Transgender Community

This needs assessment was prepared in July 2015 by the Public Health Action Support Team
on behalf of Suffolk County Council.

Contents

Summary

Transgender introduction

- Gender dysphoria is the discomfort or distress arising when a person's gender identity – their psychological sense of themselves as male or female – does not match the sex to which they were assigned at birth. People with gender dysphoria are sometimes referred to as trans-people, trans-gendered people or members of the trans-community.
- Trans is a term for people whose gender identity and/or gender expression diverges in some way from the sex they were assigned at birth. A trans-man is a person who was assigned female at birth but has a male gender identity and a trans-women is a person who was assigned male at birth but has a female gender identity. Both trans-men and trans-women propose to transition, are in transition or have transitioned to live as the gender of their choice.
- A person's gender identity is entirely distinct from their sexual orientation, for example whether they are bisexual or heterosexual. People with gender dysphoria are often attracted to people of the opposite gender to their own identity, but this is not always the case.
- Gender reassignment is the medical intervention to adjust the appearance so that it aligns with the gender identity. It is often associated with changes to the gender role and expression, as well as names and pronouns. These changes may alleviate much or all of the discomfort arising from the gender dysphoria.

Transgender key points

- The prevalence of gender dysphoria and those going through gender reassignment are uncertain. Estimates for Suffolk vary between eight and thirty trans-females and between two and twelve trans-males, to as many as seven hundred people. The evidence is weak and those presenting to services are likely to be lower than the true number due to historical stigma and prejudice.
- Gender dysphoria is characterised by mental distress. This is exacerbated by the impact of other people's reactions to trans-gender people, the stress associated with managing the condition and the disruption of personal relationships to which it often gives rise.

- Trans-people have a high incidence of anxiety and depression. They are more likely to self-harm, and attempted and completed suicide is more common.
- Consumption of tobacco, alcohol and illicit drugs is higher among trans-people.
- We found only limited evidence about the effectiveness of treatment for gender dysphoria. Research to support the use of hormonal treatments and gender reassignment surgery is of low reliability. More research of a higher quality is required as lack of evidence does not mean lack of effectiveness.
- General practitioners refer trans patients for further assessment and treatment, and provide and monitor treatment thereafter. Suffolk GPs reportedly vary in their awareness of gender dysphoria and how to treat it. We were told that some will not prescribe hormones or arrange blood tests, and some are reluctant even to refer patients for specialist assessment.
- Secondary care services assess patients before referral to a gender identity clinic. Previously in Suffolk, a designated consultant psychiatrist with an interest in gender dysphoria saw patients referred by GPs and made onward referrals, but this arrangement has lapsed. Instead, referred patients are seen by a clinician from a community mental health team without specialist knowledge or expertise in the condition. We heard reports that some patients and parents of children with gender dysphoria did not feel that the mental health professionals who saw them had the appropriate knowledge and attitudes.
- Local services also treat mental health problems other than gender dysphoria. These problems are common, but we heard that services were hard for people with gender dysphoria to access.
- Tertiary services provide gender identity clinics, where people with gender dysphoria can receive more specialised assessment, hormonal treatment and gender reassignment surgery.
- The Suffolk Lesbian, Gay, Bisexual and Trans Network provides support to local trans-adults via the Gender Xplored network.
- Patients and parents of transgender children told us that healthcare professionals seemed reluctant to accept the validity of their gender dysphoria. They “struggled to be believed” as they described their transgender issues and repeatedly had to convince apparently sceptical clinicians that they were genuinely affected by the diagnosis.
- Specifically, service users mentioned the lack of a dedicated professional to assess patients locally for referral to a gender identity clinic. Allocating this task to a generic

mental health worker reduced the appropriateness and quality of the service that they experienced, and possibly the quality of onward referrals.

- Patients fear that revealing any signs of anxiety, depression or other psychological disturbance risks causing delay in the progress of treatment. They would prefer to use local mental health services for these issues, but find them hard to access.
- More than most other diagnoses, gender dysphoria has a severe impact on family members. We heard that no local support services were available for family members of people with gender dysphoria.
- Long waiting times for assessment cause considerable concern for trans people and their families. This can creates particular problems for children who do not receive hormone blockers in a timely way.
- There is likely to be a growing demand for services that support children with gender dysphoria as the social stigma of being transgender diminishes.

