A History of Trans Health Care in Australia

A Report for the Australian Professional Association for Trans Health (AusPATH)

May 2022

Professor Noah Riseman
Australian Catholic University

With a Foreword by **Dr Fintan Harte**
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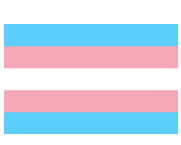

AUSTRALIAN CATHOLIC UNIVERSITY

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Suggested citation (if using Chicago referencing): Riseman, Noah. "A History of Trans Health Care in Australia: A Report for the Australian Professional Association for Trans Health (AusPATH)." AusPATH, 2022.

Foreword

I am honoured to be asked to write the foreword to this report. I first met Professor Noah Riseman in 2014 when I found myself seated next to him at a dinner party in a Catholic Presbytery. Our host, a Catholic priest and excellent cook, was and is my friend and bridge partner. The dinner guests were an eclectic group and I as a gay, Irish, Catholic (lapsed) psychiatrist found myself seated beside Professor Riseman, a gay, American, Jewish (lapsed) historian. We talked about our respective work, but it was when I mentioned that I was the head of the Monash Gender Dysphoria Clinic and President-elect of ANZPATH (now AusPATH) that Professor Riseman's eyes opened wide with delight, reminiscent of a child on Christmas morning or at Hanukkah!

Professor Riseman was clearly interested in the history of trans people in Australia. Having published a book on Indigenous soldiers in the Australian Defence Force, he was very interested in exploring the experience of trans members, past and present, of the ADF. I undertook to pass on Professor Riseman's details to my trans patients who were or had been members of the ADF and invited them to contact him. By the time desert arrived, we were still discussing the history of trans health care in Australia and Professor Riseman's interest and commitment to documenting the history was clearly evident.

Two years later in 2016, I found myself again positioned beside Professor Riseman, this time in the *International Journal of Transgenderism*. In the two years since we last met, several of my ADF trans patients had been in contact with Professor Riseman and he had published a very informative article on the history and experiences of trans people in the ADF entitled "Transgender Policy in the Australian Defence Force: medicalization and its discontents".[1] I co-authored a paper on the GPSQ (Gender Preoccupation and Stability Questionnaire) which was published in the same issue of the journal.[2] The GPSQ is a measure of gender dysphoria and now used by many clinicians.

Professor Riseman contacted me the following year in 2017 with a proposal to apply for an Australian Research Council Discovery grant: "Transgender Australians: The History of an Identity". The application was successful on the first round and the unlikely partnership of an academic historian and a psychiatrist in clinical practice may have been influential in the success of the application. Professor Riseman's distinguished track record as an historian undoubtedly helped.

"A History of Trans Health Care in Australia" draws on research funded by the grant. Professor Riseman documents clearly the challenges faced by trans Australians in accessing timely and affordable health care over the past 70 years. The report also documents the shift from a medical model of "doctor knows best" to a model where consumers have agency and input into their care.

Over time, the standards came to be seen as too restrictive by trans-consumers and by the time Version 6 of the standards was published in 2001, therapeutic guidelines were clearly seen in "gatekeeping" terms by patients. These standards were in place when the Monash Gender Dysphoria Clinic was being sued in the early 2000s and any relaxation of the restrictive guidelines was unlikely in the prevailing medico-legal climate. As noted in this report, subsequent reviews of the clinic by the Victorian Health Department documented deficiencies in the clinical governance of the clinic. Many of these problems were attributable to understaffing and gross underfunding.

The Monash Gender Dysphoria Clinic was closed for a three-month period in early 2009 and reopened in July of that year. I was appointed as the head of the unit following the retirement of the previous clinical director, Dr Trudy Kennedy. It was only possible to reopen the clinic with strict clinical assessment procedures in place and for many clients these were seen as a barrier to accessing care. The assessment procedure was a "one size fits all" approach with concerns over comorbidity and differential diagnoses being prominent. There was limited opportunity to individualise assessment and treatment plans and to give patients with complex needs the time and support that they required.

This report also highlights the legal barriers trans people face in accessing health care and in particular the barriers for young people. Progress made in legal decisions outlined in *Re: Jamie* and *Re: Kelvin* has

1 Noah Riseman, "Transgender Policy in the Australian Defence Force: Medicalization and Its Discontents," *International Journal of Transgenderism* 17, no. 3-4 (2016): 141-54.

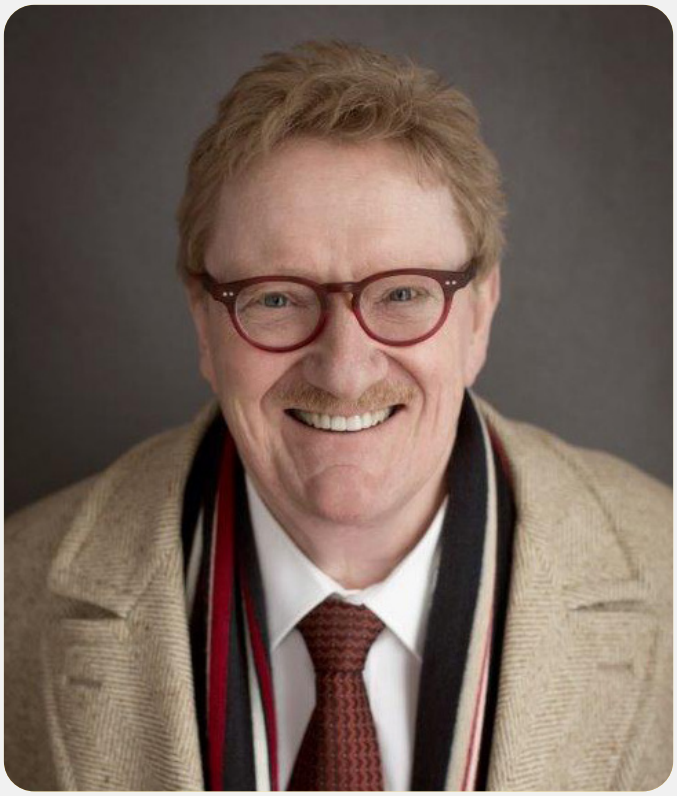
2 Az Hakeem et al., "Development and Validation of a Measure for Assessing Gender Dysphoria in Adults: The Gender Preoccupation and Stability Questionnaire," ibid.: 131-40.

taken a backward step with the recent decision handed down in *Re: Imogen.* A return to more conservative approaches is reflected in the *Re: Bell* decision handed down by the High Court in the United Kingdom. Conservative opinion is still prominent in the Australian print media represented by the Murdoch press. *The Australian* newspaper in particular has relentlessly criticised A/Professor Michelle Telfer at the Melbourne Royal Children's Hospital for her affirmative approach to trans health care for young people. The newspaper has consistently ignored the growing medical evidence base for this approach.

Professor Riseman's report also documents the conservative influences that affect trans-health care in Australia and in particular the efforts to stop the Safe Schools project and the negative fallout of the same-sex marriage debate. More recently, conservative forces have tried to stop the enactment of anti-Conversion Therapy legislation in a number of Australian states.

Trans people continue to be a very marginalised and disenfranchised group of people in Australian society. As this report outlines, there continues to be major barriers to people accessing timely and affordable health care. The underfunding of trans health services continues to be a major problem. The lack of MBS items for trans-health interventions is blatant discrimination which has persisted for several decades. Professor Riseman's report draws attention to many of these issues and will be an important document which informs trans-health care in Australia moving forwards.

Dr Fintan Harte
Consultant Psychiatrist and Senior Clinical Fellow, Department of Psychiatry, University of MelbourneObjective



Objective

This report provides an overview of the history of medical discourse and trans health care in Australia. There has long been a symbiotic and at times paradoxical relationship between medicine and trans and gender diverse people. The advent of new medical technologies has meant new opportunities for trans and gender diverse people to affirm their genders in different ways. The administration of health care – be it hormones, surgery or other treatments – has necessitated oversight and training. Yet, this has also meant that health care providers have exerted control and served as 'gatekeepers' determining who could access care. The line between safety and control has always been blurry, and it has also consistently been shifting.

Understanding the history of trans health care reveals shifts in practice, pathology and the roles played by trans and gender diverse people in seeking and affirming their own care. Knowing this history is vital to inform ongoing development and implementation of affirming care with/for trans and gender diverse people. Exploring the history of trans health care in Australia exposes:

- structural and legal barriers that have disadvantaged transgender people to access health care;
- common practices by health providers, especially specialists such as psychiatrists, as well as how transgender people responded to these practices;
- processes that led to legal, health and social reforms to improve the lives of transgender Australians;
- strategies that transgender people deployed to access affirming health care;
- changing priorities, challenges and needs of trans and gender diverse people in relation to health care

It is hoped that this report and the lessons of history will enhance partnerships between trans and gender diverse people and health practitioners to find affirming models of care.

As a warning to all readers: given this report is about the past, at times it deploys language which is now considered outdated or offensive. It also discusses some distressful topics, such as transphobia, homophobia, invasion of bodily autonomy, suicide and surgeries. Although this may cause discomfort to some readers, this is part of the history and it cannot and should not be erased. The report will give historical context to some terminology in the next section.

Aboriginal and Torres Strait Islander readers are advised that this report contains the names and images of deceased persons.

A Note on Terminology

The language used around gender diversity is constantly evolving, and in recent years the changes have been rapid. As this report will explore, there has been a consistent tension over medical versus social understandings of gender diversity, and this too has been reflected in language. Much of the Western discourse, definitions and labels derive from sexology or psychiatry. This has meant that common terminology has for many years been aligned to very specific criteria laid out in diagnostic manuals, such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or the *International Classification of Diseases (ICD)*. Some gender diverse people still happily use medical terms to describe themselves, while many others have rejected those expressions for different terminology. Moreover, people's self-identity is quite personal. Some people may use words to describe themselves which others consider offensive.

By the very nature of this being a history report, it uses a mix of present and past terminology. Where possible it uses present-day expressions like "client" instead of "patient" and "gender affirmation surgery" instead of "sex reassignment surgery". These terms are considered more empowering for trans people, seeing them as active agents in shaping their own health care. However, much of the past data, records, reports and oral histories use "patients" and as such this report does report that information as it was presented in the records. Because much of the medical history revolved around particular categories of people who now come under the trans umbrella, often the report does distinguish between them using past terminology like "transsexuals" or "transvestites". The report covers when some of the terminology changed, particularly around medical language of transsexualism, gender identity disorder, gender dysphoria and gender incongruence.

Just the term transgender has its own etymology. Archives scholars Kelly Rawson and Cristan Williams believe the first use of the word was in 1965 by psychiatrist John Oliven. He used the term to refer to those people assigned male at birth who preferred to live socially full-time as women, but who did not desire gender affirmation surgery. This was distinct from those who did desire surgery ("transsexuals") and those who only adopted female personas and dress part-time but identified as heterosexual males ("transvestites").[3]

By the 1980s some transgender activists, including Australia's Roberta Perkins, were using transgender as a more umbrella term to describe gender diverse people regardless of medical interventions. By the 1990s – and especially after the publication of Leslie Feinberg's *Trans Gender Liberation: A Movement Whose Time Has Come* – the word transgender became more commonly used with this contemporary, broad meaning.[4] This report adopts Rawson and Williams' concise and effective definition of transgender: "An umbrella term (adj.) for people whose gender identity and/or gender expression differs from the sex they were assigned at birth."[5] Historian Susan Stryker highlights how the umbrella definition of transgender encompasses diverse experiences of gender:

> [Transgender] refer[s] to people who cross over *(trans-)* the boundaries constructed by their culture to define and contain that gender. Some people move away from their birth-assigned gender because they feel strongly that they properly belong to another gender through which it would be better for them to live; others want to strike out toward some new location, some space not yet clearly described or concretely occupied; still others simply feel the need to challenge the conventional expectations bound

3 Kelly Jacob Rawson and Cristan Williams, "Transgender*: The Rhetorical Landscape of a Term," *Present Tense* 3, no. 2 (2014): 3.
4 Leslie Feinberg, *Trans Gender Liberation: A Movement Whose Time Has Come* (New York: World View Forum, 1992).
5 Rawson and Williams, "Transgender*: The Rhetorical Landscape of a Term," 1.

> up with the gender that was initially put upon them. In any case, it is the movement across a socially imposed boundary away from an unchosen starting place, rather than any particular destination or mode of transition.[6]

While acknowledging the constant changes and challenges to language, this report generally uses language around trans and gender diversity that follows best practice as outlined in the "Trans-Affirming Language Guide" developed by TransHub and ACON.[7] However, when referring to historical documents, it references the terminology of the time. Moreover, as medical practitioners often intentionally distinguished between different groups that now come under the trans umbrella, at times the report will invoke the past terminology in quotation marks to specify those specific groups.

The rest of this report will reconstruct an overview history of trans medicine and health care in Australia, especially since the mid-twentieth century. The bulk of the report will focus on the period since the 1970s because that was when there was more public discourse, medical and surgical options and specialists who worked with transgender people. The report is national in scope and makes every effort to include all states and territories. However, some regions are overrepresented, and that is in part because of the different histories where some states were more active or visible in the trans health space at different times.

The report draws on research funded by Australian Research Discovery grant DP180100322: "Transgender Australians: The History of an Identity." The main sources come from:

- oral history interviews with 18 health practitioners, past and present, who have worked extensively with trans people;
- oral history interviews with 100 trans and gender diverse Australians, with information derived especially from those who had more contact with the medical or psychology professions;
- newspaper reports accessed through Trove (National Library of Australia), interview participants' personal archives, online database Factiva and the RMIT Social Policy Archive: Social Health Press Clippings Collection housed at the Melbourne eScholarship Learning Centre;
- personal archives kept by activists and health professionals, which include newspaper and magazine articles; organisational records from past and present transgender organisations (e.g. Seahorse Victoria, Transgender Liberation Coalition, Victorian Transsexual Coalition); copies of old health studies; committee minutes of organisations including AusPATH; correspondence with government departments; and copies of old reviews or inquiries into aspects of trans health care;
- papers in the National Archives of Australia;
- mainstream newspapers, the LGBTIQ+ press and personal papers kept at the Australian Queer Archives (formerly Australian Lesbian and Gay Archives)

6 Susan Stryker, *Transgender History: The Roots of Today's Revolution*, 2nd ed. (New York: Seal Press, 2017), 1.
7 "Trans-Affirming Language Guide," available from https://www.transhub.org.au/language, accessed 13 January 2021.

Acknowledgements

The author wishes to thank all the interview participants who were generous with their time. Interview participants all had the option of being identified or being anonymous. Those who chose pseudonyms are indicated with quotation marks around their names. While it would not be possible or appropriate to list all project interview participants here, particular thanks go to those who shared personal archives, assisted in networking with other interview participants, or who reviewed drafts or excerpts of this report: Fintan Harte, Gale Bearman, Jill Blee, Eloise Brook, Neil Buhrich, Zac Cannell, Vivienne Cass, Simon Ceber, Belinda Chaplin, Russell Date, Martine Delaney, Kim Dorin, Parker Forbes, Uncle Dean Gilbert, Aram Hosie, David Hunter-Smith, Peter Hyndal, Kristine Johnson, Jasper Laybutt, Rob Lyons, Chantell Martin, Gina Mather, Gina Miller, Michael Mitchell, Norrie, Jonathan Paré, Julie Peters, Michael Ross, Darren Russell, Wez Saunders, Aunty Vanessa Smith, Lisa Taylor, Michelle Telfer, Vonni, William Walters, Garry Warne, Tim Welborn, Jeremy Wiggins, Andy Zorbas and Max Zebra-Thyone.

Just as I was finalising a late draft of this report, medical anthropologist and historian Eric Plemons from the University of Arizona contacted me with some questions about debates over IVF and trans women in the 1980s-90s. Eric gave important insights and kindly shared media and publications I had not seen which led me to add a few paragraphs about this important topic. I also must thank Dr Andy Kaladelfos, who shared some records from Western Australia that I had not seen, which included letters from one of the health practitioners I interviewed just two days prior.

Thanks also go to Geraldine Fela, who has been a fantastic research assistant on this entire project and to the members of the advisory group supporting this project: Belinda Chaplin, Katherine Cummings (who sadly passed away in January 2022), Martine Delaney, Sammantha Elmes, Parker Forbes, Nick Henderson, Peter Hyndal, Kristine Johnson, Alyce Schotte and Jenny Scott. Thanks also to Teddy Cook of ACON and AusPATH for his regular encouragement and for being the voice in the back of my head saying: “Do not make the report just about Melbourne or Monash”. Finally, a huge thanks to Rio Withall for the wonderful graphic design.

Defining and Pathologising Gender Crossing Pre-Second World War

Gender diversity has existed since time immemorial, with cultures around the world having words and traditions around individuals who did not fit into binaries of man and woman. In Thailand they are known as Kathoey; in the Indian subcontinent they are Hijra; numerous Native American cultures have third genders which, in contemporary lexicon, come under the umbrella term Two-spirit. Even in Western cultures there was discussion of gender diversity going as far back as the ancient Greeks, with it being a topic of discussion in Plato's *Republic*.

In the continent now known as Australia, too, there was gender diversity beyond the binary before European colonisation. The now-defunct Sisters and Brothers NT website used to list several words from Northern Territory Aboriginal languages which describe Sistergirls: "'Kwarte Kwarte' in Arrente, 'Kungka Kungka' in Pitjantjatjara and Luritja, 'Yimpininni' in Tiwi, 'Karnta Pia' in Warlpiri which can be interpreted as 'like a girl.' Whilst 'Kungka Wati' in Pintipi and 'Girriji Kati' in Waramungu literally mean 'woman/man'."[8] These examples show that cultures around the world, including Aboriginal and Torres Strait Islander people, saw gender diversity as having a cultural role.

In the modern West it was not until the late nineteenth century that a discourse emerged which moved beyond seeing gender and sexual diversity as about behaviour instead being an identity. This discourse emerged within the sexology and psychology professions, and these origins would have profound impacts felt well into the twentieth and twenty-first centuries. First, because the early discourse conflated gender diversity as an extension of sexuality, many popular understandings until the late twentieth century, too, conflated being transgender as something related to homosexuality.

Most importantly, because it was sexologists and then psychiatrists who were coining new terms with specific criteria attached, they were also exerting power by defining who "was" and "was not". Michel Foucault famously argued that social discourses have constantly (re)created sexual identities.[9] This has both positive and negative effects on individuals who do not fit within dominant societal constructs of gender or sexuality. For instance, many transgender interview participants recall how seeing examples of transgender people in the media made them realise there were others "like them". They often felt a sense of relief to have a word to explain their internal struggles with gender.[10]

Yet, definitions and discourses are also a form of social control and power. Those who fit the criteria of a label are also contained by it with little maneuverability. When we define who *are*, we inherently exclude those who *are not*. When medical professionals define, it is all that much harder for those who *are not* to be affirmed. As this report will show, it is this very tension which has been at the root of much of the unease between transgender activists and health professionals in the late twentieth and early twenty-first centuries.

The introduction of language around gender and sexuality was not a linear or rapid process, and it is not the intent of this report to engage with this information in depth. Hungarian sexologist Karl Maria Kertbeny coined the term homosexuality in the late 1860s, prefacing several decades of European (especially German) sexology research. Although most sexologists were focused primarily on what was seen as non-normative sexual behaviour and identities, their explanations were applied to people who did not fit gender norms or mores. Perhaps most pertinent to gender diversity was Karl Heinrich Ulrichs's concept of Urnings, published in 1864-65: people who had a male body but female souls (and vice versa).[11] In his 1894 text *Psychopathia Sexualis*, Austrian sexologist Richard von Krafft-Ebing defined another condition – metamorphosis sexualis paranoica – as the feeling of belonging to the opposite sex. These ideas – later adapted by other sexologists to theories of inversion

8 Damien W. Riggs and Kate Toone, "Indigenous Sistergirls' Experiences of Family and Community," *Australian Social Work* 70, no. 2 (2017): 230.

9 Michel Foucault, *The History of Sexuality, Vol. 1: An Introduction*, trans. Robert Hurley (London: Penguin, 1990).

10 Noah Riseman, "Representing Transgender in the 1970s Australian Media," *Gender and History* 33, no. 1 (2021): 227-48.

11 Douglas Ogilvy Prestell, *The Correspondence of Karl Heinrich Ulrichs, 1846-1894* (Basingstoke, UK: Palgrave Macmillan, 2020).

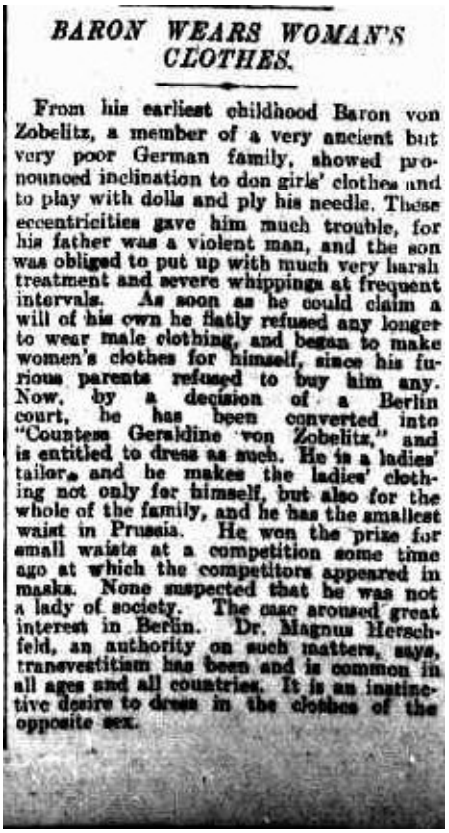
– were more often used to explain homosexuality, but they also would apply to gender diverse people.

Magnus Hirschfeld, the most prolific of all the early twentieth century sexologists, was the first explicitly to separate out gender and sexual diversity. In 1910 Hirschfeld published *Transvestites: The Erotic Drive to Cross Dress*, exploring people who had an urge to dress in clothing associated with another gender. Hirschfeld was quite broad in his examples of how and why people dressed, almost presenting a proto-recognition of diverse ways to present and express gender. The text coined the term transvestite – derived from the Latin words trans for across and vestitus for dressed – beginning the use of "trans" in relation to gender diversity. Hirschfeld defined transvestites as people "clearly faced with the strong drive to live in the clothing of that sex that does not belong to the relative build of the body…the kind of costume is not the chosen expression of an arbitrary mood, but rather is a form of expression of the inner personality as a valid symbol."[12] Hirschfeld further characterised transvestites thus:

> in the psyche of these men there is present a feminine admixture – and in the feminine counterpart a masculine one – which presses on to project itself. This alterosexual quota truly must be considerable since, as we discovered, it wants to withstand and does withstand very great resistance and inhibitions, not the least of which is the contrast between body and soul.[13]

In 1928, British sexologist Havelock Ellis used the term eonism to explain the same group: people who had a compulsion to dress in clothes associated with a sex other than that assigned at birth.

The words transvestism and eonism came out of continental European then British sexology, but their application in pre-Second World War Australia was sparse. The first use the term transvestitism was in a short 1912 newspaper article about a German baron granted permission to dress in women's clothes. The article from Melbourne's *Age* stated, "Dr. Magnus Herschfeld [sic], an authority on such matters, says, transvestitism has been and is common in all ages and all countries. It is an instinctive desire to dress in the clothes of the opposite sex."[14] The term occasionally popped up in other international reports from the 1910s-20s and would only be applied to Australian cases from the late 1930s.



BARON WEARS WOMAN'S CLOTHES.

From his earliest childhood Baron von Zobelitz, a member of a very ancient but very poor German family, showed pronounced inclination to don girls' clothes and to play with dolls and ply his needle. These eccentricities gave him much trouble, for his father was a violent man, and the son was obliged to put up with much very harsh treatment and severe whippings at frequent intervals. As soon as he could claim a will of his own he flatly refused any longer to wear male clothing, and began to make women's clothes for himself, since his furious parents refused to buy him any. Now, by a decision of a Berlin court, he has been converted into "Countess Geraldine von Zobelitz," and is entitled to dress as such. He is a ladies' tailor, and he makes the ladies' clothing not only for himself, but also for the whole of the family, and he has the smallest waist in Prussia. He won the prize for small waists at a competition some time ago at which the competitors appeared in masks. None suspected that he was not a lady of society. The case aroused great interest in Berlin. Dr. Magnus Herschfeld, an authority on such matters, says, transvestitism has been and is common in all ages and all countries. It is an instinctive desire to dress in the clothes of the opposite sex.

The first known mention of transvestitism in the Australian press. *The Age*, 28 September 1912: p. 21

Notwithstanding the dearth of terminology, from the mid-nineteenth century Australian medical professionals were still the main authorities on gender crossing but simply framed and treated it in the context of madness. The most famous case of gender crossing was Edward De Lacy Evans, previously known as Ellen Tremayne. In 1879 Evans was admitted to the Bendigo Hospital Lunacy Ward because of severe depression. Authorities moved Evans to the Kew Asylum, forcibly stripping them to bathe. The staff then discovered that Evans was assigned female at birth. Evans was transferred back to the Bendigo Asylum and released at the end of 1879, ostensibly again living as Ellen Tremayne until their death in August 1901.[15]

12 Magnus Hirschfeld, *Transvestites: The Erotic Drive to Cross Dress*, trans. Michael A. Lombardi-Nash (New York: Prometheus Books, [1910] 1991), 124.

13 Ibid., 214

14 "Baron Wears Woman's Clothes," *The Age*, 28 September 1912: 21.

15 Lucy Chesser, "Transgender-Approximate, Lesbian-Like, and Genderqueer: Writing About Edward De Lacy Evans," *Journal of Lesbian Studies* 13, no. 4 (2009): 373-94; Mimi Colligan, "The Mysterious Edward/Ellen De Lacy Evans: The Picaresque in Real Life," *La Trobe Journal* 69 (2002): 59-68.

As early as 1880 one of the Bendigo Asylum medical consultants published a case report in the *Australian Medical Journal*. The doctor described the physical examination undertaken and focused much of his description on the feminine and masculine features of Evans's body and appearance. The case report also included what, by twenty-first century standards, constituted an invasive exam of Evans's reproductive organs. Yet the article had no diagnosis for any ailment but simply noted Evans had been admitted to the lunatics ward.[16] Almost 100 years later, in 1978 Psychiatry Professor J.R.B. (Richard) Ball revisited the case notes and retrospectively (and ahistorically) diagnosed Evans as "an example of female transvestitism, and very likely an example of transsexualism."[17]

Ellen Tremayne and Edward De Lacy Evans

The framing of cases like Evans as just a bout of "madness" or "mania" continued into the early twentieth century and was particularly notable in cases of people assigned female at birth who were living as men. In 1939 Harcourt Payne was taken to a Sydney hospital after fainting in the street, and orderlies discovered that he was assigned female at birth. Payne had been living as a male for over twenty years. After a series of physical exams and bureaucratic hurdles, Payne was committed to Orange Mental Hospital and reported in the press to be ill "mainly with nervous disorder." Payne was classified as "certified" and therefore had little prospect for cure or discharge. Press reports suggested Payne would only be "cured" and therefore eligible for discharge if he accepted a female identity. Payne refused to do so and died in the hospital in 1940, with the death certificate listing one cause as arterio sclerosis. Historian Ruth Ford, who has written about Payne's case, explains: "This condition was defined by psychiatrists as abnormal thickening and hardening of the walls of the arteries of the brain causing mental deterioration and was linked to 'highly psychotic individuals' with hallucinations and a 'distinct degree of confusion and disorientation'."[18] The definition of arteriosclerosis is not confined to psychiatrists, and it is intriguing that this was the diagnosis given it is not generally a common cause of psychosis, including hallucinations.

Payne's case reveals two important points about the history of medical understandings of gender diversity: first, in order to be perceived as cured, one must accept (at least publicly) their sex assigned at birth like Edward De Lacy Evans had. Second, even by the Second World War there was not a widespread discourse or diagnosis upon which to draw, especially for people assigned female at birth who were living as men. This difference between assigned female at birth (AFAB) and assigned male at birth (AMAB) people would be important and continue until the very end of the twentieth century.

This leads to a smattering of examples from the 1930s that reveal how Australian psychologists were slowing adopting international sexology and psychology discourses. In August 1932, a Brisbane doctor wrote about eonism in the "Talk on Health" section (like a medical Dear Abby) of Brisbane's *Sunday Mail*. The doctor suggested that eonism was an inherited glandular condition caused when the mother wished for a daughter but birthed a son. The doctor further stated: "It must not be confused with homo-sexual cases; it might be described as female mind in a male body. But it is impossible to give sufficient detail here. I suggest you read Havelock Ellis's essay on Eonism, contained in the last volume of his Studies in The Psychology of Sex."[19] In 1935 Brisbane's *Telegraph* published an article in which a doctor specialising in psychology also referenced eonism to describe some people's urge to dress in clothing associated with the opposite sex. The article noted, "No vicious tendencies were ever exhibited, and in some cases the condition was one alternating with complete normality."[20]

16 Oliver Penfold, "A Case of Man-Personation by a Woman," *Australian Medical Journal* 2, no. 4 (1880): 145-47.

17 J.R.B. Ball and R. Emmerson, "A Case of Personation," *Medical Journal of Australia* 159, no. 2 (1978): 201.

18 Ruth Ford, "Sexuality and 'Madness': Regulating Women's Gender 'Deviance' through the Asylum, the Orange Asylum in the 1930s," in *'Madness' in Australia: Histories, Heritage and the Asylum*, ed. Catharine Coleborne and Dolly MacKinnon (St Lucia, QLD: University of Queensland Press in association with the API Network and Curtin University of Technology, 2003), 112-13.

19 "Replies to Queries," *Sunday Mail* (Brisbane), 14 August 1932: 21.

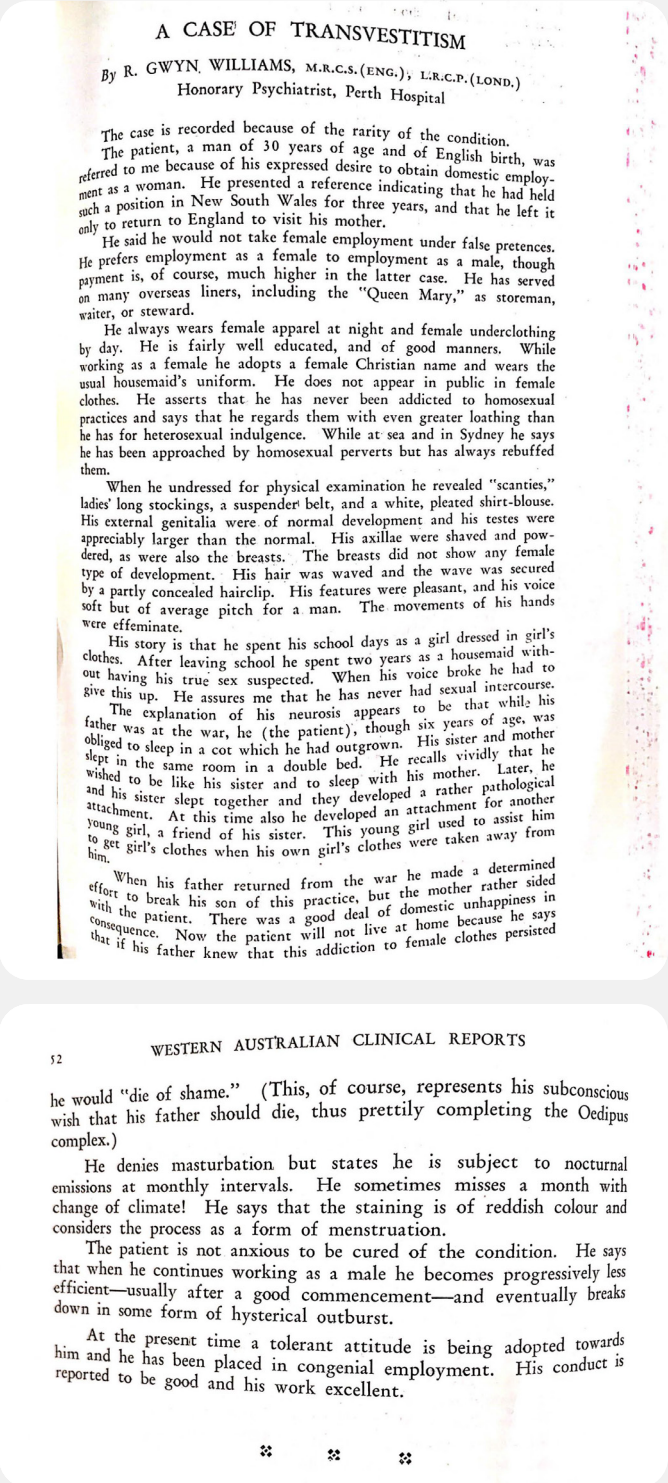
20 "Wearing Clothes of Other Sex; No Direct Prohibition in Queensland," *Telegraph* (Brisbane), 15 August 1935: 19.

Finally, an Australian diagnosis of transvestitism received attention in the August 1937 edition of *Western Australian Clinical Reports*. The case report described someone assigned male at birth who preferred to live and work as a woman. The person had worked as a steward and domestic servant and preferred to wear a woman's uniform and "always wears female apparel at night and female underclothing by day." The doctor diagnosed the patient with the "rare condition" transvestism and determined that it had been caused during childhood when the father was at war and the child slept in the same cot as their mother and sister.[21] The doctor's diagnosis aligned with the contemporaneous understandings of transvestism, looking for a familial cause and cure. The doctor also expressed some sympathy for the person and encouraged letting them dress how they were comfortable:

> The patient is not anxious to be cured of the condition. He says that when he continues working as a male he becomes progressively less efficient – usually after a good commencement – and eventually breaks down in some form of hysterical outburst. At the present time a tolerant attitude is being adopted towards him and he has been placed in congenial employment. His conduct is reported to be good and his work excellent.[22]

All this history leading up to the Second World War reveals a few important trends that would have profound consequences into the future:

1. Psychologists and other doctors were adopting medical language and understandings to diagnose individuals who dressed or lived in a gender other than their sex assigned at birth.
2. These definitions and medical conditions – particularly transvestism or eonism – almost universally applied to those assigned male at birth who had feminine gender expression. Those who were assigned female at birth were mostly treated as cases of madness.
3. Doctors and psychologists were distinguishing sexuality from gender diversity, but still sexuality had an influence because the definition of transvestism included that the individual was heterosexual (and, notwithstanding Hirschfeld's original definition, usually assigned male at birth).



A CASE OF TRANSVESTITISM

By R. GWYN WILLIAMS, M.R.C.S. (ENG.), L.R.C.P. (LOND.)
Honorary Psychiatrist, Perth Hospital

The case is recorded because of the rarity of the condition.

The patient, a man of 30 years of age and of English birth, was referred to me because of his expressed desire to obtain domestic employment as a woman. He presented a reference indicating that he had held such a position in New South Wales for three years, and that he left it only to return to England to visit his mother.

He said he would not take female employment under false pretences. He prefers employment as a female to employment as a male, though payment is, of course, much higher in the latter case. He has served on many overseas liners, including the "Queen Mary," as storeman, waiter, or steward.

He always wears female apparel at night and female underclothing by day. He is fairly well educated, and of good manners. While working as a female he adopts a female Christian name and wears the usual housemaid's uniform. He does not appear in public in female clothes. He asserts that he has never been addicted to homosexual practices and says that he regards them with even greater loathing than he has for heterosexual indulgence. While at sea and in Sydney he says he has been approached by homosexual perverts but has always rebuffed them.

When he undressed for physical examination he revealed "scanties," ladies' long stockings, a suspender belt, and a white, pleated shirt-blouse. His external genitalia were of normal development and his testes were appreciably larger than the normal. His axillae were shaved and powdered, as were also the breasts. The breasts did not show any female type of development. His hair was waved and the wave was secured by a partly concealed hairclip. His features were pleasant, and his voice soft but of average pitch for a man. The movements of his hands were effeminate.

His story is that he spent his school days as a girl dressed in girl's clothes. After leaving school he spent two years as a housemaid without having his true sex suspected. When his voice broke he had to give this up. He assures me that he has never had sexual intercourse.

The explanation of his neurosis appears to be that while his father was at the war, he (the patient), though six years of age, was obliged to sleep in a cot which he had outgrown. His sister and mother slept in the same room in a double bed. He recalls vividly that he wished to be like his sister and to sleep with his mother. Later, he and his sister slept together and they developed a rather pathological attachment. At this time also he developed an attachment for another young girl, a friend of his sister. This young girl used to assist him to get girl's clothes when his own girl's clothes were taken away from him.

When his father returned from the war he made a determined effort to break his son of this practice, but the mother rather sided with the patient. There was a good deal of domestic unhappiness in consequence. Now the patient will not live at home because he says that if his father knew that this addiction to female clothes persisted

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he would "die of shame." (This, of course, represents his subconscious wish that his father should die, thus prettily completing the Oedipus complex.)

He denies masturbation but states he is subject to nocturnal emissions at monthly intervals. He sometimes misses a month with change of climate! He says that the staining is of reddish colour and considers the process as a form of menstruation.

The patient is not anxious to be cured of the condition. He says that when he continues working as a male he becomes progressively less efficient—usually after a good commencement—and eventually breaks down in some form of hysterical outburst.

At the present time a tolerant attitude is being adopted towards him and he has been placed in congenial employment. His conduct is reported to be good and his work excellent.

A clinical case report of a case of transvestism published in 1937 in *Western Australian Clinical Reports*

21 R. Gwyn Williams, "A Case of Transvestitism," *Western Australian Clinical Reports* 1, no. 3 (1937): 51.
22 Ibid., 52. See also "A Double Life; Man Works as Maid," *West Australian*, 14 August 1937: 16.

Early Psychiatry and Surgery in Melbourne: 1951-75

In 1951, psychiatrist Dr Herbert Bower saw a patient at Melbourne's Royal Park Mental Hospital who was assigned male at birth but was identifying as a woman. Bower initially thought the patient was psychotic, but as he came to know the person he realised that the individual was quite well adjusted except for the gender identification. Decades later Bower described this patient as "almost an intellectual challenge."[23] Bower had no clear diagnosis or treatment for that person, and subsequently Bower continued to see patients with a different gender identity to their sex assigned at birth.

