may not be common).
- Maintain professional development, supervision, regular reflection on ethics, and use of quality assurance practices (Kipnis, 2004; Anderson, 1997).

On a structural level, misdiagnosis could be minimised by establishing services that ensure co-ordination across disciplines, equity of access for all people, and provide assistance and support to professionals working in the community who are providing services to people with gender identity issues.

Transgender Treatment Effectiveness Network (USA)
http://www.caps.ucsf.edu/projects/TRANS/
In an attempt to improve access and services to transgender people, the Centre for AIDS Prevention Studies (University of California, SF) supports a network of nine agencies based in San Francisco. Agencies involved include primary health care, mental health services, forensic services, drug health services, accommodation and cultural services.

Professional Training & Workforce Development

Professional training is essential for practitioners to be fully informed, educated and skilled in dealing with transgender people and people with transsexualism. In addition to clinical training, gender specific training is required to meet the requirements of the HBIGDA.

In Australia, Walters (1997) noted that the lack of reliable, consistent and expert training opportunities limits the specialisation and professional recognition of the work of many practitioners in this field. It could be argued that undergraduate and post graduate training for medical practitioners and psychiatrists provides clinical training that in principle can be applied to the care of transgender people and people with transsexualism. Postgraduate sexual health training offered by the University of Melbourne offers a one-hour lecture and the NSW Institute of Psychiatry offers one subject titled "Gender, Sexuality & Mental Health" (for further information, see www.nswiop.nsw.edu.au/).

Clinical Practice with Lesbian, Gay, Bisexual & Transgender/Transsexual Individuals and Their Families (Chicago Training Collective)
http://www.ccfhchicago.org/lgbt.html
This postgraduate program is offered through the combined efforts of the Chicago Centre for Family Health, Horizons Community Services and Howard Brown Health Centre. The course consists of core and elective seminars such as Emerging Models of Clinical Practice with GLBT Clients; GLBT Identity Development Across the Lifespan; and Gender Issues and the GLBT Population. These seminars can be taken individually and together make up a graduate certificate. It was trialled in 2000 and continues to be offered – one of the strengths of the training is the integration of theory with practice.

The HBIGDA holds a biennial international conference that brings together experts in the field. Other relevant conferences do occur such as the Tavistock and Portman NHS Trust Atypical Gender Identity Development (www.tavi-port.org) and the International Sexology Conference (www.montrealsexo.com).

Numerous organisations and private companies provide in-service programs and sensitivity training. This type of training is particularly important for health care workers, emergency service personnel and those in customer service and helping roles.

OVERVIEW OF EXISTING SERVICES IN VICTORIA

There are a number of services and supports for transgender people and people with transsexualism in Victoria, including a specialist assessment and treatment service, community based primary health care providers, private and community based counselling services, and a range of peer support and advocacy groups.

The legislative environment in Australia and Victoria continues to improve in recognising and protecting the rights of transgender people and people with transsexualism. The Australian Family Court has recognised the marriage of a transsexual man and his wife; Victorian legislation provides protection from discrimination on the basis of gender identity, and allows correction/amendment to Victorian birth certificates to reflect a person's affirmed gender.

Assessment & Treatment Services

A number of public and private access points to assessment and treatment services exist in Victoria, however, there is no established system of coordination amongst them. Cross referral and informal contact does occur amongst individual practitioners as needed. Referral to assessment and treatment services is often informal and via word-of-mouth from members of the transgender and transsexual communities.

Services and experienced practitioners are concentrated in Melbourne and surrounds. Access to services outside Melbourne is limited, however, sensitive and informed health care and community workers are available in some rural services. Many practitioners make contact with well-known Melbourne based providers to gain information, support and secondary consultation regarding a particular client.

Monash Gender Dysphoria Clinic

The Clinic offers psychiatric assessment, hormone treatment, monitoring and access to surgery. It receives minimal public funding which provides for the employment of a psychiatrist (one session/week), clinical psychologist (one session/week) and administrative officer (two sessions/week). In addition to this, the Clinic brings together the following private or academic practitioners who offer assessment and treatment services in their own rooms/services:

- two psychiatrists
- one endocrinologist
- two surgeons (though one is no longer offering genital surgery, see below)
- one speech pathologist.

The team of practitioners meet once per month to review patients and consider approval for surgery. Practitioners are not compensated for their attendance at these meetings.

The Clinic receives referrals from interstate practitioners (GPs and psychiatrists) and provides access to surgery for these clients.