Transgender recommendations

1. More awareness raising and specific training are required in primary care. The previous training was limited to only a fraction of Suffolk practices. There is a need to improve knowledge and attitudes about how to treat trans-people in primary care, and also about referral and support of those who seek treatment.
2. Providers of mental health services in Suffolk should designate a consultant psychiatrist or clinical psychologist to see patients referred with symptoms of gender dysphoria. This will improve the quality of the service.
3. These services should also provide better access to people being seen at a gender identity clinic who need support with other psychological problems such as anxiety and depression, or just emotional support in dealing with the difficulties of gender transition.
4. The specialist services need, at the least, to explain to patients and parents why the correctness of their diagnosis and their commitment to treatment require such frequent testing.
5. Support for trans-people and their families' needs to be increased. The Gender Xplored support group should continue, but with more involvement by the County Council to ensure its long-term viability and effectiveness. At present it attracts only a small fraction of the Suffolk trans-community. More active marketing and publicity and wider availability of meetings might increase the use and impact of the group.

What are gender dysphoria and gender reassignment? Why is it important for Suffolk?

The nomenclature used in this field varies, but we define here the approach that we will use in this report.

Gender dysphoria is the discomfort or distress arising when a person's gender identity – their psychological sense of themselves as male or female – does not match the sex to which they were assigned at birth. People with gender dysphoria are sometimes referred to as trans-people, trans-gendered people or members of the trans-community.

A person's gender identity is entirely distinct from their sexual orientation, for example whether they are bisexual or heterosexual. People with gender dysphoria are often attracted to people of the opposite gender to their own identity, but this is not always the case.

Those people with intense feelings of gender dysphoria want to live and be accepted as a member of a sex other than that assigned at birth. This usually involves changes to social role and presentation. These trans-people aim to make their appearance as congruent as possible with their self-identified gender, typically through dress but also hormonal and surgical treatment; this is known as transitioning. Although most trans-people are clear as to their gender identity, others have a gender identity which is neither male nor female.

Trans-sexualism used to be a term that was regularly used by medical staff and is a recognised disorder in the International Classification of Diseases. However there is challenge about the condition being a mental illness and the trans-community reject the description, trans-sexualism and the mental health label. Trans-sexualism is a term frequently seen in medical literature and will only be referred to when quoting specific information from research papers. It is not a term which should be used when speaking to trans-people or their families as it may cause offence.

Gender dysphoria can cause anxiety, depression and other serious mental health problems. These arise more from the social reception of the condition rather than from the condition itself.

Discrimination against lesbian, gay and bisexual people in Britain has become much less common in recent years, supported by changes in legislation and public attitudes. There has

been less progress in ensuring that trans-people do not suffer unfairly as a result of their sexual and gender identity, and their needs now deserve more active attention.

The health needs of trans-gender people are important because;

- the condition can give rise to substantial distress and mental illness
- meeting these health needs requires primary care and specialist services
- there are indications that current services are not fully satisfactory.

People who intend to transition, are doing so or have already done so are protected from discrimination by the Equality Act 2010. The Act also protects those associated with them, such as family members, as well as others who are perceived to have characteristics protected by the Act. The Gender Recognition Act 2004 allows adults to acquire a gender recognition certificate that records a change of gender and makes it legally effective.

What is the local picture?

There are important difficulties in estimating the prevalence of gender dysphoria:

- The conditions are not precisely defined and the terms may be used differently by different people.
- The conditions are stigmatising, so affected people may not be visible to researchers or to wider society.
- The prevalence may vary between areas and over time. There are indications that it is rising.

A research review of ten prevalence studies in eight countries found rates for trans-females (trans-sexuals assigned to the male sex at birth) ranging from 2.2 to 8.4 per 100,000, and for trans-males (trans-sexuals assigned to the female sex at birth) from 0.5 to 3.3 per 100,000 (De Cuypere, 2006). These figures show a wide range of possible prevalences and must be treated with some caution, but suggest there may be between eight and thirty trans-females and between two and twelve trans-males in Suffolk.

Another analysis suggests much higher figures (Olyslager 2007). This paper was presented at a scientific meeting but never published in a peer-reviewed journal. The authors adjusted previous prevalence estimates to produce new figures, concluding that the true prevalence of trans-sexualism was between 50 and 100 per 100,000. On this basis, there may be between 370 and 735 people with gender dysphoria in Suffolk.

