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## Response to Draft Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria



The LGBT Centre for Health & Wellbeing is a unique initiative, funded by the Big Lottery Fund and local NHS organisations, to promote healthy lifestyles and improve the accessibility of mainstream health services for Lesbian, Gay, Bisexual & Transgender communities in Edinburgh & south-east Scotland.

In the four years since the Centre opened we have been privileged in establishing a *substantive* relationship with significant numbers of transsexual and transgender (trans) people and trans community groups in Edinburgh, the Lothians and beyond.

In 2004 the Centre established a Transgender Reference Group, bringing together key local stakeholders (representing local trans community groups, LGBT organisations and trans individuals), to assist us in:

- Developing good practice in our work with trans people
- Identifying development opportunities
- Addressing issues relating to access to health and other services

The Transgender Reference Group held a special meeting to develop our response to the Royal College of Psychiatrists Draft Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria.

We agree that there is a need for Good Practice Guidelines for the Assessment & Treatment of Gender Dysphoria in the United Kingdom. Currently, assessment and treatment of Gender Dysphoria is very good within NHS Lothian but provision is patchy or even non-existent in some parts of Scotland and the wider UK, particularly in rural areas.

NHS assessment and treatment for Gender Dysphoria is effectively an unfair post-code lottery. There is also often confusion among clinicians regarding how to apply the existing internationally well-respected Harry

Benjamin International Gender Dysphoria Association's Standards of Care<sup>1</sup> within the context of the National Health Service system.

We consider that the Good Practice Guidelines needed in order to improve provision for UK individuals with Gender Dysphoria should:

- Affirm that UK clinicians should follow current HBIGDA / WPATH Standards of Care;
- Affirm that untreated Gender Dysphoria often causes intense distress and functional difficulties and that therefore the NHS has a duty to promptly provide good quality treatment including hormonal and surgical interventions in order to maximize trans people's psychological well-being and potential quality of life;
- Affirm that diverse sexual orientations, previous/current sexual behaviours and anticipated future sexual orientations and behaviours should not be barriers to receiving treatment for Gender Dysphoria;
- Affirm that non-traditionalist and non-binary interpretations of gender identity and gender expression should not be barriers to receiving treatment for Gender Dysphoria;
- Provide clear guidance on how to ensure genuine patient-centred provision in NHS assessment and treatment of Gender Dysphoria;
- Provide clear guidance on how to ensure genuine patient choice and empowerment with accessible, well co-ordinated, diverse options in NHS pathways of care and the freedom to move to and fro between self-funded private treatment provision and NHS provision;
- Provide clear guidance on how to achieve real harm reduction, not only for individuals opting for self-medication with hormones acquired via the internet or undertaking surgery abroad, but also for individuals experiencing homelessness, concurrent drug or alcohol problems, long-term mental health issues, abusive family relationships or other social marginalisation issues.

We are very disappointed that the Draft Good Practice Guidelines by the Royal College of Psychiatrists currently fail to adequately affirm these key points and also fail to provide sufficient quality guidance on genuinely making services patient centred, empowering to patient choice and harm reducing.

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<sup>1</sup> The Harry Benjamin International Gender Dysphoria Association (HBIGDA) is currently changing its name to the World Professional Association for Transgender Health (WPATH). Their current Standards of Care (the sixth version since their original 1979 document) is available at: <http://www.wpath.org/soc.htm>

We consider that the tone of the Draft Good Practice Guidelines is currently too focussed on clinicians' self-protection of their reputations with too narrow and rigid an interpretation of assessment, treatment options and overall transition process. No consideration is given to the possible treatment options for those people with Gender Dysphoria who embrace an 'Androgyne' or 'GenderQueer' non-binary gender identity or to those who would derive benefit from treatment with low dose hormones without a social transition for various reasons. It appears that the Draft Guidelines have simply consolidated current flawed practice at the two largest English NHS Gender Identity Clinics rather than seeking to positively improve service provision.

In a step backwards rather than forwards from the current HBGDA / WPATH International Standards of Care, the Draft Guidelines currently seek to impose a longer, less collaborative and more clinician controlled process of assessment and treatment. For example, at paragraph 17.1 the Draft Guidelines attempt to require psychotherapy as "essential" for those seeking treatment when this should instead be an option for the patient to choose or decline freely. For psychotherapy to be genuinely useful, it needs to be willingly and freely undertaken by the service user, not forced upon them causing mistrust and resentment.