Bower's early encounters with these individuals were around the same time that international medical discourse was concretising a pathology and language that built on the pre-war sexology as well as developments in surgery. In the 1920s doctors at Magnus Hirschfeld's Institut für Sexualwissenschaft began research into gender affirmation surgeries, culminating in Lili Elbe's momentous surgery in 1931. In 1935 there were reports of a female-to-male surgery in Czechoslovakia. In 1949 Dr David Caldwell used the word transsexual to describe a person whose gender identification was different from their sex assigned at birth.

This all came together with two momentous events in the early 1950s. First was the global media coverage of former American GI Christine Jorgensen's gender affirmation surgery in 1952. Then in 1954, psychiatrist Dr Harry Benjamin published "Transsexualism and Transvestism as Psycho-Somatic and Somato-Psychic Syndromes."[24] Benjamin explicitly distinguished transvestism from transsexualism; the former continued to align with sexologists' pre-war definition, while transsexualism referred to those individuals who identified as the opposite gender to their sex assigned at birth. In 1966 Benjamin published the book *The Transsexual Phenomenon*, which became a textbook for the medical treatment of transvestites and transsexuals.[25]

Herbert Bower, psychiatrist who worked with trans clients from 1951 until his death in 2004

Australians were conscious of these overseas developments because of the worldwide press they generated. Endocrinologist Dr Christian Hamburger, who treated Christine Jorgensen, received 756 letters from 465 people around the world inquiring about the possibility of a "change of sex" (to use the language of the time). Thirteen letters came from Australia: nine from AMAB people and four from AFAB people (there were also eight letters from Aotearoa New Zealand: five letters from AMAB people and three from AFAB people).[26]

23 Andrew Bock, "Gender Bender," *The Age*, 9 October 1997, Extra p. 7.

24 Harry Benjamin, "Transsexualism and Transvestism as Psycho-Somatic and Somato-Psychic Syndromes," in *The Transgender Studies Reader*, ed. Susan Stryker and Stephen Whittle (New York: Routledge, [1954] 2006), 45-52.

25 Harry Benjamin, *The Transsexual Phenomenon* (New York: Julian Press, 1966).

26 Christian Hamburger, "The Desire for Change of Sex as Shown by Personal Letters from 465 Men and Women," *Acta Endocrinologica* 14 (1953): 363-64.

In the 1960s, psychiatrist Richard Ball arrived in Melbourne from Newcastle in the United Kingdom, where he already had experience working with trans people. In Melbourne Ball conducted research on transsexualism, transvestism and homosexuality for his doctoral thesis. Ball explored how the research participants exhibited masculine versus feminine qualities, their family backgrounds and physical examinations. His research searched for key commonalities and differences across and within the cohorts and focused much on finding a cause for the different "conditions". Ball published a series of articles in 1967-68 detailing his research findings, with the following conclusions about what caused people to be transsexuals:

a. An apparent lack of clear physical features which may be thought to have major aetiological influence on the development of male transsexualism. This does not, however, invalidate the possibility of some form of constitutional predisposition.

b. A pattern of parental characters and personality and paternal, or paternal-equivalent, lack in what must be vital formative years.

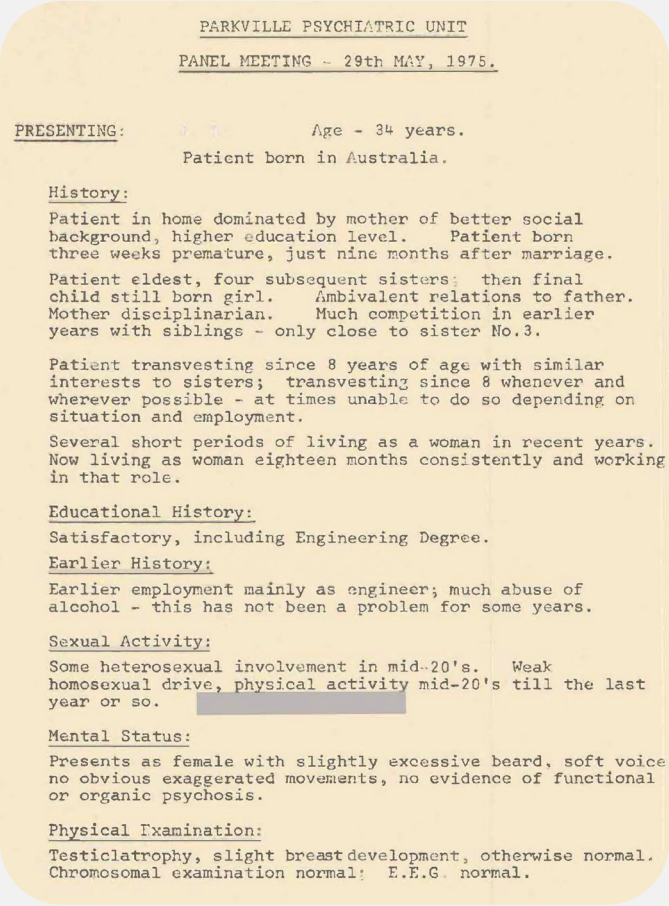
c. An apparent failure to make normal male identification with a persistent female identification, in the transsexualist cases.

d. Many related features which can be thought to be secondary phenomena to the basic anomaly.[27]

A decade later Ball acknowledged the limitations of his earlier research and suggested the aetiology was less important than the definition of a "true transsexual": "What might be regarded as 'genuine' or undoubted transsexuals demonstrated that behaviour, attitudes and interests were more compatible with the sex which they chose to join, rather than that into which they were born."[28]

Ball became associated with what are believed to be Melbourne's first gender affirmation surgeries. The Victorian Health Department ran a Transsexualism Consultative Clinic from 1969. When Ball diagnosed people as transsexuals, he referred them to surgeon Hunter Fry, who performed surgeries at Royal Melbourne Hospital usually early on Saturday or Sunday mornings. A memo from 1985 indicates that the first surgery performed in Melbourne was in 1969.[29] One letter Fry later sent to Ball suggests that he framed these surgeries as "a University Hospital project rather than a private patient of mine."[30] Classifying patients in this way was meant to keep them from conservative "prying eyes" in the general hospital system.

Transgender clients referred to Ball had to complete a questionnaire which asked questions about work, family, education and medical history. There were questions about if they dressed in clothes of the opposite sex; the frequency of dressing; if they lived as the opposite sex; and about the size and shape of their sex organs. The psychiatrist interview asked even more details about family and gendered and sexual behaviour: the closeness of relationship with parents; upbringing and favouritism (or not) of siblings; sexual education and attitudes to sex; whether or not they cross-dressed as children; and heterosexual and homosexual relationships and partners. There was a physical examination which included inspection of genitals and secondary sex characteristics. In the 1980s, other specialists would adopt similar questionnaires for trans patients.



PARKVILLE PSYCHIATRIC UNIT

PANEL MEETING - 29th MAY, 1975.

PRESENTING: Age - 34 years.
Patient born in Australia.

History:

Patient in home dominated by mother of better social background, higher education level. Patient born three weeks premature, just nine months after marriage.

Patient eldest, four subsequent sisters; then final child still born girl. Ambivalent relations to father. Mother disciplinarian. Much competition in earlier years with siblings - only close to sister No.3.

Patient transvesting since 8 years of age with similar interests to sisters; transvesting since 8 whenever and wherever possible - at times unable to do so depending on situation and employment.

Several short periods of living as a woman in recent years. Now living as woman eighteen months consistently and working in that role.

Educational History:

Satisfactory, including Engineering Degree.

Earlier History:

Earlier employment mainly as engineer; much abuse of alcohol - this has not been a problem for some years.

Sexual Activity:

Some heterosexual involvement in mid-20's. Weak homosexual drive, physical activity mid-20's till the last year or so.

Mental Status:

Presents as female with slightly excessive beard, soft voice no obvious exaggerated movements, no evidence of functional or organic psychosis.

Physical Examination:

Testiclatrophy, slight breast development, otherwise normal. Chromosomal examination normal: E.E.G. normal.

Example of a client assessment for surgery from 1975, courtesy relative of the deceased client.

In 1975 Richard Ball was appointed as professor of psychiatry at St. Vincent's Hospital, though the Transsexualism Consultative Clinic continued to run until 1987. Over its eighteen years, according to later media reports, the clinic saw approximately 700 people and referred about 100 of them for gender affirmation surgeries. All cases would have to go through a review

27 J.R.B. Ball, "Transsexualism and Transvestism (II)," *Australian & New Zealand Journal of Psychiatry*, no. 2 (1968): 30. See also "Transsexualism and Transvestism," *Australian and New Zealand Journal of Psychiatry*, no. 1 (1967): 188-95.

28 J.R.B. Ball, "Thirty Years Experience with Transsexualism," *Australian and New Zealand Journal of Psychiatry* 15 (1981): 41.

29 Dr John Grigor, 11 December 1985, in Public Records Office Victoria (hereafter PROV), VPRS 17369, P0001, unit 228, 902/L02/01523; Philip McIntosh, "From man to woman," *The Saturday Age*, 22 August 1987: 1-2.

30 Letter from Hunter Fry to Richard Ball, 3 February 1977, in confidential patient file shared with author by relative.

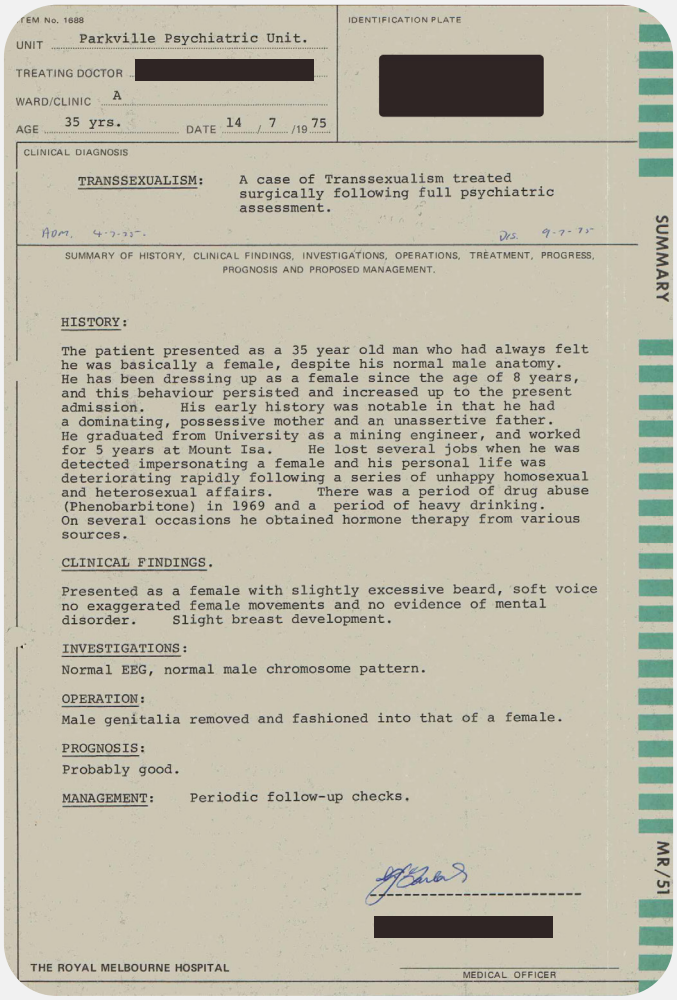
panel before being accepted as surgical candidates. Excerpts from one person's case file who had gender affirmation surgery in 1975 give some of an indication of how psychiatrists framed and evaluated transgender people:

> Patient transvesting since 8 years of age with similar interests to sisters; transvesting since 8 whenever and wherever possible – at times unable to do so depending on situation and employment.
>
> Several short periods of living as a woman in recent years. Now living as woman eighteen months consistently and working in that role…
>
> **Sexual Activity:** Some heterosexual involvement in mid-20's. Weak homosexual drive, physical activity mid-20's till the last year or so.
>
> **Mental Status:** Presents as female with slightly excessive beard, soft voice, no obvious exaggerated movements, no evidence of functional or organic psychosis.[31]

Ball's research and work with trans people represented an early example of a pattern that would echo across the country, as around the world. First, psychiatrists made a distinction between "transvestites" and "true transsexuals". To fit the criteria of a true transsexual, a person had to present as seeing themselves as the opposite gender trapped in the wrong body (this is known as "wrong body discourse"). What constituted the opposite gender reflected dominant social constructs framed around white, middle-class respectability. Richard Ball even noted in 1981:

> Arising from Melbourne conservatism, (and perhaps other subtle socio-cultural factors), together with the wish to test the quality and extent of the motivation, the female roles acceptable to the team did not include activities such as working with "Les Girls", stripping, or in the night club circuit. Patients were advised to sever all possible contacts with the homosexual world.[32]

The big distinction between transvestites and transsexuals was that the latter had to desire gender affirmation surgery and then to live indistinguishably, quietly, in their affirmed gender. Those individuals who did not meet the criteria would be denied treatment.



ITEM No. 1688

IDENTIFICATION PLATE

UNIT Parkville Psychiatric Unit.

TREATING DOCTOR [redacted]

WARD/CLINIC A

AGE 35 yrs. DATE 14 / 7 /19 75

CLINICAL DIAGNOSIS

TRANSSEXUALISM: A case of Transsexualism treated surgically following full psychiatric assessment.

Adm. 4-7-75. Dis. 9-7-75

SUMMARY OF HISTORY, CLINICAL FINDINGS, INVESTIGATIONS, OPERATIONS, TREATMENT, PROGRESS, PROGNOSIS AND PROPOSED MANAGEMENT.

SUMMARY

HISTORY:

The patient presented as a 35 year old man who had always felt he was basically a female, despite his normal male anatomy. He has been dressing up as a female since the age of 8 years, and this behaviour persisted and increased up to the present admission. His early history was notable in that he had a dominating, possessive mother and an unassertive father. He graduated from University as a mining engineer, and worked for 5 years at Mount Isa. He lost several jobs when he was detected impersonating a female and his personal life was deteriorating rapidly following a series of unhappy homosexual and heterosexual affairs. There was a period of drug abuse (Phenobarbitone) in 1969 and a period of heavy drinking. On several occasions he obtained hormone therapy from various sources.

CLINICAL FINDINGS.

Presented as a female with slightly excessive beard, soft voice no exaggerated female movements and no evidence of mental disorder. Slight breast development.

INVESTIGATIONS:

Normal EEG, normal male chromosome pattern.

OPERATION:

Male genitalia removed and fashioned into that of a female.

PROGNOSIS:

Probably good.

MANAGEMENT: Periodic follow-up checks.

[redacted]

THE ROYAL MELBOURNE HOSPITAL

MEDICAL OFFICER

MR/51

Excerpt from client case file from 1975, courtesy relative of the deceased client

31 Parkville Psychiatric Unit, Panel Meeting - 29th May, 1975, in confidential patient file shared with author by relative.
32 Ball, "Thirty Years Experience with Transsexualism," 41.

Sydney's Early Trans Health Care

In a 1981 interview, the Sydney-based psychiatrist Ron Barr suggested that about forty gender affirmation surgeries had been performed in that city over a ten-year period to 1978.[33] That would suggest that Sydney's first gender affirmation surgery was shortly before Melbourne's. Reinforcing this were some newspaper accounts from trans women which, if accurate, would mean Australia's first gender affirmation surgery was performed in Sydney in 1968.[34] Trans people from the early 1970s who had the means would travel to Morocco, Egypt or London for gender affirmation surgeries (and since the 1990s, Thailand has become the popular destination for more affordable surgeries).

Sydney's history of trans health care in the 1970s had other points of commonality with Melbourne, particularly around the role of psychiatrists and the need for a panel of specialists to approve surgery. The 1973 *Medical Journal of Australia* article explained:

> In Australia operations for male to female sex change have been done regularly only since 1971. In Sydney requests for such treatment are considered by a committee. Before a recommendation is made, patients and relatives are seen by a psychiatrist over a period of at least six months. The evaluation programme includes examination by an endocrinologist and psychologist, chromosomal studies and measurement of penile volume responses to erotic film sequences. This last technique has been shown to be a valid method of assessing sexual orientation. A small minority of males who ask for sex change operations are sexually attracted to women rather than men. If such a patient undergoes sex reassignment surgery he may later regret the loss of his penis.[35]

The article very much reflected the approaches of particular psychiatrists in Sydney. Significant differences in both psychiatry and surgeries sent Sydney's history of trans health care on a different path from Melbourne and other Australian cities.

There were actually two gender clinics running in Sydney in the early 1970s, both directed by psychiatrists. One was at the Prince Alfred Hospital under Professor Beverley Raphael. Little is known about this clinic, though Dr Rob Lyons recalls observing it during a placement while studying medicine. His recollection was that many conservatively dressed men would attend the clinic and were turned away because they were not feminine enough. The clinic director determined that gender affirmation surgery would not help them and they would continue to be depressed.[36]

The more prominent personality behind trans psychiatry in 1970s Sydney was Neil McConaghy. McConaghy is a controversial figure in Australia's history of sexuality and medicine because he was a practitioner of aversion therapy. He developed a mechanism which objectively measured men's sexual orientation by recording subtle penile volume changes when they viewed slides of nude males and females. On the clinical presentation of gay men wishing to change their sexual orientation, McConaghy always encouraged them to accept their sexuality. He only offered aversion therapy for those who – as he put it – were "Subjects with significant homosexual feelings who for religious or other

33 "Interview with Dr Ron Barr, Prince Henry Hospital," June 1981, in National Archives of Australia (hereafter NAA) C1367, 81/239.
34 "Sex Change Shock," *Daily Mirror*, 15 January 1986; "Nightclub girl was builder's laborer!" *Truth* (Melbourne), 26 December 1970: 3, G.R. papers, AQuA.
35 "Transsexualism," *Medical Journal of Australia* 2, no. 6 (1973): 252.
36 Rob Lyons, interview with author, 2 July 2021, Zoom.

reasons are totally unwilling to accept a homosexual adjustment."[37] During the aversion therapy, gay men were shown slides of naked men, at which time an electrode attached to the finger delivered an electric shock. The aim was to cause discomfort, not pain, and supposedly would allow gay men to control their sexual urges in a social setting.

When it came to trans people, though, McConaghy did not practice aversion therapy. Indeed, McConaghy's research and consultations were more in line with contemporaneous international ideas around transvestism and transsexualism. McConaghy was a consultant at the Prince Henry Hospital, and one of his senior registrars from 1972-74 was Neil Buhrich. Buhrich recalls that for transsexual people to be approved for surgery, they had to be seeing the psychiatrist for at least twelve months and be living in their affirmed gender for that period. The entire team was trying to distinguish "true transsexuals" from those whom the team believed were gay men that thought life would be easier if they became women. Buhrich also remembers that sometimes parents whose sons kept dressing as girls would bring their children for consultations. McConaghy would tell the parents to let the kids be who they were and grow up as they wanted; parents should just support and love their children.[38]

McConaghy and Buhrich also conducted research working with the organisation Seahorse: Sydney and Australia's first transgender support group, founded in 1971. Seahorse actually wrote to McConaghy asking why, with all the interest in transsexuals and homosexuals, he was not taking an interest in transvestites like them. Importantly, in the 1970s Seahorse identified as heterosexual transvestites, so that was what the research project aimed to explore. McConaghy was successful at securing a small grant from the NSW Institute of Psychiatry to research transvestism. The project methodology entailed conducting in-depth interviews and penile plethysmography (penile volume response measures) across four groups: 35 transvestites, 34 transsexuals, 34 homosexuals and 34 cisgender straight men. The results of the study, which formed the basis of Buhrich's doctorate, classified people into three types:

1. Nuclear transvestites: those who liked to dress part-time as women but were comfortable identifying as heterosexual men;
2. Nuclear transsexuals: those who were uncomfortable with their male bodies, wanted hormones and/or surgery to live as women, and had homosexual tendencies (or, to separate sexuality from gender identity, were attracted to men);
3. Marginal transvestites: a group that sat somewhere between the other two, who desired some medical interventions and alterations to their bodies and felt some femininity, but not as strongly as the second group. This group was also said to show some homosexual interest but were mostly heterosexual (or were primarily attracted to women).

In summary: transvestites were comfortable with their bodies and dressing as women was fetishistic, especially for silk, satin and clothes typically associated with women. Furthermore, they only felt feminine when they were dressed as women. Transsexuals, on the other hand, hated their bodies and always felt feminine.[39]

Reinforcing the construction of transsexuals as being homosexual (or more likely to be attracted to men) was similar research by Ron Barr, who also worked at Prince Henry Hospital and deployed McConaghy's penile volume response test. Barr concluded: "The measurement of penile volume responses may prove useful in the assessment of candidates for sex reassignment surgery. Patients who show a heterosexual pattern of response may live to regret the loss of the penis following surgery."[40] One former patient of Ron Barr's did not speak so fondly of the test. As she recalled:

> They would take us and they would connect our bits to a machine and then you'd be watching a film that would be flitting through the zoo and a baboon's ass would flash up, and then you'd go a little bit further and then there'd be this sort of large, languid sort of Spanish-looking woman with huge, hairy tits then she would be sort of lying there going like this and then you'd be flitting through the zoo again and there'd be a man's penis and it was supposedly designed to measure your sexual responses when you came to any of these diversions.[41]

37 Nathaniel McConaghy, *Sexual Behavior: Problems and Management* (New York: Springer Science + Business Media, LLC, 1993), 135.

38 Neil Buhrich, interview with author, 9 October 2020, Zoom.

39 Neil Buhrich and Neil McConaghy, "Clinical Comparison of Transvestism and Transsexualism: An Overview," *Australian and New Zealand Journal of Psychiatry*, no. 11 (1977): 83-86; Neil Buhrich, "Clinical Study of Heterosexual Male Transvestism" (University of New South Wales, 1977); Neil Buhrich and Neil McConaghy, "Three Clinically Discrete Categories of Fetishistic Transvestism," *Archives of Sexual Behavior* 8, no. 2 (1979): 151-57.

40 Ron Barr and Alex Blaszczynski, "Autonomic Responses of Transsexual and Homosexual Males to Erotic Film Sequences," *Archives of Sexual Behavior*, no. 3 (1976): 221.

41 Gina Miller, interview with author, 1 October 2019, Perth.

That same person also recalled that Barr would not approve her for surgery because she worked as a stripper, not meeting what he said was the requirement that she live full-time as a respectable woman.

Although Barr's specific test did not continue after the 1970s, physical examinations including measuring of genitals certainly did – and this was not unique to Sydney. Trans people who had to endure these invasive and degrading procedures are still uncomfortable discussing them.[42] As the final section of this report shows, still there are doctors who are conducting unnecessary and inappropriate physical exams on trans clients.

Buhrich moved on from trans health care and research when he left the Prince Henry Hospital around 1974. McConaghy would continue to work in the psychiatry of sexuality, but he, too, mostly left trans research and health care just as major changes were afoot in Sydney. The transsexualism clinic at the Royal Prince Alfred Hospital also closed when Professor Beverley Raphael accepted a new position in Newcastle in 1975.

During the early 1970s, when McConaghy, Buhrich, Barr or other specialist psychiatrists approved trans people for surgery, the operations were performed at Prince of Wales Hospital. Those surgeries stopped in 1978. When questioned in a 1981 interview why, Ron Barr gave the following explanation:

> Well, several of us felt that, and the surgeon felt, he wasn't entirely convinced it was helping. Often people who had a place in gay society, would now be ostracized and left in a twilight zone between gay and straight society – not really fitting into both … the operation does not usually lead to a better sex life, because most had fairly good sex lives before … I think being a transsexual is primarily an identity problem, not a sexual problem, because transsexuals are willing to take large doses of Oestrogens which greatly reduce/knock out sex drive and anybody who is primarily interested in sex would not take anything to know [sic] out their sex drive, they are more concerned with identity.[43]

It is interesting that Barr seemed to be adopting the notion of gender as social construct instead of embodied. Yet, his discussion – like his other publications of the era – focused extensively on sex and sexuality.

Transgender people who were active in Sydney in the late 1970s have a different recollection about surgeries and why they ceased. Gina Miller very bluntly says:

> They [surgeons] mutilated so many people and so many people just died from stuff that they did. They didn't know what they were doing and it was awful, horrible.

Miller believes the Sydney surgeons were not properly trained to perform gender affirmation surgeries and that the trans women they operated on were like guinea pigs. She recollects one friend whom she describes as having been "butchered" by the surgeons. The friend was in and out of hospital for years with a fistula in her genitals that would regularly burst. Eventually, that person completed suicide, which Miller attributes in part to her surgery. Miller believes the many complications from surgeries led Sydney surgeons to cease.[44]

Although there are conflicting accounts as to why gender affirmation surgeries terminated in Sydney in 1978, by then viable alternatives had emerged in Melbourne and shortly thereafter in Adelaide.

42 Neil Buhrich – the only doctor interviewed for this project who worked with trans clients in 1970s Sydney – was not identified by any transgender interview participants as conducting such examinations.
43 "Interview with Dr Ron Barr, Prince Henry Hospital," June 1981, NAA C1367, 81/239.
44 Gina Miller, interview with author, 1 October 2019, Perth.

Melbourne Gender Dysphoria Clinic

In the early 1970s Dr William Walters, an obstetrician/gynaecologist at Melbourne's Queen Victoria Hospital, received a transsexual patient referral from a GP. Walters was not a specialist in this field, so he did some research and referred the patient to an endocrinologist and then a surgeon. Other GPs then began referring patients to Walters, who developed a good working relationship with Herbert Bower. They jointly saw the need for a clinic that specialised in what psychiatrist Norman Fisk in 1973 began calling gender dysphoria syndrome: a spectrum of people experiencing mental distress and discomfort because their internal gender identity, presentation or sex characteristics did not fit with societal norms around their sex assigned at birth. In practical terms for the era, gender dysphoria syndrome encompassed transsexuals, transvestites and "effeminate homosexuals".[45]

Walters brought a proposal to the Head of the Monash University Department of Obstetrics and Gynaecology, Dr Carl Wood, to found a cross-specialist gender dysphoria clinic at the Queen Victoria Hospital. Wood was supportive but knew they needed to tread carefully including consulting lawyers. It was not clear if it were even legal in Australia to perform gender affirmation surgeries because that involved removing healthy organs from a person. This question arose in Western Australia during the same period as well, and in both jurisdictions the legal advice was that with proper informed consent, gender affirmation surgeries were legal. In Western Australia the Crown Law Department produced legal advice in 1976 that clarified that to be legal the surgery must be for a client's "benefit" and to meet that definition:

> (1) the criterion is not what the patient thinks or wants, it is an objective one; and (2) "benefit" appears to be used in the sense of "therapeutic to his health" (which clearly includes mental as well as physical health). Clearly, surgery just to satisfy a whim of the patient, could never be brought under this section.[46]

Walters, Bower and Wood collated overseas research on gender dysphoria and transsexualism and convinced both Monash University and the Queen Victoria Hospital board of management to found a Gender Dysphoria Clinic in late 1975, with Walters as founding director.[47] The clinic began seeing clients in early 1976 and the first gender affirmation surgery was performed in May of that year (for this reason in some records the clinic is said to have been founded in 1975 and in others 1976).

Even though Fisk's definition of gender dysphoria encompassed transvestites, transsexuals and effeminate homosexuals, the Melbourne Gender Dysphoria Clinic was focused almost exclusively on transsexuals and its work centred on screening and preparing people for gender affirmation surgery. The clinic director's role was to coordinate patients' care across the different specialists: psychiatrists, endocrinologists and eventually surgeons.

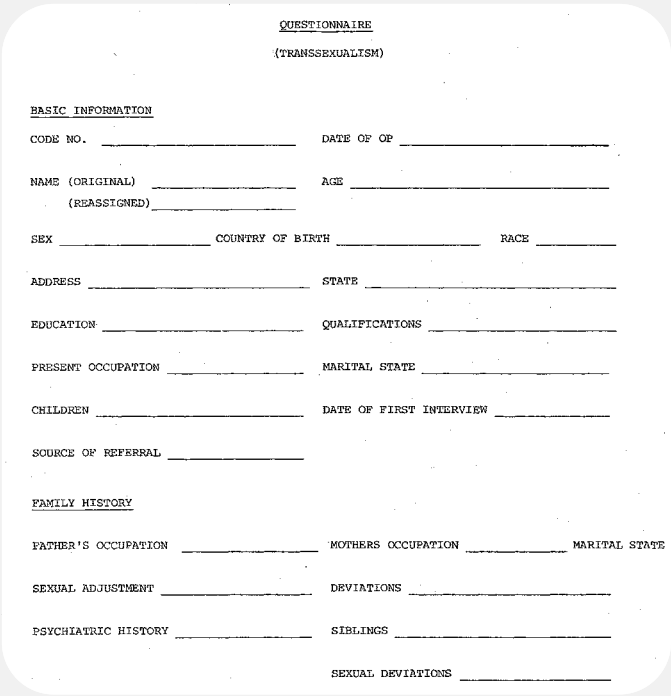
Early on the clinic developed procedures to assess if and when a trans person met eligibility for surgery. From 1979 they strictly followed the newly published Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders. These guidelines – revised in 1980, 1981, 1990, 1998, 2001 and most recently in 2011 as the WPATH Standards of Care for the Health of Transsexual, Transgender, and

45 Norman Fisk, "Gender Dysphoria Syndrome," in *Proceedings of the Second Interdisciplinary Symposium on Gender Dysphoria Syndrome*, ed. D.R. Laub and P. Gandy (Palo Alto, CA: Stanford University Medical Center, 1973), 7-14; "Gender Dysphoria Syndrome: The Conceptualization That Liberalizes Indications for Total Gender Reorientation and Implies a Broadly Based Multi-Dimensional Rehabilitative Regimen," *The Western Journal of Medicine*, no. 120 (1974): 386-91.

46 Western Australia, Crown Law Department, "Legal Implications of Sexual Reassignment Surgery," 9 January 1976, WA State Records Office, AU WA S455- cons4562 1979/5144.

47 William Walters, interview with author, 23 April 2019, Sydney.

Gender Nonconforming People – served two important purposes for health professionals. First, they provided a form of liability protection for health professionals working in trans health care because they could point to the standards of care as guiding their practice. Second, they provided an air of legitimacy in an area of health care which was, for decades, looked down upon by much of the medical profession. Of course, a flipside to the authority provided by the Standards of Care was that many professionals would adhere rigidly to the document, rather than using them as a flexible set of guidelines for trans health care.



QUESTIONNAIRE

(TRANSSEXUALISM)

BASIC INFORMATION

CODE NO. _____ DATE OF OP _____

NAME (ORIGINAL) _____ AGE _____

(REASSIGNED) _____

SEX _____ COUNTRY OF BIRTH _____ RACE _____

ADDRESS _____ STATE _____

EDUCATION _____ QUALIFICATIONS _____

PRESENT OCCUPATION _____ MARITAL STATE _____

CHILDREN _____ DATE OF FIRST INTERVIEW _____

SOURCE OF REFERRAL _____

FAMILY HISTORY

FATHER'S OCCUPATION _____ MOTHERS OCCUPATION _____ MARITAL STATE

SEXUAL ADJUSTMENT _____ DEVIATIONS _____

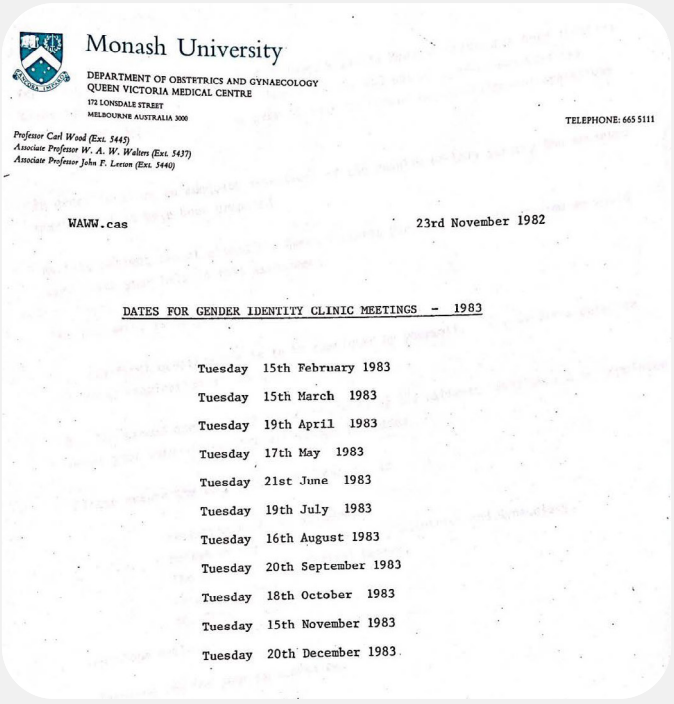
PSYCHIATRIC HISTORY _____ SIBLINGS _____

SEXUAL DEVIATIONS _____

First page of the long questionnaire from the early years of the Melbourne Gender Dysphoria Clinic, courtesy Simon Ceber

In line with the early renditions of the Standards of Care, psychiatrists would assess whether the clients were "true transsexuals" who saw themselves as the opposite gender to their sex assigned at birth and aspired to live, work and dress in line with stereotypical ideals of white, middle-class respectability. An early psychiatric questionnaire asked not only personal questions about cross-dressing history and relationships with family, but also about sexual behaviour, desires and family history, including: parents' sexual deviations; whether they played with dolls or soldiers; sports; sexual interests at puberty; masturbation; sexual fantasies; attitudes towards anal intercourse; work in the sex or stripper industry; attempts to live or dress in another sex role; suicidal ideation and other self-harm.

Doctors also conducted a thorough medical history and complete general physical examination. In addition to standard physicals, the examination assessed clients' physical build, breasts, sex organs, "attractiveness as male" and as female, and there were blood tests for hormone levels. Some individual cases required other special investigations, such as blood chromosome analysis, blood hormone profiles, or diagnostic imaging.



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WAWW.cas

23rd November 1982

DATES FOR GENDER IDENTITY CLINIC MEETINGS - 1983

Tuesday 15th February 1983
Tuesday 15th March 1983
Tuesday 19th April 1983
Tuesday 17th May 1983
Tuesday 21st June 1983
Tuesday 19th July 1983
Tuesday 16th August 1983
Tuesday 20th September 1983
Tuesday 18th October 1983
Tuesday 15th November 1983
Tuesday 20th December 1983

1983 schedule of meetings to approve candidates for surgery, courtesy Simon Ceber

Those who fit the criteria of "true transsexuals" would have hormones prescribed by an endocrinologist and then needed to meet a "real-life test": living full-time in their affirmed gender for two years. They had to wear dresses and skirts; divorce their wives; and assume an identity of their affirmed gender. Even though there were no anti-discrimination protections and trans women in particular could face violence and harassment, they still had to live this way 24/7. Those who lost their jobs then found it difficult to afford the specialist appointments, hormones and gender affirmation surgery.

Monthly a committee met to determine which patients were, by their standards, suitable for gender affirmation surgery. In the early years the committee make-up was the clinic director (who was an obstetrician/gynaecologist), two psychiatrists, one clinical psychologist, two plastic surgeons, two senior nurses, two social workers and – when requested by the clients – two hospital chaplains. Over the years the make-up of the committee has also included a lawyer, speech pathologist, endocrinologist, and sometimes a transgender community member (though this role was phased out in the 2000s over concerns about clients' privacy). Overall, though, the opinions of the psychiatrists tended to dominate the decision-making over who was allowed to proceed to gender affirmation surgery (unless there were physical reasons, determined by the surgeons, that someone would not be an ideal surgical candidate). Although there are now much changed determinants of a candidate's suitability for

surgery, regular clinical meetings are still a practice at the Monash Gender Clinic.[48]

In 1981 speech pathologists affiliated with the Lincoln Institute Speech Pathology Clinic began working with the Gender Dysphoria Clinic to offer voice modification for trans women. In the beginning they followed the Dutch practice, which advocated that clients first socially transition so they would have practice opportunities prior to commencing voice training. The speech pathologists soon saw that this was not appropriate. In fact, practitioners like Jennifer Oates and Georgia Dacakis became global pioneers in speech pathology for trans people.[49] Eloise Brook, who went through Dacakis's program in the early 2010s, described the speech pathologists as "amazing" and instrumental at helping her navigate her transition.[50]

In 1987 the Lincoln Institute merged with La Trobe University and it continues to operate as the La Trobe Communication Clinic. Their work has linked with speech pathologists and trans people from across Australia and around the world.[51] In 2013 Dacakis was lead researcher in the development of the Transsexual Voice Questionnaire (recently renamed the Trans Woman Voice Questionnaire or TWVQ), used by speech pathologists around the world. Speech pathologists at the La Trobe Communication Clinic are now developing an online module for speech pathologists who would like to work with trans and gender diverse people but who feel ill-equipped.

The Gender Dysphoria Clinic underwent a series of significant changes between 1987-90. First, in 1987 William Walters accepted an appointment as the Head of the Department of Obstetrics and Gynaecology at the University Newcastle, NSW, and psychiatrist Trudy Kennedy became the new clinic director. That same year, the Gender Dysphoria Clinic moved from Queen Victoria Hospital to Monash Medical Centre. This move posed significant challenges at first. For instance, Monash Medical Centre would only permit surgeries for patients with private health insurance. This meant that about half of the people on the books and ready for surgery would not be able to afford it. Herbert Bower complained to the press, and this contributed to negotiations behind the scenes with the Victorian Department of Health.

To resolve the financial impasse, in October 1988 the Victorian Minister for Health decided to close the Department of Health's Transsexualism Consultative Clinic and instead devote all public resources to the one gender clinic. While the clinic would be part of Monash Medical Centre, from 1990 surgeries would happen at the Masada Private Hospital. The state government would provide $30,000 per annum to support clinical assessment and $75,000 to fund gender affirmation surgeries. This would support between six to ten surgeries each year – even though in 1988 there were already waiting lists of over thirty-five people. The public-funded part of the program restarted in mid-1989.[52]

William Walters, founding director of the Melbourne Gender Dysphoria Clinic

48 Riki Lane, "'We Are Here to Help': Who Opens the Gate for Surgeries?" *TSQ: Transgender Studies Quarterly* 5, no. 2 (2018): 207-27; Simon Ceber, interview with author, 6 November 2020, Zoom.