The Amsterdam Gender Dysphoria Clinic has collected data on the Dutch trans-sexual population for more than forty years. The Clinic's estimate of the prevalence is at 1 in 10,000 assigned males and 1:30,000 assigned females (van Kesteren 1997). This suggests about thirty-five trans-females and about twelve trans-males in the County.

The disparities between these figures indicate the difficulty of reaching reliable estimates of the prevalence of gender dysphoria. This makes it hard to plan services, with two important implications:

- We cannot readily gauge the extent of unmet health need among trans-gender people in Suffolk. There are certain to be a number of trans-gender people who are at present isolated and not in receipt of services, but who might benefit from them if they were available or easier to access.
- If the range and availability of services improved, some of these under-served residents are likely to come forward seeking treatment and care. However, we know too little about the numbers of these people and their needs to reach exact conclusions about the volume of services needed.

What are the health problems for trans-gender people?

Mental health

As noted above, whether trans-sexualism is a disorder is controversial. However, gender dysphoria is undoubtedly associated with mental distress. This is exacerbated by the impact of other people's reactions to trans-gender people, the stress associated with managing the condition and the disruption of personal relationships to which it often gives rise.

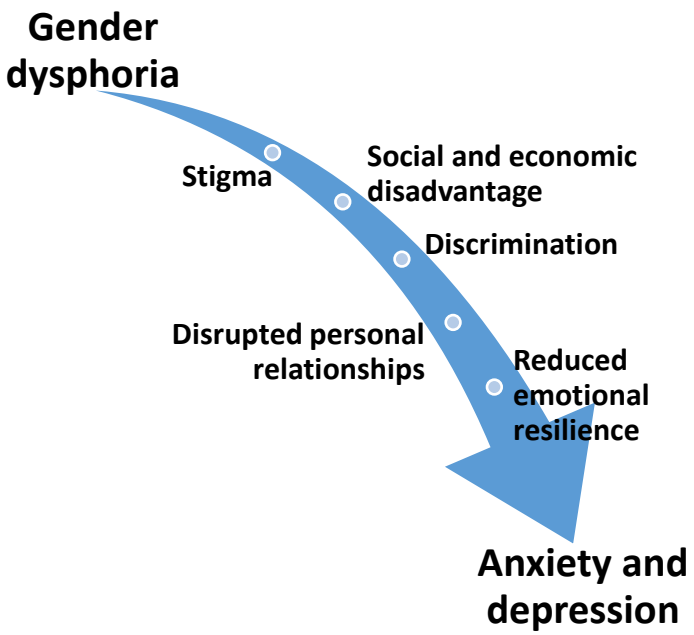
Research from the United States illustrates the nature and extent of discrimination against trans-people (Grant 2011). A survey of 6450 trans-people reported that

- 57% had experienced family rejection
- 53% had been verbally harassed or disrespected in a public place such as a hotel, restaurant or bus
- 40% had been harassed when presenting identification
- 26% had lost a job because of being transgender
- 19% had been refused a home or apartment because of being transgender
- Respondents were four times more likely to live on an annual income of less than $10,000 than the average American

- Respondents were twice as likely to be unemployed than the average American.

Figure 1 illustrates how gender dysphoria can lead to a series of socially mediated disadvantages which concatenate to undermine mental health. Trans-people can have anxiety, depression and other serious mental health problems. These arise more from the social reception of the condition than from the condition itself.

Figure 1: The relationship between gender dysphoria and mental health



Source: PHAST

For these reasons, trans-gender people have a high incidence of mental illness. A survey of trans-people recruited 889 respondents (McNeil 2012). It found that 88% of respondents reported previous or current depression, 80% reported stress and 75% reported anxiety. Fifty-three per cent of respondents had self-harmed at some point, with 11% currently self-harming. Self-harm reduced following transition for the majority of those who had a history of self-harm. Sixty-three per cent felt that they harmed themselves more before they transitioned, with only 3% harming themselves more after transition. Nearly 60% of the participants felt that there were reasons they self-harmed which related to them being trans, while 70% felt there were non-trans related reasons for their self-injury. The reasons for self-harm which directly related to being trans included:

- Gender dysphoria

- Delays in getting gender reassignment treatment
- Stumbling blocks in treatment, and negative attitudes
- Not being able to access treatment or being denied treatment
- Not being taken seriously by medical professionals
- Treatment complications
- Struggling with coming to terms with identity or suppressing gender issues
- Not understanding identity or unwilling to admit to difference
- Not being accepted or experiencing negativity from others
- Not having identity or gender recognised.

