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Experiences of parents of trans young people accessing Australian health services for their child: Findings from Trans Pathways

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ABSTRACT

Background: Many trans young people seek mental health support and gender-affirming medical interventions including puberty suppression, gender-affirming hormones and/or surgeries. Trans young people and their parents face multiple barriers in accessing gender-affirming care and mental health support, however little is known about the parent perspective on accessing services for their trans child.

Aims: This study aimed to understand the experiences of parents accessing medical and mental health services with and for their trans children within Australia.

Methods: Using data from Trans Pathways, a large mixed-methods cross-sectional study, we examined the experiences of parents (N = 194) in Australia accessing primary care, psychiatry, therapy/counseling, mental health inpatient, and gender-affirming medical services with/for their trans children (aged 25 years or younger). Qualitative data on service experiences were thematically analyzed. Quantitative analyses included frequency of access to services, wait times, service satisfaction, and mental health diagnoses of the parents' trans child.

Results: Services were mostly first accessed when the young person was between 12 and 17 years of age, with primary care physicians being the most accessed service. Parents reported that some practitioners were respectful and knowledgeable about gender-affirming care, and others lacked experience in trans health. Across all services, common barriers included long wait times, complicated pathways to navigate to access support, as well as systemic barriers such as sparsity of gender speciality services. Across services, parents reported feeling as though they do not have the necessary tools to best support their child in their gender affirmation.

Discussion: This study highlights the crucial need for systemic changes in the processes of accessing gender-affirming care and mental health support to enable access to appropriate and timely care. These findings also indicate the importance of improving individual practitioner knowledge around trans health, to enhance the support provided to trans young people and their parents.

KEYWORDS
Trans; gender-affirming care; service access; transition

Introduction

Transgender is a term for people whose gender identity differs from what was presumed for them at birth. Gender diverse refers to people whose gender identity does not conform to society's gender binary of male and female. The term trans will herein be used to encompass transgender and gender diverse people. Research has indicated that within Australia 2.3% of school-aged young people are trans and/or gender diverse (Fisher et al., 2019). Trans young people in Australia have reported high rates of adverse mental health outcomes including self-harm (79.7%), suicidal thoughts (82.4%), suicide attempts (48.1%), and diagnoses of depression (74.6%), and/or anxiety (72.2%) (Strauss et al., 2021). Support for trans young people can include psychological support, social transition, puberty suppression gender-affirming hormone therapy and surgeries (Telfer et al., 2020). Access to gender-affirming medical care for young people in Australia can involve encounters with

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multiple services including pediatric or adult hospital services, primary care services (general practitioners; GPs), mental health services, and specialist services, including endocrinologists and fertility specialists (Telfer et al., 2020). Additionally, where trans young people are accessing gender-affirming medical care, they are often supported or legally required to have a parent attend these appointments. For trans young people, being supported by their parents in their gender identity is critical for mental health outcomes (Travers et al., 2012), being able to socially transition (Olson et al., 2016), and to access services where parental consent is needed. Optimal gender-affirming medical care requires a holistic approach from a multidisciplinary team with interdisciplinary coordination (i.e., primary health, endocrinology, mental health, voice and communication as well as gynaecology/andrology) (Coleman et al., 2022). Further, access to appropriate gender-affirming care can help support the mental health of trans young people and facilitate positive emotional and physical health outcomes (Hodax et al., 2020). Specifically, access to gender-affirming hormone therapies for trans youth has been linked to decreased psychopathology and suicidality, and increased wellbeing (Allen et al., 2019). However, the relative scarcity of specialist gender services and practitioners with experience providing affirmative care to trans people constitutes a barrier to service access for both trans adults and young people (Riggs et al., 2014; Strauss et al., 2021). In Australia, consent of both parents is needed prior to commencement of any gender-affirming medical treatment, even when a young person is assessed as competent to consent, leading many families to navigate the Family Court system and creating additional barriers to care (Jowett et al., 2022). Both globally and within Australia, trans young people report difficulties in accessing services appropriate to their needs (Chong et al., 2021; Winter et al., 2016). While there has been research on trans young people's experiences accessing mental health and medical services (Strauss et al., 2020, 2021) there has been little qualitative investigation of parents' experiences of services for their trans young person.

Parents play an important role in facilitating their trans young person's access to services. A lack of parental support of their young person's gender affirmation journey can be a barrier for trans young people accessing gender-affirming care because parental consent (for those under 18) is required to access care in Australia (Strauss et al., 2020). In literature about being a parent of a trans child, parents have reported experiencing external difficulties including struggling to find information about how to support their trans child generally; struggling to find support for themselves (Rickett et al., 2021; Riley et al., 2011); stressors related to transphobia that their child may experience (Hidalgo & Chen, 2019); and a lack of information about trans health (Riley et al., 2013). Access to gender-affirming services may also play a role in a parent's relationship with their child (Riley et al., 2013). For example, one study found that parents who experience pathologising responses from mental health services are less able to support and affirm their child's gender identity at home (Menvielle & Rodnan, 2011). This often arises from a lack of support in understanding how to affirm gender identities outside of the parents' own—most often cisgender—experiences (Menvielle & Rodnan, 2011). Parents who were able to learn about gender diversity and their child's needs in a supportive and encouraging mental health service environment were better able to support and affirm their child's gender identity at home (Menvielle & Rodnan, 2011). Parental support of their child's gender identity is a key protective factor for mental health in trans youth, Olson et al. (2016) reported that socially transitioned trans children supported in their identity by their parents were reported to have normative depression levels. A study by Miller et al. (2023) has also shown that a supportive family environment is associated with a decreased likelihood of a school-aged trans young person experiencing suicidal ideation. Parental conceptions of their role in seeking gender-affirming care for their child across any, and all mental health and medical services are underexplored. Research by Riley et al. (2013) and Gridley et al. (2016) highlights the discrimination experienced by the dyad of trans young people and their parents in health care. However, an exploration of parents' individual experiences across services has been largely missing from the literature. Bartholomaeus et al. (2020) conducted an Australian-based qualitative study with 10 parent-child dyads about their experiences with healthcare professionals, finding that experiences were largely dependent on individual professionals' knowledge. Other research has shown that trans young people and their families experience barriers in accessing gender-affirming care from medical transition services (Tollit et al., 2018). Given the importance of parental support for service access and affirmation of a child's gender identity, gaining insight into their experiences of service access in the context of gender affirmation may help in identifying areas of intervention and lead to improvements in service experience for trans young people. However, parental experiences of accessing gender-related care for their child across services have yet to be investigated in a large-scale sample.