49 Jennifer M. Oates and Georgia Dacakis, "Speech Pathology Considerations in the Management of Transsexualism: A Review," *British Journal of Disorders of Communication* 18, no. 3 (1983): 139-51; "Voice, Speech and Language Consideration in the Management of Male-to-Female Transsexualism," in *Transsexualism and Sex Reassignment*, ed. William A.M. Walters and Michael Ross (Oxford: Oxford University Press, 1986), 82-91; Georgia Dacakis, interview with author, 4 September 2018, Melbourne.

50 Eloise Brook, interview with author, 19 July 2021, Zoom.

51 Georgia Dacakis et al., "Development and Preliminary Evaluation of the Transsexual Voice Questionnaire for Male-to-Female Transsexuals," *Journal of Voice* 27, no. 3 (2013): 312-20; Georgia Dacakis, interview with author, 4 September 2018, Melbourne.

52 "Public to pay for sex changes," *Truth* (Melbourne), 27 May 1989: 2; Calvin Miller, "Sex change program on again," *Herald* (Melbourne), 29 June 1989.

Demographics of Clients at Melbourne's Gender Dysphoria Clinic

Early on Melbourne's Gender Dysphoria Clinic was seeing about one or two clients per month, but within a decade there were about 100-150 people on the books. Almost all clients were trans women; most were from educated backgrounds with professional jobs. They came from all over Australia, Aotearoa New Zealand and even other countries in Asia. Various reports, conference presentations and publications over the years authored by psychiatrists and surgeons affiliated with Melbourne's Gender Dysphoria Clinic have left useful data showing numbers and demographics. Much of this data centres around gender affirmation surgeries, which is not surprising because that was seen as the normal end goal for transsexual clients. The following tables offer some breakdowns about numbers – especially the increase over the first twenty-five years of the clinic's operation:

YEAR	NUMBER OF SURGERIES
1976	1
1977	1
1978	9
1979	11
1980	14
1981	16
1982	16

Number of surgeries[53]

YEAR	TOTAL CLIENTS	TOTAL SURGERIES
1982	320	68
1984	428	100

YEAR: 1982[54] / 1984[55]

YEAR	TOTAL CLIENTS	TOTAL SURGERIES	PERCENTAGE OF CLIENTS WHO HAD SURGERY
1976-1992	697	202	29%
1993-2003	711	208	29%
TOTAL	**1400**	**410**	**29%**

Table showing client numbers from founding until 2003.[56]

53 Research notes prepared by Simon Ceber for presentation "Surgical Results of Sex Reassignment Surgery in Male-to-Female Transsexuals," 2nd Australian and New Zealand Conference on Transsexualism, 15 October 1983, courtesy Simon Ceber.

54 Simon Ceber, "Surgical Results of Sex Reassignment Surgery in Male-to-Female Transsexuals," in *2nd Australian and New Zealand Conference on Transsexualism* (Adelaide 1983).

55 Herbert Bower et al., "Gender Dysphoria: A Retrospective Study of Possible Aetiological Factors," (Melbourne: Divisions of Family Psychiatry and Surgery, Queen Victoria Medical Centre, and The Department of Obstetrics & Gynaecology, Monash University, 1985).

56 Mary Samuhel, "Review of People Presenting to the Monash Medical Centre Gender Dysphoria Clinic from 1/1/1993 to the 31/12/2003," (Department of Human Services, 2004), 13.

While the sheer numbers are interesting, they only tell part of the story. What is also important is the demographic breakdown of the people presenting at the Melbourne Gender Dysphoria Clinic. Data from both 1982 and 1985 showed that the mean age of people who had gender affirmation surgery was 32 years old, with a range of 21 to 61 years.[57]

While the trans people accessing the clinic came from across the socio-economic spectrum, they were overwhelmingly from white/European backgrounds. Of the 100 people who had gender affirmation surgery between 1976-84: 72 were born in Australia, 13 in England, 8 in Aotearoa New Zealand, and 1 each in Italy, Holland, France, Czechoslovakia, Germany, Burma and China. By 1992, this pattern had changed little, and further demographic information in a report by Herbert Bower showed that 182 out of 202 (90%) of people who had gender affirmation surgery were from white/European backgrounds. Of the remaining 10%, the majority (fourteen) were Māori or Pasifika and there had only been one Aboriginal person. There were also five Asian people: three Burmese/Cambodian, one Chinese, and one Singhalese.

Time period:	1976-1992	
Selection criteria:	Unequivocal diagnosis of transsexualism Absence of psychiatric disorders Single status Normal or above intelligence At least 21 years of age Minimum of 2 years supervised waiting period	
Number of applicants	697	
Number of surgical reassignments	202	
Mean age at time of operation	33	
Mean waiting period	2 years and 7 months	
Country of birth	Australia New Zealand United Kingdom Other European countries Asia USA Cook Island	141 20 27 7 5 1 1
Race	Caucasian Maori/Pacific Aboriginal Chinese Singhalese Burmese/Cambodian	182 14 1 1 1 3

Excerpt of table from 1995 report prepared by Herbert Bower for the Victorian Attorney-General's Law Reform Advisory Council[58]

This racial breakdown was, to an extent, a reflection of Australia being a less multicultural society in the 1970s-80s. Yet, further data from 1993-2003 about patients' country of origin showed little change:[59]

COUNTRY OF ORIGIN	NUMBER
Australia	581
Aboriginal descent	3
North America	3
South America	3
United Kingdom	40
Other European countries	15
Asia	41
Islands and New Zealand	23
Africa	3

Still less than 10% came from non-European backgrounds. These demographics suggest that trans health care of that era was not so attuned to cultural difference, be that around different cultural constructs of gender and offering services that were culturally appropriate and inclusive. The demographics also suggest that the pathologisation around gender affirmation surgery was not as applicable to trans people from multicultural and Indigenous backgrounds. In other words, gender affirmation surgery and the presumption that it should be the end goal for trans people was a Western construct.

A rare insight into the mindset of surgical candidates comes from trans activist Roberta Perkins, who had gender affirmation surgery in late 1980. Over the five-weeks of her hospital stay, Perkins kept a series of handwritten notes almost like a diary, detailing her feelings before and after the surgery (or surgeries more accurately: she had three operations over that period). The early entries express feelings of euphoria at the prospect of soon having a vagina instead of a penis. She also felt elated after the first surgery, writing:

> The next day and the day after the operation. Pain, agony, ecstasy. Pain in the crutch; agony of discomfiture; ecstasy at having a good job, according to medical staff. Haven't yet reached a stage of emotional outburst, but expect this when full realization of what has happened to me occurs. Nurses most attentive, which is hardly what I expected seeing as I underwent a form of plastic surgery. On the contrary

57 Ceber, "Surgical Results of Sex Reassignment Surgery in Male-to-Female Transsexuals."; Bower et al., "Gender Dysphoria: A Retrospective Study of Possible Aetiological Factors."

58 Herbert Bower, "Transsexualism: Medical Aspects," (Melbourne: Attorney-General's Law Reform Advisory Council, 1995), 31.

59 Samuhel, "Review of People Presenting to the Monash Medical Centre Gender Dysphoria Clinic from 1/1/1993 to the 31/12/2003," 15.

> they are fussing around us TS [transsexuals], who seem to be glamour patients of Ward 9.

Perkins's euphoria over time became less pronounced in her entries, as comments about the pain become more prevalent as did new feelings of depression. Her attitude towards the vagina were not as exciting as she anticipated; one entry summarises it well: "Feelings: not aware of having a vagina, although recognize I no longer possess a penis. My vagina appears as a great wound that gives me pain and keeps me in hospital. Full realization of it probably will not occur until after leaving hospital, and of course its total potential will not be realized until my first intercourse." By the final entry when Perkins left the hospital, she expressed feelings of uncertainty for the future.[60]

Long-time trans activist and founder of The Gender Centre, Roberta Perkins (1940-2018)

Doctors from the Melbourne Gender Dysphoria Clinic conducted some follow-up surveys with clients who had surgery in the clinic's early years. Most of this data focused on health outcomes from the surgery, with less attention paid to quality of life, mental health or other aspects of their lives. Still, a survey of surgical candidates from 1976-82 asked patients to rate their satisfaction around self-image, work, social life, sex life and overall result. In all five categories the overwhelming majority indicated "good to excellent" feelings after their surgery.[61]

Other evidence suggests that many surgical clients had satisfactory outcomes medium to long term. Several of the people who had gender affirmation surgery through the Melbourne clinic in the 1970s-80s would write letters to their surgeons talking about how happy they felt afterwards. One 1983 ABC documentary that followed a trans woman through her surgery in Melbourne quoted her afterwards as saying:

> All of us go through all this pain, and heartache, and worried- to go through all this. And then they turn around and say, "Well you're not a woman; you're a man." And they stamp you with a label. I couldn't give a damn; I know what's between my legs. I'm not worried. It's given me so much confidence. You wouldn't believe the confidence it gives you, because you think, well, "To hell now! I'm happy."[62]

Notwithstanding the positive outcomes for those trans women who had surgery through Melbourne's Gender Dysphoria Clinic, there were plenty of other people who were dissatisfied with the expectations and process. There were also those trans people who did not fit the psychiatrists' requirements and gendered expectations and therefore were not able to obtain the health care they desired. Their stories and experiences are explored in a later section.

Table 10.3 The degree of satisfaction experienced by male transsexuals after reassignment as females

	Patient grading			
	IV	III	II	I
Genital appearance	19	3		
Vaginal depth	6	10	3	3
Genital sensation	18	3	1	
Orgasmic ability	14	7		1
Self image	21	–	1	
Work situation	19	3	–	
Social life	18	2	2	
Sexual life	11	7	3	1
Overall result	18	3		

I Poor or worse
II Fair or unchanged
III Satisfactory or some improvement
IV Good to excellent

60 Roberta Perkins, autobiographical notes from November-December 1980, Roberta Perkins Papers, State Library of NSW, box 8A.

61 Lena McEwan, Simon Ceber, and Joyce Daws, "Gender Reassignment Surgery: Male-to-Female Surgical Genital Reassignment," in *Transsexualism and Sex Reassignment*, ed. William A.M. Walters and Michael Ross (Oxford: Oxford University Press, 1986), 110.

62 "Call of the Frock", *Open File*, 8 February – 16 March 1983, NAA C2831, 1056252; NAA C475, 1056252.

Flinders Medical Centre Gender Clinic and Australian and New Zealand Committee on Transsexualism

By the 1980s the Melbourne team were the biggest providers of trans health care in Australia, but they were not the only ones. Adelaide, too, had a devoted gender clinic, and there were other psychiatrists, psychologists and counsellors across Australia who worked with trans people. There were also sporadic attempts to bring professionals together in national forums and bodies.

The first Australian Conference on Transsexualism was convened at Melbourne's Queen Victoria Medical Centre in 1979. Attendees came from a variety of medical fields from across Australia and Aotearoa New Zealand as well as a few trans women. The conference even received a bit of media coverage over a paper presented by Dr Michael Ross of Flinders University which, comparing Australian data with Sweden, suggested that Australia had the highest incidence of transsexualism in the world. The paper, which had a questionable methodology, also indicated that whereas in Sweden there was approximately one trans woman for every trans man, in Australia there were seven trans women for every trans man.[63]

Out of this conference were borne two important bodies. One was the Victorian Transsexual Coalition, Melbourne's first organisation advocating for legal reform and support for trans people. The other group was the Australian and New Zealand Committee on Transsexualism, with William Walters as president and representatives from each state plus Aotearoa New Zealand. That group had a membership of about 30-40 health professionals and met annually for about five years. The group's biggest legacy came out of the 2nd Australian and New Zealand Conference on Transsexualism, organised at Flinders Medical Centre in 1983. William Walters and the conference convenor, Michael Ross, edited those papers into a 1986 Oxford University Press book entitled *Transsexualism and Sex Reassignment* – the first book on trans health care to come out of the antipodes.[64]

Michael Ross was also the driving force and director behind Adelaide's Gender Clinic at Flinders Medical Centre. Ross had a PhD in Psychology as well as a Swedish medical research degree. While conducting PhD fieldwork in Sweden, Ross worked under Jan Wålinder – one of the world's specialists on trans psychology. Ross returned to Australia and took up a position within Flinders University Medical School's Department of Psychiatry in mid-1978. Later that year, Ross's head of department approached him about the growing number of people in Adelaide who were seeking gender affirmation surgery and asked if Ross would do his clinical work with them. The person coordinating gender transitions in South Australia was the state Deputy Director of Mental Health, psychiatrist Dr John Clayer.

A few personalities and events came together, just as in other states. There had been sensational press coverage of Adelaide's first gender affirmation surgery performed in 1976 (prior to Ross's arrival). This had the effect of garnering the attention of trans people across South Australia who wanted surgery, so the numbers of interested people increased. Clayer and Ross were referring patients to Melbourne's Gender Dysphoria Clinic and thought it would make sense to set up something similar in Adelaide. They brought the proposal to Flinders University Medical School, which as a newer school already had a reputation for being a bit more controversial and progressive. The university agreed and sometime in late 1978 or early 1979 (like in Melbourne, there are conflicting dates in different records) Ross became director of the new Flinders Medical Centre Gender Clinic.

The Flinders Clinic ran similar to Melbourne's clinic, in part because they both followed the Harry Benjamin

63 Several newspapers reported this, including Jeff Wells, "Changes in Sex: We Lead West in 'Trapped People'," *The Age*, 2 June 1979; "We are tops in world of trans-sex," *Courier-Mail* (Brisbane), 2 June 1979; Carolyn Armstrong, "The big desire for changing their sex," *The Australian*, 2 June 1979. Ross's paper was published two years later as Michael Ross et al., "Cross-Cultural Approaches to Transsexualism: A Comparison between Sweden and Australia," *Acta Psychiatrica Scandinavica* 63 (1981): 75-82.

64 William A.M. Walters and Michael Ross, eds., *Transsexualism and Sex Reassignment* (Oxford: Oxford University Press, 1986).

International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders. One coincidence is that the inaugural surgeons at both clinics were women: Dr Lena McEwan in Melbourne and Dr Jill Need in Adelaide. The Flinders team consisted of a psychiatrist, two clinical psychologists, one gynaecological surgeon, one urological surgeon and one general surgeon, along with associated endocrinologists and plastic surgeons.

By the mid-1980s the clinic was seeing approximately 30-35 new clients per year. The Flinders team performed up to six gender affirmation surgeries per year starting in 1979. Although there is not as comprehensive demographic data as in Melbourne, from Michael Ross' recollections only one patient was non-white.[65]

In 1988 the Flinders Medical Centre Gender Clinic suspended its operations for up to five years. According to press reports, under the conditions of the clinic's founding there would need to be a study following up on the people who had gender affirmation surgeries (tables from the article reproduced below).[66] Ross published that study in 1989 and it indicated that over the nine years of operation, doctors at the Flinders Clinic performed thirty gender affirmation surgeries. The study explored the physical, mental and social after-effects of surgery for fourteen trans women. Much of the data analysis focused especially on the physical aspects, but the responses around mental health and social wellbeing clearly showed favourable outcomes (tables from the article reproduced below).[67]

Table III. Frequency of Response on Postreassignment Rating Scale[a]

Variable	Frequency
Economic	
Job history	
Severely unstable	2
Moderately unstable	2
Mildly unstable	3
Stable	7
Ability to support self	
On welfare	5
Financially dependent: lacks skills to support self	0
Financially dependent: possesses skills to support self	2
Financially independent/employed	7
Interpersonal relations	
History	
Frequent changes of intimates: chronically unstable relationships	1
Less frequent changes of intimates: some evidence of recent improvement	1
More recently stable relationships	6
Long history of stable relationships	6
Satisfaction gained from relationships	
None (shallow relationships)	0
Marginal satisfaction	1
Some satisfaction	5
Considerable satisfaction	8
Current support system	
No significant system	0
Marginal support system	1
Some support system	5
Significant support system	8

Table III. Continued

Variable	Frequency
Psychopathology	
Mental status	
Psychopathology with major impact on relationships	0
Psychopathology with some impact on relationships or work	2
Psychopathology but no impact on relationships or work	3
No psychopathology	9
Drug use (excluding prescribed drugs)	
Alcoholism or hard drugs	0
Heavy use of marijuana, downers, alcohol, or tranquilizers	2
Occasional use of marijuana, alcohol, or tranquilizers	4
No drug use	7
Legal problems	
Frequent criminal activities	0
Sporadic criminal activities	3
No criminal activity past 3 years	0
No criminal activity	11

Even though the suspension was only meant to be until the review was completed, the Flinders Clinic did not reopen. In the interim, Michael Ross had moved to Sydney at the beginning of 1989 and taken up a different position. Jill Need became unwell (and passed away from breast cancer in 1997) and had to cut back on her work. Psychiatrist Rob Lyons recalls lobbying for the clinic to reopen and new surgeons to train to perform gender affirmation surgeries, but the response from the South Australian Health Commission was to the effect of "Why would we do trans medicine when we can do triple bypass?"[68]

Although both the Melbourne and Adelaide clinics were focused on health issues for their clients, the staff – and especially the directors William Walters and Michael Ross respectively – were often called upon as experts to give media commentary or respond to political proposals. Indeed, when numerous state governments were considering legal reforms in the mid-1980s to recognise trans people's affirmed genders, state health departments consulted with psychiatrists rather than with trans people.[69] This set an important precedent which has persisted to the present. Although many doctors have advocated for trans rights, transgender activists have rightly challenged as problematic the notion of doctors as the experts, rather than listening to trans voices.

In the 1980s both Walters and Ross prepared submissions to state and federal bodies calling for legal recognition of trans people who had gender affirmation surgery in their affirmed gender. Ross was involved in the lobbying efforts that led to the passage of the *Sexual Reassignment Act* 1988 in South Australia, making it the first jurisdiction to offer a mechanism for

65 Michael Ross, interview with author, 24 September 2020, Zoom.

66 Kevin Murphy, "Cut-off point for sex-swaps?" *The Bulletin,* 3 May 1988: 21.

67 Michael Ross and Jillian A. Need, "Effects of Adequacy of Gender Reassignment Surgery on Psychological Adjustment: A Follow-up of Fourteen Male-to-Female Patients," *Archives of Sexual Behavior* 18, no. 2 (1989): 145-53.

68 Rob Lyons, interview with author, 2 July 2021, Zoom.

69 WA State Records Office, AU WA S455- cons4562 1979/5144; PROV, VPRS 17369, P0001, unit 228, 902/L02/01523.

trans people who had surgery to obtain a certificate of recognition in their affirmed gender. As outlined in a later section, the legislation also placed restrictions on the provision of health care to trans people which would have lasting consequences for the next twenty-five years.

The other significant space where Walters in particular made interventions was in public funding for gender affirmation surgeries. Both clinics were state-funded, but the funding was limited and consequently there were waitlists to see specialists and to access surgeries. As early as 1979 Walters proposed that private insurers offer coverage for hormones and other treatment associated with transsexualism.[70] The Commonwealth Department of Health approved Walters's proposal to bill private insurers using the rates set for Medical Benefits Schedule (MBS) items 6184 (complete amputation of the penis), 4296 (orchidectomy and complete excision of spermatic cord) x 2, 6327 (vaginal reconstruction for congenital absence, gynatresia or urogenital sinus) and 8484 (single stage local flap repair, complicated or large, excluding flap for male pattern baldness). In 1984, though, the Department of Health contacted Walters and advised that the clinic was no longer allowed to bill for item 6327 because this was reserved for "biological females" with the absence of a vagina. Walters wrote to the Department of Health asking that this be reversed because the vaginoplasty was the most time-consuming procedure and was critical to trans clients' health,[71] but to no avail.

Michael Ross, founding director of the Flinders Medical Centre Gender Clinic

This was at the same time that the Commonwealth Government set up the Medicare public health system. The Minister for Health also commissioned Judge Robyn Layton to lead a review into the MBS. The aim of the review was both to simplify the MBS, as well as to determine which items should be covered by Medicare and at what rates. The review recommended against covering gender affirmation surgeries. The report laid out the justification:

> In the Committee's view, gender reassignment surgery should only be performed on patients who attend special gender reassignment units. It believes that the best way to encourage this is to exclude the payment of Medicare benefits for such surgery and to provide funding for such units through Health Program Grants.[72]

To this day, still most gender affirmation surgeries are still not covered by Medicare. At the time of the Layton Review there were three public clinics receiving state grant funding – two in Melbourne and one in Adelaide. Since 1988 there has only been the one: the Monash Gender Dysphoria Clinic. This has meant that only a miniscule number of trans people have had access to public subsidies for gender affirmation surgeries. The vast majority must pay out of pocket in the tens of thousands of dollars.

70 Philip McIntosh, "Sex surgery cash study is welcomed," unknown newspaper, 8 June 1979.

71 Letter from William Walters to Dr. L.J. O'Keefe, Principal Medical Officer, Medical Benefits Division, Department of Health, 19 January 1984, courtesy Simon Ceber.

72 "Medicare Benefits Review Committee First Report," (Canberra 1985), 220.

Health Care Beyond the Gender Clinics: 1970s-90s

The gender clinics and psychiatry professions dominated the mainstream health care and medical discourse around transgender people, but they were not the only ones providing health care. In cities without gender clinics, the few doctors who wanted to support trans clients had to formulate their own approaches.

Psychiatrist Andy Zorbas saw approximately thirty trans clients through the public hospital system in Perth over the period 1969-2002. In the early years especially, several of those clients approached psychiatrists because there was not a visible trans community or organisation where they could turn. Zorbas recalls quite a diversity of experiences among those clients and adopted an approach of getting to know them before assessing the best way to support them. He recollects a mix of: clients who were intersex and dissatisfied with the gender surgically imposed on them at birth; gay men whom he did not assess as 'true transsexuals'; people who desired gender affirmation surgery; and some who did not want surgical interventions. Some clients arrived uncertain about who they were, while others were adamant that they were transgender and wanted Zorbas to provide the medical clearance for gender affirmation surgery.

For individuals whom Zorbas felt would benefit from gender affirmation surgery, he either referred them to doctors in Melbourne (over the years: Richard Ball, William Walters and later Trudy Kennedy) or to the obstetrician and gynaecological surgeon, Professor Shan Ratnam, in Singapore. Yet Zorbas also gave a caution which other health practitioners, past and present, have expressed: hormones and gender affirmation surgery would not necessarily resolve or alleviate all of the social and/or mental health barriers that trans clients faced.[73]

There were also several groups of trans people who could not access health care from the gender clinics and needed alternative avenues:

- Trans people who did not fit the clinical ideas of a "true transsexual";
- Those who were rejected for hormones and/or surgery because they were not "feminine" enough;
- Trans people rejected for hormones and/or surgery because they worked as strippers or sex workers;
- Trans people who did not desire surgery or could not afford it, but who still desired hormones.

Probably the most common place to obtain hormones outside the gender clinics was through the black market. One popular method was for trans women who had prescriptions to share some of their hormones with others. This meant they were taking different doses to what was prescribed, often without being monitored. One trans woman recalls that there was a chemist in Kings Cross who used to manufacture hormones and would mail them anywhere in Australia (the person who shared this story obtained them in Perth). A few chemists in St Kilda would also sell hormones to trans women without a script. The chemists would, of course, be selling for higher than the retail price and skim the money on the side. Another trans woman recalls a GP in St Kilda who would prescribe anything if paid double their normal fee. Doctors associated with the gender clinics worried that trans people taking hormones from the black market ran the risk of deep vein thrombosis, embolisms and other blood clot-related complications.

There were also the occasional friendly GPs who were willing to break with dominant practice to support transgender people. In 1958, authorities in Sydney charged one doctor with drug offences for prescribing female hormones as well as self-medicating with them.[74] Transgender pioneer Jazmin Theodora recalls a doctor in Sydney prescribing her with hormones as early as the 1960s.[75] In Melbourne, Dr Harry Imber joined a St Kilda GP practice in 1972 where the owner, Dr Edwin Knight, had about four or five trans patients. Over the next four years Imber earned a reputation for being supportive of trans clients, so more came to see him. He read the medical literature and even consulted with psychiatrist Richard Ball. By 1976, Imber had sixty-five trans women and one trans man as clients. Imber still subscribed to the medical understandings and

73 Andy Zorbas, interview with author, 23 November 2021, Zoom.
74 "Queer change affects doctor," *Melbourne Truth*, 9 August 1958, Australian Queer Archives, papers of G.R., 1953-87, boxes 5-6.
75 Jazmin Theodora, interview with author, 12 September 2019, Nimbin, NSW.

definitions of transsexualism, including the assumptions about surgery being the ultimate aim. He also would refer his patients to one of the two Melbourne gender clinics for psychiatric evaluation and as the pathway to surgery.

Yet, there was a major difference between Imber and most other GPs of the 1970s-80s: he would prescribe hormones and practice what is now known as the informed consent model. Imber wrote in a 1976 *Medical Journal of Australia* article: "When I first see a transsexual I point out the effects of hormone therapy, and that sterility may occur and be permanent. Most transsexuals already know this and it is an irrelevant point to them. After a discussion with the transsexual regarding his life (past, present and future), I prescribe oestrogen tablets for him and then review him regularly."[76] At that time, the Pharmaceutical Benefits Scheme (PBS) would not cover oestrogen prescribed for people assigned male at birth. To get around this, Imber would write the prescriptions in the person's female name and instruct them to go to chemists in St Kilda dressed and presenting as women. Imber moved his practice to Melbourne's CBD in 1981. While he continued to see trans clients, it was not as many as when he had been in St Kilda.[77]

Two oral history interview participants specifically praised the synthetic hormone stilboestrol, which doctors prescribed in the 1970s and early 1980s. Vonni said that it was better than any other hormones, injections or implants she has ever taken: "It worked so quickly and you would almost take it and wake up the next day and expect to see boobs. It was amazing."[78] Both Vonni and the other interview participant lamented when stilboestrol was removed from the market because it was linked to certain vaginal and cervical cancers (the US Food and Drug Administration has labelled it a carcinogen since 1985).

Downplayed, but not completely absent, from much of the trans health care of the 1970s-80s were trans men. A recollection common across all health practitioners interviewed is that before the 2000s there were very few trans men clients. This was in part because so much of the pathologisation around transgender – be it around transsexualism or transvestism – presumed the person to be assigned male at birth. One reason for this was because the medical understandings of transgender assumed that surgery was ultimate outcome for "true transsexuals". Until the late 1990s, phalloplasty was not available in Australia.

Medical thinking until the 1990s was that the predominance of trans men compared to trans women was about 1 to 3. A post-2000 surge of trans men (discussed later) suggests that there were always more trans men, but they were not coming forward. In part this can be explained because of (in)visibility in society. Media coverage of trans issues was predominantly around trans women, which meant that AFAB people who were questioning their gender did not necessarily see there being a possibility of transness. Moreover, it was generally easier for AFAB people to adopt behaviour and dress associated with masculinity, or even to adopt a men's identity, without being questioned, challenged or harassed.

Those trans men who did present to gender clinics could be prescribed testosterone and even could have "top surgery": mastectomies. These surgeries were more common and less specialised than other gender affirmation surgeries and therefore did not need to go through the specialist clinics and surgeons. In a 1981 interview, when asked about trans men, Sydney psychiatrist Ron Barr generalised: "I think what happens is that female to male transsexuals are given large doses of testosterone, and have their breasts removed surgically, and their womb and ovaries removed and continue in the lesbian relationship. Most female transsexuals do this process."[79] Interviews with trans men suggest that many did not and still do not desire a hysterectomy, which is another possible reason why they presented to gender clinics in smaller numbers.

Harry Imber's one trans man patient in the 1970s was not his last. Jonathan Paré, one of Melbourne's first trans man activists in the 1990s, was seeing Imber in the late 1980s and remembers him fondly. Paré was from Tasmania and at age seventeen a supportive GP prescribed him progesterone to slow puberty. The GP also referred Paré to the Melbourne Transsexualism Consultative Clinic. He was accepted into the program and then referred to a local Tasmanian psychiatrist for regular consultations and to a Tasmanian endocrinologist who prescribed anabolic steroids once Paré turned eighteen.

Paré moved to Melbourne a few months later in 1988 and very quickly got referred to Harry Imber. Paré brought a book with him: *Female-to-Male Transsexualism: Historical, Clinical, and Theoretical Issues.* Published in 1983, this was probably the first book about trans men; as was common at the time it was a medical text.[80] When Paré told Imber what prescription he had, Imber said that he should be on testosterone not anabolic steroids. Imber prescribed testosterone tablets, but a few months later Paré pointed out that *Female-to-Male Transsexualism* recommended injections over tablets. Imber agreed and negotiated with Paré over how many injections per week he would like. Eighteen months later, when

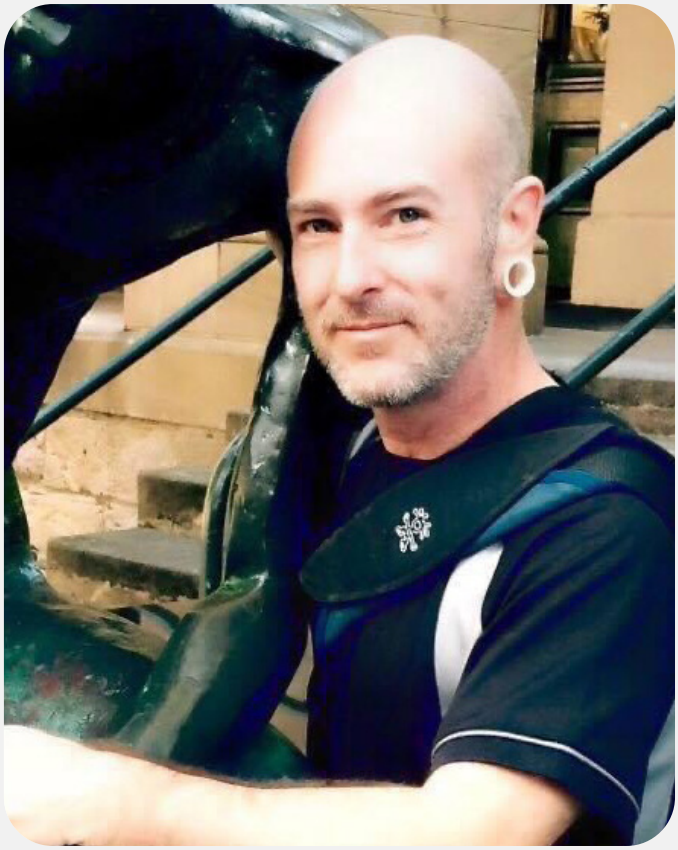
76 Harry Imber, "The Management of Transsexualism," *Medical Journal of Australia* 2, no. 18 (1976): 677.
77 Harry Imber, interview with author, 27 January 2019, Melbourne.
78 Vonni, interview with author, 7 December 2021, Adelaide.
79 "Interview with Dr Ron Barr, Prince Henry Hospital," June 1981, in NAA C1367, 81/239.
80 Leslie Martin Lothstein, *Female-to-Male Transsexualism: Historical, Clinical, and Theoretical Issues* (Boston: Routledge & Kegan Paul, 1983).

Paré met another trans man peer, he learned that the amount of testosterone he was taking was four times the appropriate course of treatment.[81] This story is not meant to disparage Paré's doctor, but rather to highlight how little information was available for GPs around trans health, and especially trans men's health. Trans clients were sometimes the ones who were educating GPs – or at least those GPs who were willing to listen and learn from trans people's lived experiences.

Medical transitions focused almost entirely on surgery and to a lesser extent hormones. Those trans people who did not seek medical transitions but only social transitions had even fewer options for affirming health care. There were some psychologists who worked specifically with such people, including clinical psychologist Vivienne Cass in Perth. Cass was active in the gay and lesbian rights organisation CAMP WA (Campaign Against Moral Persecution) from 1974 and founded the group's telephone counselling service. Through that service she first met transgender people, whom she realised also faced significant and unique obstacles to obtain positive health care, perhaps even more than gay men and lesbians. She wrote in a 1975 submission to the Commonwealth Royal Commission on Human Relationships that gays and lesbians in major cities could usually find a gay or lesbian doctor through "the grapevine", but:

> The transvestite and transsexual does not have this same facility and must be prepared to face the reaction of his doctor. One transsexual I know was told by a red-faced and disgusted doctor to leave the surgery and never return again when he asked for hormone tablets to maintain his breast development. It goes without saying that such an experience had a severely adverse effect on this man's self-respect and emotional stability.[82]

Cass's involvement with the trans community began in 1975 in Perth when she was approached by the founder of a newly set up transgender support group, the Chameleon Society of WA. The group was largely aimed at the "transvestite" or dresser community. Although open to all genders, its members were mostly assigned male at birth. Cass went on to work as a psychologist, mentor and supporter with the group and its members from the 1970s through to the 2000s.



Jonathan Paré, one of Victoria's first trans man activists, had to educate his GP about health care for trans men

With experience in the lesbian, gay and bisexual, as well as the transgender communities, Cass was aware of the need to make a careful assessment of whether someone was a transsexual, transvestite/cross-dresser (as was the language of the time), or a lesbian or gay person who had difficulty accepting their homosexuality. For dressers who did not desire gender affirmation surgery, Cass's work focussed on helping them to accept themselves, become adept at presenting as women and to work through relationship issues with their spouses. For the "transsexuals" who did desire gender affirmation surgery, Cass made sure they had correct information about what was involved and helped them through their personal, social, employment and medical transitions.

As some in the medical profession became more familiar with trans issues, Cass was also able to connect her clients with a Perth-based psychiatrist and an endocrinologist. All professionals would then see the person through the pre-surgery requirement at this time of living life as a woman for two years. Until about 2007 when she sold her psychology practice, Cass maintained her close ties to the Chameleon Society, attending meetings, participating in information and self-development seminars, giving public talks and seeing members as clients. She then trained the psychologists who bought her practice and they carried on her work with the transgender community.[83]

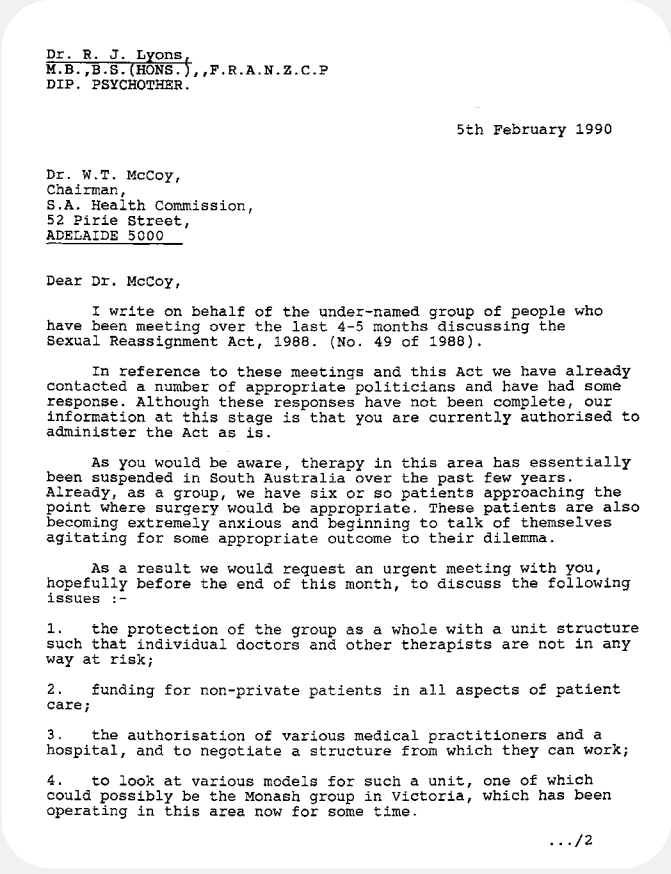
81 Jonathan Paré, interview with author, 10 December 2018, Brisbane.
82 NAA M3655, Submission 462, Folder 285.
83 Vivienne Cass, interview with author, 25 May 2021, Zoom.

From the mid-1980s, endocrinologist Dr Timothy Welborn was one of the main doctors in Perth working with trans clients. Through the 1990s Welborn received about 4-6 new referrals each year and developed a reputation as Perth's trans-friendly endocrinologist. Whereas in the eastern states most GPs referred trans clients to psychiatrists first, in Perth – with a much smaller and more insular medical community – the majority of GPs referred to Welborn first, who then referred clients for a psychiatric evaluation before he would prescribe hormones (around 2000 when psychiatrist Dr Russell Date began seeing trans clients, the referral order mostly reversed). Welborn consulted with Trudy Kennedy from the Monash Gender Dysphoria Clinic early on to learn the common standards of care, including the real-life test, but for most of his career Welborn was working independent of the eastern states.[84] Most surgical candidates from Western Australia have gone to Thailand rather than Melbourne for gender affirmation surgery because it is less expensive, but data from the Melbourne Gender Dysphoria Clinic from 1993-2003 shows that during that period there were thirty-five clients coming from Western Australia.

In Adelaide, the closure of the Flinders Medical Centre Gender Clinic and Michael Ross moving interstate left a gap in the services available to transgender people. There were extra legal hurdles, though, because of South Australia's *Sexual Reassignment Act* 1988. That law stated: "A person must not carry out a reassignment procedure unless – (a) the procedure is carried out at a hospital approved by the [South Australian Health] Commission for the purposes of this Act; and (b) the person is a medical practitioner approved by the Commission to carry out reassignment procedures of the relevant kind."[85] The drafters of the law envisioned that the South Australian Health Commission would approve the Flinders Medical Centre Gender Clinic and that trans health care would operate predominantly from there. Once that clinic closed in 1988, it became difficult for trans people to access health care, and also for any health practitioner who wished to work in this space.