The study reported that 24% of trans-people had used drugs within the previous year, the most common being cannabis, poppers and ecstasy. A separate study in Northern Ireland reported that ten per cent of trans-people had signs of severe drug abuse using the Drug Abuse Screening Test (Rooney 2012).

Suicide

Trans-people are more likely to attempt suicide than members of the general population. Suicide attempt rates between 19% and 25% have been reported in transgender people seeking surgical gender reassignment (Dixen et al 1984). More recent data from surveys of transgender people have reported that up to a third of respondents have made at least one suicide attempt (Clements-Nolle 2001, Clements-Nolle 2006, Grossman 2008, Kenagy 2005, Whittle 2007, Xavier 2007). Suicide attempts appear to occur more frequently among transgender adolescents and young adults than among older age groups (Xavier 2007). These studies report that suicide attempts are associated with higher rates of depression, anxiety and substance abuse (Clements-Nolle 2001, Xavier 2007). Transgender young people have reported parental rejection to be a particular source of stress (Grossman 2008). Reported rates of suicide attempts are much higher in trans-people. One reported that 41% of trans-people had attempted suicide at some point in their lives, compared with only 1.6% of the general population (Braveman 2006).

Eighty-four per cent of respondents to the McNeil survey had thought about ending their lives at some point, including 63% in the last year, and 27% in the last week (McNeil 2012). The prevalence of suicide attempts among those who had thought about ending their lives at some point was 48%. Thirty-five per cent of respondents had attempted suicide at least once and 25% more than once. Suicidal thoughts and attempts reduced post-transition.

Physical health

We found no UK evidence about the physical health of trans-gender people. However, there is evidence from the United States which is likely to be relevant to British trans-people (Grant 2011). The 6450 respondents to the survey reported over four times the national average of HIV infection. Rates were particularly high in trans-women, the unemployed and those who have been sex workers.

We found no specific information about the use of tobacco, alcohol and illicit drugs among British trans-people. Members of the lesbian, gay and bisexual communities are reported to smoke and drink alcohol more heavily than the general population (Lee 2009, King 2003, King 2008). However, it is not clear whether these findings are applicable to trans-people. In the United States, 35% of the respondents misused drugs or alcohol specifically to cope with the mistreatment they faced due to their gender identity or expression. The prevalence of smoking in American trans-people was 50% higher than in the general population (Grant 2011).

What is the evidence base for interventions? What is best practice?

We found only limited evidence about the effectiveness of treatment for gender dysphoria. A systematic review from 1998 found one controlled study comprising 40 participants, and 11 non-controlled studies comprising 519 participants (Best 1998). The controlled study reported that, after two years, trans-people who had undergone gender reassignment surgery were significantly more active in visits to family and friends, eating out, sport in company and sexual interest. They had significantly reduced scores on the psychoneurotic index, which measures free-floating anxiety, phobic anxiety, obsessionality, somatic anxiety, depression and hysteria, although the clinical significance of this result was not reported. Positive outcomes in the non-controlled studies were reported in cosmetic appearance, sexual functioning, self-esteem, body image, socio-economic adjustment, family life, social relationships, psychological status and satisfaction. However, little could be reliably concluded from these studies because they all had serious methodological limitations.

Postoperative complications include haemorrhage, urethral stenosis, urinary incontinence, rectal fistula, vaginal stenosis and erectile tissue around the urethral meatus. The incidence of these events varied between the studies and there were high rates of loss to follow-up. New problems may emerge following reassignment surgery, such as painful loss of jobs, families, partners, children and friends. Some people are forced to move away from their familiar environment and, despite being confident in their gender role, may have difficulty

with social adaption and acceptance by others. The extent of these problems has not been recorded in the published studies.

