

# **Report into the Medical and Related Needs of Transgender People in Brighton and Hove**

## ***The Case for a Local Integrated Service***

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## ACKNOWLEDGEMENTS

First and foremost thanks to the Brighton and Hove City NHS Primary Care Trust (PCT), for recognising and identifying the need to do funded research into the needs of transpeople in Brighton and Hove.

This is a recognition of the suspected weaknesses in aspects of care provision for this client group, and the willingness to take on the realities this might bring, understanding that this is giving the client group - often not listened to - a clear voice. This clearly demonstrates their commitment to Good Practice.

That this research should be commissioned through Spectrum, the Brighton and Hove Lesbian, Gay, Bisexual and Transgender Forum – which has always had the direct support of the PCT – is also worthy of recognition, a very clear indication of the willingness to take on board the views and experience of transpeople in this community.

With thanks for the time and wisdom of

Dr A Hermitage, General Practitioner  
Dr S Lipscombe, General Practitioner  
Dr P Levy, Consultant Endocrinologist  
Dr N Vaughan, Consultant Endocrinologist  
Dr T Ojo, Consultant Psychiatrist  
Mr P Thomas, Gender Reassignment Surgeon  
Dr L Myskow, Specialist GP  
Ms L Preston, Voice Therapist  
Mrs M Marlow, Director of Specialist Commissioning  
Mrs R Turner, The Gender Trust  
Ms T Livingstone, Gender Counsellor  
The Clare Project  
Ms P Ryder, Crossroads  
The Gender Identity Research and Education Society  
Press for Change  
Spectrum: The Brighton & Hove Lesbian Gay Bisexual & Transgender Forum  
The Transpeople of Brighton and Hove

.....and all the many people who have given their support to this research

# The Report

***'If they really understood us, they wouldn't treat us like this.'***

Trans woman at The Clare Project, Brighton and Hove, April 2004

***'One of the serious obstacles to understanding Gender Dysphoria is that it is an unimaginable and inconceivable problem to those who do not have it.***

***This distinguishes it from other forms of human suffering, for which it is much easier to generate empathy and sympathy.'***

Professor Louis Gooren MD PhD, The Free University of Amsterdam

When looking at the medical needs of transgender people in Brighton and Hove, I have focused on the medical issues of Gender Dysphoria which are particular to this client group. Other health issues that affect the population as a whole are considered to be outside the scope of this report.

Rather than the term transsexual or transgender for those who have the high degree of Gender Dysphoria that requires radical action, the terms transperson, trans man, trans woman, etc, are usually the preferred terms of this community, so this is how they will usually be referred to in this Report.

Even though there is an estimated population of transpeople in Brighton and Hove of up to 200, they are rarely seen. This is because they live ordinary lives, and after transition simply return to those lives in a different gender - their history is not necessarily relevant to the integrated lives they are leading.

Gender Dysphoria occurs across the population and includes people of every age, social group and profession. There are highly intelligent, gifted and successful transpeople in all walks of UK life: the forces, the legal profession, Oxbridge and other universities, entrepreneurs, engineering and electronics, airline pilots, information technology, education, surgery, medicine and health care, writers, journalists, composers, musicians etc etc.

The medical issues distinctive to this client group relate to the alleviation of the condition known as Gender Dysphoria, Gender Identity Disorder, or transsexualism.

The lack of true understanding tends to create profound additional suffering for those people affected, over and above the issue itself, so there needs to be some elucidation to put the entirety of this Report in context, to make it comprehensible to those who do not have that understanding.

## **SECTION 1**

### **What is Gender Dysphoria?**

Gender Dysphoria may be described as having the inner conviction of a gender identity which is at odds with the primary and secondary sexual characteristics of the body, the sexual hormones and the subsequent social role of the individual. When the anguish this condition brings about is severe to the point of a person needing to change the body and social role to alleviate it by fitting the inner sense of being with the outer life, it is often called transsexualism.

Gender Dysphoric people – transsexual, or transpeople – are generally aware of their inner gender identification from an early age. Fear of the consequence of declaring themselves to family and surrounding society often drives them to hide their reality until it becomes intolerable to do so. Change in our society is now making it easier to declare a gender issue at an earlier age, which will, with further education, lead to easing of the whole issue.

The evidence of the pain and distress that Gender Dysphoria creates is demonstrated by the actions that people take to undergo gender transition. The social transition from one gender to the other in itself is a vast undertaking, dealing with the social and personal rejection that can follow, taking powerful hormones to change the body and feelings, undergoing major and minor surgery and more. It is a path for the truly committed, people who are strong and know themselves well.

