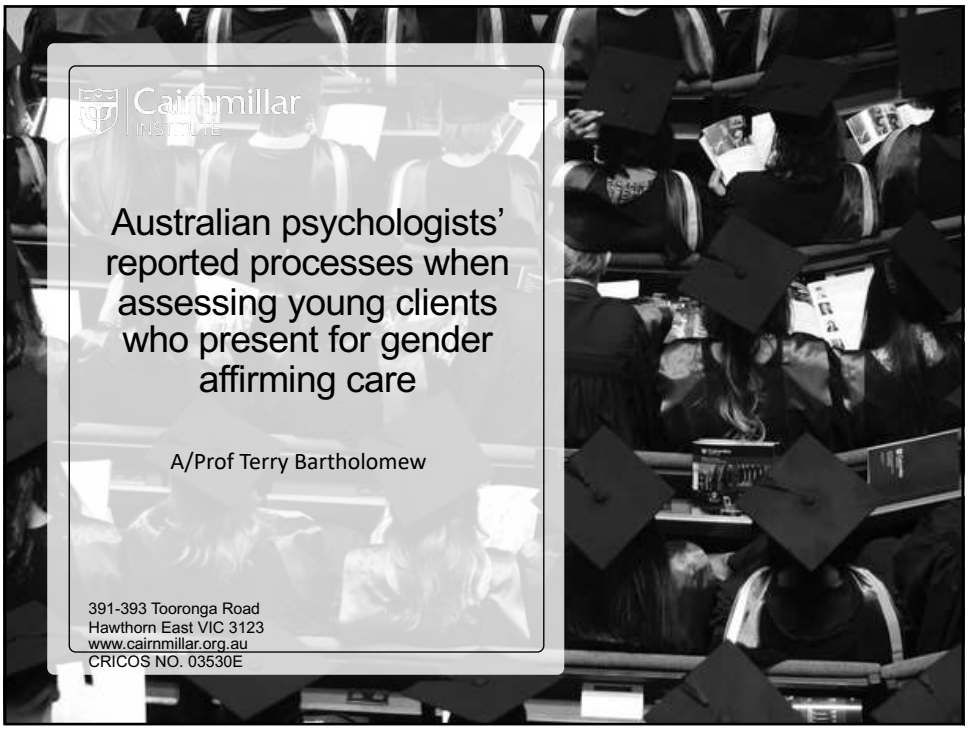

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IN Goals of this session

- To briefly outline some of the wider contextual matters impacting on clinical work in the GAC space
- To present some data from an exploratory study of how our colleagues report responding to a depicted client who is seeking GAC
- *Why*? To provide information about the frameworks, to identify (and normalise) professional uncertainty in this space, and to invite an open and expansive mindset that can increase access to informed GAC for such clients

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2

Trans and Gender-Diverse Youth in Australia: Demand and Disparities

In Australia and globally, an estimated **2–3%** of young people identify as transgender, gender diverse, or non-binary (TGDNB).

Young people typically present to primary care (e.g., GPs) prior to referral to specialised gender clinics (e.g., RCH, Monash Health), but these now have long waiting lists

The 'co-morbidities' term

22.7% of trans young people have **eating disorder Dx**

74.6% of trans young people have been diagnosed with **depression**

72.2% have been diagnosed with **anxiety**
→Both rates are **10x higher** than Aust GP data (12–17

48.1% of trans young people have attempted suicide
•**20x** higher than GP (12–17)

22.5% of trans YP reported a formal autism diagnosis

35.2% were scored in the range warranting further ASD assessment
This is significantly higher than the **1–2.5%** rate in the Australian GP

60.1% of trans young people felt isolated from medical / MH services

42.1% had negative experiences with providers, including:
• Lack of gender diversity knowledge
• Dismissal as a "phase"
• Unclear referral pathways

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Trans and Gender-Diverse Youth in Australia: Demand and Disparities II

- Referrals to gender-affirming services have increased dramatically across western jurisdictions in recent years
- Referrals to the Royal Children's Hospital (Vic) grew from **1 patient in 2003 to 473 in 2020 (AusPATH, 2022).**
- A **tenfold increase in referrals** to specialist endocrine clinics was recorded in Melbourne between 2011 and 2016 (Cheung et al., 2018).
- Entry points are shaped by service availability, funding, SES, age, parental involvement, and consumer knowledge of health system navigation.
- There are informal indicators that long waiting lists at dedicated services mean that more clients seeking GAC are attending private practices