These findings were corroborated by a systematic review from 2002 (Day 2002). This review concluded that there is not enough evidence to support the efficacy of gender reassignment surgery for specific subgroups of persons selected for surgical intervention. Subgroups of trans-sexual people who will most likely benefit from surgery could not be identified from the evidence reviewed. The quality of the evidence was poor: there was only a small number of studies, and they had unreliable study designs and important methodological limitations. The authors concluded that gender reassignment surgery may benefit some carefully assessed and selected trans-people who have satisfied recognised diagnostic and eligibility criteria, and have received recognised standards of care for surgery. More research is required to improve the evidence base identifying the subgroups of trans-people most likely to benefit from gender reassignment surgery.

A more recent review of hormonal therapy and sex reassignment also reached cautious conclusions (Hassan Murad 2010). Twenty-eight studies were included in the review, with 1833 participants. It was unclear whether three or four studies included a control group; the other studies did not. None of the studies were randomised. The overall quality of the evidence was very low. Following gender reassignment, most participants reported statistically significant improvements in gender dysphoria, psychological symptoms, quality of life and sexual function.

What is the pattern of services in Suffolk at present?

Primary care

General practitioners (GPs) have two roles with respect to patients with gender dysphoria:

- **Referring patients:** The GP will consider whether there are any co-existing conditions, mental or physical health issues, or risk and vulnerability factors which need to be taken into account. In Suffolk, GPs refer people with gender dysphoria to a local mental health professional, who in turn refers them to a gender identity clinic. This may be valuable in diagnosing the condition more thoroughly and assessing whether there are other mental health issues. It is not specifically recommended or deemed necessary in national guidance.

- **Providing and monitoring treatment:** After assessment at the gender identity clinic, the GP is responsible for the initiation and ongoing prescribing of endocrine therapy and organising blood and other diagnostic tests as recommended by the specialist gender identity clinician. In the longer term, the GP is responsible for the life-long maintenance of their patients' wellbeing. The GP is also responsible for making appropriate changes to patient record systems to reflect the patient's desired future gender role and to ensure that such changes facilitate screening.

Suffolk GPs reportedly vary in their awareness of gender dysphoria and how to treat it. We were told that some will not prescribe hormones or arrange blood tests, and some are reluctant even to refer patients for specialist assessment.

In 2013, a group of clinicians with a specialist interest in gender dysphoria prepared a guide to gender dysphoria services for primary care staff (Anon 2013). Their key recommendations were to:

- Refer early and swiftly to a reputable gender service
- Support the treatment recommended by the gender service
- Get pronouns right; if in doubt, ask discreetly
- Be particularly mindful of medical confidentiality
- Avoid misattributing commonplace health problems to gender.

The authors point out that "Of all the things that could offend a trans-person or lead them to feel misunderstood, excluded and distrustful, mistakes involving forms of gender-related speech are perhaps the most upsetting. Potentially they are also easiest to pay attention to getting right."

Screening

The screening services offered to a trans-person who has had gender reassignment surgery depend on the risk of disease, which is related to the new anatomy and any additional risk from hormonal treatment. This should be agreed after surgical treatment is complete and GPs should ensure that correct arrangements are then put in place. They must ensure that patients' gender histories are not disclosed to third parties.

Secondary services

Secondary care services have two functions with respect to people with gender dysphoria:

- Assessment before referral to a gender identity clinic
  The *UK Intercollegiate Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria* were published in 2013 (Royal College of Psychiatrists 2013). The document describes in detail how people with gender dysphoria should be managed by specialist services. It notes that "Gender dysphoria may be confirmed in different ways, for instance by engaging in a period of therapy with a counsellor, psychotherapist, psychologist or a psychiatrist. This can take place in either primary or secondary care settings."

  Previously in Suffolk, a designated specialist psychiatric nurse with an interest in gender dysphoria saw patients referred by GPs and made onward referrals, but since his retirement and subsequent service changes, this arrangement has lapsed. Instead, referred patients are seen by a clinician from a community mental health team without specialist knowledge or expertise in the condition. We heard reports that some patients and parents of children with gender dysphoria did not feel that the mental health professionals who saw them had the appropriate knowledge and attitudes.

- Treatment of mental health problems other than gender dysphoria
  People with gender dysphoria may experience concurrent mental health problems, either coincidentally or as a result of the underlying condition; these include anxiety, depression and self-harm. Gender identity clinics are highly specialised and generally do not provide treatment for these diagnoses. It is therefore for local mental health services to do this, though we heard that they were hard for people with gender dysphoria to access, partly because of the overlap with the more specialised condition.