Sampling for studies featuring dyads of parents and their trans young person including Griddley et al. (2016), Bartholomaeus et al. (2020) and Riggs et al. (2020) were largely based on those who had received clinical services in relation to their young person's gender identity. Sampling from a single service category such as gender clinics poses a problem because it excludes participants who have been unable to access services, limiting understanding and generalizability of barriers to access for any family seeking access to these services. Additionally, knowledge about families in the community who do not, or have not been unable to, seek the support of medical services, is lacking. Service access outside of medical gender clinics is also important to explore as there are often multiple service types that parents and their children will try to access in relation to gender identity. Some dyad studies (Bartholomaeus et al., 2020) have looked at service access broadly but not specific to service types (i.e., primary care or mental health). It is also important to understand the types of services parents try to access and the experiences within and across those individual services. The use of community-based samples would, therefore (1) broaden the generalizability of findings by sampling across service types, (2) build understanding from families who have been unable to access services, and (3) include experiences of different types of families seeking to support their trans young person. A greater degree of understanding of parental experiences is beneficial because it allows the identification of similarities and differences in parents' experiences across services, as well as of potential barriers and facilitators to access.

This study sought to explore the experiences of parents of trans young people accessing services with or for their child across Australia. By employing a mixed-methods approach, this study aimed (i) to describe the frequency at which the parents of trans young people accessed primary care services, psychiatry services, therapy/counseling services, mental health inpatient services, and gender-affirming medical services for a reason related to the child's gender, and (ii) to explore parental experiences of care within these services

Methods

The *Trans Pathways* survey was developed in consultation with parents and trans young people to explore the service experiences and mental health of trans young people (Strauss et al., 2017). *Trans Pathways* data were collected across Australia from a convenience sample of parents recruited via social media, word of mouth, LGBTQA + support and advocacy groups, radio, as well as medical and mental health services from February to August 2016. The proportion of respondents recruited via each medium was not collected. Qualtrics online survey software was used to collect data using branch display and skip logic. Participants consented to participate after reviewing a digital participant information sheet. Participants only completed parts of the questionnaire relevant to their experience; all responses were voluntary except those used to determine eligibility (i.e., if they were a parent of a trans young person under 25 and if they were living in Australia). The University of Western Australia Human Research Ethics Committee approved this study (RA/4/1/7958).

Measures

The survey encompassed questions on medical and medical health service access, their child's gender affirmation, demographics, acceptance of their child's gender identity, their child's living situation, and their child's mental health diagnoses. Parents were asked in an open text format about their child's gender identity. Gender identity categories presented in Table 1 were taken from open text responses by parents and may not be reflective of the full range of gender identities. Parents were asked to select which services they accessed including primary care services, psychiatry services, therapy/counseling (herein therapy), gender-affirming medical services, and mental health inpatient services in relation to the child's gender. Service types were also shown under some of these categories, for example, therapy services were sub-categorized into private psychologists, public mental health services, university or school psychologists, and headspace services (an Australian national mental health service provider for youth ages 12–25 years).

Questions on service access

Open-ended questions were asked about each service, including wait time for the first appointment, attempts to access services, and how respectful they felt the service was regarding their child's gender. Parents rated satisfaction with each service on a Likert scale from 1 = very dissatisfied to 5 = highly satisfied. Length of wait time for the first appointment was only asked for the psychiatry, therapy, and gender-affirming medical services. Parents were asked in open text form how many primary care services they accessed until they received the help they were looking for, this was categorized into the following 1, 2–3, 4–5, 6+, and 'still trying or none'. Parents who accessed mental health inpatient services were asked in open text how many times their child has been admitted to a mental health inpatient service, responses were also categorized into 1, 2–3, 4–5, 6+, and 'still trying or none' Parents were asked about their experience with each service through the open-text response item "Please tell us about your experience."

Table 1. Participant child demographics.

Characteristics	n (%)
Age Range	
4–11 years	37 (19.3)
12–17 years	68 (35.4)
18–25 years	87 (45.3)
Gender presumed at birth	
Female	112 (57.7)
Male	82 (42.3)
Aboriginal and/or Torres Strait Islander Descent	
Yes	3 (1.5)
No	191 (98.5)
Gender Identity	
Male	85 (44.3)
Female	67 (34.9)
Non-binary	21 (10.9)
Transgender	11 (5.7)
Other	8 (4.2)
State of Residence	
VIC	38 (26.8)
NSW	29 (20.4)
NT	2 (1.4)
WA	32 (22.5)
TAS	7 (4.9)
SA	12 (8.5)
ACT	4 (2.8)
QLD	18 (12.7)

Questions on the child's mental health

Parents were also asked if their child had ever been diagnosed with any of the following: depression, anxiety disorder (i.e., obsessive-compulsive disorder, generalized anxiety, social anxiety, panic disorder), post-traumatic stress disorder (PTSD), personality disorder, eating disorder, substance abuse disorder, and autism spectrum disorder. Current mental health diagnoses were asked about in relation to the each indicated diagnosis, except for autism spectrum disorder which is a lifetime diagnosis. Parents were asked about any treatment sought for each current diagnosis in open-ended questions.

