BRIEFINGS ON TRANS HEALTHCARE

RESPONDING TO THE CASS REVIEW'S RECOMMENDATIONS

2024

AusPATH

Transcend Australia

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Recommendation 1

> Given the complexity of this population, these services must operate to the same standards as other services seeing children and young people with complex presentations and/or additional risk factors. There should be a nominated medical practitioner (paediatrician/child psychiatrist) who takes overall clinical responsibility for patient safety within the service.

Our response: Every service in Australia ensures that there is a child and adolescent psychiatrist, paediatrician or adolescent physician who takes overall clinical responsibility for the patient's safety within the service. They provide comprehensive clinical governance and leadership of the multi-disciplinary team that provide a suite of individualised care to each young person.

Recommendation 2

> Clinicians should apply the assessment framework developed by the Review's Clinical Expert Group, to ensure children/young people referred to NHS gender services receive a holistic assessment of their needs to inform an individualised care plan. This should include screening for neurodevelopmental conditions, including autism spectrum disorder, and a mental health assessment. The framework should be kept under review and evolve to reflect emerging evidence.

Our response: The paediatric gender services in Australia all follow the Australian Standard of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents. The guidelines advocate for a co-ordinated multidisciplinary team approach and outline the roles of different types of clinicians (such as mental health professionals, paediatricians, endocrinologists, nurses, general practitioners, and speech pathologists) when assessing and providing ongoing care to young people. General principles of these Guidelines emphasise the importance of individualising care for young people. This includes reviewing and supporting developmental differences and mental health difficulties for all young people, making appropriate referrals for assessment and treatment as needed, and working collaboratively with relevant service providers, such as tertiary mental health services, when needed.

Recommendation 3

> Standard evidence based psychological and psychopharmacological treatment approaches should be used to support the management of the associated distress and cooccurring conditions. This should include support for parents/carers and siblings as appropriate.

Our response: To contextualise this recommendation, the Cass Review states that, in the UK when a young person was known to have a referral in place to Gender Identity Development Services (GIDS), they were then excluded from accessing care from Child and Adolescent Mental Health Services (CAMHS) while on the waiting list for GIDS. This meant these young people were denied access to standard evidence-based care for co-occurring conditions such as anxiety, depression, eating disorders, etc. This is not the case in Australia. Young people are encouraged to access mental health support (either privately, via headspace, through school counsellors, or with CAMHS services) so that there is concurrent care of co-occurring conditions. Where co-occurring complexity is identified, wrap around holistic care is co-ordinated through clinics.

Australian paediatric gender services take a family-centred approach. Parent involvement is essential, and sibling involvement is encouraged. Child-only appointments, parent-only appointments, and child-parent appointments are all routine. Parent and family support needs are identified, and clinics can refer to relevant community-led organisations and supports. Work is underway to further integrate peer support into clinics; co-design of support from the perspective of service users is crucial. We would welcome the resourcing and development of additional educational resources designed for children, adolescents, and their families.

Recommendation 4

> When families/carers are making decisions about social transition of pre-pubertal children, services should ensure that they can be seen as early as possible by a clinical professional with relevant experience.

Our response: Social affirmation is a family decision which should be child-led and child-centred. Social affirmation does not require clinical oversight or contact with specialist gender services. Support for families can be helpful in reducing their anxiety and helping them to become advocates for their child; this is where community peer-led family support is important. Families can also seek professional support if needed, but it should not be compulsory. When young people beginning the social affirmation process are in contact with specialist gender services, clinics can make appropriate referrals for these young people and/or their families as necessary and provide educational resources for families to ensure ongoing wellbeing and healthy development. It is important that Australian schools feel confident to affirm and support a child's gender expression based on what the child and their family request, rather than needing authorisation by a professional.

Recommendations 5 & 6

> 5: NHS England, working with DHSC (Department of Health and Social Care) should direct the gender clinics to participate in the data linkage study within the lifetime of the current statutory instrument. NHS England's Research Oversight Board should take responsibility for interpreting the findings of the research.