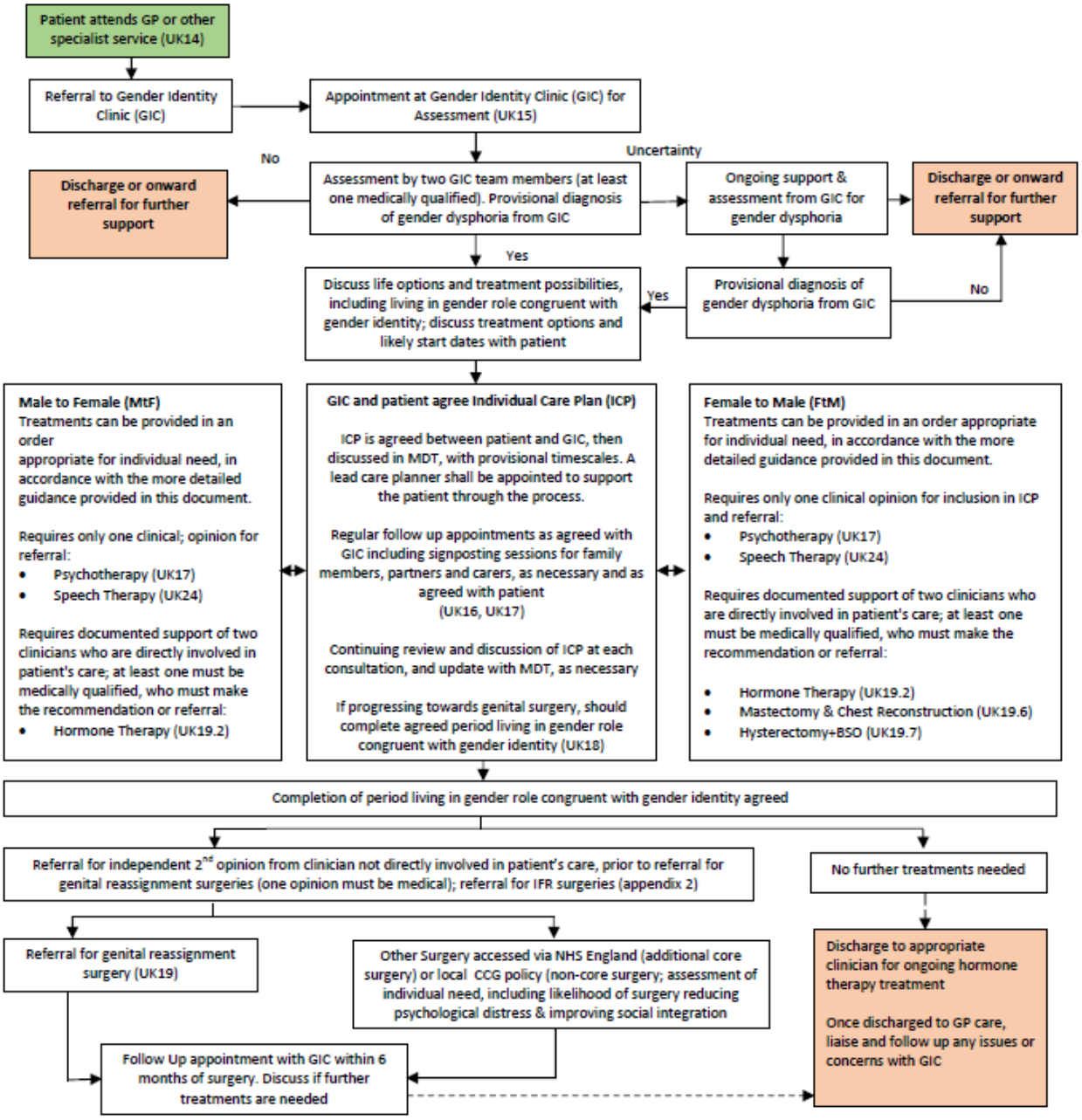
  NHS England says "Some, but not all, patients may require formal psychiatric intervention to assist with psychiatric comorbidities and in such cases shared care may be appropriate" (NHS England 2013). The document notes that "If significant medical or mental health concerns are present, they must be reasonably well-controlled". Some people seeking gender reassignment believe that revealing psychological distress, anxiety or depression will cause delay or prevent them having hormone treatment or surgery, and therefore do not disclose this to staff at the gender identity clinic. They would therefore be assisted by better access to local

mainstream mental health services for mental health problems not requiring specialised skills.