Psychiatrist Rob Lyons, who previously had some limited involvement with the Flinders Medical Centre Gender Clinic, began to receive referrals and quickly became South Australia's principal specialist working with trans clients. Yet, Lyons did not have a hospital position, so he was not authorised under the act to offer any "reassignment procedures", which included any medical or surgical procedures. Lyons could have consultation sessions with trans clients and, if he considered that they fit the diagnostic criteria, referred them to the Monash Gender Dysphoria Clinic. This meant delays for trans people in South Australia to access affirming health care, although at least there was not an extra financial burden; the South Australian Patient Assistance Transport Scheme (PATS) covered the travel costs to and from Melbourne. Rob Lyons would continue to have psychiatric consultations with the trans clients while doctors from Melbourne prescribed hormones and would perform the gender affirmation surgeries. Essentially, Lyons and other affiliated health practitioners skirted the provisions of South Australia's *Sexual Reassignment Act* by outsourcing the work to Melbourne.

Lyons for years sent letters to the South Australian Health Commission and to politicians explaining the problematic way that the *Sexual Reassignment Act* was denying health care to trans people, but to no avail. In 1995 he began to assemble a team and applied to the South Australian Health Commission to be an approved practitioner under the act. This took great persistence from Lyons and an affiliated endocrinologist and surgeon. They not only had to provide evidence of their qualifications in trans health care, but the act also required conjoint approval of a hospital which would offer access to the doctors. For this Lyons approached the Adelaide Clinic to support psychiatry and endocrinology, while Hindmarsh Hospital agreed to sponsor any surgical procedures.



Dr. R. J. Lyons,
M.B.,B.S.(HONS.),,F.R.A.N.Z.C.P
DIP. PSYCHOTHER.

5th February 1990

Dr. W.T. McCoy,
Chairman,
S.A. Health Commission,
52 Pirie Street,
ADELAIDE 5000

Dear Dr. McCoy,

I write on behalf of the under-named group of people who have been meeting over the last 4-5 months discussing the Sexual Reassignment Act, 1988. (No. 49 of 1988).

In reference to these meetings and this Act we have already contacted a number of appropriate politicians and have had some response. Although these responses have not been complete, our information at this stage is that you are currently authorised to administer the Act as is.

As you would be aware, therapy in this area has essentially been suspended in South Australia over the past few years. Already, as a group, we have six or so patients approaching the point where surgery would be appropriate. These patients are also becoming extremely anxious and beginning to talk of themselves agitating for some appropriate outcome to their dilemma.

As a result we would request an urgent meeting with you, hopefully before the end of this month, to discuss the following issues :-

1. the protection of the group as a whole with a unit structure such that individual doctors and other therapists are not in any way at risk;

2. funding for non-private patients in all aspects of patient care;

3. the authorisation of various medical practitioners and a hospital, and to negotiate a structure from which they can work;

4. to look at various models for such a unit, one of which could possibly be the Monash group in Victoria, which has been operating in this area now for some time.

.../2

One of many letters Rob Lyons wrote to the SA Department of Health requesting approval to work with trans clients, courtesy Rob Lyons

84 Timothy Welborn, interview with author, 6 October 2021, Zoom.
85 South Australia, *Sexual Reassignment Act* 1988, section 6(1).

In 1996 the South Australian Health Commission approved Rob Lyons to set up the South Australian Gender Dysphoria Unit under the *Sexual Reassignment Act*. Though a private practice, it operated similar to the Melbourne Gender Dysphoria Unit with Lyons and other psychiatrists, psychologists, gynaecologist Dr Rosemary Jones, as well as plastic surgeons. As approved practitioners under the act, the doctors could lawfully prescribe hormones and other gender affirming treatment (this was usually done by Rosemary Jones).[86] The team would follow the same practice as outlined by the Harry Benjamin International Gender Dysphoria Association Standards of Care. A surgeon was available to perform top surgeries for both trans men and women as well as hysterectomies, but any other bottom gender affirmation surgeries continued to be referred to surgeons in Melbourne.[87]

Rob Lyons, founding director of the South Australian Gender Dysphoria Unit

From 1996 until 2016, the South Australian Gender Dysphoria Unit and affiliated doctors were the only approved providers of trans health care in South Australia under the *Sexual Reassignment Act*. This meant significant waitlists of up to two years to access care, adding further distress to transgender people and their mental health. There was the occasional GP who would prescribe hormones to trans clients regardless of the state law, including at least one GP who had a reputation for doing this. They argued that their duty of care to provide medical care obligated them to prescribe hormones and overruled any provisions of the state act.

New South Wales, too, saw the resumption of some activity around trans health care by the end of the 1980s. William Walters's relocation to Newcastle in 1987 led him to coordinate care for trans people in the Hunter region, though not through a formal clinic. Throughout the 1980s-90s there were endocrinologists and psychiatrists who would work with trans clients in Sydney, but most people who desired gender affirmation surgery had to go through the Melbourne psychiatrists and surgeons. A 1996 "Review of Gender Reassignment Procedures in New South Wales", prepared for the NSW Health Department, noted that one striking difference between Sydney and other jurisdictions was that there was no clear coordination for each patient.

In the mid-1980s surgeon Peter Haertsch began performing gender affirmation surgeries in Sydney through his private practice. By 1996 he was performing approximately 40-50 surgeries each year; about 50-60% were to clients from NSW, while the remainder came mostly from Queensland, South Australia, Western Australia and Aotearoa New Zealand.[88]

86 Rosemary Jones, interview with author, 19 April 2021, Zoom.

87 Rob Lyons, interview with author, 2 July 2021, Zoom.

88 "Review of Gender Reassignment Procedures in New South Wales: Report for the Centre for Clinical Policy and Practice, Public Health Division, NSW Health Department," (Sydney 1996), 26.

Medical Models, Gatekeepers and "Playing the Game"

The data available on the Melbourne and Adelaide gender clinics from the 1970s-90s and the 1996 review into NSW trans health care very much centred on gender affirmation surgeries. This is primarily a symptom of the dominant medical discourse and health care being offered to trans people during that era. Most doctors, especially psychiatrists and most certainly surgeons, were focused primarily on transsexualism and their practices aligned with diagnostic understandings from the Harry Benjamin International Gender Dysphoria Association and *Diagnostic and Statistical Manual of Mental Disorders (DSM).*

It was in *DSM III,* published in 1980, that three trans-related conditions were first listed: Gender Identity Disorder of Childhood (GIDC), Transsexualism (for adolescents and adults), and Psychosexual Disorder Not Elsewhere Classified. *DSM III* listed the following diagnostic criteria for transsexualism:

a. Sense of discomfort and inappropriateness about one's anatomic sex.
b. Wish to be rid of one's own genitals and to live as a member of the other sex.
c. The disturbance has been continuous (not limited to periods of stress) for at least two years.
d. Absence of physical intersex or genetic abnormality.
e. Not due to another mental disorder, such as schizophrenia.

DSM III-R (1987) listed four trans-related conditions: GIDC; Transsexualism; Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT); and Gender Identity Disorder Not Otherwise Specified (GIDNOS). In 1994 *DSM IV* reclassified most trans-related conditions under the umbrella diagnosis of Gender Identity Disorder but still retained Transvestic Fetishism (with Gender Dysphoria) and GIDNOS as other classifications.[89] In practice, many psychiatrists and other health professionals continued to adopt the frames of transsexualism and transvestism well into the 2000s.

DSM III (1980) was the first volume published since the removal of homosexuality as a mental disorder in 1973. Historian Eve Kosofsky Sedgwick argues that the addition of Gender Identity Disorder of Childhood was not coincidental, but rather marked an important shift of starting to decouple sexuality from gender identity: "This is how it happens that the *de*pathologization of an atypical sexual object-choice can be yoked to the *new* pathologization of an atypical gender identification."[90] This is a significant and oft-overlooked observation. On the one hand the separation of gender identity from sexuality has allowed for greater understandings of those two parts of the self. Moreover, many trans people who were questioning their identities as adolescents in the 1970s and even '80s remember being confused about their sexuality *because* dominant medical and social discourses treated gender identity as part of sexuality. Yet, the new pathologisation of transgender as a mental disorder would pose significant legacies and barriers to acceptance for trans people.

DSM III framed transsexualism around wrong body discourse: the explanation of being transgender as a state of being one gender but trapped living in the body of the opposite sex. Critics of wrong body discourse point to how it reinforces gender binaries and essentialises the body, reproducing: "the master narrative of the wrong body that overshadows gender-variant body experiences as valid; the reference to gender and/or genital essentialism; the reification of body and self as static and separable entities; and the reproduction of gender binary norms."[91]

Psychiatrists in the 1980s – and some even today – consistently justified their strict application of the real-life test and their expectations that surgical candidates exhibit stereotypical feminine behaviour because they needed to be confident that the trans person would

89 Kenneth J. Zucker, "The DSM Diagnostic Criteria for Gender Identity Disorder in Children," *Archives of Sexual Behavior* 39, no. 2 (2009): 477-78.

90 Eve Kosofsky Sedgwick, "How to Bring Your Kids up Gay," in *Fear of a Queer Planet: Queer Politics and Social Theory*, ed. Michael Warner (Minneapolis: University of Minnesota Press, 1993), 73. Original emphasis.

91 Ulrica Engdahl, "Wrong Body," *Transgender Studies Quarterly* 1, no. 1-2 (2014): 268.

not regret the transition. In a 1984 radio interview on the Australian Transsexual Association's *Gaywaves* program, an unnamed psychiatrist explained:

> I guess that my concern is that if somebody has surgery, it is irreversible. That's one. Two, a lot of people are lined up with a fantasy of what their life is going to be like post-surgery, that somehow it's all going to be okay, that they're going to have the job, that they're going to have the relationship, that there are going to be no financial issues, that somehow their drug habits, or what have you, that things are magically going to be different. I guess that as somebody who is involved in the assessment, I see my job possibly being that of making things a little bit difficult. I don't think that my job is to facilitate things because I think it's important that whoever takes an irreversible step is pretty well aware of what the consequences, possible consequences, of that step are.[92]

Many trans people found this approach to be, as activist Roberta Perkins put it in the same radio program, "sexist", "judgemental" and "patronising". One trans person interviewed for Perkins's 1983 book *The "Drag Queen" Scene: Transsexuals in King Cross* clearly articulated:

> I'm sick and tired of sitting on my balls. They serve no purpose. I'm sick and tired of having to throw hormones down my throat to keep them inactive. I'm sick and tired of this useless, flaccid penis. I would like to walk in on the board [of psychiatrists and doctors] just for one visit and tell them just that. I don't want to go through all the hocus-pocus of going in there and having to lie through my teeth to get it done.[93]

Carmen Rupe, Roberta Perkins and an unknown member of the Australian Transsexual Association, 9 December 1981, courtesy AQuA.

Perkins challenged the medical model of transsexualism. She pointed out that gendered behaviour was something learned and felt and was separate from the body. As such, people could live in their affirmed gender without ever wanting gender affirmation surgery. Perkins was espousing this in 1984 – six years before gender studies academic Judith Butler's canonical text *Gender Trouble: Feminism and the Subversion of Identity* argued that gender is performative and people are socialised from a young age into gendered expectations, behaviour, presentation and expression.[94]

Perkins was also pragmatic, and she recognised that in 1980s Australia the medical model of transsexualism dominated. Many trans people did (as many still do) desire gender affirmation surgery. To qualify for surgery, they should, as Perkins put it, "play the game their [doctors'] way. When you've had your surgery, or had whatever you want done, then you play the game your own way." Perkins even sarcastically suggested: "You go along with your prettiest and frilliest dress when you go and see the doctors, you sit outside the office and you knit, if you want surgery, that's what you do."[95]

92 *Gaywaves*, 16th Australian Transsexual Association (ATA) program, 14 June 1984, Australian Queer Archives (hereafter AQuA)
93 Roberta Perkins, *The 'Drag Queen' Scene: Transsexuals in Kings Cross* (Sydney: Allen & Unwin, 1983), 53-54.
94 Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity*, 3rd ed. (New York and London: Routledge, 2007).
95 *Gaywaves*, 16th Australian Transsexual Association (ATA) program, 14 June 1984.

Many oral history interviews from trans women who had or considered gender affirmation surgery in the 1980s-90s make similar points about playing the game. Activist Norrie recalls being referred to a psychiatrist who was completely opposed to transsexualism and berated them. Norrie asked around the Perth LGBT community and found a more supportive psychiatrist. Of the whole experience, Norrie comments: "They [psychiatrists] moralise, they preach, they impose their own idea of what a woman is, and insist that their patients aspire to the same conformist norms. In doing this, transgender women realise that the truth is in conflict with the rigid preconceptions of individual (usually male) doctors, and learn to lie so as not to risk refusal of approval for 'the op.'"[96]

Chantell Martin saw a Sydney psychiatrist in the late 1980s and recalls that at their first session, he made abrupt comments like "Don't you think you've got good feet to be a woman?" and "Your hands are very big to be a woman." Martin persisted with that psychiatrist, and three years later he said she was "ready" for surgery. Martin then asked why he had made such comments at their first meeting. He responded that it was because society is cruel and people would make such comments and judgements, so he was testing to see if she could cope with it.[97] Martin did – but it was a curious approach which was more about testing a trans person's "commitment" and strength rather than working to support and build resilience.

Sociologist Frank Lewins in 1995 conducted research interviewing over fifty trans people who had gender affirmation surgery through the Monash Gender Dysphoria Clinic; Lewins even had access to their case files. He noted that a dominant image among interview participants was that the clinic played a gatekeeper role. Some participants saw the gatekeeper role neutrally, meaning they accepted it as necessary. An equal number of participants saw the gatekeeper role as obstructionist and believed that, as clients, they should have more say over their health care.[98]

Word spread within trans communities about who were trans-friendly GPs and about what psychiatrists expected. Thus, trans women (and the smaller number of trans men) who desired medical transitions were often armed and prepared. Among oral history interview participants there is almost universal disgust at the questions they had to answer about their sex lives, masturbation and fantasies and at the physical examinations of their genitalia (which some described as fondling). But trans people endured these processes because they knew they "had to" if they were to be approved for gender affirmation surgery.

Dress was very important when presenting to the psychiatrists, particularly those affiliated with Melbourne's gender dysphoria clinics. Kristine Johnson, current secretary of the Australian Transgender Support Association of Queensland (ATSAQ), recalls: "You had to dress as the epitome in femininity. Dresses, shoes. Didn't have to wear gloves thank god, or hats but if you wore jeans or slacks you were sent home."[99] Sally Goldner went through the Monash Gender Dysphoria Clinic in the late 1990s. A friend of hers came up with a clever and fun description of the clothes she wore to her appointments with psychiatrist Trudy Kennedy: "We coined the name for female business wear, Moneypenny suits [like from James Bond]. So I would turn up to Trudy Kennedy in my Moneypenny suits, and that really impressed her, because that was her stereotypical view of the world."[100]

Lewins's 1995 study noted that the psychiatrists at the Monash Gender Dysphoria Clinic were often making value judgements about whether the trans clients would be read in their affirmed gender. Comments in case files included "not very feminine in appearance," "she has not mastered the art of being a very feminine woman in spite of a very pleasing appearance," and "from appearance [X] came across as a woman. However, [X's] general manner was not very feminine."[101] Lewins not surprisingly found that trans clients were unhappy with the rigid and stereotypical ideas of femininity that clinic staff applied and the value judgements they made around who would, supposedly, be suitable candidates for gender affirmation surgery.

One intriguing quirk about the whole process is that the psychiatrists at the Monash Gender Dysphoria Clinic were aware that many clients were rehearsing their responses and playing the game. One psychiatrist noted: "all transsexuals are wary and want to do well on tests, after all a lot really depends on having given the 'right answer'."[102] Kim Dorin, who went through the clinic in the early 1990s, recalls: "As also you would have known and read, you present[ed] what they want[ed] to see so that the right boxes will be ticked. It's a game. I remember doing the test and doing my best to rig it in the right direction. They said, 'We can see you've rigged this but in such a way that we really don't know that you've rigged it.' Or something like that."[103] Lewins analysed numerous case files dating back to the 1970s and reconciled the tensions between gatekeepers versus game players versus gatekeepers

96 Norrie, *Ultrasex: An Autobiography by Norrie May-Welby* (Sydney: Norrie, 2019), 40; Norrie, interview with author, 10 September 2019, Sydney.

97 Chantell Martin, interview with author, 19 September 2021, Zoom.

98 Frank Lewins, *Transsexualism in Society: A Sociology of Male-to-Female Transsexuals* (South Melbourne: Macmillan Education Australia Pty Ltd, 1995), 93-94.

99 Kristine Johnson, interview with author, 3 July 2019, Brisbane.

100 Sally Goldner, interview with author, 27 August 2018, Melbourne.

101 Lewins, *Transsexualism in Society: A Sociology of Male-to-Female Transsexuals,* 116.

102 Ibid., 95.

103 Kim Dorin, interview with author, 2 September 2021, Zoom.

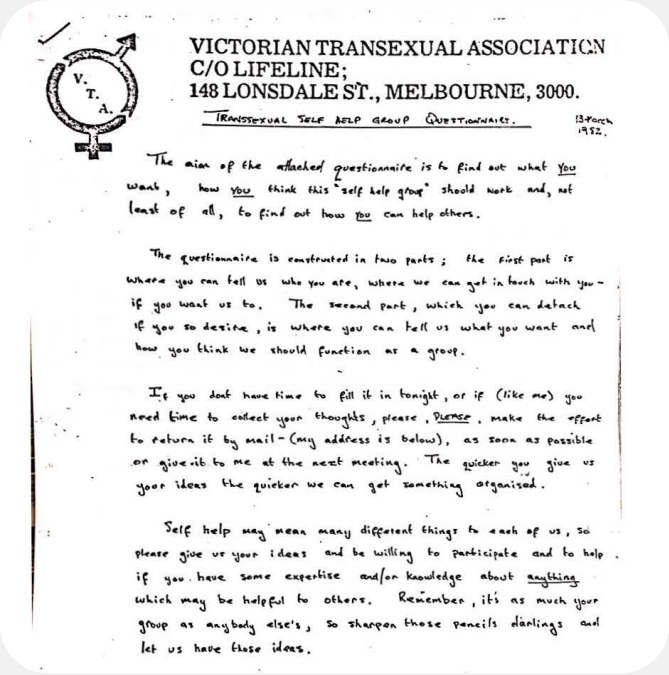
aware of game players thus: "Perseverance and consistency appear to be more important in leading to a recommendation for reassignment surgery than conformity to some moral standard."[104]

Another expectation that psychiatrists imposed on trans clients was that they divorce their spouses and cut off ties to their children. In 1997, one person who attended the Monash Gender Dysphoria Clinic threatened to lodge a complaint with the Victoria Equal Opportunity Commission on the grounds that refusing gender affirmation surgery because she would not divorce her spouse violated anti-discrimination protections for marital status. At the time the *Marriage Act* did not explicitly define marriage as being the union of a man and a woman (though it was certainly implied). Legal advice said that the clinic was indeed violating Victorian anti-discrimination law if they did not permit the person to have surgery.

Transgender organisations across Australia played an important role trying to support people who were seeking health care or to transition medically. Seahorse had begun in 1971 in Sydney and by the end of the decade there were Seahorse chapters or similar groups in Perth, Adelaide, Melbourne and Brisbane (for a short time there was even an attempt to start a Seahorse group in Launceston). Although these groups primarily supported dressers who did not desire medical transitions, they were still a site for information sharing. Many trans women who later went on to transition medically were members of Seahorse earlier in their social transition journeys, where they met other trans women and learned about affirming health professionals.

The Victorian Transsexual Coalition, founded in 1979 after the first Australian Conference on Transsexualism, ran a self-help group called the Victorian Transsexual Association that specifically focused on trans women who had or planned to have gender affirmation surgery. That group existed until about 1985. In 1983, Roberta Perkins founded Tiresias House in Sydney as a refuge for trans people facing homelessness. Over time Tiresias House grew to offer other support services for trans people. In 1993 it changed its name to the Gender Centre, and it continues to operate today.

In Brisbane, ATSAQ was founded in 1990 as both a support and advocacy group. On the support side, leaders Gina Mather and Kristine Johnson recognised there was a huge gap in offering trans health care in Queensland. Those who could afford it would visit the Monash Gender Dysphoria Clinic, but the cost of travel for consultations every three months in Melbourne in addition to the other medical bills was high. Gina Mather actually went around Brisbane reaching out to psychiatrists to see if any would work with trans people. Five responded favourably. Mather also found endocrinologists and GPs who were willing to work with trans people. ATSAQ would later be instrumental in setting up Brisbane's own gender clinic (see next section).



V. T. A.

VICTORIAN TRANSEXUAL ASSOCIATION
C/O LIFELINE;
148 LONSDALE ST., MELBOURNE, 3000.

TRANSSEXUAL SELF HELP GROUP QUESTIONNAIRE. 13 March 1982.

The aim of the attached questionnaire is to find out what you want, how you think this "self help group" should work and, not least of all, to find out how you can help others.

The questionnaire is constructed in two parts; the first part is where you can tell us who you are, where we can get in touch with you - if you want us to. The second part, which you can detach if you so desire, is where you can tell us what you want and how you think we should function as a group.

If you don't have time to fill it in tonight, or if (like me) you need time to collect your thoughts, please, Please, make the effort to return it by mail - (my address is below), as soon as possible or give it to me at the next meeting. The quicker you give us your ideas the quicker we can get something organised.

Self help may mean many different things to each of us, so please give us your ideas and be willing to participate and to help if you have some expertise and/or knowledge about anything which may be helpful to others. Remember, it's as much your group as anybody else's, so sharpen those pencils darlings and let us have those ideas.

Introduction to questionnaire from the Victorian Transsexual Association, courtesy Julie Peters

In 1993 Mather reached out to the Monash Gender Dysphoria Clinic, and both Herbert Bower and Trudy Kennedy went to Brisbane for a two-day conference for health professionals organised by ATSAQ. About eighty people attended, and subsequently a group of twelve doctors along with Gina Mather and Kristine Johnson prepared "Principles and Standards for the Management of Gender Dysphoria in Queensland," published in November 1994. The standards mostly aligned with the practice of the Monash Gender Dysphoria Clinic: a GP would refer clients to a psychiatrist, they would then authorise hormone treatment, and an endocrinologist would prescribe hormones. The standards authorised Brisbane-based doctors to work with the clients and gave more responsibility to GPs than was standard in Melbourne. Those trans people who desired gender affirmation surgery would only require two consultations with a Monash Gender Clinic psychiatrist. Although the initial standards outlined the two years real-life test, Mather takes credit for convincing Kennedy to reduce the real-life test period to eighteen months.[105] The contemporaneous Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders (version 5, 1990) stipulated that a trans person should live in their affirmed gender for a minimum of twelve months before being approved for gender affirmation surgery.

104 Lewins, *Transsexualism in Society: A Sociology of Male-to-Female Transsexuals*, 96.

105 "Principles and Standards for the Management of Gender Dysphoria in Queensland," November 1994, State Library of Queensland, 27358, box 16012; Gina Mather, interview with author, 4 July 2019, Brisbane.

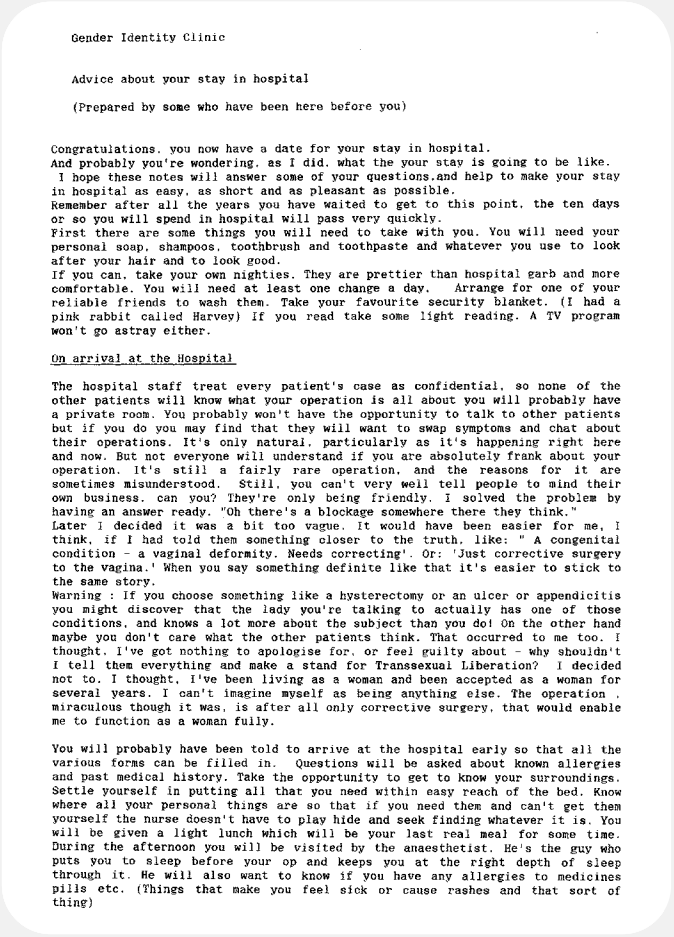
Longstanding ATSAQ leaders Kristine Johnson and Gina Mather worked to expand trans health care options in Brisbane

There were also trans individuals, separate from formal organisations, who offered support for people seeking access or advice around health care. By the mid-1980s (and likely earlier), surgeons provided patients at Melbourne's Queen Victoria Hospital with an information booklet titled "Advice about your stay in hospital (Prepared by some who have been here before you)." The guide talked about everything ranging from what to bring, to strategies to answer questions from other patients or care staff about why they were there, to preparation for the operation, through to aftercare immediately after surgery and managing pain and lubricating the vagina in weeks that followed. An updated 1990 version of the document ended:

> Once the miracle of what has happened to you dawns on you, you will probably feel like crying for sheer joy. So, go ahead and cry, and enjoy it. As I went through the process in hospital it felt like I had been released from prison and had the whole world in front of me. And indeed I did and so do you. If you feel as happy as I did (and still do), you may want to tell the whole world how you feel. It doesn't take long to realise that it's very easy to bore people with our own happiness. So we just hug our happiness privately.[106]

Trans people have mixed memories about the individual doctors and psychiatrists of the 1980s-90s. There were plenty of doctors whom trans people tolerated for no reason except that they were the only specialist in a particular city who would see trans clients. In 1995 Victorian activist Anna Langley prepared "The Good Tranny Guide", bringing together a list of trans-friendly shops, restaurants, organisations and services in most Australian states and Aotearoa New Zealand (there were none listed for the ACT, NT or Tasmania, reflecting the limited trans-friendly specialists and services in those jurisdictions, but also Langley's access to information). The guide also included speech pathologists, GPs, counsellors, psychiatrists, endocrinologists – including some whom oral histories have criticised.

It would not be appropriate to go into details about specific personalities except to say that interview participants' memories of Herbert Bower are almost unanimously fond. Bower continued to work with trans clients at the Monash Gender Dysphoria Clinic until his death in 2004. Recollections of other specialists from across the country are at best mixed. The critical comments often are directed at health professionals' abrasive demeanour, intrusive questioning, rigid gender expectations, dismissive attitudes or the "creepiness" of some doctors who conducted invasive physical examinations.



Gender Identity Clinic

Advice about your stay in hospital

(Prepared by some who have been here before you)

Congratulations. you now have a date for your stay in hospital.
And probably you're wondering. as I did. what the your stay is going to be like.
I hope these notes will answer some of your questions.and help to make your stay in hospital as easy, as short and as pleasant as possible.
Remember after all the years you have waited to get to this point. the ten days or so you will spend in hospital will pass very quickly.
First there are some things you will need to take with you. You will need your personal soap, shampoos, toothbrush and toothpaste and whatever you use to look after your hair and to look good.
If you can. take your own nighties. They are prettier than hospital garb and more comfortable. You will need at least one change a day. Arrange for one of your reliable friends to wash them. Take your favourite security blanket. (I had a pink rabbit called Harvey) If you read take some light reading. A TV program won't go astray either.

On arrival at the Hospital

The hospital staff treat every patient's case as confidential, so none of the other patients will know what your operation is all about you will probably have a private room. You probably won't have the opportunity to talk to other patients but if you do you may find that they will want to swap symptoms and chat about their operations. It's only natural, particularly as it's happening right here and now. But not everyone will understand if you are absolutely frank about your operation. It's still a fairly rare operation, and the reasons for it are sometimes misunderstood. Still, you can't very well tell people to mind their own business. can you? They're only being friendly. I solved the problem by having an answer ready. "Oh there's a blockage somewhere there they think."
Later I decided it was a bit too vague. It would have been easier for me, I think, if I had told them something closer to the truth. like: " A congenital condition - a vaginal deformity. Needs correcting'. Or: 'Just corrective surgery to the vagina.' When you say something definite like that it's easier to stick to the same story.
Warning : If you choose something like a hysterectomy or an ulcer or appendicitis you might discover that the lady you're talking to actually has one of those conditions, and knows a lot more about the subject than you do! On the other hand maybe you don't care what the other patients think. That occurred to me too. I thought. I've got nothing to apologise for. or feel guilty about - why shouldn't I tell them everything and make a stand for Transsexual Liberation? I decided not to. I thought, I've been living as a woman and been accepted as a woman for several years. I can't imagine myself as being anything else. The operation . miraculous though it was, is after all only corrective surgery, that would enable me to function as a woman fully.

You will probably have been told to arrive at the hospital early so that all the various forms can be filled in. Questions will be asked about known allergies and past medical history. Take the opportunity to get to know your surroundings. Settle yourself in putting all that you need within easy reach of the bed. Know where all your personal things are so that if you need them and can't get them yourself the nurse doesn't have to play hide and seek finding whatever it is. You will be given a light lunch which will be your last real meal for some time. During the afternoon you will be visited by the anaesthetist. He's the guy who puts you to sleep before your op and keeps you at the right depth of sleep through it. He will also want to know if you have any allergies to medicines pills etc. (Things that make you feel sick or cause rashes and that sort of thing)

Former clients provided a small pamphlet to those undergoing surgery in Melbourne, courtesy Simon Ceber

106 "Advice about your stay in hospital (Prepared by some who have been here before you)," updated August 1990, courtesy Simon Ceber.

Trans People and HIV/AIDS in the 1980s-90s

There was one other trans health space in 1980s-90s Australia where there was not nearly enough attention, and that was around HIV/AIDS. Public health experts have generally praised Australia's response to the epidemic in the 1980s because it focused on working with at-risk groups rather than moralising. The groups that received most funding and support for education and prevention programs were gay men, sex workers and intravenous drug workers.[107] Most of this funding was channelled through the state AIDS councils, and those organisations generally overlooked trans people. Indeed, some trans people recollect transphobia being rampant within the larger AIDS councils.

There were a few exceptions where AIDS councils, primarily due to the support of individual transgender advocates, paid some attention to trans communities. Trans activist Toye de Wilde recalls that at a foundational meeting of the Queensland AIDS Council (QuAC), one person demanded that she leave because HIV and AIDS were only a gay men's issue. She resisted and wound up being elected to the QuAC organisational committee, where she served for about four or five years. Toye was later made a patron of QuAC and would continue to offer the occasional training on transgender issues.[108]

Another exception was in South Australia. Throughout the 1990s the AIDS Council of South Australia (ACSA) had transgender volunteers and hosted numerous other LGBT groups, including the South Australian Transsexual Support Group and Gay and Lesbian Counselling Service. Long-time transgender advocate Jenny Scott volunteered for several of these organisations and worked as librarian for ACSA's Darling House Library. She even had a stint as elected staff representative on the ACSA board.[109] Marie-Desiree d'Orsay Lawrence (Desi), too, spent many years in the beginning in 1988 as a volunteer with ACSA and with the Positive Living Centre, People Living with HIV and AIDS (SA) and as organiser of the short-lived ACT-UP SA. Desi even ran for president of ACSA's Board of Management in 1995, noting in her candidate statement "I hope to spend many more years serving the community that has supported me and my chosen path, that is as a transsexual."[110]

The AIDS Council of NSW (ACON) employed an Aboriginal and Torres Strait Islander Transgender and Sistergirl Project Officer beginning in 1999. Common across most AIDS councils, though, was that attention to transgender people was only through the occasional program; it would not be until the mid-late 2010s that AIDS councils gave more sustained attention to trans health care (discussed in a later section).

In Sydney, the Albion Street Centre Outreach Bus was visiting the parts of Kings Cross/Darlinghurst frequented by sex workers as early as 1986. In a 1989 report by ACON, the Albion Street Centre noted an HIV positive rate of 25% among those trans sex workers known to the program.[111] Another project run by ACON in the early 1990s found that one-third of transgender participants were HIV positive. The project concluded that the high prevalence of HIV was linked to problems of low self-esteem combined with high rates of sex work and intravenous drug use.[112] An extra stress on HIV positive trans people's mental health was that they were generally denied access to gender affirmation surgery.

Trans people who were HIV positive in the 1980s-90s and later developed AIDS had access to community support programs like Ankali, run out of Sydney's Albion Street Centre. They also would be treated on AIDS wards, attended outpatient clinics in the public hospitals and consequently had access to treatments

107 Paul Sendziuk, *Learning to Trust: Australian Responses to AIDS* (Sydney: UNSW Press, 2003); Robert Reynolds, Shirleene Robinson, and Paul Sendziuk, *In the Eye of the Storm: Volunteers and Australia's Response to the HIV/AIDS Crisis* (Sydney: NewSouth Publishing, 2021); Nick Cook, *Fighting for Our Lives: The History of a Community Response to AIDS* (Sydney: NewSouth Publishing, 2020).

108 Toye de Wilde, interview with author, 11 December 2018, Brisbane.

109 Jenny Scott, interview with author, 8 December 2021, Adelaide.

110 Marie-Desiree D'Orsay-Lawrence, "Nominees for the Presidency," *Accent*, August 1995: 3.

111 Paul van Reyk, "Future Directions for the AIDS Council of NSW: A Strategic Planning Document," March 1989, 82.

112 "Discrimination - the *Other* Epidemic: Report of the Inquiry into HIV and AIDS Related Discrimination," (Sydney NSW Anti-Discrimination Board, 1992), 73.

like AZT. Roberta Perkins conducted oral history interviews with one woman who died of AIDS-related causes in 1989 and some of the people who supported her, including a hospital nurse. The oral histories suggest that staff in the AIDS wards and clinics treated trans clients with respect. This is not surprising: given the stigma surrounding HIV and AIDS in the 1980s, those health professionals who worked with people living with HIV or AIDS were generally known to be more open-minded and accepting of people on the margins of society. The oral histories also suggest, though, that trans women were more comfortable attending AIDS wards or clinics together in small groups. The safety in numbers was a psychological shield from the ostracism they may face from the public enroute to and from the clinic.[113]

Oral histories and other reports indicate that trans sex workers and groups like Sydney's Gender Centre organised and educated about safe sex and distributed condoms to transgender sex workers. Moreover, by the 1990s the Kirketon Road Centre was running an outreach van with testing and condom distribution to trans sex workers in Darlinghurst. Since the 1990s sex worker unions across the country have also consistently promoted sexual health and testing among trans workers (e.g. SWOP in NSW, the ACT and the Northern Territory; SIN in South Australia; RhED in Victoria; Respect in Queensland; SWEAR in Western Australia; and Scarlet Alliance nationally including Tasmania). Thus it was primarily grassroots efforts from within the trans community who for decades were taking responsibility and leading in sexual health.

Challenging the Medical Model

Although plenty of trans people in the 1970s-80s were discontent with the medical model of transsexualism, usually - as Roberta Perkins advocated - the short-term approach was to play the game rather than directly challenge it. That changed in the 1990s. In 1991, American transgender activist Sandy Stone's essay "The *Empire* Strikes Back" spurred activists around the world "to decenter, refract, complicate, or refuse the medical discourses that had for decades defined transsexuals as a group constituted by the desire for sex-altering surgical intervention the global push among transgender activists."[114]

It was Sydney's trans community that made the most vocal resistance to the medical model. In 1991, a small group of activists founded the Transgender Liberation Coalition to push for more government funding and resources for Tiresias House/The Gender Centre. Importantly, this was the first known Australian group that adopted transgender in its title. This was a deliberate choice for two reasons: 1. To be inclusive of anyone whose gender identity or expression did not fit dominant norms, regardless of medical or surgical interventions, and 2. To challenge the medical and psychological connotations attached to the dominant terms transsexual and transvestite.

Within a year, new activists under the leadership of Aidy Griffin were in charge of the group and it became more liberationist in message and aims, adopting ideas of queer and challenging the very notion that gender was something fixed and binary. They conceptualised transgender as an umbrella which encompassed

113 Roberta Perkins, "Transgender Lifestyles and HIV/AIDS Risk: Appendix II," (School of Sociology, University of New South Wales, 1994), 1.5-1.6.