Analysis

All quantitative analyses were conducted using IBM SPSS Statistics (Version 24.0) including frequency analysis for each nominal variable, and descriptive statistics to determine the frequency of service access by gender presumed at birth. The age of the child at the first service access attempt was stratified into the groups 4–11 years, 12–17 years, and 18–25 years to allow observation of differing rates of service access for different age groups.

Qualitative data were entered into NVivo version 12 (QSR International Pty Ltd., 2018) for general inductive thematic analysis stratified by service type. A general inductive approach was chosen to allow focus on the construction of themes from within the raw data, without testing an *a priori* hypothesis (Thomas, 2006). Interpretation of data was informed by a social constructivist theoretical framework whereby the meaning parents place on their experiences is seen as socially co-constructed by them and their interactions (Crotty, 1988). The process of inductive coding began with the familiarization of the data and recognition of multiple possible meanings conveyed (Thomas, 2006). Next systematic primary and secondary coding of responses was done within each service type to break down participant experiences (Braun & Clarke, 2006).

Coding was then used for the identification and definition of potential themes; specific themes were constructed from responses within each service and supported by phrases in the raw data (Braun & Clarke, 2006). Each theme was searched for sub-themes, contrary points and any new insights or interpretations (Thomas, 2006). Themes were constructed within each service type; the resulting thematic trees were analyzed for any commonalities across services. Key quotes from the data were chosen to provide insight into each theme. Processes used to ensure rigor and credibility in the analysis included reflective journaling and verifying coding with the research team. Theoretical saturation is originally defined as the point where no additional themes are constructed from reviewing the data (Glaser & Strauss, 1967). As data was analyzed after data collection had ceased authors GC, LS, and PS discussed and agreed to cease analysis when no new themes emerged from coding (theoretical saturation), thus, we cannot (and do not claim) to have all parents of trans young people represented in the themes presented. The first author (GC) coded the data with the last author (PS) independently reviewing the data and coding.

Open text data on how respectful parents feel service types generally were regarding their child's gender was coded into one of four categories of 'Gender acceptance within service,' including (1) did not disclose gender, (2) not respectful or mostly not, (3) sometimes respectful or mixed response, (4) respectful or mostly respectful.

Qualitative and quantitative components were mixed after separate analysis, with qualitative findings used to contextualize quantitative data regarding frequencies of service access. Service experience is first described regarding the frequency of parents who have accessed the service and their satisfaction with the service. Qualitative findings are then used to describe parents' experiences accessing each service. The combination of findings from both data types was used to create a comprehensive understanding of the parent's service access journey and experiences with implications presented in the discussion

Results

Participants

The participants were 194 parents and guardians of trans young people, comprised of 89.7% mothers, 6.7% fathers, 3.1% guardians, 0.5% stepmothers and 1.5% other. The mean age of the participants' trans young person was 16.02 years (*SD* = 4.94; range 4–25 years). Demographics of participants' trans children are provided in Table 1. Details of service access frequencies as categorized by wait time for appointments, young person's birth-presumed gender, age, service access attempts, satisfaction and gender acceptance within each service are reported in Table 2.

Parents' accounts of their child's historical mental and current mental health diagnoses and treatments received are reported in Table 3. Most parents reported that their child had previously been diagnosed with a mental health disorder: 61.1% with anxiety, and 61.1% with depression. Many parents also reported a current mental health diagnosis for their child (43.3% anxiety and 43.9% depression). Of those currently diagnosed with depression, 36.9% reported their child had used medication as a treatment, 24.6% reported accessing therapy at some point and 1.5% being hospitalized at some point. Of those currently diagnosed with anxiety, 24.2% reported their child was receiving medication as a treatment, and 37.1% were receiving therapy.

Table 2. Services access frequency as categorized by birth-presumed gender, age and wait time.

Service Type	Primary Care n (%)	Mental Health Inpatient n (%)	Psychiatry n (%)	Therapy n (%)	Gender-affirming Medical Services n (%)	Other Services n (%)
Access frequency	146 (91.8[a])	28 (17.6[a])	119 (74.8[a])	130 (81.1[a])	85 (53.5[a])	22 (13.8[a])
Age at first access attempt						
4–11 years	41 (31.1)	1 (4.8)	27 (23.5)	32 (27.1)	14 (18.9)	–
12–17 years	72 (54.5)	17 (81.0)	69 (60.0)	73 (61.9)	43 (58.1)	–
18–25 years	17 (12.9)	3 (14.3)	19 (16.5)	13 (11.0)	17 (23.0)	–
Birth-presumed gender						
Male	64 (43.8)	16 (57.1)	55 (46.2)	52 (40.0)	32 (37.6)	14 (63.6)
Female	82 (56.2)	12 (42.9)	64 (53.8)	78 (60.0)	53 (62.4)	8 (36.4)
Length of wait for first appointment						
1 month or less	–	–	42 (37.8)	82 (77.4)	15 (21.4)	–
2–3 months	–	–	37 (33.3)	19 (17.9)	22 (31.4)	–
4–6 months	–	–	21 (18.9)	3 (2.8)	13 (18.6)	–
7–9 months	–	–	5 (4.5)	1 (0.9)	6 (8.6)	–
10 months or more	–	–	5 (4.5)	0 (0.0)	10 (14.3)	–
Still waiting, or never got an appointment	–	–	1 (0.9)	1(0.9)	4 (5.7)	–
Satisfaction with service						
Very Dissatisfied	6 (4.5)	4 (19.0)	8 (7.2)	3 (2.5)	0 (0.0)	–
Somewhat Dissatisfied	6 (4.5)	6 (28.6)	3 (2.7)	5 (4.2)	6 (8.8)	–
Neutral	18 (13.5)	6 (28.6)	22 (19.8)	30 (25.0)	8 (11.8)	–
Moderately Satisfied	38 (28.6)	3 (14.3)	36 (32.4)	36 (30.0)	17 (25.0)	–
Highly Satisfied	65 (48.9)	2 (9.5)	42 (37.8)	46 (38.3)	37 (54.4)	–
Gender acceptance within service						
Did not disclose gender	4 (3.1)	2 (10)	3 (2.7)	4 (3.5)	0 (0.0)	–
Not respectful or mostly not	4 (3.1)	1 (5)	2 (1.8)	4 (3.5)	1 (1.5)	–
Sometimes respectful or mixed response	13 (10.1)	1 (5)	4 (3.6)	6 (5.3)	3 (4.5)	–
Respectful or mostly respectful	108 (83.7)	16 (80)	101 (91.8)	99 (87.6)	63 (94.0)	–

Note. Dashes represent data that was not collected for that service.
[a] Percentage of the total respondents who reported accessing services n = 159.