The result of such a transition is generally good, although, as with all human endeavour, end results vary from person to person.

The great majority of transpeople come through the transition to live more fulfilling lives - to the benefit of themselves and their community. As they become almost invisible, they are rarely noted. This is because people who live ordinary lives simply continue those lives in a different gender.

But what is notable is that the extraordinary suffering that comes with Gender Dysphoria is greatly alleviated and ended, and people who lived with intolerable personal pain now live good lives free from deeply held distress.

The causes of Gender Dysphoria are complex and individual. Dr Harry Benjamin, who introduced the syndrome to the general medical community in the early 1950s favoured a biological explanation of the syndrome, believing that the genetic and endocrine systems must provide a “fertile soil” for environmental influences. The weight of current scientific evidence suggests a biologically-based, multi-factor aetiology for transsexualism. Most recently, for example, a study identified a region in the hypothalamus of the brain which is markedly smaller in women than in men. The brains of transsexual women examined in this study show a similar brain development to that of other women. This indicates one physical/neurological basis for gender dysphoria.

This information was mostly gathered from *'Transsexualism; the Current Medical Viewpoint'*, produced for the Parliamentary Forum on Transsexualism, and may be found, with other information of relevance on the Press for Change website. ([www.pfc.org.uk/medical/mediview.htm](http://www.pfc.org.uk/medical/mediview.htm))

## **Gender Dysphoria is not a mental illness or psychological condition**

This point cannot be made strongly enough, and is confirmed by this statement by Professor Richard Green, Chief Clinician at the Gender Identity Clinic at Charing Cross Hospital in London (cited in Bellinger, 2001, para 32.)

*'Severe Gender Dysphoria cannot be alleviated by any conventional psychiatric treatment, whether it be psychoanalytic therapy, eclectic psychiatric treatment, aversion treatment, or by any standard psychiatric drugs'*

It is to be noted again that psychiatric or psychological means have never resulted in the alleviation of Gender Dysphoria, because there is no evidence that it is a psychiatric condition. A *'Government Announcement on Transsexual People'*, originating with Rosie Winterton MP, Minister at the Lord Chancellor's Department, and supported by the Chief Medical Officer, stated, *'transsexualism is not... a mental illness.'*

At this point it may be noted that the major thrust of both time and resources at present is in the psychiatric evaluation of clients; the process is in the hands of, under the control of, psychiatrists. This is considered to be the major reason why many clients choose to create their own pathways for their transition.

Psychiatric treatment - such as the aggressive electro-aversion therapy that was regularly used as an attempt at a psychiatric solution for Gender Dysphoria into the 1980s - only exacerbated the condition and was the cause of greater distress, to the point of suicide. There has been a long history of enhanced distress of this non-psychiatric condition by the misplaced intervention of psychiatrists.

There is a place for psychiatric assessment within treatment of Gender Dysphoria in order to identify those who suffer from the delusion of being gender dysphoric - in the same way as there is for people who have delusions of being Napoleon. But for genuine transpeople without concurrent psychiatric issues (the vast majority), there is no need for continuous assessment.

Some gender dysphoric people may also have psychiatric issues – or coronary heart disease – but these are both common to the population at large. There is no evidence that Gender Dysphoria, a non-psychiatric issue, is particularly linked to concurrent and significant mental illness.

That Gender Dysphoria is not a mental illness, nor does it necessarily incur the co-existence of mental illness, is a fact that needs to be stressed yet again.

This is because much of the client group's dissatisfaction with service provision appears to be linked with the supposition – encouraged by the Policy Document which defines service provision in Brighton and Hove – that Gender Dysphoria is linked with mental illness. It is not necessarily linked with mental illness at all, but as with other forms of variation from a gender stereotype – such as homosexuality – it has been treated as such historically.

People who do not fit in with expected gender stereotypes have often found themselves declared mentally ill, and this continues to this day to be a means of removing them from legitimacy, taking away their voice, and treating them unjustly, while at the same time finding good reason to do this in an otherwise fair society.

The judgement of the European Court of Human Rights in 2001 that the legal situation in the United Kingdom for transpeople had been a breach of essential human rights has brought about the change in law: **The Gender Recognition Act 2004**. With this Act, legitimacy and respect have become enshrined in the law, and with that it is expected that historical and outdated beliefs will begin to die.

Discrimination against transpeople however is still commonplace - in the workplace as well as socially and medically - although attitudes are changing within society as the reality of transsexualism becomes more widely experienced and its truth grasped.

## **Implications of The Gender Recognition Act in regard to the treatment of Gender Dysphoria**

A significant point which the new legislation brings into focus is that now the essential gender of a person is no longer necessarily linked with sexual features visible at birth. It is now recognised legally that true gender identity is within the heart and feelings of a person.