114 Eric Plemons and Chris Straayer, "Introduction: Reframing the Surgical," *TSQ: Transgender Studies Quarterly* 5, no. 2 (2018): 164. See also Sandy Stone, "The *Empire* Strikes Back: A Posttranssexual Manifesto," in *Body Guards: The Cultural Politics of Gender Ambiguity*, ed. Julia Epstein and Kristina Straub (New York: Routledge, 1991), 280-304.

diversity, or what Surya Monro and Janneke Van Der Ros years later called gender pluralism: creating space for new identity categories and celebrating a broad spectrum of genders.[115] The Transgender Liberation Coalition played a significant role in inter- and intra-community politics in 1990s Sydney and was instrumental at lobbying the NSW government to amend anti-discrimination law to protect transgender people and for legal recognition of trans people who had gender affirmation surgery in 1996.[116]

In relation to trans health and health care, where the Transgender Liberation Coalition was most influential was in changing the Gender Centre. The Gender Centre was community-run and it did not employ medical professionals. Yet, as activists of the 1990s explain, the staff and residents regularly discussed transsexualism and medical and surgical options. Pamphlets published by the Gender Centre were all about medical transitions: hormones and surgery. In other words, the management and staff, who were mostly cisgender, continued to operate under the assumption that surgery should be the desired outcome – and many members of the trans community subscribed to this notion as well. As activist Norrie explains:

> In those days, you went along to the Tiresias House and someone was talking about hormones, someone was talking about surgery. Those were like the topics, and not how to deal with the world, how to have a job, how to relate to people, how to be honest about your identity or who to share what with, what the appropriate rates of disclosure was – there was plenty of other useful skills that could have been passed on, but I guess they were doing what they could. It was like in the old days, doctors would give pills rather than listen to you talk about your problems because that was all they knew how to do.[117]

The Transgender Liberation Coalition challenged this medical model and encouraged the trans community to take control of their own transitions without needing to meet expectations of doctors and psychologists. Transgender Liberation Coalition activists were also armed with a 1994 research report prepared by Roberta Perkins into trans health and lifestyles; among its recommendations was: "We recommend that 'transsexualism' as a symptom of gender dysphoria syndrome be removed from further editions and reprints of the *Diagnostic and Statistical Manual*."[118] Norrie recalls that the Transgender Liberation Coalition did a survey of trans people and found that only 25% were completely satisfied with their lives after having gender affirmation surgery. When a surgeon gave a presentation at the Gender Centre, activists tried to present their survey findings but were expelled and banned.[119]

The battle over the Gender Centre's management – which in many ways was a proxy battle over the medical model – received significant attention in the LGBT press. Norrie wrote one letter to *Capital Q* asserting:

> Despite what the doctors said about us all these years, we are not sick or disordered or dysphoric. What we are is mad! Mad that there are still other people dictating "what's best" for us. Mad that the Gender Centre is still teaching other people that tranys are sick, disordered and dysphoric. Mad that non-tranys are running trany affairs. Mad that they've banned the tranys who got anti-discrimination for us.[120]

The Gender Centre's 1996 annual general meeting was a raucous affair that resulted in a Transgender Liberation Coalition victory on multiple fronts: their candidates won a majority of positions on the board of management, and they passed a resolution affirming that staff at the Gender Centre should be transgender.

The next year was a difficult period for the Gender Centre, where lots of long-time staff – including transgender staff – departed because they were not aligned with the Transgender Liberation Coalition. There

115 Surya Monro and Janneke Van Der Ros, "Trans* and Gender Variant Citizenship and the State in Norway," *Critical Social Policy* 38, no. 1 (2018): 72. See also Surya Monro, *Gender Politics: Citizenship, Activism and Sexual Diversity* (London and Ann Arbor: Pluto Press, 2015), 86-88.

116 Jesse Hooley, "Normalising Transgender and Policing Transgression: Anti-Discrimination Law Reform Ten Years On," *Australian Feminist Law Journal* 25 (2006): 79-98; Aidy Griffin, interview with author, 26 November 2019, Sydney.

117 Norrie, interview with author, 10 September 2019, Sydney.

118 Roberta Perkins, "Transgender Lifestyles and HIV/AIDS Risk: National Transgender HIV/AIDS Needs Assessment Project," (School of Sociology, University of New South Wales, 1994), 78.

119 Norrie, interview with author, 10 September 2019, Sydney.

120 Norrie May-Welby, "Tranys for tranys," *Capital Q*, 2 August 1996: 6.

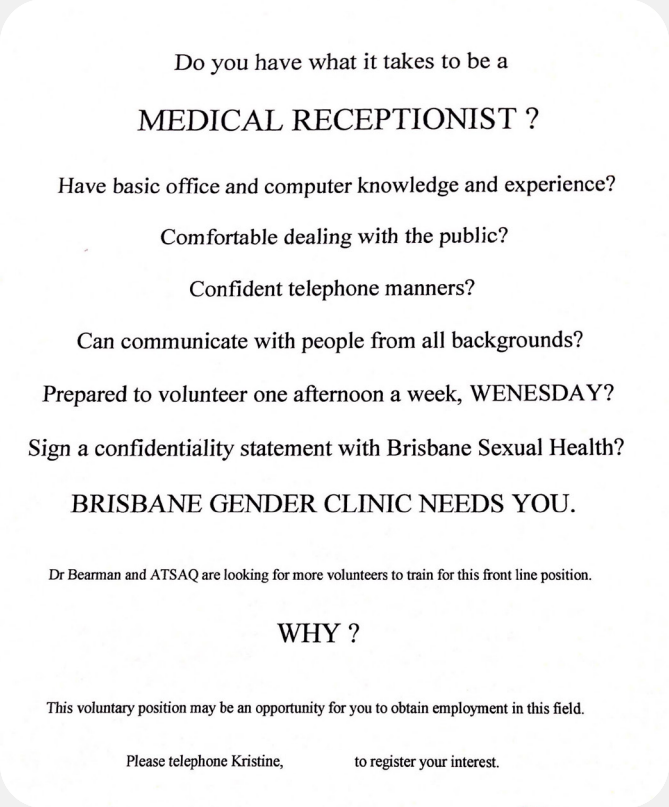
were also some reports that the Transgender Liberation Coalition's pressure was so strong that at least one Sydney psychiatrist who worked with trans people stopped taking new patients.

Yet, there also were important medium-to-long term changes at the Gender Centre. As the organisation moved on from the divisions of 1996-97, it emerged with a model of support and care for transgender people that did, indeed, break from the medical model. Counsellors and psychologists worked with clients to find mechanisms to live their daily lives. They ran group therapy sessions and counsellors offered ad hoc training to other professionals, GPs and even school counsellors. The aims and direction of the Gender Centre were no longer centred on hormones and surgery, but rather on empowerment, affirmation and psychosocial support, while still offering advice about medical transitions.

In other states and territories new transgender organisations emerged in the 1990s which also broke from the medical model, though not in such dramatic fashion. Instead, they sought to work with existing and emerging health practitioners while also offering new models of peer support. In other words, they did not push to end the medical model per se, but rather to see it as *a* model or option instead of *the* only option for trans people. In Melbourne the main group that facilitated this was Transgender Liberation and Care, founded in 1995 by Jonathan Paré and Sharon Saunders.

In Queensland, ATSAQ – which as mentioned earlier was already working to find trans-inclusive health practitioners – saw the need for a central trans health care practice in Brisbane. This was especially significant after one trans-friendly GP in Brisbane completed suicide. Gina Mather was persistent and pushed the Health Department and the then-Queensland Health Minister Peter Beattie about the need for a gender clinic. Mather learned that staff in the Sexual Health and HIV Service office on Roma Street did not work on Wednesday afternoons because it was reserved for meetings. Mather's influence secured that space, and the Brisbane Gender Clinic began to operate on 7 December 1994 for one afternoon each week in Biala City Community Health Centre.[121]

The Brisbane Gender Clinic was always a partnership between the trans community – particularly ATSAQ – and the GP who directed it. In this sense it was quite different from the gender clinics in Melbourne and Adelaide. Moreover, it was more centred on primary care rather than psychiatry or psychology. The first GP who ran the clinic left within six months, but the second director – Dr Gale Bearman – wound up directing the Brisbane Gender Clinic for seventeen years until it moved in 2012. The clinic would bulk bill and very much relied on the support of the trans community, such as through volunteers who often worked the reception space.



Do you have what it takes to be a

MEDICAL RECEPTIONIST ?

Have basic office and computer knowledge and experience?

Comfortable dealing with the public?

Confident telephone manners?

Can communicate with people from all backgrounds?

Prepared to volunteer one afternoon a week, WENESDAY?

Sign a confidentiality statement with Brisbane Sexual Health?

BRISBANE GENDER CLINIC NEEDS YOU.

Dr Bearman and ATSAQ are looking for more volunteers to train for this front line position.

WHY ?

This voluntary position may be an opportunity for you to obtain employment in this field.

Please telephone Kristine, to register your interest.

2002 advertisement for a receptionist at the Brisbane Gender Clinic

Bearman was one of a small but growing number of GPs in the 1990s who were practicing a more informed consent model of care. She would prescribe hormones and work with trans clients to find the best options that would suit them. Bearman and other GPs, like then-Melbourne based Darren Russell, remember that the literature on hormone prescription in the 1990s was thin and often relied on studies of hormones prescribed to cisgender women or men. Texts about hormones in trans people more often focused on the *effects*, rather than giving specific information about prescriptions, levels, what to monitor, etc.[122] This is one reason why for so long the medical model entailed endocrinologists prescribing hormones rather than GPs. Yet, it is also a symptom of a broader problem within the medical model of transsexualism: so much of the literature was focused on psychology or psychiatry, explanations for what "caused" people to be transgender and surgical procedures and outcomes. There was less literature or guidelines on primary care or other aspects of trans health.

121 Gina Mather, interview with author, 4 July 2019, Brisbane.

122 One Australian example is from the 1986 book edited by William Walters and Michael Ross: Alfred W. Steinbeck, "Endocrine Aspects: Hormones and Their Role," in *Transsexualism and Sex Reassignment*, ed. William A.M. Walters and Michael Ross (Oxford: Oxford University Press, 1986), 64-81

For those trans people in Brisbane who wanted gender affirmation surgery, about half would go to Thailand and half to Melbourne. Those who went through Melbourne's Monash Gender Dysphoria Clinic still had to abide by their psychiatrists' requirements, including the real-life test for a prescribed period. Bearman had a very good relationship with the Monash clinic, though she did find some of their guidelines to be arduous. She particularly recollects how hard the stipulation that trans people divorce their spouses was for her clients; she recollects at least one person who completed suicide because of that requirement.[123]

A small number of GPs in other cities were also practicing more informed consent models in the 1990s. Often these were gay or bisexual GPs who had themselves come from a community long defined, pathologised and marginalised by the psychiatry profession. In Melbourne, GPs associated with the gay-friendly Carlton Clinic and Prahran Market Clinic would prescribe hormones. They would refer those trans clients who wanted gender affirmation surgery to the Monash Gender Dysphoria Clinic, but the psychiatrists at Monash expressed dissatisfaction to GPs who were prescribing hormones independent of Monash. Still, GPs at Prahran and Carlton continued to prescribe hormones at their clients' request rather than follow the directive of doctors at the Monash Gender Dysphoria Clinic.[124] Indeed, a 2004 review into the Monash Gender Dysphoria Clinic noted that over half of the clients from 1993-2003 were already on hormones when they first presented at the clinic – some for as long as thirty years.[125]

One challenge confronting both doctors and trans people during this period and beyond was getting access to some hormones subsidised on the PBS. Some prescriptions came with restrictions as to who was an authorised prescriber or were only eligible to be prescribed for specific medical conditions. In such situations, the authorised prescriber would need to seek approval from the Health Insurance Commission (later Medicare). As one example of where this caused challenges – the Health Insurance Commission only authorised anti-androgen medication Androcur (cyproterone acetate) to treat: moderate to severe androgenisation in non-pregnant women, advanced carcinoma of the prostate, or to reduce drive in sexual deviations in males. For an authorised doctor to prescribe Androcur to trans women on the PBS, the doctor would have to indicate that it was for the latter purpose.

In 1997 transgender rights groups lobbied to have this changed. ATSAQ prepared a petition which they sent to the Federal Member for Brisbane, who forwarded it to the Health Minister.[126] Others wrote directly to the Health Insurance Commission challenging this restriction, but they would not amend the rules. In a letter to the South Australian Transsexual Support Group, a representative of the Health Insurance Commission wrote: "While the wording of the restriction may be offensive to some patients, the HIC regularly approves authority applications for Androcur for 'male to female transsexuals' where the use is 'to reduce drive in sexual deviations in males'."[127] It would not be until October 2015 that updates to the PBS removed the restricted clinical criteria for the prescription of cyproterone acetate. As the final section will show, other restrictions to prescriptions on the PBS continue to cause challenges today.

Gale Bearman, director of Brisbane Gender Clinic, 1995-2012

The GPs in the 1990s who were shifting models of care generally had the support of trans community organisations. The 1990s thus marked a subtle and important shift: no longer was the trans community centring surgery as the only objective of trans health care. Indeed, Harry Imber specifically noted at a 2001 meeting bringing together professionals in trans health care that there had been a recent rise in the number of clients not wanting surgery.[128] For those who did desire surgery, still Monash remained the dominant provider and the gatekeeper psychiatric model prevailed.

123 Gale Bearman, interview with author, 11 January 2021, Zoom.

124 Darren Russell, interview with author, 15 January 2021, Zoom.

125 Samuhel, "Review of People Presenting to the Monash Medical Centre Gender Dysphoria Clinic from 1/1/1993 to the 31/12/2003," 20.

126 Honourable Arch Bevis MP to Gina Mather, president of Australian Transgender Support Association of Queensland, 17 May 1997, State Library of Queensland, 27358, box 16013.

127 Letter from Senior Pharmaceutical Adviser, Health Insurance Commission, to South Australian Transsexual Support Group, 17 November 1997, courtesy Rob Lyons.

128 Network of Professionals Working with Transgender People, meeting minutes, 4 December 2001, courtesy Simon Ceber.

Data from Monash from the 1990s – as well as the recollections of other health practitioners including GPs – suggest that still the majority of trans people presenting for health care were still from white/European backgrounds. As the millennium approached there would be shifts in demographics – first around race, with more people of Asian and Pasifika backgrounds presenting to health professionals. As later sections will explore, in the 2000s and 2010s there were two other major demographic shifts: the rise of children and young people, and more trans men and non-binary people.

Trans Men: New Possibilities and Visibility

In 1986 Lou Sullivan founded FTM International in the United States – the world's first known organisation for trans men. In 1991, Jasper Laybutt founded Boys Will Be Boys in Sydney – Australia's first known group for trans men. Boys Will Be Boys was always small but expanded to include a Melbourne chapter and around 1995 morphed into the online group FtM Australia.

These were primarily support groups, and they marked an important shift that would become more pronounced in the 2000s: increasing visibility of trans men. With visibility came more trans people experiencing what Peter Ringo calls identity events, or processes by which seeing other trans people directly impacted on an individual's understanding of their own gender identity. Identity events go through four stages: pre-awakening, awakening, identification and maturation.[129] A common expression that summarises the importance of visibility to experience identity events is "You can't be what you can't see".

Data from the Monash Gender Dysphoria Clinic from the 1990s shows an increase in trans men presenting – albeit still the numbers were quite small.[130]

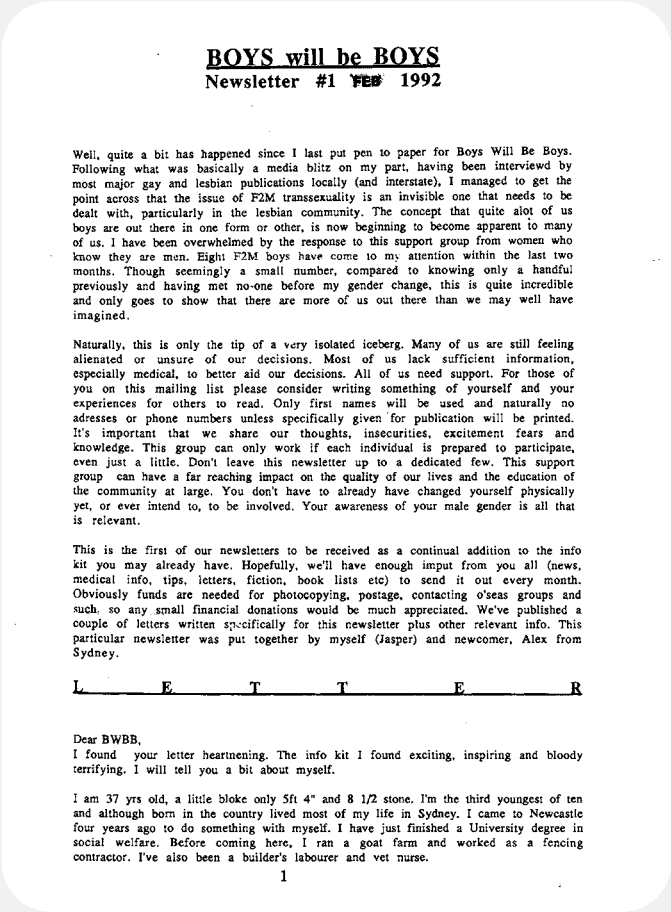
YEAR	TRANS WOMEN NEW CLIENTS	TRANS WOMEN APPROVED FOR SURGERY	TRANS MEN NEW CLIENTS	TRANS MEN APPROVED FOR SURGERY
1992	100	29	5	8

129 Peter Ringo, "Media Roles in Female-to-Male Transsexual and Transgender Identity Development," *International Journal of Transgenderism* 6, no. 2 (2002).

130 Trudy Kennedy, "Report of the Gender Dysphoria Clinic for the Divisional Report," 21 December 1993, courtesy Simon Ceber.

By 2003, out of 701 clients of the Monash Gender Dysphoria clinic, still 83.7% were trans women and 16.5% were trans men.[131]

Trans men, too, were subjected to a medical model of transsexualism that pathologised around surgery and put them through the real-life test. Many trans men who transitioned in the early 1990s desired top surgery to remove their breasts, but until later in the decade phalloplasty was unavailable in Australia. Psychiatrists subjected trans men, too, to rigid and stereotypical gender norms. If someone AFAB indicated that they were sexually attracted to men or to both men and women, then they were denied surgery because they could not be a "true transsexual". Jasper Laybutt recalls that even though he was on hormones, his psychiatrist would not approve him for top surgery because he might decide he wanted to have children. Laybutt recalls: "Blew my mind that this was a consideration, because I'm thinking I'm not considering children. So, frustratingly I had to wait this extra length of time."[132]



BOYS will be BOYS
Newsletter #1 FEB 1992

Well, quite a bit has happened since I last put pen to paper for Boys Will Be Boys. Following what was basically a media blitz on my part, having been interviewd by most major gay and lesbian publications locally (and interstate), I managed to get the point across that the issue of F2M transsexuality is an invisible one that needs to be dealt with, particularly in the lesbian community. The concept that quite alot of us boys are out there in one form or other, is now beginning to become apparent to many of us. I have been overwhelmed by the response to this support group from women who know they are men. Eight F2M boys have come to my attention within the last two months. Though seemingly a small number, compared to knowing only a handful previously and having met no-one before my gender change, this is quite incredible and only goes to show that there are more of us out there than we may well have imagined.

Naturally, this is only the tip of a very isolated iceberg. Many of us are still feeling alienated or unsure of our decisions. Most of us lack sufficient information, especially medical, to better aid our decisions. All of us need support. For those of you on this mailing list please consider writing something of yourself and your experiences for others to read. Only first names will be used and naturally no adresses or phone numbers unless specifically given for publication will be printed. It's important that we share our thoughts, insecurities, excitement fears and knowledge. This group can only work if each individual is prepared to participate, even just a little. Don't leave this newsletter up to a dedicated few. This support group can have a far reaching impact on the quality of our lives and the education of the community at large. You don't have to already have changed yourself physically yet, or ever intend to, to be involved. Your awareness of your male gender is all that is relevant.

This is the first of our newsletters to be received as a continual addition to the info kit you may already have. Hopefully, we'll have enough imput from you all (news, medical info, tips, letters, fiction, book lists etc) to send it out every month. Obviously funds are needed for photocopying, postage, contacting o'seas groups and such, so any small financial donations would be much appreciated. We've published a couple of letters written specifically for this newsletter plus other relevant info. This particular newsletter was put together by myself (Jasper) and newcomer, Alex from Sydney.

L E T T E R

Dear BWBB,
I found your letter heartmening. The info kit I found exciting, inspiring and bloody terrifying. I will tell you a bit about myself.

I am 37 yrs old, a little bloke only 5ft 4" and 8 1/2 stone. I'm the third youngest of ten and although born in the country lived most of my life in Sydney. I came to Newcastle four years ago to do something with myself. I have just finished a University degree in social welfare. Before coming here, I ran a goat farm and worked as a fencing contractor. I've also been a builder's labourer and vet nurse.

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Newsletter for Boys Will Be Boys, Australia's first trans men's group, founded in 1991, courtesy Jasper Laybutt

Another pressure trans men faced was to have hysterectomies even though many did not desire them. Max Zebra-Thyone – a close friend of Jasper Laybutt's – recalls that when the doctor suggested a hysterectomy, his reaction was: "I have an issue with that. I don't bleed and I don't see my insides, but I do see my chest every day in the shower. I need that done."[133] Canberra-based Peter Hyndal similarly recalls that the expected order for trans men's transitions was: 1. GP, 2. referral to psychiatrist, 3. hormones, 4. top surgery, 5. hysterectomy. Hyndal even recalls that after top surgery, his GP started asking when he would be scheduling a hysterectomy. Hyndal disregarded these statements, noting that because of the hormones he was no longer having periods and therefore felt no need for additional surgery.[134] Compounding the pressure was that to change their birth certificates, several states and territories required trans men to have hysterectomies. Some trans men acquiesced to the doctors' recommendations of hysterectomies, while others resisted. In the 2000s, trans men's groups and other transgender advocacy organisations would push back against hysterectomies being considered an expectation for trans men.

The mid-1990s presented another surgical opportunity for trans men previously inaccessible in Australia: the phalloplasty. Around 1995, surgeon David Hunter-Smith, who specialised in microsurgery, travelled to the Netherlands to study phalloplasty techniques to create a functioning penis for trans men. Hunter-Smith returned to Melbourne in 1996 and conducted the first operation.

These were challenging procedures which ran the risk of many complications including leaks, fistulas and strictures of the urinary shaft. One document recording statistical data around complications noted 38% of patients experiencing haematoma (major or minor) and 28% a fistula after the first-stage operation (metaoidioplasty); from the second stage operation (forearm flap phalloplasty) 50% experienced stricture and 21% fistula; and from the third stage (artificial erection device), which had a much smaller number, still 25% experienced infection/extrusion.[135] Hunter-Smith certainly was dedicated and worked with patients who experienced complications – and some even over twenty years later continue to need follow-up procedures.

Michael Mitchell was one person who had complications from his phalloplasty. Mitchell's surgery in 1999 initially seemed to be a success. Within months, though, there was an inexplicable growth on his penis that a doctor had to cut away. What was left afterwards was barely a penis, leaving Mitchell extremely upset. He returned to David Hunter-Smith and asked for another phalloplasty. Hunter-Smith made Mitchell see Trudy Kennedy and Herbert Bower again, and Bower immediately gave Mitchell a referral for another

131 Samuhel, "Review of People Presenting to the Monash Medical Centre Gender Dysphoria Clinic from 1/1/1993 to the 31/12/2003," 16.
132 Jasper Laybutt, interview with author, 21 August 2019, Newcastle.
133 Max Zebra-Thyone, interview with author, 26 August 2019, Newcastle.
134 Peter Hyndal, interview with author, 15 February 2019, Canberra.
135 "Statistics for FTM Surgery," no date but c. 2010, courtesy Simon Ceber.

phalloplasty. Yet, the second operation did not go well: the urethra failed and broke down, leaving Mitchell to rely for years on a catheter to pee.

For years Michael Mitchell went back and forth between Hunter-Smith and another surgeon at St Vincent's Hospital, who both tried different ways to create a functioning urethra. One technique entailed taking a graft from the small intestine which succeeded in giving Mitchell a functioning urethra, but one which consistently leaked mucous. In 2009 Mitchell went for a fourth phalloplasty with David Hunter-Smith and this time it was successful. Michael Mitchell emphasised in his interview how incredibly supportive and determined David Hunter-Smith was. When asked if he had any regrets given the ten-years and consistent complications, Mitchell definitively said no. He recalls telling a friend, "I'm over the moon. This is it; this is the end. No more. There doesn't have to be any more."[136]

Although Michael Mitchell's case ultimately had a positive outcome, it did take a lot of persistence on both his part and the surgeons. Around 2010 Hunter-Smith ceased to perform phalloplasty, believing the risks and complications outweighed the benefits. Over the period between 1996-2010, he worked with approximately forty trans men patients and performed over 100 operations.[137] After 2010 trans men who desired phalloplasty again needed to travel overseas, though since 2016 a different surgeon has been performing them in Brisbane. For many trans men interviewed for this project, phalloplasty has not been on their agenda. Rather, they have expressed similar views as trans women and non-binary people: seeking access to affirming care without having to meet professionals' expectations of what constitutes performing masculinity.

Trans men still have a need for gynaecology. Because that specialty is generally seen as women's health, trans men have faced the extra obstacles of finding clinical practices which are respectful and inclusive. Wez Saunders's experience in 2014 highlights the awkward position this can place on trans men. He was suffering significant pain when he was orgasming and decided he wanted a hysterectomy. He knew of one gynaecologist in Newcastle who had performed a hysterectomy for at least one trans man, so rang to make an appointment. The telephone conversation did not go well; the receptionist said that they did not deal with men, and when Saunders said he needed a hysterectomy she laughed and said "Ha-ha-ha, men don't have hysterectomies." Fortunately, another receptionist grabbed the phone and then spoke to Saunders with respect and made him an appointment.

When Saunders had his appointment, the waiting room experience was awkward as the only man not accompanying a female partner. The doctor was respectful and recommended against a hysterectomy because Saunders was healthy. Saunders advised the doctor that he had read that cancer can be a problem for trans men, so the doctor agreed to perform the hysterectomy. It turned out that Saunders was right: there were pre-cancerous cells, and the doctor did research confirming the risk of uterine cancer for trans men. This story is not meant to indict the doctor, who was always respectful and even apologised to Wez Saunders for doubting him.[138] Rather, this story highlights the barriers facing trans men to access gynaecology as well as the need for gynaecologists to understand the particular health needs and risks for trans men who present as clients.

Wez Saunders, former ACON Newcastle employee who has advocated for trans men's health and wellbeing

136 Michael Mitchell, interview with author, 25 January 2022, Mornington Peninsula.
137 David Hunter-Smith, interview with author, 2 December 2020, Zoom.
138 Wez Saunders, interview with author, 11 September 2018, Newcastle.

Reproductive Health and IVF

The world's first successful in vitro fertilisation (IVF) pregnancy and birth was in 1978, and by the 1980s Australia was seen as a pioneering nation in IVF conceptions and research. In 1979, news of a successful ectopic pregnancy in Aotearoa New Zealand led some doctors to predict IVF could, in the near future, be adapted to implant embryos in bodies without a uterus.

For trans women, the new IVF technology meant the imagined possibility of pregnancy, and by extension another experience of womanhood. A small number of clients at the Melbourne Gender Dysphoria Clinic queried about the possibility of pregnancy. Television and newspaper reports sporadically covered this issue and included quotes from trans women expressing the desire to be mothers and bear children. In 1984 a member of the Victorian Transsexual Coalition explained, "Pregnancy and having a baby would be the ultimate way many transsexuals could prove their femininity,"[139] while another good summative quote comes from trans woman Estelle Croot in 1986: "I am a woman, and like any woman I want to feel complete. I want to be fulfilled and for me that means having a baby."[140]

The topic of trans women and pregnancy only received minor attention in Australia's mainstream media, but as medical anthropologist Eric Plemons explains, it was a recurring theme from the 1970s-90s during global debates about the ethics of IVF. When there were discussions about potential future uses of the technology, alarmists would point to the possibility of trans women's pregnancies as almost the ultimate abuse of IVF. Australian doctors working in trans health rarely engaged in these debates, with the notable exception of William Walters, whose background in obstetrics/gynaecology perhaps made him uniquely qualified to discuss the intersections of IVF and trans health. He participated in an interview on ABC's *Nationwide* as well as several newspaper reports when the topic peaked in mainstream media in June-July 1984. Walters took a very measured and almost neutral approach, noting that "it's not a question of whether we will embark upon them [research studies into trans pregnancies] or not; it's a question of whether society is prepared to accept that people who have been biological males and have been reassigned as females should be entitled to realise their femininity completely by attempting to bear children in this way."[141]

In 1990 the National Bioethics Consultative Committee requested that Walters provide information and ethical comment about the possibility of pregnancy in trans women. The final paper, distributed at the Australian Health Ministers' Conference, provided an overview of the medical science of "transsexualism", the processes for hormones and gender affirmation surgery and the legal status of trans people. It then discussed some of the science of IVF and what this meant for a future possibility of trans women's pregnancies. Walters framed the main ethical challenge facing doctors as being around risk – the risk of mortality and morbidity for the parent or foetus versus the patient's autonomy "to make the final decision about what risks they are prepared to take after thorough medical counselling including detailed explanation of possible adverse complications."[142] Walters was relatively neutral in his conclusions, though he erred on the risks outweighing the patients' autonomy.

Rebecca Albury's introduction to Walters's paper took a different approach. Albury pointed out that Walters's analysis of transsexualism and pregnancy was strictly medical, not considering social constructivist ideas about gender and the broader societal implications around trans women's pregnancies. Albury further problematised the notion of patient autonomy and questioned whether just because a patient desired a treatment meant that they should be entitled to it. Albury's analysis of (trans)gender was in many ways an early example of the shift towards depathologisation, but in line with this approach she also opposed medical interventions to facilitate trans women's pregnancies. She asserted:

> the body of the transsexual is itself a technological artifact, which has been totally transformed by a variety of social and technical practices ranging from major surgery, through use of hormones, to make up and dress. Serious questions need to be raised about

139 Larry Galbraith, "Transsexuals and IVF," *Campaign*, October 1984, Australian Queer Archives, John Hewson Collection, notebook 8.
140 Paul Mann, "The man who became a woman," *New Idea*, 22 March 1986: 9.
141 ABC, *Nationwide*, 11 June 1984, courtesy Eric Plemons.
142 William Walters, "Transsexualism and Abdominal Pregnancy," in *Developments in the Health Field with Bioethical Implications*, ed. The National Bioethics Consultative Committee (April 1990), C23.

> the acceptability of including pregnancy as an inscriber of feminine identity on the formerly male body. In addition there is as yet no way of knowing the effects of such a pregnancy on the developing foetus nor on the social identity of a child who might result.[143]

Albury and Walters's analyses of the bioethics of trans women's pregnancies essentially closed the debate in Australia. Moreover, the technological possibility did not, as some doctors predicted in the 1980s, come to fruition.

In the 2000s, a new prospect around trans people and IVF emerged: trans men who wanted to become pregnant. In this space, too, Peter Hyndal was an Australian pioneer. In 2002 Hyndal went off hormones and sought a referral from his GP to access IVF. The plan was to use Hyndal's egg, donor sperm, and his partner would carry the child. The GP refused. Hyndal insisted she give a referral and the GP said she would only do so if he first saw a psychiatrist. The psychiatrist, too, scolded Hyndal with very harsh and judgmental words. He then went to a different clinic in Canberra which provided a referral for IVF.

Hyndal still faced significant obstacles to access IVF because most providers refused to offer their services to a trans man either carrying or genetically contributing to a child. Eventually, one provider agreed to it after much pressure from Hyndal, including pointing out the inconsistencies in law and documents over whether he was female or male. The doctor had one condition which was quite demeaning: Hyndal must present as female. To "play the game" Hyndal did – he shaved and went to appointments in a skirt. The entire process was fraught with inconsistencies and ups and downs (not to mention demeaning); some staff at the fertility clinic were affirming including using Hyndal's correct pronouns, but ultimately, less than twenty-four hours before treatment had been scheduled to commence, he was advised that it had been cancelled. When pressed, the clinic advised him that they thought he would make other clients in the waiting room "uncomfortable" and therefore they would no longer see him.

Hyndal had to search more IVF clinics and often he came across a problem where a doctor would be willing take him as a patient, but a required adjunct specialist (e.g. counsellor, anaesthetist) would not. Eventually, after a series of complaints to the anti-discrimination commission and arbitration, he found a new clinic that did agree to the procedure.[144] A 2018 qualitative study of twenty-five trans men who birthed in Australia found similar experiences of discrimination from fertility clinics.[145]

In the years since Peter Hyndal's experience – and especially since the 2010s – there has been more visibility of pregnant trans men and non-binary people, as well as more understanding among professionals who already work with trans clients. A 2015 episode of *Australian Story* followed the pregnancy of trans man A.J. Kearns, and his psychiatrist Dr Fintan Harte was quoted as saying:

> In my opinion, there's no reason why A.J. shouldn't have a child if he chooses to – and he did. My concerns in relation to the pregnancy were whether his depressive symptoms would resurface when he was confronted with his female anatomy and physiology. Prior to becoming pregnant, he was addressed by family and friends with male pronouns and he was seen as male – and clearly that going to change.[146]

Kearns expressed distress at the feminisation of his body through the pregnancy, and this, too, echoed the findings of Rosie Charter, et al's 2018 study.[147] Research on trans men and trans-masculine people's experiences of pregnancy in Australia is a recent field – as is research on fertility preservation for all trans people. A common theme across this emerging research is the continuing importance of professionals acting as informers and affirmers rather than gatekeepers.[148]

143 Rebecca Albury, "Introduction to Transsexualism and Abdominal Pregnancy," ibid., ed. The National Bioethics Consultative Committee, C7.

144 Peter Hyndal, interview with author, 15 February 2019, Canberra.

145 Rosie Charter et al., "The Transgender Parent: Experiences and Constructions of Pregnancy and Parenthood for Transgender Men in Australia," *International Journal of Transgenderism* 19, no. 1 (2018): 75.

146 "From Daddy's Tummy," *Australian Story*, 10 August 2015, ABC, https://www.abc.net.au/austory/from-daddys-tummy/6684254, accessed 22 June 2021.

147 Charter et al., "The Transgender Parent: Experiences and Constructions of Pregnancy and Parenthood for Transgender Men in Australia," 70-72.

148 Damien W. Riggs and Clare Bartholomaeus, "Toward Trans Reproductive Justice: A Qualitative Analysis of Views on Fertility Preservation for Australian Transgender and Non-Binary People," *Journal of Social Issues* 76, no. 2 (2020): 314-37; Clare Bartholomaeus and Damien W. Riggs, "Transgender and Non-Binary Australians' Experiences with Healthcare Professionals in Relation to Fertility Preservation," *Culture, Health & Sexuality* 22, no. 2 (2020): 129-45.

In the 2010s state law changes around access to IVF and changes to gender recognition at both the state/territory and federal levels have also facilitated more access for trans men. One of the most significant changes was in 2013 when the Commonwealth Government removed gender-specific restrictions on funding procedures for Medicare. This meant that pregnancy and birthing-related procedures would now be covered for trans men and non-binary people under Medicare item 16519 "Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days".[149] Figures released by the Department of Human Services in 2019 suggested that from 1993-2009, there were no trans men who gave birth (though there was one "unknown" case). From 2009-2019 that figure was 228, with twenty-two in the twelve-month period from July 2018 – June 2019.[150]

In recent years trans and LGBTIQ+ health services have been promoting messages around gynaecological health for trans men and trans masculine people. For instance, in late 2019 the Cancer Council of Victoria and Thorne Harbour Health ran a public health campaign targeting the LGBTIQ+ community around cervical screenings. The slogan was: "whatever your sexual or gender identity, if you have a cervix, then you need cervical screening every five years." The campaign featured trans man Aram Hosie, thus explicitly including trans men in the target audience.[151] Around the same time, Brisbane-based GP Dr Fiona Bisshop also promoted the importance of pap smears for trans men through the LGBTIQ+ media.[152] Other trans men and trans masculine issues around sexual health and access to testosterone are discussed in later sections.

Thorne Harbour Health and Cancer Council cervical screening campaign from 2019 featuring a trans man, courtesy Thorne Harbour Health

Detransitioning: Challenges to Monash Gender Dysphoria Clinic's Model of Care

Media sensationalism around trans health care has been increasingly vociferous since the 2017 marriage equality plebiscite and is arguably worse than in earlier decades. Still, even in the 1990s-2000s there were occasional media stories shining the light on trans health care and causing controversy. For instance, one doctor recalls when what was meant to be a human-interest story in 1997 about trans people and surgery turned into a sensational headline which caused a stir. Such attention not only could cause mental and emotional hardship for trans people, but also had fall-out for the doctors mentioned in the stories. The media reports could also have the unintended effects of leading medical administrators to place greater restrictions on health professionals' practice, even further disadvantaging and disempowering trans clients.

149 Damien W. Riggs, "Law and Policy Review: Australia," in *Trans Pregnancy: An International Exploration of Transmasculine Practices of Reproduction* (2018), 10.

150 Stephen Johnson, "Australian academic says it can be 'masculine' to be pregnant as it is revealed 22 transgender men in the country gave birth last year," *Daily Mail*, 7 August 2019, https://www.dailymail.co.uk/news/article-7329731/Medicare-data-shows-22-trans-gender-men-gave-birth-year-228-past-decade.html, accessed 22 June 2021.

151 "Public Cervix Announcement," https://thorneharbour.org/news-events/news/public-cervix-announcement/, accessed 13 July 2021.

152 Fiona Bisshop, "Sexual health and pap smears for trans men," *QNews*, 16 October 2019, https://qnews.com.au/sexual-health-and-pap-smears-for-trans-men/, accessed 13 July 2021.

In November 2003, *The Age* broke the story of a person who was suing the Monash Gender Dysphoria Clinic. The person had been diagnosed with transsexualism in 1986 and had gender affirmation surgery two years later. The person had celebrated the transition in the media in a 1989 article in *Woman's Day*,[153] but by 1996 the person was unhappy and detransitioned. In September 2003, that person appeared on an episode of *Australian Story* and lodged a writ against the Monash Gender Dysphoria Clinic and four of the specialists there, alleging medical negligence. Because the statute of limitations had passed, a court had to approve leave to pursue the writ. The person won the right to sue the clinic in the County Court of Victoria in November 2004 and the decision was upheld by the Court of Appeal in August 2005.[154] The clinic, doctors and plaintiff subsequently settled the case.

The case triggered two Department of Human Services reviews into the Monash Gender Dysphoria Clinic. One focused on collating client data from 1993-2003 and presented a comprehensive overview of: state or country of residence; employment history; age; marital status; referral sources; patient outcomes (e.g. surgery, stopped attending clinic, deemed unsuitable for gender affirmation surgery); and data about what specialists they saw and follow-ups. This data reinforced Herbert Bower's analysis of similar data from the period 1976-92. In relation to detransitioning – that which sparked the review – the report indicated:

> The vast majority of patients coming for review at the clinic are happy with their outcome. In the 10 year period under investigation there was a request for a reversal of surgery from a patient who had been operated on in 1981. Another who reverted to living in the previous role. Some people also wanted the functionality of their vagina's [sic] improved. Overall the people returning to the clinic were happy with their progress.[155]

Importantly, detransitioning is often equated with regret, but some people who have detransitioned do not express regret and report living in an alternative gender as being part of their spiritual life journey.