Table 3. Historical and current mental health diagnoses by age and birth-presumed gender.

	Total N	Depression n (%)	Anxiety Disorder n (%)	Post-Traumatic Stress Disorder n (%)	Personality Disorder n (%)	Psychosis n (%)	An Eating Disorder n (%)	Substance Abuse Disorder n (%)	Autism Spectrum Disorder n (%)
Historical Diagnoses									
Total ever diagnosed	180	110 (61.1)	110 (61.1)	14 (7.8)	13 (7.2)	21 (11.7)	14 (7.8)	6 (3.3)	33 (18.3)
Birth-presumed gender									
Male	74	39 (35.5)	44 (40.0)	4 (28.6)	6 (46.2)	8 (38.1)	3 (21.4)	1 (16.7)	17 (51.5)
Female	106	71 (64.5)	66 (60.0)	10 (71.4)	7 (53.8)	13 (61.9)	11(78.6)	5 (83.3)	16 (48.5)
Age Group									
4–11 years	35	3 (2.8)	9 (8.3)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	3 (9.4)
12–17 years	65	40 (37.0)	42 (38.9)	5 (35.7)	2 (15.4)	4 (20.0)	4 (28.6)	0 (0.0)	9 (28.1)
18–25 years	78	65 (60.2)	57 (52.8)	9 (64.3)	11 (84.6)	16 (80.0)	10 (71.4)	6 (100.0)	20 (62.5)
Current Diagnoses									
Total currently diagnosed	180	78 (43.3)	79 (43.9)	7 (3.9)	6 (3.3)	5 (2.8)	3 (1.7)	0 (0.0)	–
Birth-presumed gender									
Male	74	29 (37.7)	31 (39.2)	3 (42.9)	4 (66.7)	2 (40.0)	1 (33.3)	0 (0.0)	–
Female	106	48 (62.3)	48 (60.8)	4 (57.1)	2 (33.3)	3 (60.0)	2 (66.7)	0 (0.0)	–
Age Group									
4–11 years	35	0 (0.00)	3 (3.9)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	–
12–17 years	65	29 (37.7)	31 (40.3)	4 (57.1)	2 (33.3)	3 (60.0)	0 (0.0)	0 (0.0)	–
18–25 years	78	48 (62.3)	43 (55.8)	3 (42.9)	4 (66.7)	2 (40.0)	3 (100.0)	0 (0.0)	–
Treatment received									
Medication	–	24 (36.9)	15 (24.2)	2 (50.0)	3 (75.0)	3 (75.0)	0 (0.0)	0 (0.0)	–
Therapy	–	16 (24.6)	23 (37.1)	2 (50.0)	4 (100.0)	3 (75.0)	2 (100.0)	0 (0.0)	–
Hospitalisation	–	1 (1.5)	1 (1.6)	0 (0.0)	0 (0.0)	1 (25.0)	0 (0.0)	0 (0.0)	–

Note. Dashes represent data that was not collected for that service at the 'current' timepoint.

Primary care services

Primary care services were the most commonly accessed service, with 91.8% of parents having visited a primary care physician with or on behalf of their trans child. Many parents reported first accessing a primary care physician when their child was aged between 12 and 17 (54.5%). Most parents (76.7%) reported needing to visit one primary care physician to receive the help they were looking for, 15% visited 2–3 physicians, 1.5% 4–5 physician, 3.8% 6+ physicians, and 3% no physician or still trying to find the right fit. Most parents accessing primary care felt their child's gender identity was respected (83.7%), but only 48.9% reported being highly satisfied with the care received.

Physician accepting and respectful of the young person's gender identity

Parents reported positive experiences with physicians who were accepting and supportive of their child's gender identity. This was demonstrated through respectful and affirming care. Primary physicians' use of correct pronouns and using gender-affirming language often served as demonstrations of acceptance and a welcoming environment reported by parents.

> They [the physician] have consistently called him by his chosen name even before he changed it legally.

Primary care physicians seeking to understand a young person's needs

Another positive aspect was when primary care physicians were supportive of the young person's need for gender-affirming care and were willing to provide the care needed. Even physicians who did not have expertise in trans health were viewed positively by some parents due to their willingness to help the young person.

> Our [doctor] – even though she had never had a trans patient before was amazing and so helpful and respectful.

Parents appreciated physicians who were willing to expand their knowledge about trans health and gender affirmation if they were not currently knowledgeable.

> GP didn't really know much about gender dysphoria, particularly in children. I had more info than she did, but she was very supportive and has become knowledgeable about the subject now.

Needing to educate the primary physician on gender diversity

Many participants reported the experience of seeking support from primary physicians who were not knowledgeable about the needs of trans young people and were unable to facilitate gender-affirming care. Parents reported having to educate their physicians on their child's needs and guide them through the process of accessing gender-affirming care.

> Our GP was as helpful as she could be, but unfortunately had no experience with trans issues or the process of accessing further help.

This gap in physician knowledge not only impacted trans young people's care pathways but also burdened parents' experiences as they reported having to educate their physicians about gender diversity.

> GP is very nice. Possibly out of her depth. She desperately wants to help, but I find she is guided by me. I can't seek specific advice from her. It's the other way around.

Parents respected that their physician wanted to help their child but did not have the knowledge to do so, impacting their child's care, as well as leaving parents to drive their child's care without appropriate support.