The old psychiatric model of understanding Gender Dysphoria as a mental illness is thus invalidated in the United Kingdom, and with it any supposition of psychiatric treatment for it. No longer do transpeople have to prove their sanity, and thus their ability to make their own rational decisions about their identity.

This is a critical point to grasp when considering commissioning treatment in Brighton and Hove, and any other community in this country.

Transpeople interviewed for this research who are highly informed on the issues affecting their lives, often associated ignorance of these issues with the quality of service offered them through the NHS in Brighton and Hove.

## **SECTION 2**

### **How is Gender Dysphoria alleviated?**

The essence of the process of alleviating the distress of Gender Dysphoria lies in altering the body and the social role – which are intertwined – to fit the inner gender identity. When the inner sense of identity and the body and social role are in harmony, so the distress caused by Gender Dysphoria is no longer present, and the individual can live a more complete life. Results of this transition are generally very good, with a high rate of satisfaction, effectiveness in social role, and simple happiness. Transpeople more often than not become more socially integrated, more effective, and contribute more to the whole of our society due to the integration of their own being. Additionally, the medical effects of the long-term stress caused by Gender Dysphoria no longer affect the individual, so that stress related illness is greatly reduced.

As it understood that much of the distress that gender dysphoric people face are as a result of the effects of inappropriate hormones at adolescence, one of the major therapies is endocrine – the prescription of oestrogen or testosterone. As well as affecting the body, for example in developing facial hair and breaking the voice for trans men, softening of the skin and breast development in trans women, these hormones affect the way the client *feels*.

In both the case of trans men and trans women, an inner sense of oppression and incorrectness that haunts their days begins to be lifted, and as the hormones take effect upon the body, the relief and sense of correctness is profound. Hormone therapy is of the essence and effective, and is one of the Triadic Therapies noted in the Harry Benjamin International Gender Dysphoria Association's Standards of Care ([www.hbgda.org/soc.html](http://www.hbgda.org/soc.html)).

In some gender clinics, such as that in The Free Hospital in Amsterdam, which is regarded by many as being enlightened and true in its approach to treatment, Gender Dysphoria is regarded primarily as an endocrine issue, and psychiatry is in a supportive role - for those with psychiatric issues.

Endocrine treatment may be followed by Gender Reassignment Surgery, to bring the primary gender characteristics into correctness with the gender identity, both for trans men and trans women. It is notable in the **Gender Recognition Act 2004** that this surgery is not necessarily a criterion for legal recognition of gender, further affirming the legal and actual case of gender identity being within the mind and heart of the individual – in essence, their own self-declaration, when put together with diagnosed gender dysphoria.

Hormone treatment only affects the body to a limited degree. Physical intervention is necessary, in the form of surgery for gender re-assignment, mastectomy, electrolysis, facial surgery, tracheal shave, etc.

The transition from one gender to another is always done in the eyes of the world, and is more often than not very challenging, due to social attitude based on misunderstanding and negative assumptions due to ignorance of the issue. This can be true within the medical profession and NHS as much as with the general public (refer to the Policy Document, Appendix 1)

During this period of transition, when a new hormonal system is affecting the body and mind powerfully – as they do during the transition years of adolescence – and while the world around is adjusting themselves to a new reality in the person they have known, the transperson can often feel isolated and distressed.

As any major transition in life, such as divorce or even moving house, can lead to high levels of stress, so too can this transition. This is not evidence of mental illness, as it is not during other major life transitions, such as divorce, or death of a loved one. It is to be noted, however, that during this often long and difficult transition a supportive environment is essential, and the provision of this within the medical pathway may be regarded as a duty of care.

Even the most conservative of estimates gauge that a transsexual transition is generally successful. People from a wide range across society simply continue their lives, with a greater sense of integration and happiness, rather than intolerable distress.

There is always a case for a wider range of treatment to be included in the package funded by the NHS Trust according to local policy. This varies in different NHS trusts across the country, according to experience and understanding, but at this time we are looking only at the essential package which is delivered in Brighton and Hove.

Further suggestions can be made when a new policy fit for this era is written, when widening of treatment available may be considered, with reference to need and models in other communities.

## **Who are Transpeople?**

The truth is that Transpeople make a representative slice of our society, and most are just normal people getting on with normal lives. In the course of this study I have interviewed a composer/conductor, an academic, a priest, an engineer, a lawyer, an airline pilot, entrepreneurs, a cleaner, a care assistant, and unemployed people who are trans.