Throughout the description of assessment within the Draft Guidelines, it is strongly implied that the clinician decides on the basis of the patient's history whether or not they are suitably Gender Dysphoric to receive treatment in the form of hormones and surgery. We are very concerned that this artificially sets up the clinician in the role of 'Expert' and 'Gatekeeper' consequently reducing the likelihood of patients feeling able to work honestly and openly with the clinician to find the best individual pathway of care for their unique circumstances.

The clinician is dependant on the quality of the communication with the patient in forming an accurate understanding of their situation and the appropriateness of various treatment options. Therefore, it is essential that the Guidelines be modified to better describe the assessment process and treatment decisions as equal partnership collaboration between the clinician and the patient in a truly patient centred manner. The Guidelines also ought to be modified to highlight that the clinician should be working to assist patients to become fully informed regarding the treatment options

available and the risk / benefit profiles of these options so that the patient can be the one who reaches a rational, well-informed, stabilised and realistic decision on what treatment to undertake. The clinician should only be slowing the patient's progress in making such decisions if the patient is not yet able to demonstrate a rational understanding of the effects and risks of treatment options or has seriously compromised reality-testing ability due to a current psychosis.

In relation to the Real Life Experience, the Draft Guidelines mistakenly focus upon document verification (paragraph 19.4) rather than on a collaborative exploration and consolidation of the patient's self-understanding of their gender identity, gender expression and long-term social presentation and surgical options. Breast reduction / mastectomy for trans men is particularly important to undertake early in any transition process for reasons of personal safety in male social spaces. Although this is mentioned much later on in paragraph 33.1, the Guidelines need to be clarified within section 19 to more clearly encourage referral for mastectomy even prior to any Real Life Experience beginning.

The current Draft Guidelines disempower trans people by insisting on two psychiatric opinions before treatments, such as breast reduction or breast enlargement, which would not normally require such opinions before being undertaken by non-trans people. Even for genital surgery, where two opinions could be justified, we have great concerns that requiring both opinions to be by either Psychiatrists or Psychologists will cause major difficulty and delay in service provision, particularly in south-east Scotland. The long established and highly regarded Edinburgh-based Gender Specialist is a medical doctor with specialist training in Psychosexual Medicine not a Psychiatrist or Psychologist. It is completely unacceptable to us that the Draft Guidelines would not recognise her ability to provide a medical opinion for genital surgery for the many trans people she assists. It is imperative that the Guidelines be modified to enable the two opinions for genital surgery to be provided by experienced clinicians who are neither Psychiatrists nor Psychologists. Psychosexual Specialists, General Practitioners, Psychotherapists and Mental Health Social Workers should all also be able to provide the opinions in favour of surgery for trans people.

We are also very dissatisfied that section 12 regarding children and adolescents begins in such a negative tone with the first sentence stressing that surgery under the age of 18 would be "highly unlikely". In Scotland the

legal age of majority is 16 so young trans people must be automatically treated as adults from the age of 16. Furthermore, throughout the UK, the recognised automatic age of consent for the purposes of Medical Treatment for all people for all treatments is taken to be 16 and a child of any age may be deemed to have the capacity (in Scotland) or be competent (in England) to give informed consent to medical and surgical interventions, provided they are able to understand and retain the relevant information (pros and cons), weigh this up and freely make a decision (without bias from other interested parties e.g. relatives or anyone else who might have a vested interest in a decision either way). Apart from being ageist (by encouraging clinicians to focus on the individual's age rather than the individual's maturity and readiness), section 12 of the draft guidance is in our view also transphobic guidance, as it is recommending treating trans (young) people differently from non-trans (young) people.

Therefore, we strongly urge that Section 12 of the Guidelines to be revised to more positively encourage clinicians to follow European good practice (particularly in the Netherlands) of using hormone blockers at the earliest opportunity to delay puberty thus enabling the young person to determine their long-term gender identity and desire for transition without the possibly irreversible changes that ordinary puberty would impose upon them. The possible benefits of early transition for future economic and social achievement in severe cases of Gender Dysphoria are so huge and the risk of suicide and self-harm when treatment is delayed are so high that we advocate that the Guidelines should be far more positive in encouraging clinicians to look favourably on early hormone and surgical treatment for severely Gender Dysphoric adolescents.

Finally, we are dissatisfied that the Guidelines provide no meaningful guidance on harm reduction strategies. Paragraph 14.1 entitled Harm Reduction appears to just be a rewording of paragraph 16.2 and is therefore more appropriately considered to be about acknowledging and supporting the different stages of progress in transition a person may have reached upon initial presentation rather than guidance on harm reduction in complex cases involving some of the most vulnerable, marginalised and chaotic of trans people.