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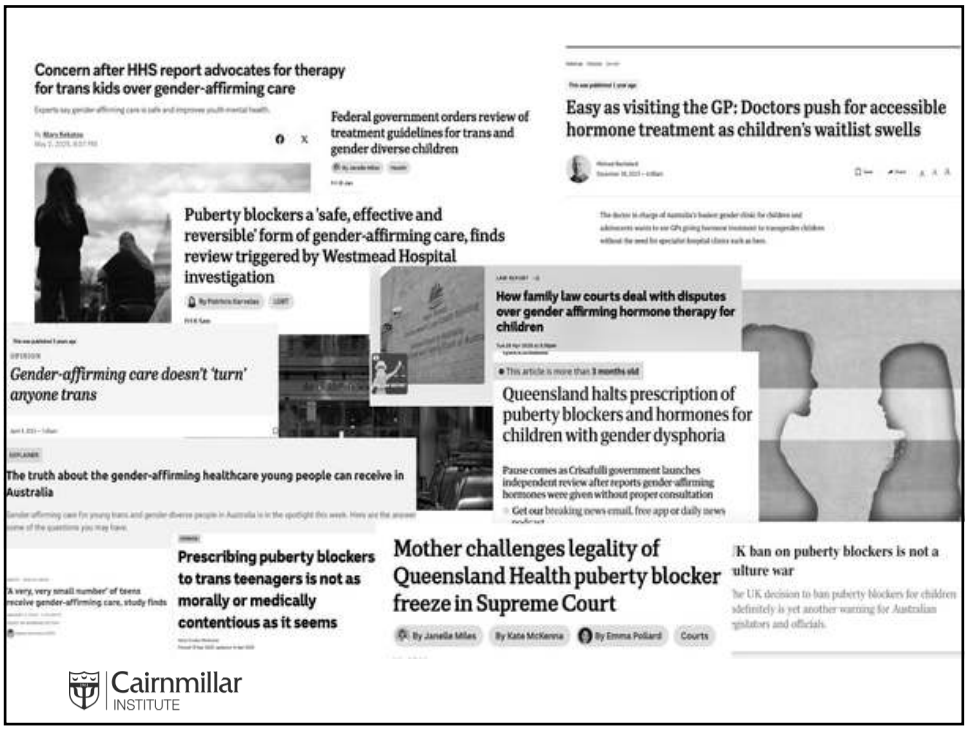

5

The legal landscape: Some relevant common law decisions

***Gillick* Competence:**

- A young person can consent to medical treatment if they demonstrate sufficient maturity and understanding of the nature and consequences of the treatment.
- *Gillick v West Norfolk and Wisbech Area Health Authority [1986].*

Pivotal Family Court of Australia (FCA) decisions:

- *Re Kelvin (2017):* Court approval not required for Stage 2 (Gender affirming hormone therapy) treatment if:
  - There is agreement between adolescent, parents and treating team
  - The adolescent is *Gillick* competent
- *Re Imogen (2020):* If there is any dispute (e.g. between parents, adolescent, or clinicians) in regard to treatment:
  - Court approval is still required
  - Gillick competence alone is not sufficient
  - South Australia, NSW (and to a lesser extent Vic) have specific legislation that outlines Minor's rights in medical tmt dec making also.

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Models of Care

	WPATH Model World Prof Asoc for Transgender health	Informed Consent (IC) Model
Setting	Specialist clinics (e.g., Monash Health Gender Clinic) **Used across all three stages of care*	Primary care clinics (e.g., Equinox, Austin Health, Private GPs) **Stage 2-GAHT only*
Standards	**WPATH SOC-8** and The Australian Standards of Care and Treatment Guidelines (ASOCTG)	**AusPATH I**nformed Consent Standards
Assessment Process	Biopsychosocial assessment by MH and medical teams Sustained gender incongruence; Capacity to consent; Review of co-occurring mental/physical health conditions; Fertility preservation	Four stages: (1) Introduction, (2) Medical History, (3) Hormone Education & Readiness, (4) Hormone Initiation
Session Count	Median: 5 sessions	Median: 2 sessions
Assessment Professionals	Conducted by a multidisciplinary team, involving diagnostic evaluation, risk assessment, and collaborative decision-making.	Conducted by medical professionals; Mental health assessment not required always **(unless the case presents clinical complexity)*
Population	Clients with complex clinical or psychosocial needs	Streamlined access; often preferred by TGDNB clients