General Practitioners

There are a number of general practitioners/sexual health physicians who provide access to hormone treatment, ongoing monitoring and primary health care, and referral to surgeons as needed. This is similar in other states of Australia (Lowe, 1996). Many of these clinics offer access to on-site private counselling services or referral to community based services.

Private psychiatrists, psychologists & other counsellors
There are a small number of private psychologists and psychiatrists who provide assessment and ongoing counselling/therapy. Access to these services is dependant on an individual's capacity to pay and/or the practitioner's capacity to negotiate payment.

Specific services for children and young people
Young transgender people and young people with transsexualism can access public services at the Royal Children's Hospital, though this is not promoted or well-known at this time. The referral pathway to these services is via general practitioner referral directly to the paediatric endocrinologist (Associate Professor Garry Warne) and/or the consultant child psychiatrist (Associate Professor Campbell Paul). The establishment of a formal gender clinic for children and young people is currently being considered.

Speech pathology
Speech pathology services are provided by the Communications Clinic of La Trobe University - at the Bundoora Campus and at the Eye, Ear, Nose & Throat Hospital. The Manager of the Communications Clinic is an active member of the Monash Gender Dysphoria Clinic and is involved in treatment decisions. Fees are charged for speech pathology services as no public funds are specifically provided to the Communications Clinic. Fees range from $50 for assessment to $42 for treatment sessions; there is limited scope for negotiation.

The Communications Clinic has an international reputation due to the active involvement in research (resulting in numerous publications and conference presentations) and professional education over the 20 years of operation.

Private speech pathologists can be accessed at any time and would not require a referral or letter of support.

Surgery
Access to surgery is extremely limited at this time in Victoria. Chest surgery (breast augmentation or chest reconstruction) and laryngeal surgery is accessible through private surgeons. Usually, a letter of referral from a GP would suffice in accessing such surgery. The cost of this surgery needs to be met by the individual, private health insurance is recommended, though not essential. The cost is often beyond the capacity of many transgender people and people with transsexualism.

The two surgeons performing genital surgery in Victoria are associated with the Monash Gender Dysphoria Clinic. Genital reconstructive surgery is usually considered only with at least 18 months of real-life experience. A recommendation from the treating psychiatrist and other health care workers involved in the care of the individual (such as GP, therapist) are required. The Monash Gender Dysphoria Clinic has access to public funds to minimise (or fully cover) the out-of-pocket expenses of a few clients each year.

Genital surgery is also available in NSW, New Zealand and in south-east Asia, for those able to pay the full cost of surgery (and travel). Post surgical care and follow up surgery may be difficult to access in these circumstances.

Care

Access to services is mediated by the financial resources of transgender people and people with transsexualism. Private services may be available but cannot be accessed by individuals who cannot afford them. Demand on community or publicly funded services may be so great that waiting time is high.

Counselling and therapy services

Transgender people and people with transsexualism can access counselling services through mainstream health services, through private practitioners (psychologists, psychiatrists and counsellors) or a community based counselling Service (for example, Victorian AIDS Council/Gay Men's Health Centre, Bouverie Family Therapy Service). There are a limited number of practitioners with experience in counselling regarding gender identity. Transgender people and people with transsexualism often seek out gender sensitive and experienced therapists to deal with non-gender identity related issues.

Primary health care

As noted above, there is a small number of general practitioners providing sensitive primary health care in addition to access to and monitoring of hormone treatment. GPs who are working with a transgender person or person with transsexualism for the first time often make contact with these experienced GPs for information and guidance.

Accommodation

At this time, no funded accommodation service exists for transgender people or people with transsexualism in Victoria. Peer support groups offer limited accommodation support, especially for those travelling from rural Victoria to access services in Melbourne. Demand on supported accommodation services is not known, nor is it known how sensitive mainstream services are to transgender people and people with transsexualism.

Employment

At this time, no employment service in Victoria promotes their willingness and ability to work with transgender people and people with transsexualism. It is possible that existing mainstream services may be working with individuals. The extent and efficacy of this is not known.

Peer support groups

There are a number of established peer support groups operating in Victoria and others operating across Australia (see Appendix II for more details). No public funding is provided to any transgender support group. Key community agencies such as the ALSO Foundation and the Victorian AIDS Council/Gay Men's Health Service may provide informal support (such as access to meeting space, mail facilities).