Complex pathways to receiving adequate care

Parents described complex pathways while accessing care for their children due to their physician being unable to guide them to appropriate services. This resulted in an extended time before a young person received care.

> The GP was unaware of the public gender clinic at the children's hospital. We were messed around with a private clinic who eventually said they didn't deal with transgender [people].

Parents reported being sent to unnecessary services due to their physician's lack of knowledge of gender-affirming care pathways and appropriate specialist services.

> I felt our GP is kind and understanding and helps in the best way they can. I feel there is probably not enough information out there for GPs. Our GP was unsure about where to send us for assistance hence we have ended up going privately to the psychiatrist/psychologist and endocrinologist.

Gender-affirming medical services

Gender-affirming medical services had been accessed by 54.5% of participants and slightly more commonly sought by those whose young person was presumed female at birth (62.4%). About half of parents reported being highly satisfied with the care their young person received (54.4%) and 94% reported the service was respectful of their child's gender. Of those who accessed gender-affirming medical services, 63.1% attended a children's hospital, 6.7% saw a pediatrician, 17.3% attended an adult hospital, 34.4% saw a private endocrinologist, and 24% saw a private surgeon.

Services as a guide through transition

Many parents described accessing gender-affirming medical services that were knowledgeable and experienced on the needs of their trans young person and able to share information about a young person's care pathway. Part of sharing information was the service being attuned to the gender-affirming needs of the young person.

> Going straight to someone who knows why you're there, has researched this area and who can provide the questions you don't yet know to ask is powerful.

Parents indicated the value of a knowledgeable practitioner who could guide them in their child's care. Parents described part of guidance from services as educating parents and young people about the care pathway within that service, and supporting the family to be part of the young person's care.

> We've only had the initial assessment, we got a full explanation of the service, the team, and the process for trans changes. It was very thorough and very enlightening for both of us (child and myself).

Parents reflected on the benefits for both themselves and their child of knowing what to expect from the service experience, especially around processes and timelines. These reflections showed that parents valued being understood by service providers, being given information, as well as feeling involved and aware of their child's gender affirmation journey.

Frustrations experienced with navigating service pathways

Many parents encountered difficulties in the processes and timelines for hormone access within pediatric settings, causing distress for parents and their young people. Parents reported only being able to access hormone prescriptions with their child aged under 18 through a pediatric hospital gender clinic, a process of which some parents were not aware until they began trying to access hormones.

> Every private endocrinologist we contacted would not see our child because they were under the age of 18. The children's hospital gender clinic did not have an endocrinologist for 12 months which was very frustrating.

Several parents described frustration around the singular pathway for pediatric hormone prescription as the high number of people seeking prescriptions within limited capacity services led to long wait times. Parents also described the negative impact of long wait times and complex processes for accessing hormones on themselves and their young people. Some parents reported feelings of helplessness at having to witness their child's distress while waiting to access treatments that would relieve that distress.

> My son got very disheartened and distressed by the long wait, feeling that he would never access treatment. This led to spiking anxiety, recurrence of self-harm for my son, frustration and a feeling of helplessness for us all.

Psychiatry services

Psychiatry services had been accessed by 74.8% of participants with 46.1% accessing a public psychiatrist, 30.4% a private psychiatrist, and 18.3% accessing both a private and public psychiatrist. Most of these parents reported feeling highly (37.8%) or moderately satisfied (32.4%) with the service and most indicated that the service was respectful of their child's gender (91.8%). Findings were mostly reflective of negative aspects of care, with some positive aspects.

Support for the parent to help their child

Parents described positive experiences when seeing a psychiatrist who both supported their child's mental health, and equipped parents with knowledge so they could be a part of their child's support.

> The psychiatrist was very welcoming and helped me, especially to be able to understand and accept what was going to be happening with my child's treatment.

Specifically, a psychiatrist educating parents about their child's treatment and supporting them to be active participants in the young person's care was seen as important.

> They [the psychiatrist] listened to our circumstances and assured us that we were making the right choices for our child.

When a psychiatrist supported parents' understanding of their child's mental health through the transparency of information as well as assurance, parents reported both themselves and their child having a positive service experience.

Lengthy waiting periods to see the right psychiatrist

Parents described barriers around accessing an appropriate psychiatrist and a lack of clarity around support after an initial diagnosis. Parents reported struggling to find a psychiatrist with expertise in trans mental health and having to endure long wait times.

> Some services were awful. Others inexperienced but willing to put us in contact with other services. And those services who specialise in the field are hard to access and costly.

Responses show that parents often had to access multiple psychiatrists to find an experienced psychiatrist usually associated with a higher cost for private services.

Navigating the public and private health systems

After long wait times to access services, parents also reported a lack of clarity around the process of accessing further support after a mental health diagnosis. Parents reported having to swap service systems, from private to public, due to lacking availability of practitioners.

> Due to lack of funding, my son had to see several psychiatrists and counsellors over a course of 5 years, he was unable to have the same doctors for that time. Which caused a lot of anxiety, which turned to self-harm as he was shoved from one system to another.

Many parents reported having to repeat processes, such as getting a diagnosis, in the public health system as the information regarding how to access gender-affirming hormones was not clear.

> Despite getting a diagnosis through the private system, we cannot now access an endocrinologist, so we have recently rebegun the process through the public system. But the public system does not take into account their private colleagues, so we are back at the start and need a diagnosis from a new practitioner.

This lack of information regarding procedures for hormone access communicated to parents also was reported to lead to further distress for the young person waiting for further care.

Role confusion: the role of a psychiatrist in gender affirmation

Parents recounted feeling that psychiatrists acted as gatekeepers for the prescription of hormones rather than as a support for their child's mental wellbeing. Parents' experiences reflected a lack of transparency about the psychiatrist's role in gender-affirming care. They described psychiatry appointments as a 'hoop to jump through' for hormones access, in which they faced the expense of an appointment without benefit to their child.

> Found the appointment was needed just due to red tape. The psychiatrist did not tell me anything that I didn't already know. And the bill excessive at $450.