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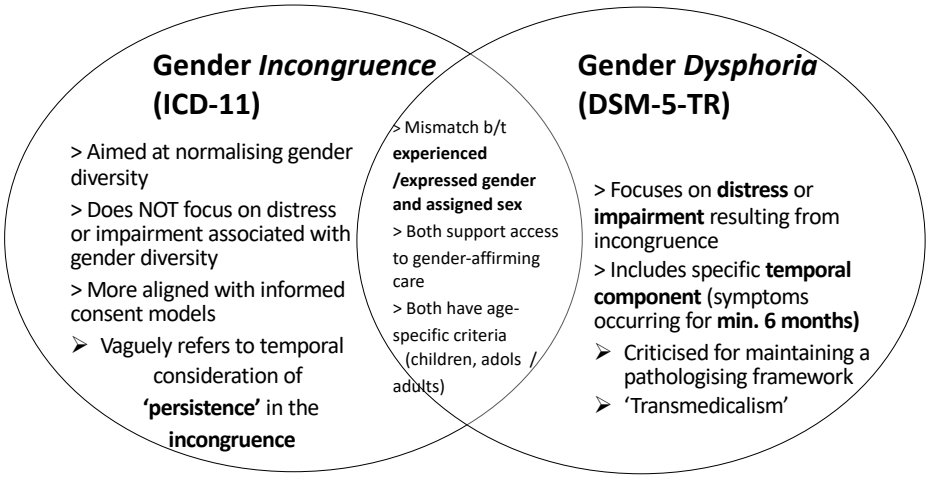
Diagnostic Frameworks for us



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Stages of Gender-Affirming Care

Stage 1
Puberty Blockers

- Suppresses the progression of puberty by halting the development of secondary sex characteristics
- Typically initiated at Tanner Stage 2 in early adolescence
- Requires multidisciplinary assessment and parental consent (some legal variations)

Stage 2
Gender-Affirming Hormone Therapy (GAHT)

- Involves the use of oestrogen or testosterone to induce physical changes aligned with the individual's affirmed gender
- *Often the first medical step: **93% of youth receiving GAHT do not access puberty blockers beforehand**
- Access remains limited: ~50% want GAHT, only 14% receive it
- Can commence at under 18, provided parental consent (legal variations)

Stage 3
Surgical Interventions

- Rarely accessed under 18. Genital surgery is **not** recommended before age 18
- Chest surgery may be considered for transmasculine youth aged 16–17 under specialist care and assessment

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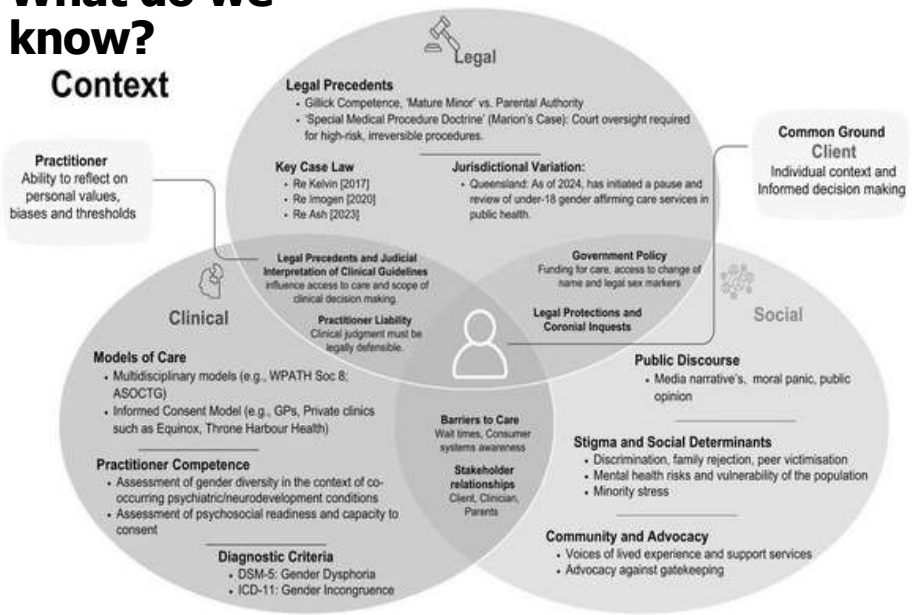
What do we know?