GLBTI youth groups

Various local government and community health services have established support groups for same sex attracted young people – some of which explicitly include young transgender people or young people with transsexualism. The Rainbow Network lists all these groups and contact people for them (see http://www.latrobe.edu.au/rainbow/). Anecdotal information suggests increasing number of young people questioning and exploring their gender identity access these groups or make contact with the workers responsible for them.

Needs of partners, family, & friends
There is no specific or independent support group operating for partners, family members and/or friends. However, the majority of peer support groups in Melbourne (in-person and internet based groups) welcome the participation of partners and family members at some time. A small number of partners of transgender people and people with transsexualism provide informal support to other partners, though access to this is not always easy.

There is no support network for parents of young people who identify as transgender or transsexual. Internet based support is available with peers overseas.

Professional Training & Workforce Development
Professionals involved in assessment, treatment and care of transgender people and people with transsexualism maintain informal links with each other, however, no formal links or systems exist.

During 2001, a professional Network was established in Melbourne to promote information exchange, cross referral and support. The Network met a number of times over two years; while interest was high, attendance at meetings was low. The Network ceased to operate in December 2003 (Sinnott, 2003).

Professional workshops and seminars have taken place from time to time; and have addressed issues of ethics or provided opportunity to hear from key researchers and or practitioners such as Milton Diamond. The Royal Children's Hospital and the Australian Research Centre in Sex, Health & Society have been instrumental in organising such events. In 2004, two individuals organised and facilitated an educational workshop for general practitioners and other interested professionals.

There is no formal education or training in gender identity issues available in Victoria. The Postgraduate Certificate in Public Health (Sexual Health) offered by the University of Melbourne includes one lecture on the needs and issues faced by gay, lesbian, bisexual and transgender people.

PRIORITY NEEDS

The following priority needs were identified by transgender people and people with transsexualism and submitted to the Ministerial Advisory Committee on Gay and Lesbian Health during their community consultation in 2002. In addition, the author consulted with key practitioners, service providers and community members to verify and update areas of priority need.

Multidisciplinary Assessment, Treatment & Care Service

Transgender people and people with transsexualism continue to ask for access to a comprehensive assessment and treatment service that is respectful, responsive, able to provide ongoing monitoring and support (including post surgery support), that has a choice of practitioners and is able to offer appointments out of working hours. Support should extend to clients after surgery and there is some concern about the lack of services able to work with those individuals not able to access surgery.

Private, community based general practitioners have identified the need to access assessment and counselling services that are responsive to and respectful of the needs of people seeking support. Such a service may also be able to work with general practitioners to provide ongoing monitoring during treatment.

A specialist service for children, young people and their families is needed to support and streamline access into appropriate services.

Needs of Particular Communities

The particular needs of individuals and communities were raised by a number of key informants. Consistently identified priority issues were:

Cultural sensitivity
There is an identified need to increase the sensitivity and attention to the needs of culturally and linguistically diverse transgender people and people with transsexualism. It was noted that the understanding and expression of gender varies across cultures and that assessment, treatment and care services need to be sensitive to this diversity.

Indigenous transgender people
The specific needs of indigenous transgender people and people with transsexualism and their communities require attention and resourcing.

Individuals in custodial care
Access to assessment, treatment and appropriate care for people in custodial care is not standardised in Victoria. Meeting these needs in a custodial setting can be difficult and complex; access to the input of an experienced practitioner may be of benefit. The needs of people in the justice system (goals and detention) were identified as an urgent priority - policy and program development in this area is needed.

Development of Victorian Standards of Care

Key informants raised concerns about the lack of common standards shared by professionals in the field. Many of the current services and providers in Victoria do not meet the requirements of the HBIGDA Standards of Care or alternate standards. There are many reasons for this including lack of coordination, differing theoretical stance, the difficulties in managing access to a mix of public

and private services, the lack of referral options, and clients' preference not to undergo detailed assessment processes. The need for coordination is high. In particular, attention needs to be given to concerns about the ease with which hormonal treatment is available without assessment or second opinion.

The development of Victorian (or Australian) standards of care would provide all practitioners with an agreed and endorsed approach to assessment, treatment and care. Such standards would need the input of various disciplines and would be a significant undertaking. In reality, the number of practitioners involved across Australia is relatively small – organising a symposium to draft a framework would be achievable with sufficient resources.