The Chief Psychiatrist conducted the other review, which focused on the clinical practices, policies and procedures at the Monash Gender Dysphoria Clinic. The review noted the chronic underfunding of the clinic being a significant structural problem. The review was critical of inconsistent processes at the clinic, particularly around: record management; referrals; application of *DSM* or *ICD* diagnostic criteria; recording of case histories; monitoring of the real-life test and hormone treatments; closure of cases and follow-ups after surgery; and education/training of staff within or associated with the clinic. A good summative statement from the report was: "There did not appear to be a systematic framework for determining eligibility for the various processes e.g. acceptance into the program, psychotherapy and other interventions, and the 'triadic therapy' – real-life, hormonal treatments and surgical interventions."[156]

Research and clinical experiences present diverging perspectives about the responsibility for follow-up appointments. As early as 1985 Perth-based psychiatrist Andy Zorbas pointed out that:

> in many patients there is an active resistance to being followed up or to be seen by anyone attempting psychological evaluation. I appreciate that the patients often wish not to be different, certainly not seen as mad, and ideally not seen to be visiting a psychiatrist or a hospital routinely. Some have told me that it reminds them of their former life and they have left that character behind.[157]

153 Bunty Avieson, "Goodbye, Alan, hello Helen…and happiness," *Woman's Day*, 19 December 1989: 12-13.
154 *Finch v Southern Health & Ors* [2004]; *Walters & Ors v. Finch* [2005], VSCA 203.
155 Samuhel, "Review of People Presenting to the Monash Medical Centre Gender Dysphoria Clinic from 1/1/1993 to the 31/12/2003," 20-21.
156 "Clinical Review of Gender Dysphoria Service, Monash Medical Centre," (2004), 17.
157 Andy Zorbas, to Dr J.C. McNulty, Executive Director, Public Health, Health Department of Western Australia, 18 January 1985, WA State Records Office, AU WA S455- cons4562 1979/5144.

More recent health practitioners have similarly commented on trans clients themselves not responding to calls for follow-up appointments. Yet, Dr Belinda Chaplin's PhD research with trans people in Australia who had gender affirmation surgery found that once their surgery was approved, they believe the specialists did not offer enough support – particularly psychosocial support.[158] These contrasting views suggest a lack of early, clear expectations on the part of both trans clients and the doctors.

On the one hand, the review identified serious deficiencies in the operation of the Monash Gender Dysphoria Clinic. Yet, the suite of recommendations very much reinforced the medical model. Indeed, the report argued that the psychiatrists were not being rigorous enough in their application of diagnostic criteria and documentation – all at a time when there was greater push from the trans community to shift *away* from this model.

Another case of transition regret and alleged mismanagement again put the Monash Gender Dysphoria Clinic under the public spotlight in 2009. In 2007 another person lodged a writ arguing medical negligence against several psychiatrists, a surgeon and a psychologist associated with the clinic. Like the case in 2003 the individual needed to seek leave to pursue the case because the statute of limitations had passed. In early 2009 the court refused the leave, but there was an important line of reasoning argued in that lawsuit: the plaintiff asserted that the staff at the Monash Gender Dysphoria Clinic did not observe the diagnostic criteria for Gender Identity Disorder as laid out in *DSM IV*.[159]

Even though this did not go to trial, again it seemed that the best defence the doctors could mount – or the best way to pre-empt any future lawsuits – would be strict adherence to the medical model. The medico-legal department liked conservative protocols in place because they feared lawsuits. This left staff at the clinic with no room to individualise their work with trans clients, be that around clients who needed more support than the standards of care outlined or those who, in psychiatrists' opinions, did not need such arduous and recurring consultation sessions.

Later in 2009 the story of transition regret reached the media, and it prompted another review of the Monash Gender Dysphoria Clinic. Pending that review, the clinic was temporarily shut down and Trudy Kennedy was forced to resign as director. The review noted: disparate recordkeeping and the need for better, consistent documentation processes; better responses to meet the mental health needs of clients; and the need for regular internal review processes through the establishment of an independent review committee. The review also noted challenges and confusion because the Monash Gender Dysphoria Clinic ran as both a public and private service and was chronically underfunded. Finally, the review made recommendations around developing an outreach and training program to educate other practitioners and service providers around trans health. The recommended aim was to develop a shared care model:

> A shared care model could incorporate general practitioners, sexual health physicians and a range of private mental health practitioners in a team approach. This would require a formal arrangement with external service providers regarding criteria for inclusion, referral processes and care planning. The GDC [Gender Dysphoria Clinic] could play an important role in overseeing the development of a network of providers and a comprehensive approach to the need of transsexual clients.[160]

The Monash Gender Dysphoria Clinic reopened three months later in 2009 with Dr Fintan Harte as its new director. Under Harte, the clinic would see a shift towards consultation with trans people to inform practices and processes, though underfunding and the fall-out of the detransition lawsuits hindered wider reforms towards an informed consent model.

158 Belinda Chaplin, "'Why Are You Crying? You Got What You Wanted!': Psychosocial Experiences of Sex Reassignment Surgery." (Queensland University of Technology, 2016).
159 *Edwards v Kennedy & Ors*, [2009] VSC 74.
160 Louise Newman, "Final Report: Review of Gender Dysphoria Clinic, Southern Health Mental Health Program," (2009).

Sistergirls and Brotherboys

Across the memories of trans advocates and health professionals alike is that the vast majority of people presenting for support – especially before the 2010s – were white, Anglo or other European people. Trans people of colour – be they from Asian, Pasifika or other backgrounds – often found the main trans support and activist groups to be uninformed about their cultural backgrounds or needs. Similarly, health practitioners were often unfamiliar with different cultural constructs of gender diversity or the particular contexts and effects that medical interventions could have.

Aboriginal and Torres Strait Islander people, for example, have had very different understandings of sexuality and gender from the West. Perhaps of most significance is the emphasis on spirit rather than body. Aunty Vanessa Smith, a long-time Sistergirl activist and advocate, explains:

> We don't have to take hormones. We don't have to have gender reassignment. We don't have to have breast implants. We don't have to dress as women and live as women because our spirit is female, and our spirit is who we are. It's not about the dress; it's not about the physical side of us that you see. Some people might just have a flower over their ear or something like that. Someone might just pluck their eyebrows. Someone might grow their hair, to feel like a female for themselves. But the reality is, it's a spiritual thing with us. It's not about anything else. That's more important than anything – knowing that what's in here is who you are.[161]

Aunty Vanessa's explanation concisely explains why Sistergirls, Brotherboys and gender diverse Indigenous people have for so long not fit the Western, medical model of transgender.

This is not to say that no Sistergirls, Brotherboys or gender diverse Indigenous people desire hormones or gender affirmation surgery. Indeed, challenges which have been particularly pronounced for Sistergirls, Brotherboys and gender diverse people from regional or remote communities are: the accessibility of friendly doctors; language barriers when English is not the first or even second language; cost and access for hormones and gender affirmation surgery.[162] Yet, what Aunty Vanessa highlights, reinforced by other testimonies, is that Sistergirls, Brotherboys and gender diverse Indigenous people have historically faced other priorities in health care.

Aunty Vanessa Smith, long-time Sistergirl activist and advocate, sadly passed away in January 2022, courtesy Lisa Taylor

161 Vanessa Smith, interview with author, 27 September 2019, Perth.

162 Stephen Kerry, *Trans Dilemmas: Living in Australia's Remote Areas and in Aboriginal Communities* (Abingdon, UK and New York: Routledge, 2018), 83-85.

Advocacy for Sistergirl and later Brotherboy health care grew out of responses to the AIDS epidemic in Indigenous communities. In 1994 the Australian Federation of AIDS Organisations (AFAO) hosted Anwernekenhe I, the first national conference for Indigenous gay men and Sistergirls, on Arrente country in the Northern Territory. AFAO subsequently recognised the need for specific strategies for HIV/AIDS prevention and treatment in Aboriginal and Torres Strait Islander communities. AFAO launched a series of working groups and hosted Anwernekenhe II, the Second National Indigenous Gay and Transgender Conference, in 1998 on Kombumerri land at Tambourine Mountain, Queensland. At that meeting, Aunty Vanessa Smith was elected chair of the National Indigenous Gay and Sistergirl Steering Committee under AFAO. For the next four years Aunty Vanessa travelled across Australia to various Indigenous communities, talking about HIV/AIDS and especially working to break the stigma around HIV. She also took on Sistergirl issues, both talking and listening to the Sistergirls she met along the way.

In July 1999, Aunty Vanessa chaired the First National Indigenous Sistergirl Forum on Magnetic Island, the lands of the Wulgurukaba peoples. The conference brought together thirty-five Sistergirls from across Australia (except for Victoria and Tasmania). The organisers invited one Brotherboy as well, though he was not able to attend. Conference themes revolved especially around: identity; sexual health; HIV/AIDS; violence including physical and sexual abuse; human rights; and substance abuse. Just these themes show a sharp difference from the medical profession, which still focused so much discussion and research on trans health on gender affirmation surgery. In fact, the "Report of the First National Indigenous Sistergirl Forum" made only one brief mention of surgery in its recommendations: "That the full costs of gender reassignment surgery be covered under the Commonwealth Medicare system."[163]

The themes discussed and recommendations that came out of Magnetic Island highlight what were the more pressing health and social challenges facing Sistergirls. Moreover, these challenges were all intricately connected. All of the recommendations centred around making space and/or education programs about Sistergirls within Indigenous community, health and/or LGBTIQ+ service providers. Some of the more health-specific recommendations included:

- That governments and government-funded agencies promote employment opportunities and training for sistergirls, particularly in the health sector.
- That AFAO develop a national sistergirl sexual health strategy to complement the Indigenous Gay and Transgender Sexual Health Strategy 1998 - 2000.
- Indigenous health services, including outreach services, provide support, education and counselling to the families of sistergirls to promote family reconciliation.
- That AMSs and AIDS Councils conduct HIV/AIDS and sexual health workshops for sistergirls and employ sistergirls to conduct this training where possible.
- That NACCHO [National Aboriginal Community Controlled Health Organisation] promote cultural appropriateness in health services to Indigenous Australians, and to that end, ensure that non-Indigenous providers of health services to Indigenous Australians provide diagnoses, tests and treatments which are culturally appropriate and which address the needs of sistergirls.
- That nationally applicable Indigenous sistergirl resource materials be developed by AFAO/NACCHO/AIDS Councils and AMSs and that these resources address safe sex and drug use, gender issues and mental health.
- That AIDS Councils, AMSs and other health organisations establish support groups for sistergirls.
- Sexual Health Clinics make office space and other support available to sistergirl communities so that support groups may be run.
- Indigenous health services, including outreach services, provide counselling services for sistergirls, with this counselling ideally being provided by sistergirls themselves.[164]

163 Michael Costello and Rusty Nannup, "Report of the First National Indigenous Sistergirl Forum: A Forum for All Indigenous Poeple Who Identify as Sistergirl or Who Have Transgender Qualities," (1999), 9.
164 Ibid., 9-10.

Aunty Vanessa and other Sistergirl advocates continued to work in the health space, especially through the Anwernekenhe National Aboriginal and Torres Strait Islander HIV/AIDS Alliance. In the late 1990s the Gender Centre also had a Sistergirl on its board of management, and in September 1999 ACON appointed Kooncha Brown into an Aboriginal HIV infection role, and Kooncha used that position to double as ACON's first Aboriginal and Torres Strait Transgender and Sistergirl Project Officer.

Brotherboy and Sistergirl advocates Dean Gilbert and Lisa Taylor, courtesy Lisa Taylor

Sistergirl Lisa Taylor played an important role creating a safe space for Brotherboys as they grew in visibility from the late 2000s. When chair of Anwernekenhe in the 2000s, Aunty Vanessa created a Sistergirl representative position on the board. Around 2009 Aunty Vanessa convinced Taylor, who had attended the Magnetic Island Sistergirl Forum, to take up that position. During her six years in the role, Taylor was particularly keen to ensure greater Brotherboy visibility and representation. She organised the first Brotherboy panel at the Anwernekenhe 6 conference in 2015. She also advocated to create a Brotherboy representative on the board, though that would require constitutional change. In 2012 Taylor started the closed Facebook group Sistergirls & Brotherboys Australia (recently renamed Sistergirls & Brotherboys + Gender Diverse Mob), which continues to be a resource for sharing information.[165]

Tekwabi Giz members worked with the National LGBTI Health Alliance around issues affecting Aboriginal and Torres Strait Islander people, courtesy Lisa Taylor

Since 2014, Aunty Vanessa Smith, Lisa Taylor and other LGBTIQ+ Indigenous Australians – including Sistergirls and Brotherboys – have been members of Tekwabi Giz. Tekwabi is a Tiwi word meaning "all of us" and Giz is a Torres Strait word for "connected"; Tekwabi Giz thus means "all of us connected". Tekwabi Giz grew out of a National LGBTI Health Alliance (now LGBTIQ+ Health Australia) mental health conference in 2014. Recognising the need for leadership and training around issues confronting Indigenous LGBTIQ+ people, Sistergirls and Brotherboys, the group was then formalised in 2015.[166] In its early years Tekwabi Giz did consulting work, especially for the National LGBTI Health Alliance, around issues affecting Aboriginal and Torres Strait Islander people. Aunty Vanessa Smith sadly passed away in January 2022 after a long battle with cancer.

In the 2010s other organisations supporting Sistergirls, Brotherboys and gender diverse Indigenous people have emerged, such as Sisters & Brothers NT in Central Australia. In the late 2010s some of the state and territory AIDS councils also began funding programs specifically working in Sistergirl and Brotherboy health, such as QuAC's 2Spirits and ACON's Trans Mob. Like their forerunners, these programs have the multi-purposes of: health promotion within Indigenous and LGBTIQ+ communities; advocacy within politics and the media; education and training; and peer support programs.

The growing visibility of Sistergirls, Brotherboys and gender diverse Indigenous people since the 2000s has highlighted the intersectional challenges facing these communities. They have pushed extant trans community groups and health providers to be more culturally inclusive and, in the process, have challenged Western constructs of gender and sexuality. They have also contributed to the broader push for health practitioners to see trans health care as more than just hormones and surgery.

165 Lisa Taylor, interview with author, 12 July 2021, Zoom.

166 "Tekwabi Giz (Aboriginal, Torres Strait and South Sea Islander inclusion)," LGBTIQ+ Health Australia, https://www.lgbtiqhealth.org.au/tekwabigiz, accessed 23 June 2021.

AusPATH: A New Forum for Trans Health Care Professionals

After the disbandment of the Australian and New Zealand Committee on Transsexualism in the early 1980s, there was no specific forum or organisation to bring together professionals working in trans health care. There were still informal conversations within and across state lines, with the Monash Gender Dysphoria Clinic generally – though not always – representing the hub for information. For instance, in addition to the aforementioned workshop Trudy Kennedy and Herbert Bower presented at in Brisbane, in the early 2000s Trudy Kennedy also went to Tasmania at the request of activist Martine Delaney to deliver professional development for General Practice Training Tasmania.[167]

Psychiatrist Russell Date recalls that as one of the few psychiatrists in Perth working with trans clients in the 2000s, he mostly had to learn best practice on his own. He notes that the isolation from the eastern states could be a challenge, but it also had its advantages. For instance, he did not apply the rigid and stereotyped expectations around gender presentation which were so common among east coast practitioners. Date has been grateful to learn from his trans clients and to have, as he puts it, "freedom to deviate." Still, a community of practice would have made him more comfortable in his work – particularly in the early years.[168]

In late 2001, psychologist Vikki Sinnott recognised the need for coordination and discussion and brought Melbourne-based professionals together to form the Network of Professionals Working with Transgender People. The group included GPs, psychiatrists, speech pathologists, surgeons, psychologists, endocrinologists and other specialists and allied health workers. The group met three times a year and received updates from organiser Vikki Sinnott. At meetings the members discussed emerging areas of concern as well as heard presentations about pertinent topics such as legal issues affecting transgender Victorians. The group disbanded at the end of 2003 when Vikki Sinnott moved interstate.

A sustained association for workers in trans health care came at the end of the decade and grew out of international (re)organisations. In 2007 the Harry Benjamin International Gender Dysphoria Association changed its name to the World Professional Association for Transgender Health (WPATH). The organisation had been holding biennial conferences since 1979 and Australian professionals were regular attendees since at least the 1990s. At the 2009 conference in Norway, several Australians were in attendance and, at the initiation of Rob Lyons, ten held their own informal caucus over breakfast. They discussed the formation of an Australian association similar to Canada's (CPATH), and unanimously voted to adopt the following aims:

- To promote training and education in the field of transgender health within the various professional training programs.
- To serve as a forum for communication and collaboration amongst professionals involved in transgender health.
- To encourage and share research in the field of transgender health.
- To promote collaboration with health providers and professionals in Australia and internationally in the field of transgender health, and establish a known network of providers for our patients.[169]

The following day some of the inaugural members met with colleagues from Aotearoa New Zealand and they proposed a name that would stick: The Australian and New Zealand Professional Association for Transgender Health (ANZPATH). Whereas similar organisations in other parts of the world are chapters of WPATH, ANZPATH would consistently resist efforts to become a part of WPATH and thus has always been an independent organisation with control of its own finances.

Over the next several months the inaugural leaders of ANZPATH went through the legal process to form an association and recruited a membership base among health practitioners across Australia and Aotearoa New

167 Martine Delaney, interview with author, 11 September 2021, Zoom.
168 Russell Date, interview with author, 17 September 2021, Zoom.
169 Minutes of ANZPATH Inaugural Planning Meeting, 19 June 2009, courtesy Simon Ceber.

Zealand who were already known for working with trans clients. ANZPATH incorporated in June 2010; by March 2011, at the organisation's first biennial conference and annual general meeting, there were thirty-two members. The vast majority of members were cisgender, but there were a small number of transgender members from as early as the breakfast in Oslo – including one doctor and one lawyer. In 2019 the New Zealanders formed their own separate organisation – The Professional Association for Transgender Health Aotearoa (PATHA) – and ANZPATH was renamed AusPATH (for convenience the rest of this section just uses AusPATH).

While AusPATH has become the main national forum bringing together health practitioners, there have continued to be informal regional networks as well. Elizabeth Riley recalls that there used to be an informal network in Sydney of mostly psychiatrists but also herself as a psychologist and some GPs who met once a month. That group disbanded, but some of the psychologists have started a new online group for practitioners in trans health which is called the Gender Galaxy. Originally the group was Sydney-based, but the shift online during the Covid-19 pandemic has made the group go national, and it now has about 100 members.[170]

In 2008, the Commonwealth government began to fund the development of local interdisciplinary networks of primary mental health, known as the Mental Health Professionals Network. These networks provide a forum for networking, information sharing and professional development among specific interest groups. There are currently ten networks across the country about LGBTIQ+ health; the Perth Gender Network (also known as Perth Gender Diversity) is the only one which focuses specifically on trans health. That Perth group was one of the first, started in the early 2010s, and informed the Western Australian Department of Health's development of a children's gender service in 2013.[171]

In 2015 a group of professionals in the Hunter Region of New South Wales began a new group with the aim of improving communication, education and access to affirming health care. This organisation grew into not just a health network, but a broader education and support service for trans and gender diverse people in the region and is now known as the Hunter Gender Alliance. Another more recent association is the quarterly meeting of the Canberra Transgender Care Network.

Early on the presence of trans people in groups like AusPATH would prove significant at pushing health professionals to shift away from the pathologisation of transgender people. For instance, at AusPATH's first annual general meeting, it was a trans member who challenged the organisation *not* to endorse WPATH's statement on the proposed updates to *DSM V* because it still referred to transsexualism as a disorder. The motion that passed was "That ANZPATH at its AGM noted concern amongst its membership about the proposed DSM-V criteria and that ANZPATH is committed to reviewing these criteria and making a statement in due-time concerning these criteria."[172]

Throughout its history, though, AusPATH has had a mixed relationship with members of Australia's trans community. From the start the constitution stipulated that the executive committee had to approve membership applications and members had to work in transgender health, the law or other related fields. This practice was modelled on WPATH and it entailed inspecting applicants' CVs and being rigorous that they were all registered with relevant regulatory authorities (e.g. The Australian Health Practitioner Regulation Agency). The practice reinforced perceptions of the organisation perpetuating the gatekeeper model of trans health care.

In the build-up to the 2014 conference, AusPATH leaders made efforts to reach out to transgender organisations and invited several trans community members to attend. At that year's annual general meeting the constitution was amended to create a new category of associate membership, which could include trans community members and other non-registered professionals. Moreover, as noted above, since AusPATH's beginning there have been trans people involved in the leadership team. The organisation's subcommittees – policy, research and education – have also consistently included trans health practitioners among their members. Oral history interviews with trans health practitioners – be they doctors or nurses – have generally presented favourable opinions and recollections of AusPATH and its history.

Where there has been more criticism, though, is from trans people without medical backgrounds. Some of these people have worked in transgender organisations; others have worked in trans community health. Their criticism can be summarised as AusPATH reinforcing the medicalised model of transgender and the gatekeeper approach. They have advocated for more community involvement in the organisation's leadership and conferences, where community members as experts can be just as valuable as the professionals or the P in AusPATH.

They also express that AusPATH's focus on clinical practice and medical approaches overlook the lived and living experiences of trans people, many of whom suffer significant disadvantage because of the discrimination rife in Australian society. Trans health, or the TH in

170 Elizabeth Riley, interview with author, 31 May 2021, Zoom.

171 Mental Health Practitioners Network, https://www.mhpn.org.au/, accessed 28 September 2021; Russell Date, interview with author, 17 September 2021, Zoom.

172 ANZPATH Annual General Meeting minutes, 26 March 2011, courtesy Simon Ceber.

AusPATH, has centred too much on medicine, without sufficient attention paid to the psychosocial needs of trans people. At the 2017 AusPATH conference, a group of trans community members in attendance even quietly walked out. They were uncomfortable with how some of the presenters – including trans speakers – were talking from positions of privilege, without adequate understanding of the disempowerment felt by many members of the trans community.[173]

In recent years, the AusPATH Board of Directors has slowly been responsive to the calls to be more inclusive of trans voices and perspectives from the ground. AusPATH has grown the membership base to include more trans community members who work in health and/or wellbeing. The constitution now has more flexible eligibility for full membership: "the applicant must demonstrate a relevant professional background or experience in the health, rights or wellbeing of trans, gender diverse and non-binary people."[174] AusPATH conference organisers have extended more invitations to trans community members to present. Trans community members have stepped up and been on the Board of Directors, most prominently ACON's Manager of Trans Health and Equity, Teddy Cook, elected vice president in 2019. The majority of the current Board of Directors are now trans or gender diverse.

Concurrent with this shift towards more engagement with the trans community, AusPATH has also taken a more active role putting out public statements responding to news items on a range of trans issues. Many of these topics would not traditionally be seen as health matters, but as trans community organisations and activists have long advocated, *all* debates about trans people's lives have an impact on their mental health and wellbeing.

Broadening Trans Health Care and Relationships with the AIDS Councils

The shift to seeing trans health care as about more than just medical transitions has long been on the agenda of activist and community organisations.

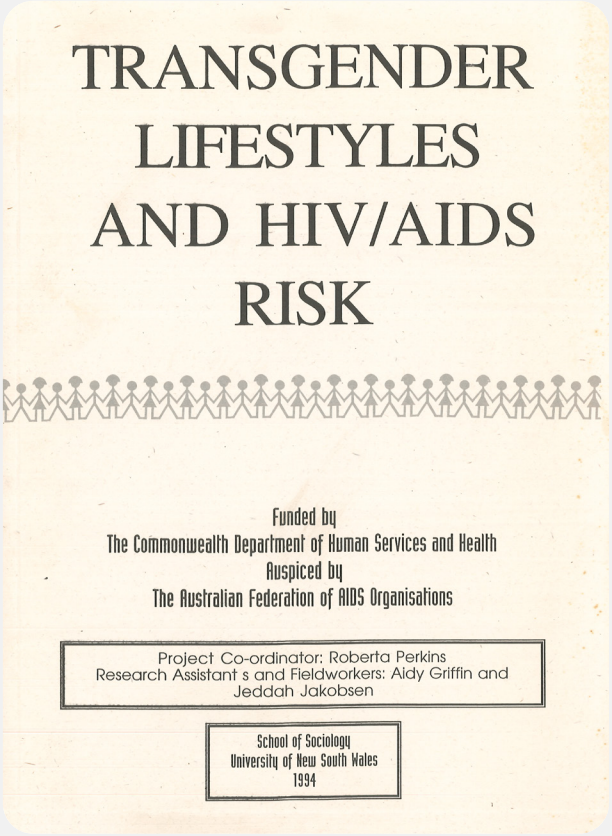
In 1994 Roberta Perkins published the first Commonwealth-funded study into transgender health and wellbeing: "Transgender Lifestyles and HIV/AIDS Risk: National Transgender HIV/AIDS Needs Assessment Project." Notwithstanding the title, the report was about more than just HIV and AIDS; it examined a range of challenges facing the trans community and reported findings of high unemployment, drug use, sex work, physical and sexual abuse, and poor physical and mental health outcomes. The report clearly articulated how the health care and outcomes for trans people were intricately connected to broader social attitudes, behaviours and laws:

> In general, transgenders suffer with much greater health problems than the community at large, but much of this is related to social attitudes to crossing gender and society's inability to deal with it as a variance of normal human behaviour. The outcome then leads to a number of health problems, most directly

173 "Liz", interview with author, 8 July 2021, Zoom.

174 Australian Professional Association for Transgender Health, Constitution, 6.2 (a)(1), https://auspath.org/wp-content/uploads/2019/06/AusPath_Constitution.pdf, accessed 2 July 2021.

stress, depression and emotional instability. Indirectly these may in turn lead to drug addiction to avoid confronting transgender social issues, and to unsafe sex practices as part of an emotional need to develop less tenuous relationships than with commercial sex clients, one-night-stands and casual non-transgender lovers.[175]



Roberta Perkins's 1994 report was the first Commonwealth-funded study into trans issues

The report's recommendations centred on: changing legal frameworks to recognise affirmed genders, funding for transgender organisations, improved media depictions and anti-discrimination laws and policies. The health-specific recommendations were around sexual health education for trans sex workers, the establishment of trans-specific counselling services in each state, substance abuse programs for trans people, state-funded services for trans people escaping family and domestic violence, greater employment of trans people in state departments and health services, and HIV education and prevention programs targeting trans people.

Transgender community groups and activists continued to advocate for more holistic approaches to health care, especially primary care. One challenge was that by the early 2000s, often trans representation in health advisory bodies was part of the LGBTIQ acronym. More often than not, trans health concerns (as well as intersex) were given minor attention or were subsumed by the dominant concerns of the gay and lesbian community (and often, just gay men). As one example, in Victoria the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) produced two discussion papers in March 2002.[176] Transgender Victoria put out a response that highlighted key priority areas for trans health which the MACGLH did not address:

- Normalising transgender so that trans people would be more comfortable attending specialist appointments and services which were related to health needs other than gender affirmation;
- Prioritising support for trans people at two key life stages: puberty and gender affirmation; this meant the need for more accessible specialist counselling at both life stages;
- "Prioritising the mental health issues for people with gender identity issues: early non-intimidatory non-outing diagnosis, delaying puberty, self-esteem issues, dealing with internalised transphobia."
- Devising sexual health strategies that acknowledged trans women as women and therefore would make them more comfortable attending sexual health clinics and other vital preventative screenings;
- Counselling and education to workplaces to support trans people going through transition;
- Support for trans people to live in their affirmed gender, which would also support trans people's self-esteem;
- Medical Benefits Scheme coverage for hormones and gender affirmation surgeries;
- Increased funding for the Monash Gender Dysphoria Clinic as well as research into whether specialist primary care centres for trans health would be beneficial.

175 Perkins, "Transgender Lifestyles and HIV/AIDS Risk: National Transgender HIV/AIDS Needs Assessment Project," 53.
176 Victoria, Ministerial Advisory Committee on Gay and Lesbian Health, "What's the Difference? Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians," ed. William Leonard (Victoria, Department of Human Services, July 2002).

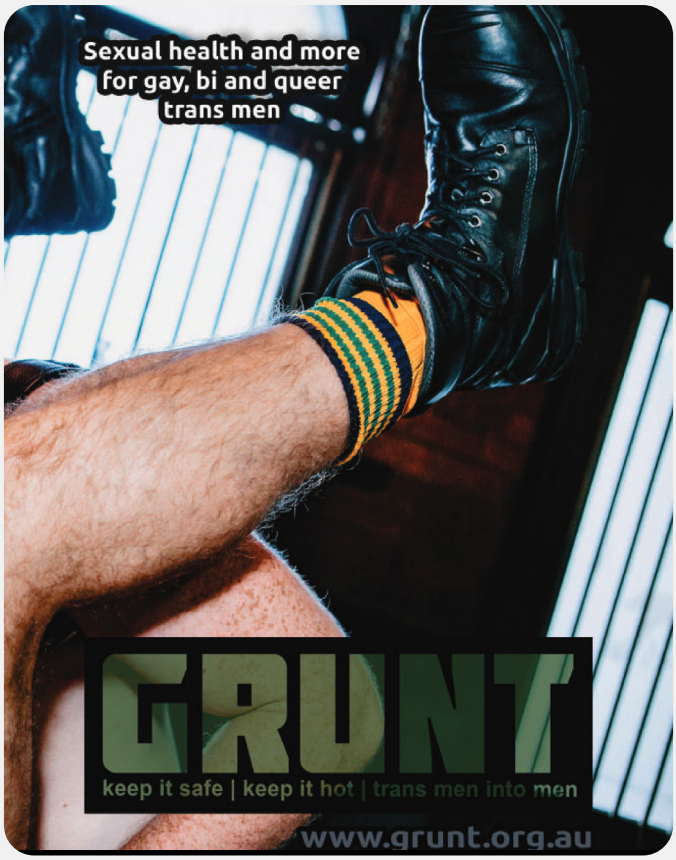
Perhaps the best summative recommendation was one around reconceptualising what constituted standards of care for trans health: "Only a multi-disciplined approach can give us practical realistic patient care. The definition of Standards of Care at least need[s] to include medical, familial, social and the psychological disciplines."[177]

These recommendations mostly went unheeded, and a decade later trans activists across the country continued to advocate for changing models of care which were more holistic, as well as which saw trans health care as distinct from gay and lesbian health. QuAC was perhaps the first AIDS council to offer support to trans clients and community groups. In early 2013 the Newman Government ended the arrangement in place since 1994 where the Brisbane Gender Clinic could operate out of the Department of Health. For a few months the clinic was essentially homeless until QuAC offered a room. PFLAG national spokeswoman Shelley Argent donated $20,000 to convert the room into a proper medical suite where GP Gale Bearman could continue to run the Brisbane Gender Clinic one day a week. Moreover, being at QuAC gave Bearman the opportunity to train other doctors and nurses to work with trans clients. That same year, trans man Parker Forbes started working at QuAC as a finance officer. During his five years at QuAC he applied for small grants to support trans health and wellbeing programs and at one point was almost daily making calls for a trans health promotion officer. Forbes's persistence paid off and QuAC created the role of transgender health promotion and community development officer in late 2016.[178]

Progress in other state AIDS councils came in the mid-2010s and grew out of grassroots efforts by trans people – especially trans men – who were concerned about sexual health. Jeremy Wiggins was a Melbourne-based trans man who had been the subject of a documentary where he underwent chest surgery and worked with Headspace speaking in schools. Wiggins was also the creator of the international zine *Dude Magazine*, which regularly featured messages promoting trans men's visibility and health. Wiggins saw the need not only to promote messages around trans men's sexual health, but also to challenge transphobia – especially transphobia against trans men and trans masculine people – coming from cisgender gay men.

In early 2014, Wiggins organised a national tour featuring the American trans man porn star Buck Angel. This proved wildly popular with sell-out crowds, with the discussions promoting significant visibility around trans men and trans men's health to the gay community. Accompanying the tour was a series of sexual health workshops and panels discussing STI and HIV prevention. On the back of this, Wiggins was invited to present at the International AIDS Conference hosted in Melbourne later that year. His work also attracted the attention of the state AIDS councils and AFAO.

Wiggins then worked with three other trans men – Aram Hosie, Teddy Cook and Eden St James – to found the Peer Advocacy Network for the Sexual Health of Trans masculinities (PASH.tm). PASH.tm received funding from AFAO and the leadership group presented workshops at various HIV conferences and networks. They also prepared position statements on sexual health topics such as Pre-Exposure Prophylaxis (PrEP) access and guidelines for trans men and trans masculine people. They ran a sexual health campaign called Grunt.[179]



PASH.tm, the first peer advocacy network focused on trans men's sexual health, ran the popular Grunt campaign in 2014, courtesy Jeremy Wiggins and Teddy Cook

Later in 2014 the then-Victorian AIDS Council (now Thorne Harbour Health) hired Jeremy Wiggins as a worker in their alcohol and drug services area. He notes that at that time, he was the only openly trans person working at Thorne Harbour. He saw this as an opportunity to push the organisation to do more to reach out to the trans community and make their health needs part of the association's central mission and actions. Changing attitudes within Thorne Harbour was hard, as was changing the trans community's perception of the organisation as being just for cisgender gay men.

177 Transgender Victoria, "Reaction to MACGLH discussion papers by Transgender Victoria," 15 March 2002, courtesy Julie Peters.
178 Parker Forbes, interview with author, 16 September 2019, Brisbane.
179 https://www.grunt.org.au/, accessed 25 June 2021.

For much of his four years working at Thorne Harbour, Wiggins became the de facto trans health person. Later in his employment Thorne Harbour officially made Wiggins the trans health promotion officer, but this was only .2 FTE of his role and came with little funding or additional support. The efforts to make Thorne Harbour Health more trans-inclusive had mixed results, though the biggest achievement was the founding of a peer-led health service (discussed in a later section).[180]

What Jeremy Wiggins experienced trying to change the relationship between the AIDS council and trans community in Victoria was mirrored in other states. In New South Wales, for instance, Wez Saunders – a trans man who worked in ACON's Newcastle office – saw that the organisation was not adequately supporting trans people. In 2010 he started a peer support group for trans men, especially children and young people. Saunders had to do this work independent of his role at ACON. While initially a supportive supervisor let Saunders take the time to run the group, it was also made clear that ACON could not have its brand associated with the trans group. Around 2016, though, Saunders was told he had to step back from that group because it clashed with his role at ACON.[181]

The person who really influenced ACON's more proactive work in trans health and wellbeing was Teddy Cook. Cook commenced employment at ACON in 2012 and from 2017 worked as Regional Outreach Development officer overseeing southern and western NSW. Cook was already involved in PASH.tm and was, where possible, trying to incorporate trans people into ACON staff's thinking. Working across multiple organisations and community networks positioned Cook well to build ACON's capacity in the trans space. For instance, he co-authored a December 2017 discussion paper jointly published by ACON, the Gender Centre and PASH.tm about trans inclusion in HIV prevention. The discussion paper highlighted how most states' reporting and data collection processes around HIV do not account for the diversity of genders, sexualities and sexual practices of people who come under the trans umbrella. These practices at best dilute and at worst erase the distinct experiences and needs of trans people around HIV.[182]

In 2017 ACON's CEO met with a group of three trans people, and their advocacy convinced the CEO to direct more resources and programs into supporting trans health and wellbeing. Out of this was borne the new trans health and equity portfolio.[183] In 2018 ACON disseminated a trans community survey which elicited 450 responses, as well as held several consultation meetings across the north and central coasts of New South Wales, Sydney, Wagga Wagga and Wollongong. Out of the consultation process, in 2019 ACON released "A Blueprint to Improve the Health and Wellbeing of the Trans and Gender Diverse Community in NSW", which highlighted six priority areas to promote trans and gender diverse people's health and wellbeing in NSW:

- Clear and easy pathways for accessing gender-affirming care
- Affordable and available gender affirming healthcare
- An inclusive and knowledgeable NSW health sector
- Official government I.D.s and records that reflect trans and gender diverse people's gender through simple administrative procedures
- Workplaces, education settings and other environments that are inclusive and respectful of the needs of trans and gender diverse people
- A vibrant, resourced trans and gender diverse community advocating for its own needs and priorities.[184]

In April 2020, ACON launched TransHub: a comprehensive online resource for trans and gender diverse people, health practitioners and allies which provides a raft of information on a range of topics. ACON has also rolled out training programs and resources such as the Trans Vitality Toolkit which aim to build resilience, improve mental health outcomes and reduce suicidality.[185]

In the smaller states the AIDS councils have fewer resources (or in the case of South Australia, the AIDS council was insolvent and closed in 2013; Thorne Harbour Health now auspices South Australia through SAMESH). Like in the larger AIDS councils, the opportunity to provide trans-specific programs has generally been at the initiative of trans employees. In the Northern Territory AIDS and Hepatitis Council this has entailed securing small grants to design brochures specifically targeting Sistergirls and Brotherboys. Programs run by Belinda Chaplin offer referral pathways (medical, legal and social) for trans people, as well as a support group funded through the Northern Territory Primary Health Network promoting social inclusion. They have also facilitated events like a Trans Day of

180 Jeremy Wiggins, interview with author, 24 June 2021, Zoom.

181 Wez Saunders, interview with author, 11 September 2018, Newcastle.

182 Zahra Stardust et al., "Effective and Meaningful Inclusion of Trans and Gender Diverse People in HIV Prevention," (Sydney: ACON and PASH.tm, December 2017).

183 Teddy Cook, interview with author, 3 February 2022, Zoom.

184 ACON, "A Blueprint for Improving the Health and Wellbeing of the Trans and Gender Diverse Community in NSW," (Sydney AIDS Council of New South Wales, 2019).

185 https://www.transhub.org.au/, accessed 25 June 2021.