Context



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Method

Study Design

- Exploratory, descriptive phenomenological design

Recruitment

- Eligible: Australian psychologists holding general registration with PsyBA
- Convenience / snowball sampling

Data Collection

- Online, anonymous questionnaire via Qualtrics
- Hypothetical case study of 'Morgan' (16/18 year old seeking assessment for gender-affirming care)
- Open and closed-ended questions around initial clinical reactions, interp's of diagnostic criteria, and Morgan's competence,

Data Analysis

- Reflexive Thematic Analysis (O'Reilly, 2025)

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Sample and Australian psychology workforce comparison

	Current Sample N	**Psychology workforce (PsyBA, Dec 2024)**
N (% of workforce)	80 (0.002%)	39,717
Female (%)	57 (72%)	32,084 (80.8%)
Male	18 (23%)	7,623 (19.2%)
Other	4 (5%)	10 (0.0003%)
Age (mean)	38.6	N/A
Age (mode)	29	40-44
Age (median)	36.5	N/A
Age (range)	25-69	N/A
Years practicing as a psychologist (mean)	9.4	N/A
At least one Practice Endorsement	35 (44%)	15,633 (39%)

12

Name: "Morgan"
Age: 16 / 18
Referred by: GP for low mood and anxiety
DASS-21: Moderate x 3

THE CASE STUDY

Initial Session - Morgan alone

- Morgan reported a year-long experience of low mood and anxiety.
- The home is generally supportive but emotionally unavailable due to parental work demands.
- Morgan has social difficulties at school but recently formed online friendships, including with a transgender peer.
- Cannabis use began in the context of these new peer relationships.

Second Session - Morgan alone

- Morgan expressed discomfort with being perceived as feminine and expressed distress re menstruation and body image.
- Described a childhood preference for traditionally masculine activities and noted parental criticism of their clothing.
- Morgan researched gender-affirming hormone therapy (GAHT) and showed interest in beginning assessment.
- Requested that you speak with their mother, Michelle, who is covering the cost of sessions and may have concerns about testosterone.

Third Session - Parent session

- Mo noted nil past psychiatric/medical issues and typical dev milestones for M.
- Mo reported gender discussions began after new peer rel's and described Morgan as long being a "tomboy".
- Mo expressed limited understanding of gender diversity and GAHT, concern about 'long-term effects' and uncertainty about how to best support Morgan.
- Mo stated commitment to Morgan's wellbeing while wanting to ensure decisions are not rushed.

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Initial Reactions

it's **daunting** and **feels like a lot of responsibility** without a lot of definitive help from rep bodies

I want to understand more first

I'm anxious and **unsure**

Am feeling empathetic and **protective**

A very **complex** and difficult presenting situation

My initial reaction is that I am not qualified to provide this assessment…

Morgan has few signs of prior gender dysphoria until one year ago when meeting an online friend

I'm curious and want more information

I feel for Morgan. I can only imagine how hard considering a transition would be…

"There is much to consider and my sense is to slow things down here

it does sound like gender dysphoria has plagued them for some years

She states she has felt like this for a long time but she has only recently started to talk about it

"Identity confusion

I worry about the urgency Morgan is expressing about commencing hormone therapy

This sounds like a Rapid Onset Gender Dysphoria case

I honestly wouldn't know what advice to give

(A note on prof use of pronouns)

I WANT TO DIFFERENTIATE B/T PUBERTY AND HORMONAL CHANGES

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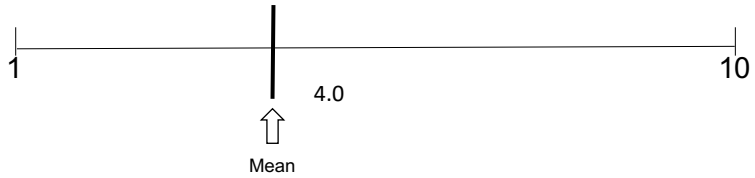
Please mark (on the line) your level of experience assessing clients with gender-related concerns (1 = No experience, 10 = Very experienced).

Please mark your level of *confidence* assessing clients with gender-related concerns (1 = No confidence, 10 = Very confident).