> 6: The evidence base underpinning medical and non-medical interventions in this clinical area must be improved. Following our earlier recommendation to establish a puberty blocker trial, which has been taken forward by NHS England, we further recommend a full programme of research be established. This should look at the characteristics, interventions and outcomes of every young person presenting to the NHS gender services.

- The puberty blocker trial should be part of a programme of research which also evaluates outcomes of psychosocial interventions and masculinising/feminising hormones.
- Consent should routinely be sought for all children and young people for enrolment in a research study with follow-up into adulthood.

Our response: Established gender services in Victoria, Western Australia, and Queensland all have clinical registries. This means that young people and their families are invited to consent to their de-identified clinical data being used for research purposes. In New South Wales, the development of a similar clinical registry is underway. Consent is requested from all patients to be a part of these registries; if patients do not wish to be part of these registries, that decision is respected, and they will continue to receive the care they need regardless. Research participants have the right to withdraw from these registries at any time if they wish.

The Australian Research Consortium for Trans Youth and Children (ARCTYC) has recently been funded by the Medical Research Future Fund (MRFF) to harmonise the data across all major paediatric centres to allow a very large sample (N>2800) to answer important questions about gender-affirming care, including the psychosocial effects of puberty blockers. As part of the work, ARTCYC are planning on initiating linkage to administrative datasets as suggested by the Cass Review. Health research with trans adults in Australia is also well established.

Our leading researchers in trans health in Australia are fundamentally opposed to conducting randomised controlled trials, or other compulsory studies, of puberty suppression or gender-affirming hormones in adolescents. This is because: a) it is highly unethical to force a person to be a part of research in order to receive a treatment; b) the overwhelming evidence from both longitudinal and cross-sectional studies demonstrates that puberty suppression, used appropriately in early to middle puberty, is successful in suspending puberty and achieving current and future physical characteristics which are more congruent with the person's gender identity, reducing gender incongruence; and either stabilises or improves mental health and wellbeing.[1–5] Thus it would be unethical to withhold treatment from an adolescent.[3,4,6]

More information about puberty blockers is available here.

Recommendation 7

Long-standing gender incongruence should be an essential pre-requisite for medical treatment but is only one aspect of deciding whether a medical pathway is the right option for an individual.

Our response: In line with the Australian Standards of Care, best practice in Australian gender clinics is an individualised, person-centred approach. A medical pathway is never "routine," and takes into consideration a person's psychosocial circumstances, preferences, developmental stage and co-occurring mental and physical health conditions, as part of a multi-disciplinary team assessment. This person-centred, collaborative, approach with shared decision-making between clinicians across disciplines, young people, and their families is the foundation of ethical paediatric gender-affirming healthcare as provided in Australia.

Some adolescents experience gender incongruence for the first time at puberty or after puberty, and some of these young people express a need for gender-affirming medical care. It is important there are no arbitrary barriers to eligibility for gender-affirming treatment based on the age a child first voices gender-related concerns. There are many reasons why a young person may not experience or express gender dysphoria until, during, or after puberty. This may have nothing to do with the legitimacy of their identity but to do with the family/social acceptance of gender diversity and their own understanding of their gender diversity. Expert individualised multi-disciplinary team assessment considers this context.

Recommendation 8

NHS England should review the policy on masculinising/feminising hormones. The option to provide masculinising/feminising hormones from age 16 is available, but the Review would recommend extreme caution. There should be a clear clinical rationale for providing hormones at this stage rather than waiting until an individual reaches 18.

Our response: This recommendation is not in line with existing guidelines such as the WPATH Standards of Care 8 and the Australian Standards of Care. It does not take into consideration the evidence of benefits for gender-affirming hormones in those younger than 18. For some young people, the commencement of gender-affirming hormones is appropriate and may be life-saving. There is no rationale for delaying treatment until 18, when there has been an appropriate assessment, and informed consent has been obtained from young people and their parents. For some trans young people, oestrogen or testosterone treatment is medically necessary at age 15 or younger, for example, for mental health reasons, or to support healthy adolescent growth and development following earlier puberty suppression. The Cass Review fails to consider the risks of actively withholding hormone treatment from young people who wish for it and are eligible for it. As the recommendation is to actively restrict and reduce access to gender-affirming hormone treatment, the risks of this approach must be considered. To restrict gender-affirming hormone treatment to those over 18 years of age would be a highly unusual approach, out of step with all other medical treatments. Legally this undermines Gillick competence.