Mental Health Services

Transgender people and people with transsexualism who have concurrent mental health issues need to be able to access services that are aware of and sensitive to gender identity issues. The lack of response and sensitivity of existing mainstream mental health services to the needs of people with GID was raised as a major service gap. This requires education and training of mental health staff, communication between service providers, and effective case management.

Counselling & Therapy

In addition to a multidisciplinary service, there is a need for counselling services to be available for individuals, couples and families. Strong referral and case management links between the counselling services and the multidisciplinary team and other mental health services would need to be established to ensure coordination of care.

Local mainstream counselling services (such as community health) may be able to provide counselling and social work support to many people in their communities if there was access to secondary consultation, supervision and training.

Primary Health Care

Transgender people and people with transsexualism have identified their need for sensitive, educated and informed primary health care provision. In addition, they have identified a number of primary health care concerns that need to be addressed, including breast and cervical cancer screening, prostate health, polycystic ovaries, osteoporosis, bone density testing, body image issues, drug and alcohol use.

Sensitive and appropriate primary health care services are needed outside of Melbourne.

Sexual Health Needs
The sexual health needs of transgender people and people with transsexualism were identified as a key need. Sexual health services and physicians are often more aware of and sensitive to the needs of transgender people; however, there are only a few dedicated sexual health clinics in Victoria (Russell, 2005 (a) and (b)).

A small number of sex workers are transgender people or people with transsexualism. Their needs are often overlooked even though Australian research indicates their needs are significant (Harcourt & Donovan, 2000; Perkins, 1995). Outreach services are provided by the peak body (Resourcing Health & Education in the Sex Industry).

Accommodation
The community has identified the need for access to emergency, supported and short term accommodation, especially for people from rural Victoria visiting Melbourne to access services. There is considerable interest in the possibility of establishing a service similar to the NSW Gender Centre that provides supported accommodation.

Employment Assistance
Workplace transition education and support is provided by a small number of private practitioners. Access to such support is therefore mediated by capacity to pay. The need for publicly available workplace transition education and support is high. The Victorian Employers' Chamber of Commerce and Industry (VECCI) in the development of 'Practical Transitioning Guidelines for Employers' is a positive beginning to potential ongoing projects (such as employer training).

Retraining and careers counselling is also needed by a large number of transgender people and people with transsexualism who wish to (re) enter the workforce in their affirmed gender.

Peer Support
There are many peer support groups meeting the needs of specific transgender or transsexual communities – some are age specific, others only for women or men, while others may be for people with transsexualism only. While such diversity may provide options for individuals, it can be confusing and overwhelming.

At this time, no transgender or transsexual peer support group receives government funding (or other assistance) to provide outreach, information, support, resources and workshops of issues of interest and need (such as 'passing' skills, rights and responsibilities, communication and assertiveness skills).

The Seahorse Club has held a peer conference on a number of occasions, the last was in 2002. This event has been a useful way to bring together many transgender people and people with transsexualism and provide information, support and to introduce service providers. Funding may enable greater participation if costs were lessened and promotion extended.

The establishment of a single point of contact, with access to information, resources, referrals and meeting space has been identified and strongly supported.

Partners, Family & Friends Support
There is a need to provide responsive peer and professional support to partners, children (adult and younger), family members (parents in particular), and friends.

Those involved in assessment, treatment and care could include partners more in the process (though it is acknowledged that this would need to be with the consent of the transgender person or person with transsexualism).

Family members often need access to accurate information, support and counselling – which at times can be provided by peer support groups. The need for 'independent' or professional support was also noted.

Professional Training & Workforce Development
Training and workforce development is a significant need at a number of levels. Health care workers need to be informed of and sensitised to the existence and needs of transgender people and people with transsexualism. Particular attention and more detailed training needs to be provided to priority professions including general practitioners, emergency department personnel, nurses, psychologists, psychiatrists, counsellors, youth workers, teachers and custodial care workers. Such training needs to be included in basic professional training and available as workshops or in-service training programs depending on need.

Workers in mainstream services who have contact with a transgender person or a person with transsexualism often need access to secondary consultation and ongoing support.

Professionals involved in the care and support of transgender people and people with transsexualism may also need access to effective referral networks and peer review/support systems.

There is a significant need to increase the number of health care workers interested in working with transgender people and people with transsexualism. In particular, there is a need to increase access to general practitioners, psychiatrists, endocrinologists and surgeons. Increasing opportunities for medical residents to work with a multidisciplinary team may be one approach worthy of development and resourcing.