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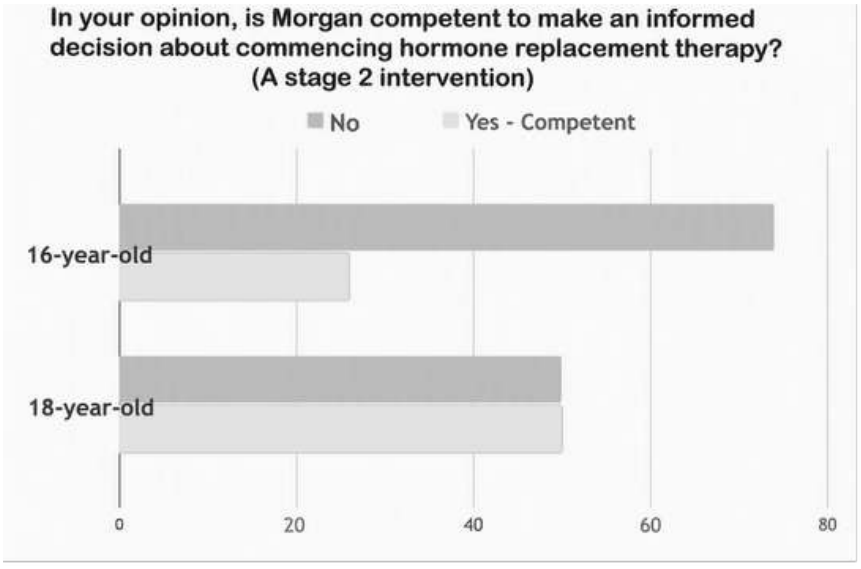

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Respondent rationales for competence determinations

Respondents often cited more than one factor, so column percentages do not total 100

16-year-old (n = 44)

Considered competent (n=13, 29.5%)	
Age / "mature minor" cited as sufficient	**54%**
No indication of cognitive impairment or unsound reasoning	**31%**
Has researched the topic / engaged with the process over time	**23%**
Functioning well - school, independence, parental trust	**15%**
Caveat: leaning yes, but wants more evidence first	**15%**

Not considered competent (n=31, 70.5%)	
Needs further information, assessment or time before deciding	**45%**
Age / being under 18 cited as a limiting factor	**36%**
Doesn't yet understand HRT risks/consequences well enough to consent	**19%**
Mood or anxiety symptoms complicate the picture	**19%**
Cannabis use raises doubts about decision-making	**16%**

18-year-old (n = 36)

Considered competent (n=20, 55.6%)	
Legal adult / age of majority cited as the key factor	**70%**
No cognitive impairment / sound reasoning noted	**20%**
Longstanding, persistent feelings backed by own research	**20%**
Good support system (family involved)	**15%**
Caveat: adult status treated as sufficient despite limited exploration so far	**10%**

Not considered competent (n=16, 44.4%)	
Needs further assessment / more sessions before deciding	**31%**
Doesn't yet understand HRT risks/process well enough to consent	**31%**
Other co-occurring mental health/psychosocial issues need addressing first	**25%**
Main source of information is social media/peers, not professionals	**19%**
Age of consent alone isn't treated as sufficient	**13%**

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Other Item response patterns - by Morgan's depicted age

			16-year-old		18-year-old	
Question			**n**	**%**	**n**	**%**
Would you proceed with the assessment Morgan has requested?*	**Yes**		9	**20.5%**	17	**47.2%**
	No		15	**34.1%**	8	**22.2%**
	Other		20	**45.4%**	11	**30.6%**
Is Morgan experiencing significant distress?	**Yes**		39	**88.6%**	32	**88.9%**
	No		5	**11.4%**	4	**11.1%**
Does Morgan demonstrate a significant preoccupation with their gender?	**Yes**		36	**81.8%**	30	**83.3%**
	No		8	**18.2%**	6	**16.7%**
Is Morgan's incongruence between experienced/expressed gender and sex assigned at birth marked and persistent?*	**Yes**		22	**50.0%**	24	**66.7%**
	No		22	**50.0%**	12	**33.3%**
Does Morgan demonstrate a strong conviction and/or desire to medically transition from their assigned sex?	**Yes**		26	**59.1%**	21	**58.3%**
	No		18	**40.9%**	15	**41.7%**

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Respondent rationales for judging whether Morgan was showing a significant preoccupation with gender

16-year-old (n = 44)

Considered significant preoccupation (n=36, 81.8%)	
Repeated focus / self-report / presenting concern	64%
Body or menstruation distress cited	42%
Research, social media or peer influence	28%
HRT / transition framed as a desired solution	28%
Longstanding history or duration cited	22%