More information about gender-affirming hormones is available here.

Recommendation 9

Every case considered for medical treatment should be discussed at a national Multi Disciplinary Team (MDT) hosted by the National Provider Collaborative replacing the Multi Professional Review Group (MPRG).

Our response: All cases at paediatric gender services in Australia are discussed by multi-disciplinary teams within the clinic before the initiation of medical treatment.

The Cass Review suggests an administrative, bureaucratic national body to oversee decisions, comprised of people who may not have seen the young person clinically. To introduce a requirement for a national-level external multidisciplinary review body for each and every young person before commencement of gender-affirming medical treatments introduces several risks:

- Delay in timely access to treatment for those who need it and are eligible for it.
- Decision-making by people who have not met the patient and family, which is likely to lead to errors.
- Time-consuming report writing and documentation burden for clinicians, which would have an impact on other aspects of care provision.
- No difference in the process for otherwise well young people with simple and non-contentious presentations and good family support, compared to young people for whom there are complex aspects to their presentation.
- Financial cost of establishing and maintaining such a body.
- Risks to patient confidentiality, including patients' and families' fears at being involuntarily placed on a national register.

It is not clear that there is any benefit to outweigh these obvious risks, and such a process does not exist for other standard medical interventions.

Recommendation 10

> All children should be offered fertility counselling and preservation prior to going onto a medical pathway.

Our response: Across Australia, fertility counselling and preservation is offered to all patients who seek gender-affirming healthcare. Access to fertility preservation varies across the country and is predominantly via private clinics. We would welcome public funding to ensure anyone who wishes to access fertility preservation is able to do so without financial barriers. The recent independent review of the Queensland Children's

Gender Service provides recommendations for streamlining this process in Queensland (recommendation 18).

Recommendation 11

> NHS England and service providers should work to develop the regional multi-site service networks as soon as possible. This could be based on a lead provider model, where NHS England delegates commissioning responsibility to the regional services to subcontract locally to providers in their region.

Our response: The purpose of this recommendation is to ensure that one gender service does not serve the entire country. In Australia, we effectively work this way because paediatric gender services are state-based and independent. However, in light of Australia having large regional and rural areas where gender-affirming healthcare can be sparse, we welcome and encourage funding for integrated and networked health systems to meet regional need. This was highlighted in the recent independent review of the Queensland Children's Gender Service (recommendation 2).

Recommendation 12

> The National Provider Collaborative should be established without delay.

Our response: Australian paediatric gender health services have a strong track record of open and collaborative sharing of expertise and resources. For example, patient education materials and informed consent documentation are openly shared between clinics, which has assisted continuous quality improvement. Clinics across the country meet online every quarter and are involved in the ARCTYC national research collaboration.

Patients who have completed assessment and commenced treatment at one Australian or Aotearoa New Zealand paediatric gender service can be transferred without delay to the care of another Australian or Aotearoa New Zealand paediatric gender service in the event of geographical move, with continuity of care, thanks to longstanding agreements and shared understanding of care needs.

We would welcome continued and increased funding for ARCTYC to formalise a national collaborative structure that enables clinics to easily benchmark across each other to constantly improve the quality of care provided, as well as align outcomes and key performance indicators.

Recommendation 13

> To increase the available workforce and maintain a broader clinical lens, joint contracts should be utilised to support staff to work across the network and across different services.

Our response: We welcome the increase of regional and rural services and ensuring consistency in clinical processes across Australia. However, due to the nature of differing governance structures of individual state and territory health departments, the recommendation of joint contracts is not relevant in the Australian context.

This recommendation arose from the Cass Review's criticism that clinicians at specialist gender clinics often work solely in this field and were thus supposedly losing their broader clinical focus. This is not an issue in the Australian context as most clinicians only work part-time in specialist gender clinics, and already work across other services/activities.

Recommendation 14 & 15

> 14: NHS England, through its Workforce Training and Education function, must ensure requirements for this service area are built into overall workforce planning for adolescent services.