It was noted that private practitioners involved in assessment, treatment and care services bear the insurance burden and the potential threat of a legal suits for misdiagnosis and/or inappropriate treatment.

Resource Development & Distribution
There is a need for reliable, accurate and readily available resources for transgender people, people with transsexualism, their partners, families and friends, and health care providers. There is considerable information available on the internet however it is not all accurate, up-to-date or relevant to people in Victoria.

Research & Publication
Little has been published of the work being done in Victoria with transgender people and people with transsexualism. This is indicative of the paucity of research being conducted (though this has increased in recent years). Support for research and publication is needed to ensure the experiences of Victorian services

and practitioners is documented and available for international comment and review.

Advocacy

Advocacy is needed to progress a number of major platforms. Legislative reform in Victoria has achieved recognition of transgender people and people with transsexualism. However, some areas of legislative reform are still needed to ensure the human rights of transgender people and people with transsexualism.

Medicare reform is needed to ensure adequate benefit is provided for all elements of surgical reassignment. The Medicare Benefits Review Committee considered this issue in 1985; the recommendations have not been implemented (Medicare Benefits Review Committee, 1985). This needs to be reconsidered and updated. It is noted that 'cosmetic surgery' (such as breast augmentation) attracts no benefits. The out-of-pocket expense of genital surgery (approximately $15 000 - $20 000) places it out of reach of many individuals.

Discrimination and vilification continue to be experienced by many Victorian transgender people and people with transsexualism. There is a need for broad community education, education and training of police and other emergency personnel (ambulance officers, fire fighters and hospital Accident & Emergency Dept staff).

MODELS OF SERVICE DELIVERY: OPTIONS FOR CONSIDERATION

Listed below are a range of elements of a comprehensive service delivery model that could be considered for implementation in Victoria. One single model is not suggested, instead, a number of projects and programs are offered that bring together existing services, maximise resources, and build capacity. Some options are based on projects and programs operating overseas; some are based on existing or proposed services in other Australian jurisdictions; while others are suggestions provided by members of the community and/or professionals working with them.

The options presented are made with recognition of the existing mix of private and public service provision and the expectation that this mix will continue. The suggestions are made without presumption of a significant increase in public or private funding. It should be noted, however, that there are significant limitations to what can be achieved without additional resources dedicated to the many needs of transgender people and people with transsexualism.

Multidisciplinary Assessment, Treatment & Care Team

It is proposed that an effective, highly regarded and accessible multidisciplinary service is central to any model of service provision. In addition to providing high level quality assessment, treatment and care services to individuals, it would also provide leadership, support and training to other health care workers and services involved in treatment and care; it would be actively involved in research and contribute to international understanding of transsexualism. Such a service would have links with a major teaching hospital and be actively involved in health care worker education, training and supervision. Adequate funding would be required to enable such a service to be developed in Victoria. A variety of government programs may be able to contribute to such a team, for example, Mental Health, Supported Accommodation Assistance Program, Community Health, and the HIV/AIDS Program.

Monash Gender Dysphoria Clinic

There is a need and opportunity to develop the Monash Gender Dysphoria Clinic so it more effectively meets the needs of individuals seeking assistance. The minimal public funds provided severely limits the capacity of the service to be responsive to needs, resulting in limited access to practitioners, long waiting periods and limited secondary consultation provided to other health care workers (which is an essential component of an adequate multidisciplinary service).

A publicly accessible multidisciplinary team needs to be available to transgender people and people with transsexualism, and to other professionals working with them. At a minimum, such a team would coordinate the assessment and monitoring of transgender people and people with transsexualism; consider and make recommendations for surgery; and provide post-surgery care. This team needs to:

- be adequately staffed to ensure a minimal delay in response to referrals
- have capacity to deal with emergency referrals
- provide options of practitioners for clients
- offer out-of-hours appointments
- provide services to partners and families
- document and publish their work
- initiate and participate in research and

- provide training and other supports to other practitioners working in the field.

The key disciplines to be involved in such a team are psychiatry, psychology, endocrinology, surgery, and social work. If a shared-care model was implemented, general practitioners, sexual health physicians and other community based or private practitioners would also be involved in the team. A Community Liaison and or Shared Care Coordinator position could also be part of the team. At best, the team would be attached or associated with a public teaching hospital as this would provide the potential to access other services (such as social work, family therapy, and occupational therapy). It may also provide an academic and professional focal point for research, training and networking.