Parents described their experiences of feeling the support received did not meet their expectations. Experiences reflected a lack of transparency from a psychiatrist to parents regarding the function of the appointment.

> [Our psychiatrist] does not answer questions or offer support - it's all about assessment for Stage 1 and Stage 2 transition[1]. Little transparency.

Parents experienced a lack of information from psychiatry services. This highlights the importance of services disseminating information regarding care processes to parents.

Therapy and counselling services

Therapy and counseling services (herein therapy services) were commonly accessed, with 83.3% of parents having sought therapy with or for their child. Parents reported short wait times for the first appointment, with 77.4% of those who accessed the service waiting for one month or less. More than one-third of parents reported being highly satisfied with the service (38.3%) and the majority reported feeling as though their child's gender was respected (87.6%). Types of therapy accessed include private psychologists (71.1%), public mental health services (35.5%), headspace (28.1%), and university or school psychologists (25.6%). Experiences of parents accessing these services were mixed between positive and negative aspects of care.

Therapist working with the family

Parents described the experience of having their child's mental health supported by a therapist who also helped the parent build an understanding of their child and the gender-affirming service pathway. Parents reported positive experiences with therapists, supporting them to understand their child's mental health.

> It was a fantastic relief to get the initial diagnosis, and our son's shoulders visibly lifted. It was also great to have the psychologist articulate to we parents things that our son had felt unable to say himself to us. It helped him to talk more with us afterwards.

A family inclusive approach to therapy was useful, whereby a therapist supports the relationship between the parent and young person through education as well as the young person individually.

> We found a transgender psychologist near our home she is very excellent at understanding and supporting my child, myself and even my child's father visiting from overseas.

Parents' experiences with therapy services often reflected a dichotomy between having concerns about their child's mental health dismissed, and then seeing a therapist who was supportive and accepting. Seeing a therapist who was supportive and able to guide the family, especially after previous negative experiences, was relieving for parents.

> When we first started this journey, it was very hard to find someone that would listen and show interest in our case. We were told repeatedly to not worry about it, that it was a phase, to leave it. Until the beginning of this year, when we were finally able to talk to someone that understood and could guide us on the right path to take.

Part of a therapist guiding a family involved transparency and education regarding service pathways for gender-affirming care as well as showing support for parents' concerns for their child's mental health. Central to this was the importance of the therapist's communication to parents and young clients about mental health and gender affirmation, as well as validation of young people's need for psychological support.

Health system constraints

Many parents reported struggling when trying to support their child's mental health within a health system that could not provide long-term support or trans appropriate care. There was a responsibility placed on parents to find an appropriate therapist or to educate their therapist on gender diversity, often leaving their child unsupported.

> We were pleased with our psychologist from a general point of view, but she had very little knowledge of gender dysphoria. My son and I were able to research and find out information quicker than she did. This is why we have been seeking the services of a psychologist who specialises in gender issues. So far, the first two referrals have been declined due to client books being full.

Parents described therapists with trans expertise as rare and difficult to access due to long waitlists, leaving parents searching for appropriate mental health support. Parents also reported a lack of support for their child's mental health because of the difficulty in accessing long-term mental health support. Parents recounted that mental health care plans (MHCP; an Australian government subsidy for therapy costs by referral from a GP) were not suitable for their young people's needs because they are time-limited (10 sessions per annum).

> The problem here becomes cost as the standard 10 sessions for a MHCP is not a suitable system for someone with long term needs regards psychology support, so we will have to cover the additional costs after the 10 sessions are used.

Mental health inpatient services

Mental health inpatient services had been accessed by 17.6% of participants with 31.8% of those participants reporting one admission, 40.9% 2–3 admissions, 4.5% 4–5 admission, 9.1% 6 or more admissions, and 13.6% still trying or no admissions. Over half of the parents who reported accessing mental health inpatient services reported feeling neutral (28.6%) or moderately dissatisfied (28.6%) with the service, but 80% reported feeling the service was respectful of their child's gender.

Lack of follow-up care

Parents reported feeling a lack of support for their child beyond their current crisis. Parents describe trying to support their child in crisis while not being supported by mental health inpatient services.

> She was admitted to [mental health inpatient service] for a week due to severe OCD. Nothing was cured. Nothing improved. No plan of action.

Parents reported little improvement in their young people after accessing inpatient psychiatric services, leaving their needs unmet. Parents described having to develop an understanding of services without clinician support and identified that this led to distress in both themselves and their child.

> The first few admissions were horrifying for both of us and did very little help, after we learnt how the system worked, we then used this time constructively.

Parents described having to make the most of their experience with their child without being supported by services.

Discussion

The results of this study demonstrate that parents have a mixture of positive and negative experiences when accessing mental and medical health care with their trans child. These findings represent novel data given the lack of relevant literature utilizing large Australian community-based samples, covering a variety of services, and focusing on the experiences of parents accessing gender care for their child. The main themes reported across all services reflect that while individual practitioners can be respectful and inclusive, the Australian health system overall is not constructed to provide general care or gender-affirming care for trans young people. Across services, findings suggest that respectful, supportive, and helpful practitioners are central to positive experiences, and inexperienced practitioners, long wait times, and complicated procedures for support (i.e., hormone access) are central to negative experiences.

Primary care physicians were often the first service accessed by families. However, many participants reported that those physicians usually lacked knowledge of the health needs of trans people. Findings regarding parents' experiences within primary care settings reflect the importance of a doctor who is both supportive of a young person's gender identity and knowledgeable about trans people's health care needs. While parents reported valuing a respectful primary care physician even when they were unable to provide the needed care, they did reflect on having to supplement their physician's knowledge as being inadequate. These results converge with findings by Strauss et al. (2020) reporting on youth perspectives on the importance of physicians being open to supporting trans youth as well as seeking relevant clinical knowledge. Rickett et al. (2021) U.K. based study with parents of trans children aged 4–12 also described a lack of knowledge within primary care services that contributed to a parental sense of isolation from having to 'battle' the health system alone. In our study, many parents described having to locate specialists and navigate the public and private health system through trial and error, leaving them and their child distressed by the extended time it took for their child to receive care.