Not considered significant preoccupation (n=8, 18.2%)	
More information needed to judge frequency/intensity	50%
Gender seen as one part of broader difficulties	38%
Not enough evidence that preoccupation is significant	63%
Concern may reflect other or more recent factors	25%

18-year-old (n = 36)

Considered significant preoccupation (n=30, 83.3%)	
Repeated focus across sessions / self-report	63%
Body or menstruation distress cited	37%
Research, social media or peer influence	27%
HRT / transition framed as a desired solution	30%
Longstanding thoughts / duration cited	20%

Not considered significant preoccupation (n=6, 16.7%)	
More information needed to judge significance	33%
Gender seen as one part of broader difficulties	33%
Preoccupation not viewed as sufficiently significant	50%
Peer influence / alternative framing raised	33%

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Why respondents judged Morgan's gender incongruence as marked and persistent

16-year-old (n = 44)

Considered marked & persistent (n=22, 50.0%)	
Duration / longstanding feelings cited	73%
Self-report supported by parent or history	32%
Body / menstruation distress linked to incongruence	27%
Childhood gender-nonconforming history cited	23%
Caveat: intensity or persistence still uncertain	23%

Not considered marked & persistent (n=22, 50.0%)	
Insufficient longitudinal information / duration	55%
Recent onset or exposure to peers/social media	23%
Tomboyism or pubertal discomfort not sufficient evidence	23%
Markedness/intensity or alternative explanations unclear	27%

18-year-old (n = 36)

Considered marked & persistent (n=24, 66.7%)	
Duration / longstanding feelings cited	71%
Parent and Morgan reports corroborated history	38%
Childhood gender-nonconforming history cited	29%
Body / menstruation distress linked to incongruence	29%
Caveat: further exploration still needed	25%

Not considered marked & persistent (n=12, 33.3%)	
Insufficient longitudinal information / duration unclear	42%
Recent onset or peer influence raised	33%
Tomboyism not treated as evidence of dysphoria	25%
Markedness/intensity or other explanations unclear	25%

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What did we notice?

- Responses very consistent with prof's under conditions of uncertainty
- Disparity across prof's who saw the same case – in terms of determinations and reasoning
- Psych's cited the same factor as rationale for opposing conclusions
- Client age was linked to movement that often indicated an intuitive 'values-based' approach rather than a deontological one
- Some rationales more aligned with W-Path and others Informed Consent models
- Some legal omissions / misinterpretations
- Citation of clinical criteria was sparse until we asked overt questions, and then thresholds varied

- So, does all this disparity mean they are getting it *wrong*?

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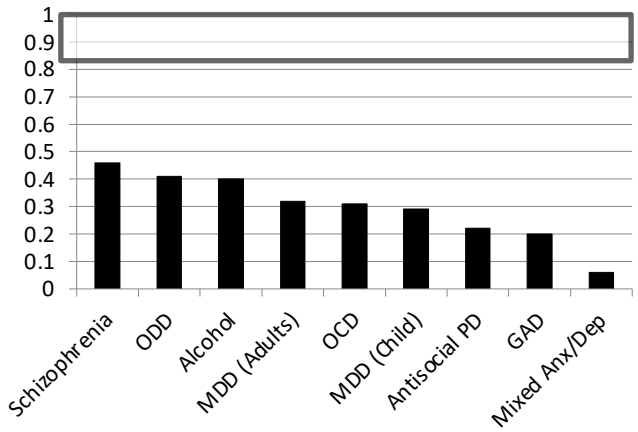
Well…..
Inter-rater Reliability (*kappa*) of some DSM-5tr Diagnoses according to recent meta-analyses…



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‚Finally,

- Uncertainty is a huge part of what we do. Let's allow it for ourselves and our client (if they have it)
- *We* need to be guided by the 'rule books', but our task in this context is surely to provide our client with permission to fully engage in these high-stakes decisional tasks and for us to assess their readiness in justifiable and reviewable ways
- *One of the earlier-listed session goals was :*

'To provide information about some frameworks, to normalise professional uncertainty in this space, and to invite an open and expansive mindset that can increase access to GAC for such clients'

- It's a challenge to become more familiar with the range of frameworks and criteria, and to embrace both our and the client's uncertainty, but doing so represents our best chance of promoting an open dialogue that increases access to care for these under-serviced clients

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