Other initiatives and services need to be able to refer to an assessment and treatment team that will be able to provide support and work together with clients.

Child & youth specific service
Access to support for families with children with gender identity issues is not easy. Currently, a small range of agencies provide support; however, referral pathways are not clear nor are the services well known. As noted above, consideration is being given to establishing a dedicated clinic at the Royal Children's Hospital that would include existing practitioners involved in assessment, treatment and care of transgender young people and young people with transsexualism. This includes a paediatric endocrinologist, consultant child psychiatrist with possible access to other practitioners with social work and/or family therapy experience. Current experience indicates the demand for services for children (under 10 years) is small; however, promotion of a service may result in increased referrals.

It should be noted that the Royal Children's Hospital has an established history and reputation for the treatment and care of children with an intersex condition, and their families. Combining intersex and gender identity services may contribute to joint learning, sharing of knowledge and resources, and improved continuum of service provision.

Should a child and adolescent service be established, the relationship between it and the Monash Gender Dysphoria Clinic would need to be clear. There would be areas of potential overlap and also areas where referral arrangements would need to be clearly documented, most notably young people aged 16 and above, access to hormone treatment, and surgery.

In Melbourne, young people questioning or exploring their gender access 'queer' support groups and/or seek counselling support through youth specific services (such as the Action Centre, Family Planning Victoria). There is a need to ensure these workers have access to education and training, secondary consultation, and are familiar with the referral pathways to clinical services. There are existing professional networks amongst youth workers that could be used to promote such awareness.

A specific model of service provision for children and adolescents has been drafted for possible implementation in the public health system of NSW (Sinnott, Newman & Koder, 2005). Should this service be established, it would be wise for links to be created and resources shared.

The Development of Victorian Standards of Care

At this time, there is no consistency across services and practitioners in Victoria regarding assessment and treatment. As noted above, there are concerns about the ease of access to hormone treatment without mental health assessment or second opinion. Agreed standards of care could be developed in Victoria to inform, support and protect those in private practice and to ensure the publicly funded multidisciplinary team recognises the appropriateness of services provided by them.

A number of practitioners involved in assessment, treatment and care have expressed an interest in developing national standards of care, including the Gay, Lesbian & Bisexual Interest Group in Psychiatry (Harte, 2004) and the Chapter of Sexual Health Physicians (Russell, 2005 (c)). This would take time, effort and resources, but may also have the secondary benefit of bringing all practitioners together to discuss issues and perhaps standardise practice.

Shared Care

Given the diverse range of community based and private practitioners involved in treatment and care, a shared care approach may maximise outcomes for transgender people and people with transsexualism. A formal arrangement could be developed between general practitioners, therapists, psychologists and other practitioners and the Monash Gender Identity Dysphoria Clinic. The arrangements would clearly define referral arrangements, recognition of community based care, and streamlined access to surgery. This model would enable the multidisciplinary team to focus on assessment and psychiatric monitoring, and to support endocrine care and primary health management provided by other services.

Considerable effort would be needed to develop protocols, criteria for service provider inclusion (such as ongoing participation in training, case conferencing or supervision). This could be coordinated by a dedicated Community Liaison Officer position in the multidisciplinary team (this would require additional resources). Case conferences could be organised to ensure high quality care is provided and documented. The involvement of general practitioners could be supported with Medicare rebates for care planning. When appropriate, private and community practitioners could refer people for surgery and participate in decision-making.

This model would be particularly useful in ensuring access to high quality services outside of metropolitan Melbourne. The combined efforts of a multidisciplinary team and local health care providers would minimise the disruption of travelling to Melbourne for regular appointments. Over time, a strong network of rural providers could be established.

Access to Professional Secondary Consultation & Supervision
Practitioners working in the field may need to consult with another, more experienced practitioner to discuss strategies, interventions, referral options and other issues. An effectively functioning multidisciplinary team would be in a prime position to be able to provide this service directly or to maintain and support a network of professionals willing to provide such a service. Issues of cost will need to be considered.

Counselling & Therapeutic Support
There are a number of community-based, publicly funded and private practitioners providing counselling services that are not necessarily considered part of the assessment, treatment and care continuum of services (such as Bouverie Family Therapy Services, Victorian AIDS Council/Gay Men's Health Service Counselling and Melbourne Sexual Health Centre). These services provide important additional support to potentially vulnerable clients.