Parents' experiences with gender-affirming medical services indicate that the process of accessing gender-affirming care can create distress for both parents and their children. A sparsity of gender-affirming medical services leads to delays in accessing pubertal blocking hormones specifically, increasing distress, as well as to a lack of support for young people during the waiting period. Within Australia pediatric gender-affirmation services are mainly found in capital cities, meaning there is a geographical sparsity of trans specific services, leading some parents to travel to access care. Geographic sparsity of trans specific services as a barrier to care is also reported along with difficulty finding appropriate services in Paceley et al. (2021) U.S. study of parents and trans youth. Many parents described being unaware of the process for accessing puberty-blocking hormones and being frustrated at the requirement of accessing multiple specialist services before a prescription could be obtained, adding to the long journey for their child to access the care they need. Parents frequently reported feelings of helplessness as their child experienced distress over developing secondary pubertal characteristics that do not align with their gender identity (e.g., facial hair, widening hips, and a deepening voice). Process-based delays in accessing gender-affirming treatments may preclude the suppression of such characteristics, resulting in long-term implications due to the irreversible nature of some characteristics. These process-based systemic delays were also frustrating and increased distress as these are - or could be - avoidable (i.e., if primary care providers know the correct referral pathway to gender services, and gender services have sufficient resources to allow timely access to support and gender-affirming medical treatment).

Across mental health services, parents reported a lack of continuity of care and long-term support. Given the high rates of mental health difficulties trans youth experience (Hill et al., 2021; Strauss et al., 2017), this void in care is important to identify and rectify. Specifically, over 60% of these parents reported their child having had a diagnosis of anxiety and/or depression. A lack of continuity of care was reported across all the mental health services due to difficulties finding an appropriate practitioner and being able to access that support long term. Parents described difficulties in getting appointments with trans experienced practitioners as they often were fully booked and not accepting new clients. Mental health care plans were described as a key barrier to long term care as the plans only financially supported short-term care, leaving parents to financially support further care. The sporadic nature of subsidized care also meant that young people often had to access multiple therapists over time, in which recounting their experiences could be distressing. Findings across both therapeutic and psychiatric services also reflect the importance of practitioners being both supportive and knowledgeable, as well as the negative impact of not getting adequate mental health support when that knowledge is lacking. Additionally, parents described feeling that the system they had to navigate to access care did not enable the delivery of the type of mental health support their child needed.

Psychiatric services in particular were often seen as a gatekeeper for hormone prescriptions, that parents describe as being unnecessary. Trans young people report seeking psychiatric services for transition-related needs, mainly the facilitation of hormone prescription or surgeries as well as mental health needs (Strauss et al., 2020). For young people (under 18) to access pubertal or gender-affirming hormones, they must first receive a gender-related evaluation (e.g., a diagnosis of gender dysphoria) from a psychiatrist, aligning with current standards of care (Coleman et al., 2022). Research has indicated that the gatekeeping role mental health professionals play can create challenges in establishing an authentic relationship with trans clients as they might not want to disclose information that may undermine access to hormones (Ellis et al., 2015). Research by Riggs and Bartholomaeus (2016) reported that, compared to other health professionals, psychiatrists had the lowest level of accurate knowledge regarding trans needs, mirroring the current findings. The aforementioned study also advocated for further upskilling of Australian mental health professionals' trans literacy, a need further supported by the current findings. Findings within mental health inpatient services showed parents' experiences of feeling the care their child received was not enough to improve their mental health, and that follow up care is needed. Within adolescent care generally, Hayes et al. (2018) reported that the combination of a treatment program during admission and aftercare was important for admission to be beneficial, highlighting the importance of support beyond admission for positive outcomes.

Findings across services reflect systemic experiences of marginalization reported within healthcare sought by trans people. Parents' experiences around the shortage of appropriate services, complex service pathways and policies around access to gender-affirming hormones (specifically pubertal blockers) all reflect institutional-based erasure. That is, the overall health system that parents must navigate to support their trans child is not designed to provide inclusive and affirming support for trans people. When systems are based on cisnormativity, the assumption that all people identify as their birth presumed gender, staff and systems become unprepared to provide the care that trans people need. This marginalization within institutions and health systems often results in poor service experiences for trans individuals, and this study shows that it also results in poor experiences for parents (Kcomt, 2019). Institutional-based erase is not only reported within this Australian study; Chong et al. (2021) systematic review including articles from 17 countries refers to the erasure experiences of trans youth including a pervasive lack of trans-specific services as well as strict laws and insurance policies preventing access to any care.

The findings from this study highlight similarities between the experiences parents have accessing services with their child, and the individual experiences of trans young people themselves. Barriers to accessing care that are present in both the young person and parent sample of *Trans Pathways* include: seeing multiple practitioners before finding one suitable (due to lack of practitioner knowledge on trans health); long wait times for appointments with those professionals who specialize in trans health; unavailability of services (due to geographic sparsity of services); the high cost associated with specialist services such as private endocrinologists (Strauss et al., 2020, 2021). Care experiences of parent-child dyads explored by Bartholomaeus et al. (2020) showed that care at specialized gender clinics was rated as more affirming than other services, but that clinics were often not able to provide the frequency of care needed, with psychological support being particularly limited. Parental support can help buffer the above barriers, such as through the provision of financial support, which may not be an option for all parents. This paper's findings show that even supportive parents who are trying to obtain medical and/or mental health support for their child still are impacted by the barriers outlined. Most young people (57.5%) featured in Strauss et al. (2020, 2021) were over the age of 18 when they first accessed services in relation to their gender identity compared to the current study, where parents mostly reported first accessing services when their child was aged between 12 and 17 years. Most of the parents who participated in this study were supportive of their young person's gender identity and a part of their gender affirmation journey while the young people featured in Strauss et al. (2020, 2021) came from families exhibiting a wider range of support (extending in some cases to hostility).