Tertiary services

Tertiary gender identity services are commissioned by NHS England, based on an interim gender dysphoria protocol and service guideline 2013/14 (NHS England 2013). Figure 2 is illustrates the model of care that NHS England commissions.

Figure 2: NHS gender identity services



Source: NHS England (NHS England 2013)

Adult patients from Suffolk are referred to the gender identity clinic at the Charing Cross Hospital in West London. Patients under 18 are referred to the Tavistock and Portman Clinic, London for assessment and then to University College London Hospital for possible hormone blocking treatment. The hormone blockers are used to stop the onset of puberty or

diminish its progress, giving time; for further assessment and reflection before a decision is made about gender alignment.

NHS England requires the clinics from which it commissions gender identity services to:

- have an effective multi-disciplinary team that meets regularly, either in person or through electronic communication
- deliver patient care that is based upon individual care plans that are agreed and reviewed by the provider's multi-disciplinary team
- offer the complete range of multi-disciplinary services described in the commissioning document
- meet team member training and quality standards that will be determined from time to time by NHS England.

Tertiary treatment in a gender identity clinic includes:

- hormonal treatment to render the patient's appearance more congruent with their intended gender
- a period of living in the gender role that is congruent with the individual's gender identity, referred to as real-life experience, before the provision of genital reassignment surgery. It typically lasts one to two years. At the beginning of this, the clinic and the patient should discuss the practicalities and requirements of the experience and patient and family support, as well as the possible treatments available. The period can be extended. Patients who elect not to have surgery can continue on hormone therapy.
- Gender reassignment surgeries to provide sexual anatomy as close as possible to that of the intended gender. For a trans-man this may include bilateral mastectomy with male chest reconstruction, phalloplasty (creation of phallus), metoidioplasty (creation of micropenis), urethroplasty (creation of urethra), scrotoplasty (creation of scrotum) and placement of testicular prosthesis, implantation of penile prosthesis, vaginectomy (removal of vagina), salpingo-oophrectomy (removal of ovaries and fallopian tubes) and hysterectomy. Trans-women may have a penectomy (removal of penis), orchidectomy (removal of testes), vaginoplasty (construction of neovagina), labioplasty (construction of labia) and clitoroplasty (creation of clitoris).

Hospital activity analysis

We analysed hospital episode data about Suffolk residents admitted to hospital with a main diagnosis of trans-sexualism (an historical medical term still used by many practitioners) or gender identity disorder.

In the thirty-five months[1] to February 2015, eleven Suffolk residents were admitted to hospital at least once with one of these diagnoses. There were six admissions in 2012/13, eight in 2013/14 and five or fewer[2] in the first eleven months of 2014/15. Sixty-one per cent of the admissions were to Cambridge University Hospitals NHS Foundation Trust, and the rest were to one of Imperial College Healthcare, University College London Hospitals, St George's Healthcare, Norfolk and Suffolk or Papworth Hospital NHS Foundation Trusts. Imperial College Healthcare is the organisation responsible for gender-identity and gender-reassignment services at the Charing Cross Hospital in London. The small numbers mean that no more detailed analysis can be published, to protect confidentiality, including what treatment was provided during the admission.

Awareness raising and professional education

In June 2014, a workshop was held with for thirty people from three groups of Suffolk GPs. The aim was to gather information about the GPs' information needs in providing care to trans-gender people and improve their understanding of gender dysphoria and the transition process. It focussed on trans-people who wanted gender reassignment surgery and the GP as gatekeeper in this process. It emphasised a holistic approach to treating and supporting a person living with gender dysphoria and that the GP was best placed to co-ordinate the diverse aspects of care needed, as well as influencing the development of a safe and supportive culture across the practice.

Support groups

The Suffolk Lesbian, Gay, Bisexual and Trans Network (www.suffolklgbtnetwork.org.uk) is a registered charity and support organisation that aims to promote equality and diversity in Suffolk, and combat sexual orientation and gender identity discrimination and prejudice. The network provides help, support, advice and events, and hosts equality and diversity training for businesses and organisations. It receives funding from Suffolk County Council for specific projects.