To support best practice, it would be useful for counsellors and therapists to have access to training, secondary consultation and/or the potential for a clinical supervision as needed. A round table meeting of interested services could result in shared and agreed standards of care; effective support for practitioners; and the ability to cross-refer when required. If a multidisciplinary team was adequately resourced, a practitioner from that service could provide such support. Alternatively, a peer support system could be encouraged and it could meet as required.

Surgery & Post Surgery Support
Not all transgender people and people with transsexualism will seek gender affirmation surgery. As genital surgery is only provided in the private sector at this time in Victoria, some may not be able to access it due to costs. The mental health implications of this are considerable.

For those who do access surgery, post-surgical care (physical and mental health) is needed. Facilitated group support may be a more efficient way to provide ongoing access to support. This could be explored by the multidisciplinary team or could be provided by a peer support group with additional support, training and funding.

Peer Support
Creating a first point of contact for anyone exploring his or her gender identity or who identifies as transgender or a person with transsexualism is needed. Attempts to bring the diverse peer groups together have not been productive or sustained as there are strong points of disagreement. If peer support groups would like to come together to provide one point of contact, facilitation and support will be needed. Establishing a peak body with representation from all peer support groups may be one option.

Alternatively, a clearinghouse of information about all the existing peer support groups could be provided by another peak body such as the ALSO Foundation or Gay & Lesbian Health Victoria.

Advocacy
There is considerable need for advocacy at a community, policy, program and legislative level. The combined efforts of peer support groups and professionals

involved in their care may, in many instances, provide a stronger base. Of particular concern is the need to standardise and improve treatment and care for people in custodial care; policy and practice regarding reproductive health options available to people prior to hormone treatment; school-based education and program development; and improved Medicare coverage for gender affirmation surgery.

Professional Training & Workforce Development

As a principle, training and workforce development initiatives should actively involve members of the transgender and transsexual communities. Consideration could be given to the development of a 'speaker's bureau' along similar lines to the successful HIV Positive Speakers Bureau provided by People Living with HIV/AIDS. Selection, training, promotion and management processes established for the HIV speakers group may be transferable to a transgender/transsexual speaker's bureau. Even without such a project, transgender people and people with transsexualism should be involved in training programs where possible and appropriate.

Workforce development

Services for transgender people and people with transsexualism are vulnerable given the relatively few practitioners involved in their assessment, treatment and care. There is a great need to develop interest in and commitment to provide services from other service providers – both in the private and public sector. This will take time however it has a high degree of urgency.

There is an urgent need to increase the number of surgeons interested in and providing surgery to transgender people and people with transsexualism (see below). It is estimated that there are no more than five surgeons providing genital surgery in Australia, and one of those surgeons based in Melbourne is not currently available.

The potential to create incentives and/or scholarships for general practitioners and scholarships for other practitioners to learn more about the treatment and care of transgender people and people with transsexualism may be worth exploring.

In-service and sensitivity training

A wide range of mainstream organisations and specialist services request or need in-service training, especially when working with a transgender person or person with transsexualism. Providing information and sensitivity training would have a significant impact on the quality of service provided to clients. Unfortunately, many agencies cannot afford to pay private practitioners to provide such training. With the input of existing practitioners, a short in-service program could be developed and offered by a peak organisation (such as Gay & Lesbian Health Victoria). The efficacy of such a project would require funding and support.

Professional conference

As a beginning point, it would be useful to trial a professional conference where practitioners could share their experience and knowledge with others in Victoria (or Australia). The proceedings of such a conference could be produced and begin documenting the experience gathered by practitioners in the field. If it was successful, it could grow to being a biennial event either for Victoria alone or a national conference could be established. Given the diversity of disciplines involved in this field, it would

be difficult to piggy-back such a conference on to any other; however, this could be considered (for example, the National Health In Difference Conference).

It may be useful to offer a biennial update following the HBIGDA Conference and/or other relevant conferences to distribute current knowledge, and to engage Victorian practitioners in international debates and issues.

Undergraduate and post-graduate training
A longer-term strategy to increase practitioners' awareness of gender issues would be to ensure the inclusion of education and sensitivity training in undergraduate and post-graduate health care worker training. This may best be achieved through existing efforts to ensure adequate attention is given to the needs of gay, lesbian and bisexual people in medical and other training. The expertise of current practitioners may be needed when presenting to professional groups.