The results in this study highlight a discrepancy between parents' reported satisfaction with services and their reported experiences, with high levels of satisfaction reported across services but more negative experiences shared in the open questions. The higher levels of satisfaction may reflect patients' ultimate success in obtaining necessary referrals from primary care services, irrespective of the negative experiences in the process. Other research has found that affirming experiences in pediatric gender clinics are related to higher service satisfaction for both trans young people and their families (Pullen Sansfaçon et al., 2019; Tollit et al., 2018). Within the current study, moderate to high satisfaction was most commonly reported for primary care, as well as psychiatry, gender-affirming medical, and therapy services. This may be due to the success of participants obtaining the sought referrals, medications, or diagnoses from services, even when having negative interpersonal experiences doing so. Further, it may be that parents who are supportive of their child's gender identity are more likely to seek gender-affirming care in the first place and to participate in research on this issue such as the current study.

Implications

The results of this study highlight the importance to parents of practitioners being an important source of support for their child regarding their gender identity and their need for care, as well as having clinical knowledge to provide that care. Individual practitioners within services need to be respectful of gender diversity and examine how they can adapt care to provide for trans patients by seeking further knowledge and adhering to both international (Coleman et al., 2022) and domestic (Telfer et al., 2020) current standards of care. Systemic structures are also needed to support providers knowing where to refer families if they are unable to provide the care required. Individual practitioner knowledge also needs to be supported by professional bodies which can highlight the value of gaining an understanding of trans health on an institutional level. For example, in primary health services, physicians can seek professional development through resources such as the Australian Professional Association for Trans Health (AusPATH). Knowledge of trans health needs and standards of care (Coleman et al., 2022) should also be disseminated within training curricula (i.e., medical and nursing degrees) to ensure an understanding of the value of this knowledge to future practitioners.

As the invisibility of trans experiences is maintained by broader systems such as health care, Kcomt (2019) reports the need for self-assessment of institutional policies and practices to change the structural inequalities that contribute to trans marginalization. The SOC offer recommendations at multiple levels including government and institutional that can be used to increase access to appropriate and holistic care (Coleman et al., 2022).

Our current findings suggest that an assessment of public service funding, hormone access procedures is required as well as longer duration of government subsidized psychological support.

Findings highlight the need for parents to be better supported through the process of accessing services for their trans young person. Trans young people show more positive health outcomes when supported by their parents, and therefore in turn parents themselves need to be supported (Alegría, 2018). We suggest the following. a) Across all services, parents reported confusion about service pathways and a desire for more information. Services should provide information before appointments about the processes of accessing gender-affirming care, potential waiting periods, and the differing roles each service type plays (e.g., the role of a psychiatrist). b) Support for parents of trans young people could also be provided in other ways such as support groups for parents to aid the development of peer support systems within local communities. This study highlights the importance of capturing the experiences of parents within the services they access with their child.

Study limitations

The nature and structure of the data collection method (online, anonymous and, within a set time period) resulted in some pragmatic limitations. Firstly, the number of participants recruited via each medium was not collected. Secondly, where qualitative rigor is concerned, a theoretical saturation point was utilized due to the fact that data could not continue to be collected until no new themes emerged in analysis. Member checking of the themes, elaboration, or clarification of responses could not be performed due to the anonymous online nature of data collection. The way parents were asked about their service experience may also act as a limitation; parents were asked about their experiences with each service broadly without being asked to specify their child's age at the time of the experience they describe. Some parents of older children referred to earlier experiences in their child's life, the exact age of the child at the time of these experiences is not known. It is important to note that parents who were supportive of their child's gender identity would be more likely to participate in the study. This may have influenced the experiences described as these are parents who have been willing to advocate for their child to receive the support they need. Another limitation may be the representativeness of the sample in regard to gender identities the number of non-binary trans people represented in this study was lower than appears to be the case in the contemporary Australian population of trans youth with 10.9% of parents in this study reporting their child identified as non-binary. Comparatively a large Australian reported 19.5% of their LGBTQIA + sample identifying as non-binary comparatively to 1.2% trans women and 6.5% trans men in their sample (Hill et al., 2021). Parents may have different experiences depending on their child's may want to express their gender and the services they may seek. The proportion of parental types may also be a limitation, as a majority of the respondents identified themselves as mothers, fathers may have different experiences that were not captured.

Future directions

Findings suggest that engaged and trained practitioners also helped parents to grow their support of their trans child. This should be explored through further research to identify what kinds of support parents want and how this can be delivered within a service context. Future research may benefit from seeking parents who are not fully supportive of their trans young person to explore how services could support parents to develop their support and acceptance of their child's gender identity.

This study is cross-sectional, and we were unable to document the experiences of parents over time around the impact of these service access experiences on them and their child. Further research could employ more in-depth methods - such as interviews regarding parents' service experiences over time -to access further influences not captured. It is crucial to assess how parents were affected by their service experiences in the context of advocating for their trans young person's needs within other contexts such as with family, friends, and schooling, given that support within these contexts has also been shown to impact a parent's ability to support their child (Alegría, 2018).

Conclusion

Our findings indicate that across services some individual practitioners delivered care in a gender-affirming way, but overall, there is a need for systemic improvement in gender-affirming healthcare for trans youth. Many parents had experiences in which individual practitioners did not understand the needs of their trans child and could not help their child in accessing gender-affirming care. Sparsity and limited capacities of services specializing in gender-affirming care led to long wait times, as well as parents using time and resources to find appropriate services through trial and error. Our findings reflect the erasure of trans identities in health systems that impacts parents of trans young people. Institutional and provider level changes are needed to ensure that parents have positive service access experiences with their trans child.

Note

1. Stage 1 and 2 transition refer to outdated terminology about the use of pubertal blockers (stage 1) and gender-affirming hormones (stage 2).

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