15: NHS England should commission a lead organisation to establish a consortium of relevant professional bodies to:

- develop a competency framework,
- identify gaps in professional training programmes,
- develop a suite of training materials to supplement professional competencies, appropriate to their clinical field and level.

This should include a module on the holistic assessment framework and approach to formulation and care planning.

Our response: AusPATH is the peak professional body for trans healthcare in Australia, and provides education through conferences, online resources, and collaborative training. We would welcome funding from the federal government as part of the 10-year LGBTIQ+ Action Plan for AusPATH to further develop relevant materials in collaboration with relevant stakeholders (specialist gender clinics, community organisations such as Transcend, professional training bodies, and universities). There is a need for further integration of content about gender diversity and transgender health across the life span, into medical school curricula, specialise medical college training programmes and other health professional training and teacher training programmes, at both a national and state/territory level. This needs ongoing funding and resourcing. We would welcome the support of state/territory governments to advocate for such funding on a national level.

Recommendation 16

The National Provider Collaborative should coordinate development of evidence-based information and resources for young people, parents and carers. Consideration should be given as to whether this should be a centrally hosted NHS online resource.

Our response: Each paediatric gender service in Australia has its own set of resources available for patients and their families. These are freely shared between services for quality improvement. AusPATH and Transcend are currently developing a standard set of evidence-based information and resources for young people and their families. We would welcome ongoing funding for this important work. Identified gaps include the development of evidence-based information and resources for those who are culturally diverse or neurodiverse, and visual and video resources to support those with different learning needs. There is also a need for nationally consistent resources, endorsed by clinical services in each state and territory, that are publicly available.

Recommendation 17

> A core national data set should be defined for both specialist and designated local specialist services.

Our response: ARCTYC has identified the current data collected by Australian paediatric gender services, with some similarities and differences across jurisdictions. Development of a unified recommended data set would ideally be the next stage of this initiative. To enable accurate and complete data collection and analysis, all paediatric gender services need to have adequate resourcing with funds for database development, research staff, and administration staff.

We welcome both the federal government's ongoing commitment to developing national integrated data sets and infrastructure. This, alongside the Australian Bureau of Statistics' ongoing development of comprehensive gender questions as a potential inclusion for Census 2026 would enable the collection of whole-of-population data on trans and gender diverse communities. Together, this would allow researchers and relevant state, territory, and federal government institutions to carry out high-quality research. This would, amongst other things, facilitate a better understanding of the healthcare interactions of this population across the broader healthcare system. Such knowledge would enable, for example, the targeted upskilling of providers and identification of where tailored educational materials might be needed.

Recommendation 18

> The national infrastructure should be put in place to manage data collection and audit and this should be used use this to drive continuous quality improvement and research in an active learning environment.

Our response: This recommendation aligns with several policy priorities outlined in The National Preventive Health Strategy 2021-2030; specifically ones regarding the compilation and timely publication of national data sets, reporting frameworks, and standardising approaches to the creation, access, and sharing of data across Australia. It also identifies transgender and gender diverse communities as a priority population. In line with this, we advocate for the role of ARCTYC in contributing to the development of such infrastructure and nationally agreed indicators as they pertain to trans-specific healthcare.

Recommendation 19, 20, & 21

19: NHS England and the National Institute for Health and Care Research (NIHR) should ensure that the academic and administrative infrastructure to support a programme of clinically based research is embedded into the regional centres.

20: A unified research strategy should be established across the Regional Centres, co-ordinated through the National Provider Collaborative and the Research Oversight Group, so that all data collected are utilised to best effect and for sufficient numbers of individuals to be meaningful.

21: To ensure that services are operating to the highest standards of evidence the National Institute for Health and Care Research (NIHR) should commission a living systematic review to inform the evolving clinical approach.

Our response: Clinical research is currently conducted at some, but not all, Australian paediatric gender services. Within ARCTYC, there is a variety of clinical research planned, including long-term follow up of outcomes of medical gender-affirming treatment, and several randomised controlled trials of psychosocial interventions. A research strategy is an excellent opportunity to guide research into paediatric trans healthcare, and the development of one could be led by ARCTYC. It is essential that a research strategy should be developed with trans and gender-diverse young people and their families, to ensure relevance, appropriate priorities, and cultural safety for research participants. We would welcome funding for ARCTYC to undertake a living systematic review; this would support clinicians to access and apply a standardised body of information in a timely manner.