Remembrance candlelight vigil hosted at Government House in 2020.[186] Finally, while there has been some ad hoc trans representation on AFAO's board, it would not be until the *Eighth National HIV Strategy 2018-2022* that the national peak body, too, recognised trans people as a priority population for HIV prevention.[187]

What all these efforts show is a common pattern: trans community groups and specific advocates have pushed hard for trans health care to be seen as about more than just medical transitions. Instead, all dimensions of trans people's health and wellbeing – be it physical, mental, emotional or sexual health – are intricately connected to the law, employment, education, medicine, the media and, perhaps most importantly, societal attitudes.

TransHub was launched in 2020 as a comprehensive online resource targeting trans people, health practitioners and allies, courtesy TransHub/ACON

Global Shifts and Local Reforms at Monash

The 2010s saw even greater international pushes from trans activists to shift away from the gatekeeper model of health care to an informed consent model. Activists also pushed for depathologisation of what it means to be trans, which has borne some fruits.

In 2013, *DSM V* removed gender identity disorder and replaced it with gender dysphoria. Moreover, gender dysphoria was not listed as a sexual disorder but instead was in a category of its own. Going even further, in 2019 *ICD-11* removed gender identity disorder from the list of mental health disorders and created the new category of gender incongruence, defined as "a marked and persistent incongruence between a person's experienced gender and assigned sex."[188] The key objective behind the changes to *DSM V* and *ICD-11* was to depathologise and destigmatise being transgender by no longer classifying it as a mental health disorder. Rather, mental health challenges associated with being trans were related to legal and social discrimination as well as ongoing stigmatisation. That said, still many trans people are uncomfortable with any association between their identities and mental illness. As Brotherboy Elder, Uncle Dean Gilbert, succinctly states: "It's when they say that you had gender dysphoria, like it's a mental issue. It's a mental problem. I don't have a mental problem."[189]

Beginning under Fintan Harte's term as director of the Monash Gender Dysphoria Clinic in 2009, there, too, was a greater push for trans clients to be seen as consumers and to facilitate trans community input into the clinic's operation and practices. There were new

186 Belinda Chaplin, interview with author, 30 September 2020, Zoom.

187 J.R. Latham, "HIV Prevention Needs of Trans and Gender Diverse People in Australia," AFAO, https://www.afao.org.au/article/hiv-prevention-needs-of-trans-and-gender-diverse-people-in-australia/, accessed 9 March 2022.

188 "Transgender no longer recognised as 'disorder' by WHO," *BBC News*, 29 May 2019, https://www.bbc.com/news/health-48448804, accessed 7 July 2021.

189 Dean Gilbert, interview with author, 15 August 2021, Zoom.

information forms which explicitly were designed to facilitate informed consent around taking hormones. Psychiatrists at Monash were more comfortable with GPs looking after "routine" cases and instead have focused on those individuals with more complex mental health needs, histories of trauma or substance abuse.

A research satisfaction survey conducted over a one-month period and published in 2015 showed signs that changes at the Monash clinic were effective. A whopping 88% of respondents expressed satisfaction with the service they were receiving, with particularly high rates of satisfaction reported for the administration, professionalism and care provided. That said, within the open-ended questions, one of the three most common responses to the question about the negative aspects of the clinic was "the gatekeeper model".[190]

The staff at the Monash Gender Dysphoria Clinic have been conscious that many clients expected to encounter a gatekeeper model. Eloise Book, for instance, recalls consistently feeling the need to justify herself when meeting with doctors and psychiatrists (though not specifically at the Monash clinic). As she explains:

> There was always this idea in the process of transitioning that you were coming up with reasons as to why you were legitimately a trans person and why you had to transition…And maybe that's because of the literature. Everything at the time, people were going, were still talking that the holdover from decades when you had to kind of go through the gatekeepers. But there was no gatekeeping when I went through.[191]

Staff at Monash and elsewhere knew they had to make a conscious effort to build rapport and dispel the perception of themselves as gatekeepers. Fintan Harte was quoted in a 2018 scholarly article about the Monash Gender Clinic: "'My job is not to say whether you can or cannot have hormones or surgery, that's your decision. My job is to help you make an informed decision.' At the end,…they'll either…say 'I've found it really helpful' or 'it's been a complete and utter waste of time and money.'"[192] This was a sharp change from an article about the clinic published in 2000 and co-authored by then-director Trudy Kennedy, which described the assessment process: "Psychological supervision allows the team to assess the reality-based adjustment of the patient during the [real-life test] process."[193]

Changes in both *DSM* and the WPATH "Standards of Care for the treatment of individuals with gender dysphoria" have loosened the clinical requirements to approve gender affirmation surgery. This has facilitated practitioners' move towards an informed consent model and, as Riki Lane summarised in the 2018 article about the Monash Gender Clinic, shifting their role to "assessing whether a client meets requirements under guidelines, ensuring that a client's decision-making process is sound and not influenced by medical conditions, and making sure that there is good understanding of planned procedures and consequences."[194] The word *towards* in the previous sentence is deliberate because there is still sometimes a tension at play between clients' desires and doctors' readiness to meet them. As Lane notes, doctors do not see informed consent as the same as treatment on demand. This is a tension where ongoing dialogues between health care providers like the Monash Gender Clinic and transgender representative groups can prove fruitful.

By 2015, Fintan Harte's frustration over the continuing under-funding of the clinic reached breaking point. The clinic had a waitlist of twelve months for new clients. Research shows that waiting twelve months before accessing hormones or other treatment can have fatal consequences, as that delay risks mental health deterioration and suicide. Indeed, at one point a person on the clinic waitlist did complete suicide, triggering another review of the clinic but no further funding. Angry at the state government's continuing unwillingness to boost funding, Harte resigned as director of the Monash Gender Dysphoria Clinic in late 2015.

Harte's resignation – along with other lobbying by trans activists and health professionals – at last shocked the Victorian government into action. In April 2016 the Monash Gender Dysphoria Clinic received an increase of $6.7 million over four years. This was the first significant injection of new money since 1989. That same year, under the leadership of new director Jaco Erasmus, the clinic established a consumer advisory group of trans people to meet bi-monthly with staff as part of an effort to co-design policies and practices. One reform was an expansion of the mental health staff, especially clinical psychologists. The trans community welcomed this change and saw the hiring

190 Jaco Erasmus, Harjit Bagga, and Fintan Harte, "Assessing Patient Satisfaction with a Multidisciplinary Gender Dysphoria Clinic in Melbourne," *Australasian Psychiatry* 23, no. 2 (2015): 158-62.

191 Eloise Brook, interview with author, 19 July 2021, Zoom.

192 Lane, "'We Are Here to Help': Who Opens the Gate for Surgeries?" 216.

193 Saji S. Damodaran and Trudy Kennedy, "The Monash Gender Dysphoria Clinic: Opportunities and Challenges," *Australasian Psychiatry* 8, no. 4 (2000): 356.

194 Lane, "'We Are Here to Help': Who Opens the Gate for Surgeries?" 219-20.

of more psychologists rather than psychiatrists to be an important marker of shifting away from the gatekeeper model. Other investments included purchasing a laser hair removal machine and hiring endocrinologists. Finally, the name of the clinic was changed to the Monash Gender Clinic – removing the medical and pathological lingo from the title. Erasmus has supported the shift towards informed consent with GPs taking a greater involvement in prescribing hormones. As such, the Monash Gender Clinic positions itself as primarily for complex cases where GPs need specialist advice, or to service clients whose GPs are not themselves familiar with or supportive of the informed consent model.[195]

A 2019 review by the Victorian Department of Health and Human Services recommended that the Monash Gender Clinic be moved out of the mental health area of Monash Health and instead sit under the specialist clinic area. This change happened in August 2020 and represents another symbolic shift away from seeing being trans or gender diverse as a mental health disorder.

Notwithstanding these changes – as well as the increase in GPs and other specialists beyond the clinic working with trans clients – there is greater demand for the Monash Gender Clinic's services than the resources can handle. Even with the funding boost, still the Monash Gender Clinic was only able to subsidise eighteen clients' surgeries in 2018, or about 5%. Moreover, as of May 2021, the wait time for new clients was sixteen months.[196] The long waitlist is due to a mix of greater demand, under-resourcing and the lockdowns associated with the Covid-19 pandemic.

Trans and Gender Diverse Children and Young People: Legal Hurdles

Oral history interviews with trans people overwhelmingly indicate that from a very early age they recognised that there was something different about their experience of gender to societal expectations. Given the little trans visibility before the 2000s – not to mention the discrimination or stigmatisation experienced by gender non-conformists – it was not until adulthood that many trans people experienced identity events and had the language to articulate their experiences.

Most interview participants tried to repress or hide their feelings of being a gender other than that assigned at birth. Yet, a small number of participants whose parents caught them dressing in clothing associated with another gender took them to child psychologists. Since 1980 *DSM III* had a diagnosis for Gender Identity Disorder of Childhood, but none of the interview participants were ever diagnosed with this by a psychiatrist. Before 2000, the GPs, psychiatrists and gender clinics in Adelaide and Melbourne generally only worked with transgender adults or the occasional teenager approaching age eighteen. Trans children in Australia were, for all intents and purposes, silenced and invisible.

195 Jaco Erasmus, "Monash Gender Clinic: An Overview of the Current Model of Care," *Australasian Psychiatry* 28, no. 5 (2020): 533-35.
196 https://monashhealth.org/services/gender-clinic/, accessed 28 June 2021.

By the early 2000s, though, as there was more trans visibility in the media and the proliferation of information over the internet, children and young people began to come out as trans and seek medical interventions. This has happened across Australia, but it is from Melbourne where the most comprehensive data and historical information is available. The first child referred to the Royal Children's Hospital for access to gender affirming care was in 2003. The hospital then only had one referral in each of 2005 and 2007. Until 2012 Melbourne's Royal Children's Hospital still received under ten referrals per year, so this was a niche paediatric specialty. These referrals came not only from Victoria, but across Australia. Of the 39 referrals between 2003-11, twenty-one were approaching puberty or pubertal and therefore considered for hormone treatment. The mean age at which these children reported feeling a sense of gender incongruence was 3.26 ± 1.11 years, and the mean age at which they presented to specialists at the hospital was 10.0 ± 4.13 years. A subset of this group did go on to seek hormone treatment.[197]

Legal changes played a significant role at slowing access to affirming health care for trans children and adolescents. Until 2004, doctors could prescribe puberty blockers then affirming hormones with parental consent – and anecdotal evidence suggests this did happen on occasion.[198] What changed this was a case involving a young person subject to a care order by a state Children's Court. "Alex" was a thirteen-year-old trans man and wanted to commence puberty blocking hormones and then testosterone. Because of the care order, he could not simply have parental consent and instead his case went to the Family Court. In 2004 the Chief Justice of the Family Court approved Alex to commence puberty blockers at age thirteen and testosterone at age sixteen. The judge even expressed support for trans people's right to change their birth certificates without needing gender affirmation surgery. Still, the case *Re: Alex* set a different legal precedent that would limit trans children's access to medical care: the judge dubbed hormone treatments "special medical procedures" under the *Family Law Act*. Consequently, henceforth the Family Court would need to grant permission in *all* cases for children to undergo medical transitions.[199]

The need to go to the Family Court made it more costly for children and adolescents and their families to access affirming health care, and it also meant significant delays of sometimes up to ten months. The delays also meant significant mental health barriers for the trans children and adolescents, not to mention the distress of having to face the Family Court.[200] These challenges became even more pronounced in the 2010s when the number of trans children and young people presenting for medical interventions increased substantially. For example, Sydney's Westmead Children's Hospital went from 1 referral in 2013 to 56 in 2017, and Newcastle's John Hunter Children's Hospital was up to 44 referrals by 2018. Melbourne, which runs the largest children's gender service in Australia, was at 250 new referrals in 2017, another 269 in 2018, 336 in 2019, and 473 in 2020.[201]

An alliance of trans activists, parents and doctors lobbied hard for legal change. The doctor leading the charge was Associate Professor Michelle Telfer, director of the Royal Children's Hospital Gender Service since 2012. In May 2015 Telfer addressed the Royal Australasian College of Physicians conference in Cairns to explain the legal barriers to care and called for legal reform so that the Family Court was not making decisions which should be reserved for the trans person, their parents and the doctors. Other activists like Georgie Stone and her mother Rebekah Robertson adeptly used media (including appearances on *Australian Story*) and political lobbying to pursue the legal reforms.

In the end, a new series of Family Court rulings changed the law. In 2013, *Re: Jamie* removed the requirement of Family Court approval for stage 1 hormones but still affirmed the requirement for stage 2. That requirement was finally rescinded in the 2017 ruling *Re: Kelvin*. Thus, since late 2017, doctors have generally been allowed to facilitate hormone access for trans children and adolescents without any extra legal hurdles. In early 2018, another ruling, *Re: Matthew*, went even further: the Family Court would no longer have to authorise gender affirmation surgeries for trans adolescents. The Family Court took a step back, though, in 2020. In *Re: Imogen* one parent was willing to consent to hormone treatment but the other was not. The Family Court ruled that in the absence of unanimous consent among the child, all parents or guardians and the doctors, the Family Court would have to approve hormone treatment. That said, in that particular case the Family Court determined that Imogen was competent to make the decision and approved the treatment.

197 Jacqueline K Hewitt et al., "Hormone Treatment of Gender Identity Disorder in a Cohort of Children and Adolescents," *Medical Journal of Australia* 196, no. 9 (2012): 580.

198 Rachael Wallbank, "Re Kevin in Perspective," *Deakin Law Review* 9, no. 2 (2004): 465.

199 Kim Atkins, "Re Alex: Narrative Identity and the Case of Gender Dysphoria," *Griffith Law Review* 14, no. 1 (2005): 1-16; Eithne Mills, "Re Alex: Adolescent Gender Identity Disorder and the Family Court of Australia," *Deakin Law Review* 9, no. 2 (2004): 365-73.

200 Michelle Telfer et al., "Transgender Adolescents and Legal Reform: How Improved Access to Healthcare Was Achieved through Medical, Legal and Community Collaboration," *Journal of Paediatrics and Child Health* 54, no. 10 (2018): 1097.

201 By 2015 there was over a year's wait for new client consultations at the Royal Children's Hospital Gender Service. In June 2015 the Victorian Government announced a funding boost of $6 million over four years.

The Royal Children's Hospital Gender Service and Australian Standards of Care

Notwithstanding the legal restrictions on accessing hormones, specialists across the country have been working with trans children and young people since the early 2000s. Endocrinologist Garry Warne received the first trans referral ("Alex") at Melbourne's Royal Children Hospital in 2003, in part because he already had almost two decades' experience working with intersex children. Warne worked with psychiatrist Campbell Paul to support Alex and became the de facto Australian expert on working with trans children and young people.

Warne recalls three important points that guided his practice in this space. First, he attended an international conference run by the UK-based Gender Identity Research & Education Society (GIRES), where he met doctors from the UK and Europe who worked with trans clients. Warne found what he calls the Dutch approach, which was around affirming care at a young age, preferable to the British approach, which was more around waiting until someone approached adulthood. Second, Warne chatted with the director of the Monash Gender Dysphoria Clinic, Trudy Hart, who informed him that all of her new clients had known since childhood that they were transgender and would have benefited from earlier affirming care. Third, the Family Court intervention in *Re: Alex*, while it did create new barriers, also gave a sense of assurance around the legalities of providing affirming care for trans children and young people.[202]

After Warne retired in 2012, Melbourne's Royal Children's Hospital established the country's first formal gender service within the Department of Adolescent Medicine, with Michelle Telfer appointed its director. This service has consistently worked with any children and young people under age seventeen. The WPATH standards of care suggested that trans children and young people should wait until age sixteen to commence stage 2 hormones. However, Michelle Telfer and other specialists within Australia and around the world had data suggesting that the delays could cause unnecessary distress for young people, particularly as their peers went through puberty. Telfer recognised there was a need for specific standards of care for doctors and other professionals working with trans children and young people. She brought together trans children, families, doctors from other gender services and other stakeholders to prepare what would prove a global first. In late 2017 the team at Melbourne's Royal Children's Hospital Gender Service published the first "Australian Standards of Care and Treatment Guidelines For trans and gender diverse children and adolescents".[203]

The document takes a holistic approach, noting the importance of terminology, affirming language, legal requirements, culture and family before even going through some of the specifics of medical treatment. It covers topics where practitioners should provide counselling and information, such as around the effects of hormones, fertility considerations, communication and voice and social transitions. The guidelines are very cautious in that they describe every transition journey as different and there is not a simple one-size-fits-all model. Finally, the document gives advice for particular specialists (e.g. endocrinologists, GPs, nurses) about their roles to support trans children and young people through transition.[204]

The standards of care received the endorsement of AusPATH and in 2018 were published in the *Medical Journal of Australia*.[205] Then, the internationally-

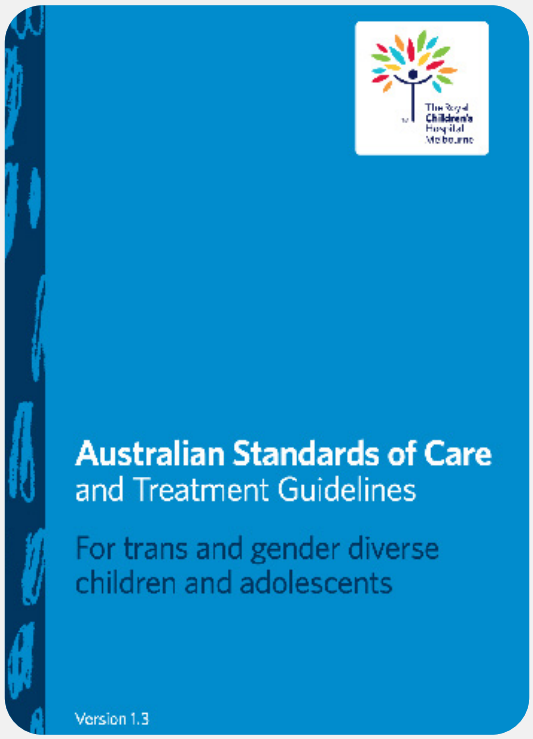
202 Garry Warne, interview with author, 20 July 2021, Zoom.

203 Michelle Telfer, interview with author, 12 July 2021, Melbourne.

204 Michelle Telfer et al., "Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.1," (Melbourne Royal Children's Hospital, 2018).

205 Michelle M. Telfer et al., "Australian Standards of Care and Treatment Guidelines for Transgender and Gender Diverse Children and Adolescents," *Medical Journal of Australia* 209, no. 3 (2018): 132-36.

renowned medical journal *The Lancet* published an editorial endorsing the standards of care, confirming their status as an international trailblazer in providing affirming care to trans children and young people. *The Lancet* editorial specifically praised the consultative design process, the rich data informing the standards of care, the attention paid to social as well as medical transitions, and the centrality of the child or young person to guide their own health care and transition journey.[206] The guidelines are now in their third version. In 2019 *The Lancet* also published a profile about Michelle Telfer and her pioneering work with trans children and young people.[207]



The world-leading guidelines for trans children's health care published by Melbourne's Royal Children's Hospital in 2017

One reason the Royal Children's Hospital Gender Service has been so successful is that the Andrews Labor Government (2014-) has made LGBTIQ+ equality a significant part of its social agenda for Victoria. In June 2015 the government announced $6 million of additional funding over four years, much of which evaporated very quickly because of the surge in demand for the service. To triage the demand, in 2016 the service established a First Assessment Single-Session Triage (FASST) clinic where a clinical nurse meets with new clients and their families in a 90-minute session. The nurse does an initial assessment and provides education and information. The FASST clinic has proven to cut wait times by up to ten months and alleviate mental health challenges and distress among new clients referred to the service.[208]

In the 2021 budget, the Victorian government again increased funding, offering $21.4 million divided between the Royal Children's Hospital Gender Service and Monash Gender Clinic. Much of this funding will go towards designing and delivering training programs with Orygen, a provider of mental health services to young people. By preparing training modules for GPs and other health professionals, the aim is to enable the delivery of primary care to more children and young people through their regular GPs rather than necessarily needing the Royal Children's Hospital Gender Service.[209]

The Royal Children's Hospital Gender Service has, since 2015, only accepted referrals from Victoria and Tasmania – and more recently as more clinicians have begun working with trans children and young people in Tasmania, those referrals have also tapered off. One program that has effectively supported clients in regional Victoria has been a partnership with the WayOut Wodonga (WOW) project at Gateway Health, implemented since 2015. WOW had already been working since October 2013 to train local service providers to support trans clients, but there was a recognition about the gap in service for children and young people. In May 2015 there was a roundtable bringing together stakeholders including transgender community members, local GPs, paediatricians, child psychiatrists, Michelle Telfer, ACON, Gateway Health, WOW, Hume Medicare Local and the Centre for Excellence in Rural Sexual Health. The roundtable came up with a pathway of referrals for trans children and young people in Albury-Wodonga and even established, as a first of its kind, a nurse-led multidisciplinary gender clinic for under seventeen-year-olds in Albury-Wodonga.[210] It is hoped that, with the new money promised in the 2021/22 budget, similar services can be set up in other parts of regional Victoria.

206 "Gender-Affirming Care Needed for Transgender Children," *The Lancet* 391 (2018): 2576.

207 Rebecca Akkermans, "Profile: Michelle Telfer," *The Lancet Child & Adolescent Health* 3 (2019): 524.

208 Sarah Dahlgren Allen et al., "A Waitlist Intervention for Transgender Young People and Psychosocial Outcomes," *Pediatrics* (2021): 1-10.

209 Michelle Telfer, interview with author, 12 July 2021, Melbourne.

210 "Gender Clinic at Gateway Health," 20 September 2016, http://gatewayhealth.org.au/images/Employment/2016/Gender%20clinic%20background%20-%20September%202016.pdf, accessed 14 July 2021.

Children's Gender Services Beyond Victoria

Although Melbourne has been at the forefront of health care for trans children and young people, other states and territories also established specialist gender services within their children's hospitals in the 2010s. These services usually grew out of doctors who were already seeing trans children and adolescents and saw the need for coordinated, multidisciplinary care. These doctors also all noticed significant increases in the number of referrals, especially since around 2009. Among the specialist units founded across Australia are Melbourne's Royal Children's Hospital Gender Service (2012); Perth Children's Hospital Gender Diversity Service (2015); and Queensland Children's Hospital Gender Clinic (2016).

Other cities' children's hospitals have been seeing trans children and adolescents in the absence of a formal gender service. Adelaide's Women's and Children's Hospital has been seeing clients since about 2009, Sydney's Westmead Children's Hospital received its first referrals in 2013, Newcastle's John Hunter Children's Hospital also around 2013, and Canberra Hospital in 2014. A NSW Health review of services for trans children in the state, conducted in 2019, recommended a holistic model of care bringing together specialists, schools and community groups. The first site to implement this approach, opened in 2021, is Maple Leaf House: a new specialist hub for trans children and young people in Newcastle. Although there is no specialist service in Tasmania, there are now doctors there who work with trans children and young people. Health departments in Tasmania and the Northern Territory have information on their websites for trans children which refer them to other local services. Outside the public health system there is also a small but growing number of clinical psychologists who have worked with trans children and young people since the 1990s.

Numerous research studies have shown the need for health services to trans children and young people. The most comprehensive Australian study was Trans Pathways: a survey of 859 trans young people in Australia, along with 194 parents or guardians. Some of the damning statistics that Trans Pathways published in 2017 were:

- **79.7%** of trans young people have self-harmed
- **48.1%** of trans young people have attempted suicide
- **74.6%** of trans young people have been diagnosed with depression
- **60.1%** of participants reported having felt isolated from medical and mental health services
- **42.1%** of participants reached out to service providers who did not understand, respect or have previous experience with gender diverse people

Trans Pathways recommended increased funding and expansion of health services to support trans and gender diverse young people.[211]

Cities where gender clinics have been part-time or more informal have come under scrutiny and pressure to establish them to meet the growing demand for

211 Penelope Strauss et al., "Trans Pathways: The Mental Health Experiences and Care Pathways of Trans Young People. Summary of Results," (Perth Telethon Kids Institute, 2017).

services. For instance, in 2019 the South Australia Commissioner for Children and Young People released a report which investigated how the state's health care system was fairing in its support for trans children and young people. The report was unique in that it focused on the voices and perspectives of children and young people to express what they wanted to improve health outcomes. The report's recommendations centred around: more visibility around gender diversity both in the health system and broader society; better information for parents and carers of trans children and young people about services available; better training and education for GPs and other health workers around gender diversity; and greater accessibility of gender-affirming services for children and young people.[212]

Regarding the latter point, the report recommended increased funding to the services operating at the Royal Women's and Children's Hospital, both for regular consultations and also to prepare online resources to support other health practitioners (especially GPs) and so that services could be more accessible in regional South Australia. That report did influence the South Australian Government to increase funding, and the Women's and Children's Hospital Gender Diversity team has been consolidating and streamlining more along the lines of the established gender clinics in Melbourne, Brisbane and Perth.

As another example, in late December 2016 the NSW branch of the Royal Australian and New Zealand College of Psychiatrists prepared a detailed proposal to establish a child, adolescent and young adult gender dysphoria service in the state. Although the Children's Hospital at Westmead had limited clinical services to support trans children and young people since 2013, the three departments involved – Adolescent Medicine, Psychological Medicine and Endocrinology – were insufficiently resourced to deliver integrated multidisciplinary specialist services. The proposal called for a metropolitan hub in Sydney which would then link to regional spokes, GP networks, trans community organisations and other non-teaching hospitals.[213] In the 2018-19 financial year NSW Health provided Westmead Children's Hospital with $160,000 to found a multidisciplinary gender service.[214] In early 2021 NSW Health allocated additional funds to strengthen and increase the capacity of Westmead's gender service, but still the clinic operates only one day a week and has a long waitlist.

In early 2021 several senior doctors associated with the Westmead Children's Hospital Gender Service published two peer-reviewed articles which sparked widespread controversy. The second article used colourful language around the prescribing of hormones, and the fundamental argument was that by focusing so much attention on hormones the clinic was not providing adequate psychosocial support for trans children and young people.[215] *The Australian* framed the articles to suggest doctors at Westmead have been unnecessarily prescribing children and young people hormones because social and parental expectations are forcing the doctors to compromise their personal ethical standards. Right-wing groups across the globe which have been pursuing anti-trans agendas have already picked up on the journal articles and been referencing them as "evidence" to support their campaigns to deny affirming care for trans children and young people.

Sydney's Gender Centre put out a media statement which added nuance to the journal article and important contexts not mentioned in the media. For instance, there *is* a need for greater psychosocial support for trans children and young people and their families. Many families with trans children are under financial and emotional strain because of the significant delays accessing affirming health care, the bullying their children experience, and the discrimination they too encounter for having a trans child. As the Gender Centre statement summarised:

> There remains serious concerns from gender clinicians, support organisations and professionals – not about the right or rightness of trans and gender diverse children to live their authentic selves – but rather as a direct consequence of historically inadequate funding, and a focus on medical transition without the absolutely essential social and welfare support that is vital to making sure that families and their trans and gender exploring young people get to be their authentic selves healthily.[216]

212 Commissioner for Children and Young People SA, "First Port of Call: Supporting the South Australian Health Care System to Better Meet the Needs of Trans and Gender Diverse Children and Young People," (Adelaide 2019).

213 Royal Australian and New Zealand College of Psychiatrists New South Wales Branch, "Mental Health Reform Proposal for a Child, Adolescent and Young Adult Gender Dysphoria Health Service in NSW. Stage One: Establishing a Tertiary Specialist Metropolitan Network 'Hub'," (Sydney 2016).

214 Phoebe Moloney, "Transgender teens and their parents say there is a gap in the Hunter's health system," *Newcastle Herald*, 7 April 2019, https://www.newcastleherald.com.au/story/5955649/parents-of-transgender-teens-say-they-are-fighting-to-get-support/, accessed 1 July 2021.

215 Kasia Kozlowska et al., "Australian Children and Adolescents with Gender Dysphoria: Clinical Presentations and Challenges Experienced by a Multidisciplinary Team and Gender Service," *Human Systems* 1, no. 1 (2021): 70-95.

216 "The Gender Centre's observations of the Westmead article," *The Gender Centre*, 7 May 2021, https://gendercentre.org.au/media-events/media/media-releases, accessed 8 July 2021.

Defending Affirming Care for Trans and Gender Diverse Children

Media attention about Westmead's approach to trans children was part of a larger set of right-wing attacks on trans people. Transphobic media and politicians have always been mainstays in Australia (and the world). Yet, since the attack on the Safe Schools Coalition in 2016 and especially the marriage equality survey in 2017, conservative media have weaponised trans children and attacked any moves to provide them with affirming health care.[217] Conservatives have often turned to doctors or academics who do not work in the field of trans health care to give an air of legitimacy to their arguments. Many of these supposed "experts" have ties to conservative anti-trans organisations. Much of the coverage has also selectively chosen examples or research studies as "evidence" that an affirming model of care is harmful to children whilst ignoring the overwhelming body of scholarly work.

Michelle Telfer has been a particular target of conservative media. In 2020 she prepared a complaint to the Australian Press Council and a submission to the Senate Inquiry on Media Diversity in Australia, where she noted:

> During the period of August 2019 to July 2020, 45 articles and editorials were published [in *The Australian*] with 80 direct references to my name ('Telfer') and 282 direct references to the work of my team at the Royal Children's Hospital (RCH) Gender Service in Melbourne, the inaugural Australian Standards of Care and Treatment Guidelines (ASOCTG) and to our longitudinal cohort study known as Trans20. The publications were consistently of a highly critical nature and were repetitious in their false, inaccurate, unfair and unbalanced information that questioned my credibility, integrity and honesty. I was portrayed as someone who was harming children.

Telfer's submission went on to list the numerous inaccuracies and examples of bias in the reporting, as well as the adverse health outcomes such reporting could produce:

> The impact of each individual article and editorial published by The Australian in the series outlined above, is known to have caused distress. More importantly however, it is the repetitious nature of this inaccurate and unfair reporting, over a long period of time, which causes accumulative harm through the exacerbation of the stigma, discrimination, marginalisation, social rejection and abuse that this community receives on a day to day basis.[218]

217 On the attacks on Safe Schools, see Benjamin Law, *Moral Panic 101: Equality, Acceptance and the Safe Schools Scandal*, Quarterly Essay 67 (Carlton, VIC: Schwartz Publishing Pty Ltd, 2017).

218 Associate Professor Michelle Telfer, submission 66, Senate Inquiry on Media Diversity in Australia, 9 December 2020.

Michelle Telfer has bravely stood up to the bullying of conservative media and politicians. Various transgender organisations and even AusPATH, too, have consistently put out public statements asserting the importance of affirming care for trans children and young people.[219] In August 2021 the Australian Press Council affirmed part of Telfer's complaint and determined "that by repeatedly quoting the views of professionals from various fields of medicine and psychology that the treatment was experimental and harmful without explaining they are not medical specialists in the area, and linking the criticism so personally to the complainant, the publication failed to take reasonable steps to ensure fairness and balance."[220]

Michelle Telfer, director of the Royal Children's Hospital Gender Service since 2012

Various conservative forces were pressuring the Commonwealth Health Minister to hold a public inquiry into trans young people and the health system. The minister instead wrote to the Royal Australian College of Physicians (RACP) in August 2019, seeking advice on health care for trans children and young people. The RACP undertook extensive consultations with paediatricians, endocrinologists, stakeholders from other colleges, specialist researchers and experts in bioethics. The RACP relied on evidence and released their advice in March 2020. Not only did they recommend against a public inquiry, which they explicitly noted "would further harm vulnerable patients and their families through increased media and public attention," but they also recommended: greater coordination across states and territories to develop a national framework for providing and monitoring care; funding for research into the long-term outcomes of care for trans and gender diverse young people (a project which the Royal Children's Hospital Gender Service is already undertaking); and the development of evidence-based fact sheets to support families seeking affirming care.[221] This proved a productive exercise that, one could argue, provided cover to the Health Minister: he rejected the call for a public inquiry.

In August 2021 the Royal Australian and New Zealand College of Psychiatrists (RANZCP) released a position statement titled "Recognising and addressing the mental health needs of people experiencing Gender Dysphoria / Gender Incongruence." This was the first time the RANZCP released any position statement specifically on trans health care (though there had been a few relating to LGBTIQ+ health more broadly). The statement emphasised the importance of psychiatrists who worked with trans clients to be person-centred, accommodate cultural safety and be cognisant of the mental health needs of the client. The statement intended to be balanced in weighing up the need to affirm trans clients' identities with broader psychiatric and medical assumptions about gender incongruence.

The RANZCP statement generated controversy amongst the trans community and specialists in trans health care. It presented what critics saw as equivocation around affirming care for trans and gender diverse young people, implying that practitioners do not question young people before offering affirming care. The RANZCP statement further noted:

> There are polarised views and mixed evidence regarding treatment options for people presenting with gender identity concerns, especially children and young people.[222]

Yet, as trans people and professionals who work specifically with trans children and young people pointed out, the evidence is not mixed. Rather, opposition to affirming care has primarily been ideologically (rather than evidence) driven and from non-specialists.

219 "AusPATH: Public Statement on Gender Affirming Healthcare, including for Trans Youth," 26 June 2021, https://auspath.org/gender-affirming-healthcare/, accessed 1 July 2021.

220 "Adjudication 1799: Complainant / The Australian," Australian Press Council, 20 August 2021, https://www.presscouncil.org.au/document-search/adj-1799/, accessed 3 September 2021.

221 Associate Professor Mark Lane, letter to Health Minister Greg Hunt, 5 March 2020, https://www.racp.edu.au/docs/default-source/advocacy-library/racp-letter-hon-greg-hunt-minister-for-health-gender-dysphoria-in-children-and-adolescents.pdf?sfvrsn=3c2de91a_4, accessed 14 July 2021.

222 Royal Australian and New Zealand College of Psychiatrists, Position statement 103, "Recognising and addressing the mental health needs of people experiencing Gender Dysphoria / Gender Incongruence," August 2021, https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/gender-dysphoria, accessed 2 December 2021.

The chair of AusPATH's policy committee, Associate Professor Sam Winter, wrote in the *Sydney Morning Herald*:

> there is research readily available and it confirms clinical experience – that the vast majority of trans people benefit from the gender-affirming model. It ain't an experimental approach.[223]

Moreover, trans people were not consulted in the preparation of the RANZCP position statement.[224] The RANZCP statement and its fallout thus show that the debates over health care for trans and gender diverse children and young people show no signs of abating.

Jeremy Wiggins marching at ChillOut 2022 with Transcend, one of several Australian organisations supporting parents and families of trans and gender diverse children and young people

Peer-Led Health

The 2009 review of the Monash Gender Dysphoria Clinic recognised an important point that trans people always knew: health care had to be about more than just preparation for gender affirmation surgery. Service delivery also had to be attuned to different client bases, accounting for diversity of genders, cultures and families. While some health providers offered support to trans clients, the majority of work came from trans community organisations.

Peer support underpinned the vast majority of transgender groups since as early as the 1970s. Even groups like Seahorse and its counterparts in other states (e.g. Chameleon Society of Western Australia and Carrousel Club in South Australia), which were on the surface primarily social gatherings, represented a form of peer support. Members regularly had conversations about health and wellbeing and throughout their histories the organisations regularly invited health practitioners as guest speakers.

Other early groups explicitly promoted themselves as peer support groups. The Australian Transsexual Association, founded by Noelena Tame in Sydney around 1978, ran at the Wayside Chapel in Kings Cross. The group transformed into a mix of activism and peer support under Roberta Perkins's leadership in 1982. Since 1983 Tiresias House (later the Gender Centre) has offered peer support to trans people in Sydney. From 1979 until c. 1985 the Victorian Transsexual Association Self-Help Group convened in a member's house in Melbourne. In the mid-1990s, new groups that offered peer support included Transgender Liberation and Care (Melbourne), Crossfire Contacts (Ballarat), South Australian Transsexual Support Group (Adelaide), TransWest (Perth), ATSAQ (Brisbane) and Boys Will Be Boys (Sydney and Melbourne).

Telephone counselling services that began in the 1970s from gay and lesbian organisations such as CAMP (the Campaign Against Moral Persecution) had a mixed

223 Sam Winter, "Evidence is clear on how to support trans youth," *Sydney Morning Herald*, 4 November 2021: 28.
224 Caitlin Fitzsimmons, "Caught between doctor's and court orders," *Sun Herald* (Sydney), 31 October 2021: 30.

record at offering support to trans clients. Volunteers who staffed these services as early as the 1970s recall trans people ringing in asking for help. More often than not, the counsellors were ill-equipped to offer advice to such callers – though they did give them information about existing organisations, be they Seahorse or the Chameleon Society.

In the 1990s, the gay and lesbian counselling services began to become more educated about gender diversity so they could better support trans callers. For instance, in 1997 the Victorian Gay and Lesbian Switchboard invited trans activist Julie Peters to deliver training about transgender issues. Her training covered topics including terminology, the medical model of transsexualism, discrimination confronting transgender people in both the mainstream and gay and lesbian communities, legal rights and the local transgender peer support groups.

In Adelaide, transgender activist Jenny Scott was actually president of the Gay and Lesbian Counselling Service of South Australia in the mid-1990s and through that role was instrumental at ensuring that the service was trans-inclusive.[225] In the 2000s, the LGBTIQ+ counselling services across the country similarly incorporated transgender education as part of their training and have been more equipped to support trans clients. In 2013 the state-based counselling services partnered together under the national service QLife. Trans interview participants have found other LGBTIQ+ counselling services (e.g. Queerspace in Melbourne) to be incredibly helpful at supporting their mental health.