[1] Data for March 2015 was not yet available. Data for 2014/15 is provisional.
[2] To protect patient confidentiality, values of five or less are not published.

The network includes four groups that meet monthly, respectively for gay and bisexual men, for lesbian and bisexual women, for 18 to 30 year olds and for trans-people. The group for adult trans-people is called Gender Xplored; five to ten people attend its monthly meetings. We heard concerns that the Network needed strengthening organisationally and financially in order to be fully effective. Specifically, there is no funding for a facilitator for Gender Xplored.

What problems are reported by trans-people and parents in Suffolk?

- Patients and parents of trans-children told us that healthcare professionals seemed reluctant to accept the validity of their gender dysphoria. They "struggled to be believed" as they described their trans-gender and repeatedly had to convince apparently sceptical clinicians that they were genuinely affected by the diagnosis. They felt that professionals were holding out the diagnosis as a prize to be earned. Few other NHS patients face this, and it made the distress of the condition all the more painful.
- Specifically, service users mentioned the lack of a dedicated professional to assess patients locally for referral to a gender identity clinic. Allocating this task to a generic mental health worker reduced the appropriateness and quality of the service that they experienced.
- There are often delays between referral and assessment – we heard that these may be as long as eighteen months. There are further delays before gender reassignment is offered. These delays stand between patients and their goal of having a body congruent with the gender with which they identify, and also exacerbates the dysphoria that they experience. These delays can be of particular concern to trans-children and their parents as a delay in receiving hormone blocker treatment can make gender dysphoria more distressing for children than it could be due to body changes brought on by puberty.
- Older children being treated by gender dysphoria services can find poor transition arrangements between child and adult services increases the length of time it takes for them to get the right support.
- Patients fear that revealing any signs of anxiety, depression or other psychological disturbance risks causing delay in the progress of treatment, as it might be seen as evidence that they were not adjusting well to living openly as a member of the gender to which they are transitioning. They would prefer to use local mental health services

for these issues, on grounds of convenience and separation from the gender identity clinic, but find them hard to access.

- Travelling to London to attend the gender identity clinic is not easy for some patients. In addition to the costs of travel, often in the peak period, some people find it difficult to be on a crowded train, especially trans-women who may have facial hair growth in preparation for electrolysis.
- More than most other diagnoses, gender dysphoria has a severe impact on family members. They may feel that a change of gender is such a large step that it constitutes the loss of the relative that they loved. We heard that no local support services were available for family members of people with gender dysphoria.

What additional information is needed?

- The epidemiology of gender dysphoria is not well understood. We need to know more about who has the condition.
- Research into the effectiveness of treatments for gender dysphoria is of low reliability. We need more evaluations of the clinical and cost effectiveness of hormonal treatment and gender reassignment surgery.
- We found no investigations of patient satisfaction with gender identity services. This group of patients may be disempowered by the consequences of their gender dysphoria and are dependent on the decision of their clinicians for access to the treatments they are seeking. This makes it harder for them to influence their care and more importantly to find ways to promote this in a way that protects their anonymity.

What can be concluded?

1. Primary care services are not always responsive to people with gender dysphoria. When they first present, they are sometimes not given appropriate support and referral, and there are problems with primary care staff using the correct name, gender and title.
2. There is no single point of referral locally for people seeking access to tertiary services such as gender dysphoria clinics in London. There used to be a consultant psychiatrist who saw and assessed patients and made onward referrals, but now GPs refer to generic professionals without specialist knowledge or interest. This is a less satisfactory approach because it does not provide concentrated expertise in a single clinician who has an interest in gender dysphoria.
3. There is little local support for trans-people. They see a need for local peer support and also for access to local mental health services for the anxiety, depression and

other common mental health problems that follow from their position. These are apparently difficult to access.

4. Trans people and their parents often experience specialist services as sceptical. They feel that they need to repeatedly "prove" that they have the diagnosis in a way no other type of NHS patient does. It is necessary to ensure that the diagnosis is correct, but the rationale for repeatedly testing the patient's dysphoria and commitment to change is not clear, at least to the patients themselves
5. The financial and personal cost of travelling to London is burdensome for some people.

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