Recommendation 22

Within each regional network, a separate pathway should be established for pre-pubertal children and their families. Providers should ensure that pre-pubertal children and their parents/carers are prioritised for early discussion with a professional with relevant experience.

Our response: While the specifics vary from state to state, all specialist clinics in Australia aim to see pre-pubertal children in a timely manner, and young people and their families are provided with necessary support and information, as well as referrals to community and peer-led support organisations. However, due to resourcing pressures, wait times are often longer than is ideal. We would welcome increased funding and staffing so that services can offer initial visits for psychosocial assessment and support in a timely manner. It is important, however, to recognise that gender diversity and gender-nonconformity in young children is part of normal human variation, is not a disorder, and should not be seen as a problem. Children and families should be able to access professional care and support if they feel they need it, but this should not be compulsory.

Recommendation 23

NHS England should establish follow-through services for 17-25-year-olds at each of the Regional Centres, either by extending the range of the regional children and young people's service or through linked services, to ensure continuity of care and support at a potentially vulnerable stage in their journey. This will also allow clinical, and research follow up data to be collected.

Our response: Some services in Australia see young people until 18 years of age (i.e., WA, Queensland, SA) while others have a model for 12–25-year-olds (i.e., NSW and Victoria). Part of the ARCTYC research program will focus on evaluating the strengths and weaknesses of each of these systems, including patient and family satisfaction with service.

In jurisdictions where services see young people until 18 years of age, we welcome improvements to the ability for 16 and 17-year-olds to access care in a timely manner, so that they are not disadvantaged by aging out of paediatric services. We also support strengthening the transition to adult services.

Recommendation 24

> Given that the changing demographic presenting to children and young people's services is reflected in a change of presentations to adult services, NHS England should consider bringing forward any planned update of the adult service specification and review the model of care and operating procedures.

Our response: This recommendation is not relevant to the Australian context.

Recommendation 25

> NHS England should ensure there is provision for people considering detransition, recognising that they may not wish to reengage with the services whose care they were previously under.

Our response: Sometimes, trans people may later re-identify with their birth-registered sex, and no longer identify as trans. This is often referred to as "detransition" or "desistance." Research indicates that approximately 2-10% of people re-identify with their birth-registered sex, and that of those, only a smaller subset had ever started to medically transition.[7–12] Specific Australian research shows that only 5.3% of young people attending at a Western Australian clinic had subsequently re-identified with their birth-registered sex, and of all young people who had begun medical therapy, only 1% later re-identified with their birth-registered sex during the time that they were attending the clinic.[7]

In Australia, re-identification with birth-registered sex and cessation of medical treatments are not a reason for discharge from a gender service; patients are still able to receive any follow-up care they may need, such as ongoing mental health support. Patients who wish to reverse the effects of a previous gender-affirming treatment may have a range of care needs, which can ideally be co-ordinated through a person's specialist gender clinic. They can also access care in other parts of the healthcare system, with referrals and co-ordination of care from the person's general practitioner. The person's preference for care setting and care provider should be taken into account.

Education in all professional disciplines about transgender healthcare across the life span should include education about meeting the needs of people who wish to stop or reverse a gender-affirming treatment, with a person-centred, non-blaming and non-stigmatising approach.

More information about re-identification is available here.

Recommendation 26

The Department of Health and Social Care and NHS England should consider the implications of private healthcare on any future requests to the NHS for treatment, monitoring and/or involvement in research. This needs to be clearly communicated to patients and private providers.

Our response: Australian healthcare encourages patient and family choice, and good, open liaison and collaboration between public health services and private providers. Many patients who attend an Australian paediatric gender health service also attend private healthcare providers, for example private psychologists, and this is encouraged.

Attendance at a private healthcare provider does not, and should not, disqualify a person from eligibility for assessment at an Australian paediatric gender service. If patients are having all their gender-affirming health care needs met by private provider/s, and they are happy with this, then it may be mutually agreed that no further care from a public service is needed. These decisions can be made on an individual basis, with a person-centred, family-centred, flexible, and respectful approach.