Peer support often extended to families of trans people as well. As early as the 1970s Seahorse, Chameleon and Carrousel chapters invited spouses of members to attend regular meetings and held special meet-ups just for partners. In 2002-03 the Monash Gender Dysphoria Clinic ran a pilot peer support group for nine partners of trans women going through transition. The review of the pilot found that a major challenge facing partners of transitioning people was the feeling that their needs were sidelined. The review stated:

> Partners described feeling devalued and disrespected in what they described as the evolving "self absorption" of the transsexual partner. Gains made by transitioning transsexuals resulted in losses for partners. These issues were also relevant for those who entered a relationship knowing the transgender status of their partner. Transsexualism was not the only issue in these relationships. For example, communication sex, affection, financial issues and household responsibilities were made more complex by the transitioning process.[226]

The group facilitators, psychiatrist Fintan Harte and psychologist Vikki Sinnott, extended the pilot program in 2006. In the 2010s, parents of trans children and young people founded their own organisations to offer peer support, with the Gender Centre founding a parents' peer support group around 2009/10 and new national organisations such as Transcend (founded in 2012) and Parents of Gender Diverse Children (2016).

In the 2010s the importance of peer-led care extended beyond just support groups to the very design and operation of clinics to provide affirming health care. Most of this work came out of Melbourne and again Jeremy Wiggins drove much of it. Even though Wiggins's role at Thorne Harbour Health was initially not a specific trans health promotion role, he was the de facto person working in that space. He knew that Thorne Harbour's free peer-led sexual health clinic Pronto! saw clients primarily in the evenings. This meant that there was already a space with appropriate medical fit-outs which had a lot of daytime availability. With the support of Thorne Harbour Health's clinical practice manager, Peter Locke, and Dr P Cundill, Wiggins put a proposal together to create a peer-led trans health service, and Thorne Harbour Health endorsed the proposal.

To ensure that the project was peer-led, Wiggins recruited members of Melbourne's trans community to establish a consumer advisory group. Together, they worked with Wiggins as well as the recruited GPs to co-design the model of health care that the clinic would provide. In July 2016, Equinox opened in Fitzroy in Melbourne. Equinox provides GP services including access to hormones, sexual and mental health support and offers referrals to the Monash Gender Clinic for those clients who desire gender affirmation surgery.[227]

Jeremy Wiggins saw Equinox and the day-to-day clinic work as a starting point, not an ending point. In 2017 Wiggins and Dr P Cundill prepared Equinox's "Protocols for the Initiation of Hormone Therapy for Trans and Gender Diverse Patients". Perhaps the most innovative feature of the guidelines was the introduction of a peer navigator: someone to meet with new clients, register

225 Jenny Scott, interview with author, 8 August 2018, Adelaide; Jenny Scott papers, State Library of South Australia, PRG 1629.
226 Fintan Harte, John Tiller, and Vikki Sinnott, "Supporting the Partners of Transsexuals: A Pilot Program," (2004), 6.
227 Jeremy Wiggins, interview with author, 24 June 2021, Zoom.

them, introduce them to Equinox's services and share information about other services offered by Equinox and Thorne Harbour Health. Subsequent appointments with the GP would involve not only routine medical histories and blood tests, but also discussions around the client's goals, their needs during social transitions, explanations about effects of any hormones or other medical interventions and – if the client desires – referrals to specialists such as endocrinologists or psychiatrists. Ongoing appointments are with a mix of the GP, peer navigator and a practice nurse who can monitor blood tests, discuss any mental health challenges, instruct around safe hormone injections and assist with navigating any change of documents (e.g. Medicare, passport).[228] An updated version of the protocol with additional details – particularly around legal requirements to access PBS-subsidised testosterone – was published in June 2020.[229] Equinox's website also includes resources on hormone prescription and other aspects of primary care for trans people.[230]

Jeremy Wiggins has worked in several roles promoting access to affirming health care for trans people in Victoria

In 2021 a team of researchers published a peer-reviewed study evaluating the efficacy of Equinox's informed consent model. The research evaluated de-identified data about 589 Equinox clients over a two-year period. The demographic data revealed the mean age to be 25 years old, and "52% who were assigned female at birth, 46% were assigned male at birth, and the remaining 2% preferred not to say. In terms of gender identity, 39% identified as female, transfemale, or trans feminine, 31% as male, trans-male, or transmasculine, 27% had a non-binary or genderqueer identity, and 3% were unassigned." Among those clients who were seeking access to hormones, 92% were assessed only by a GP; the remaining 8% were referred for mental health assessments. Thus, the study found that 92% of clients presenting had the capacity to make an informed decision without need for further mental health evaluations. The response rate to the satisfaction survey was low (only 43), but still found more than 80% of respondents were extremely satisfied or moderately satisfied with the process to commence hormones, including with the information provided and the consultation process.[231] These figures show significant support for Equinox's informed consent model – though importantly, the results are not dissimilar to the satisfaction rates uncovered in the 2015 evaluation of the Monash Gender Clinic.[232]

Building on his work setting up Equinox, in 2017 Jeremy Wiggins undertook a Churchill Fellowship to travel to Thailand, the UK, USA and Canada to research best practice in trans-led health services. His final report reinforced much of what trans activists had been advocating since the 1980s and which Equinox and Brisbane's Gender Clinic were already practicing to various degrees. The report conclusions and recommendations centred around ensuring that trans health services employed and empowered trans people in co-design and operation. It also noted that non-trans specific services – particularly those offered by LGBTIQ+ organisations – needed adequate trained to ensure that they could provide affirming service and care. Among the report's specific conclusions were:

- Program design needs to incorporate a whole of life experience, with responses and services that support trans and gender diverse people throughout their lifespan.
- Program design needs to involve family of origin, family of choice and wider support and peer networks.
- Programs and services need to recognise the diversity within the trans and gender diverse communities, such as people from faith-based backgrounds, Aboriginal and First Nations people, people of colour, people living with HIV, people with a disability and people living with mental illness or drug and alcohol issues. Nobody

228 "Protocols for the Initiation of Hormone Therapy for Trans and Gender Diverse Patients," V1.0, Equinox and VAC, June 2017.

229 "Protocols for the Initiation of Hormone Therapy for Trans and Gender Diverse Patients," V2.0, Equinox and Thorne Harbour Health, June 2020.

230 https://equinox.org.au/resources/, accessed 30 June 2021.

231 C. Spanos et al., "The Informed Consent Model of Care for Accessing Gender-Affirming Hormone Therapy Is Associated with High Patient Satisfaction," *The Journal of Sexual Medicine* 18, no. 1 (2021): 201-08.

232 Erasmus, Bagga, and Harte, "Assessing Patient Satisfaction with a Multidisciplinary Gender Dysphoria Clinic in Melbourne," 158-62.

should be turned away from accessing a gender affirmation process that is based on their desires and relationship to their culture and identity.

- Health care pathways need consumer guidelines for clients to have access to in order to understand the care and treatment they should expect
- Australia needs the formation of a new national advocacy group for all TGD [trans and gender diverse] issues, with TGD people involved/TGD-led. Increasing trans membership of existing groups such as ANZPATH and making it more accessible and adopting a co-design framework to every level of developing policy needs to be a priority.[233]

In June 2019, after lobbying by Jeremy Wiggins and members of the Victorian LGBTI Task Force, the Victorian Government announced plans to fund two new trans health clinics operating on a similar informed consent model as Equinox. Wiggins was hired as project manager to coordinate the development of these clinics, so he repeated the model he used for Equinox and implemented the best practice principles derived from his Churchill Fellowship: establishing a trans and gender diverse consumer advisory group, preparing guidelines which included the important role of peer navigator, and ensuring that the clinic operators and staff implemented an informed consent model. The first Victorian Trans and Gender Diverse Community Health Services opened in Preston and Ballarat in November 2019.[234]

The reason many of these expanded trans primary health care services have come out of Victoria is because the Andrews Labor Government (2014-) has made LGBTIQ+ equality and inclusion a priority. The important relationships trans activists like Jeremy Wiggins and former chair of the Victorian LGBTI Task Force, Brenda Appleton, have fostered have generated political support and funding which has not been mirrored in other states. That said, there certainly have been grassroots pushes in other jurisdictions to shift existing services to align with the informed consent model. For instance, the Brisbane Gender Clinic has been operating on many of those principles since its founding in 1994, in part because ATSAQ was instrumental in its development and support over the years.

In New South Wales, Sydney's Gender Centre has since 2014 partnered with Dubbo Sexual Health to enhance access to affirming care in western New South Wales. The initiative grew out of a Gender Centre staff member recognising the drift of trans people to the city to seek services and affirming care. She reached out to numerous health services across regional New South Wales, and Dubbo Sexual Health replied with interest. A staff member from the Gender Centre flew to Dubbo and, on that first visit, met with nine trans clients to answer questions about both social and medical support. Since then the program has ballooned, and now the Gender Centre staff member travels to towns across the Western New South Wales Local Health District once every twelve weeks. Both Orange and Dubbo sexual health centres operate as the primary care providers and doctors there deliver an informed consent, affirming model of care, including prescribing hormones that trans clients can pick up at pharmacies in the region. The Gender Centre staff member has also done a great job being available to have a yarn and offer support and information to the Aboriginal Sistergirls, Brotherboys and gender diverse people across the Western New South Wales Local Health District.[235] This partnership is unique and offers a potential model that could be replicated in other regional and remote communities across the country. The Gender Centre also has, since 2018, provided a peer case worker to the Albion Centre's T150 program which provides sexual health services to trans clients.

Legal changes have also meant more possibilities to shift trans health care towards primary care – but only if GPs seize the opportunities. After much lobbying by trans activists and professionals like psychiatrist Rob Lyons, in 2016 the South Australian government repealed the *Sexual Reassignment Act*. This removed the rigid restrictions on which health professionals could work with trans clients and opened the door for GPs to prescribe hormones and other opportunities for more affirming care. Oral histories suggest, though, that still very few GPs outside LGBTIQ+ and sexual health services have felt comfortable doing so.

This is not unique to South Australia; in most regional centres (e.g. Cairns, Dubbo) and smaller states and territories (e.g. Tasmania, Northern Territory) it is mainly sexual health clinics which offer primary care to trans people. In Darwin, doctors from interstate have run a monthly LGBTI Health Clinic since 2016. At least one trans interview participant who was struggling to find affirming care accessed this service in 2017 and was able to commence testosterone. Dr P Cundill also operates a private practice three days per week, and Danila Dilba Health Service has recently begun a gender affirming service for Brotherboys and Sistergirls.

In May 2021, SA Health convened a forum which brought together doctors, other health professionals and trans activists and community leaders to discuss pathways for trans health care in South Australia. Out

233 Jeremy Wiggins, "Best Practice Models of Trans and Gender Diverse Health," (LEAP LGBTQ Education and Advocacy Project 2019), 23.
234 Jeremy Wiggins, interview with author, 24 June 2021, Zoom.
235 "Liz", interview with author, 8 July 2021, Zoom.

of that forum came suggestions for a similar model of peer-led primary care as in Victoria, and it is hoped that SA Health will take up these suggestions with new initiatives in 2022.

Although most activity around peer-led trans health care has been state or local-based, there has since 2020 also been national work in development through LGBTIQ+ Health Australia (formerly the National LGBTI Health Alliance). The organisation set up a steering committee of trans and gender diverse peers from across Australia. One of their aims is to develop a consensus statement on the health and wellbeing needs of trans Australians. Like so many other peer-led initiatives, the steering committee is recognising and conceptualising health as being about so much more than just transitions, but rather all aspects of trans people's lives. Given the diversity of people, backgrounds and views within the trans community, this is by necessity a long consultation process which is ongoing.[236]

Contemporary Challenges

As this report has highlighted, there has been a long evolution of trans health care from notions of madness to medical models of wrong body discourse and emphasis on gender affirmation surgery through to shifts towards primary care and informed consent. These changes have always been uneven across time and geography, though the internet and social media have meant that both health professionals *and* trans people have more access than ever before to information. This has, in part, accelerated many of the rapid changes in the 2010s-20s.

Notwithstanding the increased trans visibility, support organisations and legal reforms to support gender affirmation, discrimination against trans Australians is still rife. Studies regularly show disparities in physical and mental health outcomes for trans people. Importantly, these are not because of any inherent mental illness, but rather because of the distress that discrimination and stigma places on trans people. Some of the most recent figures from the "Private Lives 3" survey on LGBTIQ+ health and wellbeing, published in November 2020, include:

- 69.8% non-binary (AFAB) and 57.6% of non-binary (AMAB) participants reported being diagnosed or treated for a mental health condition in the past 12 months
- 67.4% of trans women and 65.3% of trans men reported being diagnosed or treated for a mental health condition in the past 12 months
- 90.6% of trans men and 86.2% of trans women reported ever having thoughts about suicide
- 61.2% of trans men and 58.3% of trans women reported having thoughts about

236 "Ash", interview with author, 2 March 2022, Zoom.

suicide in the past 12 months

- Just over 60% of non-binary participants (AFAB and AMAB) reported thoughts about suicide in the past 12 months[237]

Oral histories and press reports suggest that transphobic comments, campaigns and media coverage can trigger mental health challenges for trans people. Perhaps the most prominent example was the marriage equality survey in 2017, where the "no" campaign centred much of their arguments around attacking trans people. Counselling providers such as QLife and other LGBTIQ+ services across the country reported spikes in calls, and several oral history interview participants cited knowing trans people who completed suicide during the marriage equality campaign.

"Private Lives 3" found that access to hormones and gender affirmation surgery are still important for many trans people. In response to the statement "Gender affirming surgery has been a high priority for me", 83.1% of trans men, 61.4% of trans women and 31.6% of non-binary people agreed or strongly agreed. For the statement "Gender affirming hormonal therapy has been a high priority for me", a whopping 94.5% of trans men and 95.7% of trans women agreed or strongly agreed, while 41.5% of non-binary participants agreed.[238] These high numbers reflect why there have been waitlists at the Monash Gender Clinic, the various children's gender units, and at trans-friendly GP clinics and other specialists.

Responses to another statement in the survey – "I have been easily able to access gender affirming care when I have needed to" – reveal both the progress and the ways to go in trans health care in Australia: 49.5% of trans men strongly agreed or agreed; 49.5% of trans women also strongly agreed or agreed; and 25.8% of non-binary participants strongly agreed or agreed.[239] These numbers are not high – particularly for non-binary people – but there does need to be an acknowledgement that they are a marked increase when compared to the 1960s-90s when there were only a handful of specialist clinics or doctors scattered across Australia who would see trans clients. Notwithstanding the progress, though, there is a way to go to ensure that all trans people have access to affirming care.

Trans community organisations have, to varying degrees, been able to offer advice about trans-friendly services or other health information. Other grassroots initiatives have compiled information about community organisations, health providers and legal rights. One great example of this is the website Trans Health South Australia, started by trans activist Zac Cannell in 2016 and funded by Dr Damien Riggs.

> Cannell describes the website as a **"place of empowerment" which is "community owned, community run, for the community."**[240]

One challenge is ensuring that trans people who are not necessarily plugged into community groups are aware of these web resources, but the publicly visible number of hits on the Trans Health South Australia website suggest that people are accessing them.[241]

Trans people also, of course, have health needs which are not just primary or trans-specific care. Discrimination and inadequately trained professionals are serious problems that may lead trans people to defer or avoid seeking treatment, or may put them in uncomfortable situations where they are misgendered or mistreated. Michael Mitchell, for instance, said that the most blatant transphobia he has ever come across is in the health system. One doctor's team once was laughing at him; another once kicked Michael out of the office when he learned Michael was trans; and a nurse once went out of her way to avoid treating Michael.[242]

One extreme example of inappropriate behaviour by a doctor highlights so much about why many trans people are wary of accessing the health system, particularly if they do not know if the specialists are trans-inclusive. In September 2015 a doctor working as Principal House Officer at a suburban Brisbane hospital examined a trans man who presented suspecting that he suffered a seizure. The trans man had a diagnosed, functional neurological disorder. The doctor not only conducted an "unnecessarily rough and painful" neurological exam, but also insisted on examining the trans man's genitals. The trans man refused to consent but still the doctor pulled down his pants to look at them, later claiming this was for "self-education". There was action taken against this doctor and the Medical Board of Australia imposed significant restrictions on his registration.[243] Still, the trauma the trans man experienced – which the Queensland Civil and Administrative Appeals Tribunal noted may have constituted sexual assault – is of the

237 Adam O. Hill et al., "Private Lives 3: The Health and Wellbeing of Lgbtiq People in Australia," in *ARCSHS Monograph Series* (Melbourne Australian Research Centre in Sex, Health and Society, La Trobe University, 2020), 81-92.
238 Ibid.
239 Ibid., 83.
240 Zac Cannell, interview with author, 24 July 2021, Zoom.
241 http://www.transhealthsa.com/, accessed 1 July 2021.
242 Michael Mitchell, interview with author, 25 January 2022, Mornington Peninsula.
243 *WSS v Medical Board of Australia* [2021] QCAT 5.

very nature that many trans people fear: that doctors feel entitled to control trans bodies.

Even affirming doctors and health professionals need to be conscious of their clients' broader health needs and health care environments. Andrew Eklund shared stories about doctors who specialised in trans health who missed cancer diagnoses because they consistently dismissed symptoms as relating to anxiety around the clients' transness. A recent United Kingdom study into the experiences of non-binary people with the health care system similarly found several participants reporting how doctors attributed their ailments to their transness. One participant referred to it as the "trans cold", while another sarcastically wrote:

> Got acne?
> It's because you're trans*
> Aching muscles?
> It's because you're trans*
> Headaches?
> It's because you're trans*
> Bruised toe?
> Because you're trans*
> Stress? Trans*
> Trans*
> Trans*
> Trans*[244]

Eklund also cautioned about how even well-meaning professionals could jeopardise trans people's safety if they unwittingly out them in an environment where there are other people. In an extreme but scary example, visitors at a hospital bed next to Dale Crane (Hewinson) overheard a nurse out him as trans. The visitors saw Crane's genitals because the nurse did not close the curtain and they took photographs – even as Crane was protesting to the nurse. Subsequently the visitors were verbally abusive and threatening, yet hospital staff refused to move Crane to another space. Staff believed that moving him would be discrimination rather than an action to ensure his safety. Eventually one visitor brought an axe to attack Crane; disaster was only averted because an employee spotted the man with the axe and was able to stop him in the corridor and call security.[245]

Drawing on oral history interviews, some of the more pronounced contemporary obstacles to accessing affirming care are:

- Continuing discrimination and stigmatisation in society and among health professionals, making trans people fearful of coming out and seeking affirming care
- Wariness of gatekeeper practices; some of this suspicion is a legacy of past practices which have since changed, but in other cases oral histories have cited recent examples of specific health practitioners whom they feel still act as gatekeepers
- GP wariness to prescribe hormones for multiple reasons:
    a. because they do not feel sufficiently educated to prescribe them;
    b. they are not aware of resources where they can learn about prescribing hormones for trans people;
    c. they believe that specialists (e.g. endocrinologists) should be or are required to prescribe hormones;
    d. transphobia and denial of affirming care
- Finding trans-inclusive or knowledgeable GPs in regional or remote areas
- Cultural insensitivity among health practitioners who are not familiar with Sistergirls, Brotherboys or other gender diverse cultures (e.g. Fa'afafine, Kathoey)
- Financial difficulties – bulk-billing clinics specialising in trans health are few and far between, and Medicare still does not cover most gender affirmation surgeries
- Family rejection and lack of other support
- Lack of awareness about trans-friendly health services or specialists
- Inadequate training to support trans clients in both the aged care and disability sectors, including among National Disability and Insurance Scheme (NDIS) providers
- Inadequate funding and resources devoted to children's gender services, meaning long waitlists and delays to access affirming health care
- Ongoing culture wars playing out in the media and politics which stigmatise trans people and which especially target affirming care for children and young people

The need for more GPs and other specialists to be educated and empowered to work with trans clients was highlighted in Sydney in 2019. Endocrinologist Jon Hayes had, for over thirty years, been working with trans clients and was popularly seen as the main

244 Ben Vincent, *Non-Binary Genders: Navigating Communities, Identities, and Healthcare* (Bristol: Policy Press, 2020), 136.
245 Andrew Eklund, interview with author, 7 February 2022, Zoom.

specialist in Sydney who would prescribe hormones. By 2019 he was seeing approximately eighty people per week and had, by his own account, 7,962 clients on his books. In early 2019 the New South Wales Medical Council was investigating Hayes for unknown reasons and, according to Hayes, placed unreasonable conditions on his practice. In June 2019 Hayes abruptly closed his practice as a direct response to the New South Wales Medical Council's investigation.[246] Hayes's shock retirement left hundreds of trans people in Sydney scrambling to find other specialists or GPs who would be willing to prescribe hormones. It highlighted the lack of adequate trans health care in Australia's most populous city.

Comments about GPs who are wary about prescribing hormones are disappointing given efforts in recent years to disseminate online resources and publications which are readily available. For instance, AusPATH's website offers numerous free training modules about primary care for trans people.[247] Numerous regional health services subscribe to HealthPathways, a web-based portal with evidence-based information about assessing and managing common clinical conditions. HealthPathways has since at least 2017 included a section on Transgender Health and Gender Diversity as a step-by-step resource for GPs. Groups like Trans Health Research at Austin Health have also collated and prepared resources which health professionals can access.[248]

Other health services have prepared their own training modules for GPs which are similar to those offered by AusPATH.[249] In 2019, several trans health specialists led by endocrinologist Dr Ada Cheung authored a "Position statement on the hormonal management of adult transgender and gender diverse individuals" published in the *Medical Journal of Australia*, detailing information for GPs about assessment, prescription and monitoring of hormones.[250] In July 2020 P Cundill published "Hormone therapy for trans and gender diverse patients in the general practice setting" in *The Australian Journal of General Practice* – the official, open access journal of the Royal Australian College of General Practitioners.[251] On 31 March 2022, AusPATH also published its first "Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy," centring trans people and seeking to empower clinicians to support trans clients to access hormones.[252] The ever-growing sets of online resources, training modules and publications mean that ignorance is no excuse; GPs and other specialists just need guidance on where to look.

There are also the challenges that health professionals, too, face in trying to deliver affirming care. They share trans community members' frustration that gender affirmation surgeries are not covered by Medicare. Doctors express frustrations over MBS rates which do not accurately reflect the cost of delivering care (and this is not unique to trans health care). This means that many specialists do not bulk bill or have to be selective about to whom they offer bulk billing.

Many trans people who are financially strapped have to access their superannuation to pay for health care, be it hormones, specialist appointments or gender affirmation surgery. Yet, the superannuation industry places barriers on withdrawing money for medical treatment. They require that a psychiatrist – not a psychologist or other practitioner – certify that a trans person has a "chronic mental illness" which requires treatment. Thus, even as many psychiatrists support the agenda to normalise gender variance and to depathologise gender incongruence, they must deploy the language of mental illness for trans clients to secure funding for health care denied by the public system.

Another challenge is around the prescription of testosterone. From 1 April 2015, changes to the PBS restricted access to subsidised testosterone to prescriptions from urologists, endocrinologists, sexual health physicians and paediatricians. The purpose of the restriction was to limit what the Pharmaceutical Benefits Advisory Committee considered was over-prescribing for non-essential purposes (e.g. cisgender men who were bulking up). One of the unintended side-effects of this decision was that it made it harder for trans men and trans masculine people to obtain testosterone affordably.

GPs now need to consult with one of the approved specialists, which adds an extra layer of work and delays for all parties involved. The GP or specialist must then call the Department of Health and give the name of the approved prescriber. As sexual health physician Darren Russell explains: "I have to ring up the government each time and say that I'm prescribing this testosterone for the condition of hypogonadism due to an established testicular condition. Mainly, they don't have testicles, which is a condition. So I have to say those words each time and then they ask for the name

246 "Retired doctor says NSW Medical Council disapproved of his focus on trans patients," *Star Observer*, 18 June 2019, https://www.starobserver.com.au/news/national-news/new-south-wales-news/retired-doctor-says-nsw-medical-council-disapproved-of-his-focus-on-trans-patients/184025, accessed 18 July 2021.

247 https://auspath.org/education/, accessed 1 July 2021.

248 https://www.transresearch.org.au/professionalresources, accessed 1 July 2021.

249 For example, see https://nwmphn.org.au/our-work/priority-populations/lgbtiq/, accessed 1 July 2021.

250 Ada S. Cheung et al., "Position Statement on the Hormonal Management of Adult Transgender and Gender Diverse Individuals," *Medical Journal of Australia* 211, no. 3 (2019): 127-33.

251 P Cundill, "Hormone Therapy for Trans and Gender Diverse Patients in the General Practice Setting," *Australian Journal for General Practitioners* 49 (2020): 385-90.

252 AusPATH, "Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy," 31 March 2022.

of the specialist and I give my name."[253] Fortunately, many GPs specialising in trans health have strong working relationships with sexual health physicians or endocrinologists, and that has facilitated ensuring that trans clients do get testosterone on the PBS. At the time of writing, a group of trans activists and trans health specialists under the leadership of Ada Cheung have been lobbying the Pharmaceutical Benefits Advisory Committee to carve out an exemption to the testosterone prescription restrictions to facilitate easier access for trans men and trans masculine people.

In 2018, a confluence of local regulatory and international pharmaceutical company changes highlighted how tenuous access to testosterone was. At the time, there were three main prescriptions available in Australia: Primoteston, Reandron and Testogel. First, in February 2018 Primoteston was removed from the PBS. Although this limited access for low-income people, even at full price it cost about $40. In fact, the ability to source Primoteston outside the PBS made it relatively accessible and thus the most popular testosterone prescription. Then in September 2018 the pharmaceutical company Bayer Australia sent a letter to pharmacies advising that due to difficulty sourcing a specific ingredient, there was a global shortage of Primoteston which would limit supply until mid-2019.[254] This had significant adverse effects on trans men and trans masculine people. First was the ripple effect that the other injectable testosterone, Reandron, went into short supply. Some people switched to Testogel, but that too went into supply shortage. Some people reduced their dosages of Primoteston as a form of rationing; others stopped testosterone altogether for a period of time. The crisis only abated when supply was restored in mid-2019.[255]

Restrictions on the prescription of puberty blockers also pose a barrier to access affirming and affordable health care. Puberty blockers are only listed on the PBS with restricted purposes which do not apply for trans health care. Doctors can still prescribe them, but without PBS subsidies they are expensive. The various children's gender services across Australia essentially subsidise these medications by dispensing them directly. Children and young people either go to the hospitals/clinics for the administration of the medication, or the hospitals courier them to the clients' GPs to administer them. This financial burden and the fact that only the public hospital system has been able to dispense the medication affordably is an obstacle to more GPs being able to prescribe and dispense puberty blockers. Seen another way, even if GPs are willing to prescribe puberty blockers, the prohibitive cost is too much for most families, which is another reason for the long waitlists at the children's hospital gender services.

Finally, there are of course the challenges that the Covid-19 pandemic has posed for trans people since 2020. The isolation from lockdowns – particularly the extended lockdowns in Melbourne in 2020 and 2021 and Sydney and Canberra in 2021 – only exacerbated the mental health barriers confronting many trans people. Trans organisations across the country rallied to offer online peer support sessions, and some state governments allocated extra funding for such activities. Yet, even such attempts could not always alleviate the distress caused by the pandemic and ancillary effects like sometimes being stuck at home in dangerous situations (e.g. family and domestic violence; with unsupportive family; or in a closeted situation). Covid-19 also meant the delay of gender affirmation surgeries and, for people who were only just beginning medical transitions, delays to access primary care (e.g. delays getting blood tests and therefore unable to commence hormone treatment). Perhaps one of the few silver linings of the pandemic was the greater increase in Telehealth. This has the potential to revolutionise access to affirming health services for trans people who live in regional or remote areas.

Notwithstanding these challenges, as this report has shown, there has been a massive increase in awareness, access and understandings around how to provide affirming health care to trans people. No doubt there is a way to go, but the lessons of history suggest that listening and ongoing advocacy can continue to provide new models of care and better outcomes for trans Australians.

253 Darren Russell, interview with author, 15 January 2021, Zoom.
254 Archie Barry, "Primoteston shortage affects transmen," *The Saturday Paper*, 9 March 2019.
255 Zac Cannell, interview with author, 24 July 2021, Zoom.

Timeline

national	international	Victoria	NSW	South Australia	Queensland	Western Australia

Time immemorial	several Aboriginal and Torres Strait Islander mobs have understandings of gender that go beyond the binary, with names for third or non-binary genders
1864-65	Karl Heinrich Ulrichs's concept of Urnings describes people with a male body but female souls (and vice versa)
1879	Edward De Lacy Evans discovered to be assigned female at birth (Ellen Tremayne) when admitted to the Kew Asylum
1894	Richard von Krafft-Ebing's *Psychopathia Sexualis* defines metamorphosis sexualis paranoica
1910	Magnus Hirschfeld publishes *Transvestites: The Erotic Drive to Cross Dress*
1912	first mention of the term transvestitism in Australian newspaper
1928	Havelock Ellis coins term Eonism
1931	Lili Elbe's gender affirmation surgery
1935	reports of a female-to-male gender affirmation surgery in Czechoslovakia
1937	*Western Australian Clinical Reports* documents case of transvestism
1939	Harcourt Payne committed to Orange Mental Hospital after discovered assigned female at birth
1949	Dr David Caldwell adopts term transsexual to describe a person assigned one sex at birth with a strong desire to be another gender
1951	Dr Herbert Bower treats first patient at Royal Park Mental Hospital who was assigned male at birth but identified as female
1952	Christine Jorgensen's transition gains international attention, including attracting interest from people in Australia desiring gender affirmation surgery
1954	Dr Harry Benjamin publishes "Transsexualism and Transvestism as Psycho-Somatic and Somato-Psychic Syndromes"
1966	Dr Harry Benjamin publishes *The Transsexual Phenomenon*, which becomes the textbook for medical treatment of trans people
1967-68	Dr Richard Ball publishes research on transsexualism, based on research conducted in Melbourne
1968	First gender affirmation surgery in NSW and possibly Australia believed to have been performed
1969	Victorian Health Department begins running Transsexualism Consultative Clinic with Dr Richard Ball as first director

1969	First gender affirmation surgery in Victoria believed to have been performed
1969	psychiatrist Andy Zorbas sees his first trans client in a Perth public hospital
1973	Norman Fisk coins expression gender dysphoria syndrome to encompass a spectrum of mental distress caused by discomfort around sex, gender and sexuality
1975	transsexualism clinic at the Royal Prince Alfred Hospital closes (uncertain when it opened)
c. 1975	Neil McConaghy finishes work with trans clients at Prince Henry Hospital
1975	Gender Dysphoria Clinic founded at Queen Victoria Hospital with Dr William Walters as director. The clinic would see the first clients and refer the first gender affirmation surgeries in 1976.
1976	sensational press coverage of first known gender affirmation surgery performed in Adelaide/South Australia
1977	Neil Buhrich publishes research on transvestism and transsexualism conducted with Seahorse NSW and clients at Prince Henry Hospital
1978	Gender affirmation surgeries cease at Prince of Wales Hospital, effectively ending surgeries in Sydney/NSW
1978	Gender Clinic founded at Flinders University Medical Centre with Dr Michael Ross as director
1979	Harry Benjamin International Gender Dysphoria Association (present-day WPATH) founded and hosts its first biennial conference
1979	first version of Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders published
1979	first Australian Conference on Transsexualism convened at Melbourne's Queen Victoria Medical Centre
1979	Australian and New Zealand Committee on Transsexualism founded. This group would exist until c.1985
1980	*DSM III* lists transsexualism for the first time, along with other transgender-related classifications
1981	speech pathologists at Lincoln Institute Speech Pathology Clinic begin working with clients from Gender Dysphoria Clinic. The Lincoln Institute merged with La Trobe University in 1987 and continues to operate as the La Trobe Communication Clinic
1983	*Female-to-Male Transsexualism: Historical, Clinical, and Theoretical Issues* published, possibly the first monograph about trans men
1983	2nd Australian and New Zealand Conference on Transsexualism convened at Flinders University
1984	Commonwealth Department of Health ceases funding MBS item 6327 (vaginal reconstruction for congenital absence, gynatresia or urogenital sinus) for trans women
1985	Layton review into the MBS recommends against Medicare payments for gender affirmation surgery, instead suggesting state health departments provide block grants
c. 1985	surgeon Peter Haertsch begins performing gender affirmation surgeries in Sydney
1986	*Transsexualism and Sex Reassignment*, edited by William Walters and Michael Ross, is first book on trans health care published out of Australia

1987	Gender Dysphoria Clinic moves from Queen Victoria Hospital to Monash Medical Centre. For 18 months only clients with private health insurance could access gender affirmation surgeries.
1987	Dr Trudy Kennedy becomes director of the Monash Gender Dysphoria Clinic
1988	*Sexual Reassignment Act* passed, restricting the provision of trans health care to 'approved' practitioners and clinics/hospitals
1988	Flinders Medical Centre Gender Clinic closed
1988	Victorian Department of Health's Transsexualism Consultative Clinic closed and state public funding allocated exclusively to Monash Gender Dysphoria Clinic
1990	Masada Private Hospital becomes primary site for gender affirmation surgeries in Melbourne
1991	Sandy Stone's essay "The *Empire* Strikes Back" becomes a new manifesto challenging the medical model of transsexualism
1994	*DSM IV* replaces transsexualism and most other trans-related categorisations with gender identity disorder
1994	Publication of Roberta Perkins's study "Transgender Lifestyles and HIV/AIDS Risk: National Transgender HIV/AIDS Needs Assessment Project," the first comprehensive survey of trans health, employment, welfare and wellbeing in Australia
1994	Brisbane Gender Clinic, focused on primary care, founded and operates one afternoon per week at Biala City Community Health Centre
1994	Australian Federation of AIDS Organisations hosts Anwernekenhe I, the first national conference for Indigenous gay men and Sistergirls
1996	Battle over the Gender Centre's support for the medical model of transsexualism culminates in Transgender Liberation Coalition-backed candidates elected to the board at the annual general meeting
1996	South Australian Gender Dysphoria Unit founded and approved under provisions of the *Sexual Reassignment Act*. Doctors associated with the unit have consultation sessions with clients and prescribe hormones but continue to refer clients to Melbourne for most gender affirmation surgeries
1996	David Hunter-Smith begins performing phalloplasty for trans men. Because of common complications, he would cease offering the procedure from around 2010.
1999	First National Indigenous Sistergirl Forum on Magnetic Island
2001	Network of Professionals Working with Transgender People formed in Melbourne. This group would meet semi-regularly for about two years
2003	lawsuit against Monash Gender Dysphoria Clinic sparks a series of reviews and stricter adherence to the medical model of transsexualism
2003	first referral of trans child to Melbourne's Royal Children's Hospital
2003	*Re: Alex* ruling sets precedent that the Family Court must approve any hormone treatment for trans children under eighteen
2007	Harry Benjamin International Gender Dysphoria Association changes its name to the World Professional Association for Transgender Health (WPATH)
2009	following another lawsuit and publicity, Trudy Kennedy forced to resign as director of the Monash Gender Dysphoria Clinic as another review recommends a shared care model. Fintan Harte appointed new director.

2009	Australian and New Zealand attendees at the WPATH conference meet and found ANZPATH
2012	Royal Children's Hospital Gender Service founded with Michelle Telfer as director
2013	*Re: Jamie* removes requirement that trans children go to the Family Court for approval to access stage 1 hormones (puberty blockers)
2013	after the Newman Government forces the Brisbane Gender Clinic out of the premises at Biala, it moves to QuAC
2014	national tour of Buck Angel raises awareness of trans men's sexual health and sparks greater interest in trans health among the AIDS councils
2015	*DSM V* replaces gender identity disorder with gender dysphoria
2015	changes to PBS rules around testosterone place extra hurdles to prescribe testosterone to trans men and trans masculine people
2015	first Brotherboy panel at the Anwernekenhe 6 conference
2015	Tekwabi Giz founded to support National LGBTI Health Alliance to develop strategies for Indigenous LGBTIQ+, Sistergirls and Brotherboys
2015	Perth Children's Hospital Gender Diversity Service established
2016	Victorian government injects $6.7 million of new funding to Monash Gender Clinic, as new director Jaco Erasmus embarks on further reforms around co-design with members of Victoria's trans community. Clinic name also changed to Monash Gender Clinic
2016	Queensland Children's Hospital Gender Clinic established
2016	repeal of *Sexual Reassignment Act* removes restrictions on only approved providers offering health care to trans people in South Australia
2016	Equinox opens in Melbourne as primary care clinic for trans people, built on a peer-led, co-designed model
2017	Trans Pathways report published, highlighting challenges confronting trans children and young people
2017	Royal Children's Hospital Gender Service publishes first "Australian Standards of Care and Treatment Guidelines For trans and gender diverse children and adolescents". They are published the next year in the *Medical Journal of Australia* and gain international attention after a praising editorial in *The Lancet*
2017	*Re: Kelvin* overturns requirement that trans children must go to Family Court for approval to access stage 2 gender affirming hormones
2018	global shortage of Primoteston leads to broad testosterone shortage for trans men and trans masculine people
2019	gender identity disorder removed from the *ICD-11* list of mental health disorders and new category created for gender incongruence
2019	ANZPATH splits into two separate organisations: AusPATH and PATHA
2019	ACON releases "A Blueprint to Improve the Health and Wellbeing of the Trans and Gender Diverse Community in NSW"
2019	South Australia Commissioner for Children and Young People releases report which calls for greater resourcing in the health care system for trans children and young people

2019	Victorian Trans and Gender Diverse Community Health Services open in Preston and Ballarat
2020	Royal Australasian College of Physicians recommends against an inquiry into health care for trans children, instead advocating further research and increased funding for existing services
2020	ACON launches TransHub
2020	*Re: Imogen* ruling states that Family Court must authorise hormone treatments for trans children if there is not unanimous consent among the child, doctors and all parents or guardians
2021	Maple Leaf House established as service in Newcastle for trans children and young people
2021	SA Health convenes forum with health professionals and representatives of the trans community to provide input into funding and design of new trans health services
2021	Royal Australian and New Zealand College of Psychiatrists releases position statement 103: "Recognising and addressing the mental health needs of people experiencing Gender Dysphoria / Gender Incongruence". AusPATH representatives and trans community representatives criticise the statement for not adequately defining or supporting affirming health care, and for lack of community consultation
2022	AusPATH publishes its first "Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy"

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