Evidence Base & Research
Existing services and practitioners in Victoria need to be encouraged to document and publish their experience. The work of the Gender Dysphoria Service is worthy of further documentation – but will need financial and research support to ensure it is done. Bringing practitioners together to critically reflect on their own experiences and that of their colleagues (such as the conference suggested above) may be an effective starting place.

Research projects have increased in the recent past; even so, opportunities need to be increased for a range of disciplines. This appears to be done well at La Trobe University's Communications Clinic under the supervision of Georgia Dacakis and Jenny Oates. Opportunities for medical practitioners and specialists, psychologists, psychiatrists and others need to be promoted and well supported. The active involvement of the transgender and transsexual communities would be of significant importance in identifying priority projects and ensuring community support.

Support for community based and/or peer group research needs to be found and provided. Peer support groups provide a significant amount of support to isolated and in need individuals; some basic research would provide significant information about people who may need but do not necessarily access services.

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APPENDIX I LIST OF KEY INFORMANTS

Monash Gender Dysphoria Clinic

Dr Fintan Harte*	Psychiatrist
Dr Trudy Kennedy*	Psychiatrist
Ms Mary Samuhel*	Clinical Psychologist
Dr Anthony Hunter	Endocrinologist
Mr David Hunter-Smith	Surgeon
Mr Simon Ceber	Surgeon

General Practitioners

Prahran Market Clinic

Dr Rebecca Overbury*	GP
Dr Darren Russell*	GP
Dr Beng Eu	GP
Dr Sven Striecker	GP

Centre Clinic, Victorian AIDS Council/Gay Men's Health Centre (VAC/GMHC)

Dr Nick Medland*	Director

Department of General Practice, University of Melbourne

Dr Ruth McNair*	Director, Undergraduate Studies
Dr Ron McCoy*	Consultant

Counsellors/Therapists

Ms Linda Midalia*	Psychologist (private practice)
Ms Nicci Rossel*	Coordinator, Counselling Service, VAC/GMHC
Dr Mark Arber	Consultant Psychiatrist, Centre Clinic, VAC/GMHC
Mr Peter Dunn	Psychologist (private practice)
Dr Andrew Pethebridge*	Psychiatrist, Sydney South West Area Health Service

Speech Pathology

Ms Georgia Dacakis*	La Trobe University Communications Clinic

Royal Children's Hospital

Dr Yasmin Jayasinghe*	Adolescent Gynaecologist, Centre for Adolescent Health
Dr Sonia Grover*	Adolescent Gynaecologist
Assoc Prof Garry Warne*	Director Royal Children's Hospital International
Assoc Prof Campbell Paul	Consultant Child Psychiatrist

NSW Institute of Psychiatry

Dr Louise Newman*	Director

Victorian Department of Human Services

Mental Health

Dr Ruth Vine*	Director Mental Health Branch

Ministerial Advisory Committee on Gay & Lesbian Health – Project Steering Committee

Ms Anne Mitchell
Dr Ruth McNair
Ms Lauren Christopher
Mr Terry Laidler

NSW Dept of Health

Ms Su Reid*	Senior Policy Advisor & Executive Officer, Expert Group on Variation in the Formation and Expression of Sex

NSW Gender Centre

Ms Elizabeth Riley*	General Manager

Peer Support Groups

TransGender Victoria*
Seahorse Club (Vic) *
FTMA Network (NSW)*
TLC

* Indicates responses were received from these organisations/people via face-to-face meeting, email and/or phone contact

APPENDIX II PEER SUPPORT GROUPS, ADVOCACY SERVICES

VICTORIA

Gender Identity Support Group
PO Box 373
Bairnsdale VIC 3875
0421 209 608
GISG@bigpond.net.au
http://www.gisg.org/

Seahorse Club of Victoria
PO Box 86
St Kilda VIC 3182
(03) 9513 8222
seahorse@yahoo.com.au
http://www.seahorsevic.com

Gender Affirmation and Liberation
PO Box 245
Preston VIC 3072
(03) 9517 1237
translib@vicnet.net.au

TransGender Victoria
PO Box 762
South Melbourne VIC 3205
(03) 9517 6613
transgendervictoria@yahoo.com.au
www.vicnet.net.au/~victrans/

Trans Melbourne Gender Project
Trans_melbourne_gender_project@yahoogroups.com

AUSTRALIA

Australian Woman Network
http://www.w-o-m-a-n.net/

Men's Australia Network (MAN)
http://home.vicnet.net.au/~man/

FTMA Network
http://www.ftmaustralia.org