Recommendation 27

> The Department of Health and Social Care should work with the General Pharmaceutical Council to define the dispensing responsibilities of pharmacists of private prescriptions and consider other statutory solutions that would prevent inappropriate overseas prescribing.

Our response: This recommendation is not relevant to the Australian context.

Recommendation 28

> The NHS and the Department of Health and Social Care needs to review the process and circumstances of changing NHS numbers and find solutions to address the clinical and research implications.

Our response: This recommendation is not relevant to the Australian context.

Recommendation 29

> NHS England should develop an implementation plan with clear milestones towards the future clinical and service model. This should have board level oversight and be developed collaboratively with those responsible for the health of children and young people more generally to support greater integration to meet the wide-ranging needs of complex adolescents.

Our response: We welcome the collaborative development of gender-affirming healthcare models and would emphasise the importance of including young people/service users with experience and expertise of these services to be involved across every level of governance. A key weakness of this recommendation is that it does not specify that trans young people and their families must be involved in the ongoing development and improvement of clinical and service models.

Recommendation 30

> NHS England should establish robust and comprehensive contract management and audit processes and requirements around the collection of data for the provision of these services. These should be adhered to by the providers responsible for delivering these services for children and young people

Our response: This recommendation reportedly arose out of NHS governance issues, with a lack of process for data collection and tracking of prescriptions. It does not apply to the Australian context as clinical evaluation data is already collected. However, we continue to welcome open and transparent data collection and analysis, and would welcome funding from health departments to ensure all Australian clinical services can establish robust data collection processes. For further discussion of data and evaluation, please refer to our responses to recommendations 12, 12, 18, 19, 20, and 21.

Recommendation 31

> Professional bodies must come together to provide leadership and guidance on the clinical management of this population taking account of the findings of this report.

Our response: The following Australian professional bodies have provided support for paediatric gender-affirming care:

- The Australian Medical Association.
- The Australian Psychological Society.

- The Royal Australian and New Zealand College of General Practitioners.
- The Royal Australian and New Zealand College of Psychiatrists.

This is in addition to multiple international bodies including (but not limited to) the World Health Organization, the World Medical Association, the American Medical Association, the American Psychiatric Association, the American College of Physicians, the American Psychological Association, the Canadian Medical Association, a group of authoritative Italian paediatric health care organisations, the American Academy of Pediatrics, and many others expressing their support.

We recommend that AusPATH and trans community-led organisations should remain central in these structures so trans and gender diverse communities are contributing to the development of their care at all levels, supported by expert clinicians and researchers. A regular forum for college presidents to come together and consider how they will address the needs of this population within the scopes of their practice would be welcomed.

Recommendation 32

> Wider guidance applicable to all NHS services should be developed to support providers and commissioners to ensure that innovation is encouraged but that there is appropriate scrutiny and clinical governance to avoid incremental creep of practice in the absence of evidence.

Our response: The Australian Standards of Care, together with the WPATH Standards of Care 8, inform the provision of care at all Australian paediatric gender services, and are recommended for use in education and training providers in other areas of the Australian health system. As we have discussed elsewhere, there is an established observational evidence base regarding gender-affirming healthcare, and research continues. In line with the recent independent review of the Queensland Children's Gender Service, we would welcome resourcing for ongoing clinical training and the consideration of specialised credentialling for clinicians providing gender-affirming healthcare. With appropriate funding, training can be supported by clinical guidance from regular updates to the Australian Standards of Care, informed by the living systematic evidence review as proposed in recommendation 21.

Intended use of information

While we make every effort to make sure the information in this resource is accurate and informative, the information does not take the place of professional medical advice.

Do not use our information as a substitute for the advice of a health professional.

If you are an individual seeking medical or health information for yourself or for someone else, you should obtain advice relevant to your particular circumstances from a health professional.

More information and support

For clinicians, please contact AusPATH for resources and support. www.auspath.org.au

For families and young people, please contact Transcend Australia for resources and support. www.transcend.org.au

This resource and associated evidence briefs and fact sheets can be downloaded from www.transcend.org.au/resources/evidence

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