There is a high level of unemployment amongst transpeople, often due to the discrimination still found amongst employers. This means that the transpeople who follow the NHS pathway in Brighton and Hove will have a high proportion of people who are either unemployed or have low-paid work, as those who can manage to find the money will almost certainly follow a private pathway.

Those transpeople interviewed tended to pay for their own treatment despite the high cost, even when this means going into debt. So this is not just the option of the wealthy, but a critical choice made when considering the desirability of the NHS pathway offered.

This means that the transpeople who take the NHS pathway are unrepresentative of the whole body – those who are either unemployed or have financial limitations – so that the present system discriminates against the financially limited, while giving a false impression of transpeople as a whole.

## **SECTION 3**

### **What are the needs of Transpeople and how are these needs met at present?**

To answer this question, 25 transpeople were interviewed, and 5 extensive questionnaires were completed.

The transpeople interviewed came through The Clare Project (the Brighton and Hove Self-Help Group for People with Gender Issues). This is the single group that exists exclusively for transpeople in this community, and is attended by a wide range of people, both those who are undergoing a gender transition, as well as those who have completed the transition.

Transpeople do not have a community apart from this. Before transition they are invisible – undeclared - and after transition they are once more invisible, mostly, as they now live normal lives as individuals within the community.

For this reason it is impossible to know precisely how many transpeople there are in Brighton and Hove. As many of them paid for private treatment – most of those surveyed – there is no record of them in the NHS records either. Government figures are again an estimate, for the same reasons, and put the national population at about 5,000.

The Harry Benjamin International Gender Dysphoria Association (HBIGDA) puts the prevalence at the transsexual end of the Gender Dysphoria spectrum at 1:11,900 for male to female (trans women), 1:30,400 for female to male (trans men), following figures from The Netherlands. As there is variance according to the cultural acceptability of transsexualism, these figures are approximate only.

According to that estimate of prevalence, there should be around 21 trans women, and around 8 trans men in Brighton and Hove. However, informed guesswork from within the trans community puts the figure much higher, certainly. There is no way that precise figures will ever be known.

What is really important is not those who have successfully finished their transition, but those who are undergoing gender transition within the NHS system, and figures from the Charing Cross GIC put that figure at 20 individuals for the last year in Brighton and Hove. It is certain, however, after interviewing transpeople and noting their experiences, that the numbers of people undergoing transition is higher than those attending Charing Cross GIC, so this figure too is not precise.

This is the client group that is taking treatment now, and these are the people we are focused on. Transpeople who have completed their transitions – with a very high success rate – no longer have a need for special treatment. The focus needs to be on the rolling numbers of people passing through transition, as these are the people who are actually taking treatment, and are therefore relevant to those providing treatment.

What was notable in talking to transpeople was the variety of experience of the transition, no two stories are the same. Some never considered the NHS pathway and took choices that took them through a private route, which tended to be simple and effective, with client satisfaction of the process and the outcome. Some started on the NHS pathway and became disillusioned, and after a longer or shorter time they began to pay for themselves. Some even returned to the NHS pathway, only to rejoin the private pathway.

The outstanding difference between the choice made by those taking the private route and those taking the NHS route was the comparison of time spent on psychiatric assessment, and the manner in which they were treated.

The NHS route is dominated by this evaluation and monitoring: in the private route it is significant, but not arduous and testing. The result is the same. Those who are gender dysphoric receive hormone therapy and, usually, surgery.

Some people do not choose to have gender reassignment surgery, but to intents and purposes belong to the acquired gender and sometimes they call themselves transgender rather than transsexual for this reason. There are no fixed rules. There is a wide range of possibilities, and transpeople recognise this well.

Everything is flexible: the medical part of the transition process may be swift or slow, according to the route taken and the personality involved. The NHS route is always significantly longer. As the Director of Specialist Commissioning said to me, the clients have to 'jump through hoops.' The question arises as to why any client group of the PCT needs to jump through any hoops at all to undergo treatment.

Of the transpeople interviewed, only two had completed the NHS pathway. All the other people typically had 'lost heart', feeling as if they were getting nowhere, with no information as to their progress, and unhappy with the manner in which they were treated at the GIC at Charing Cross.

Some selected statements demonstrating typical experience are as follows:

Client A

*'...all my appointments were being cancelled. I could feel the depression coming back because of the lack of forward progress. It was clear that it would take many years before I would be eligible for surgery and I would be able to get out of the turmoil I was in. I had also heard a number of "horror stories" about surgery at Charing Cross, both in terms of surgical and infection risks and the ward environment. By then I also knew a number of people who had had surgery abroad, with excellent results and what appeared to be comparatively low risks. I had decided that, even if I had a phone call in a few weeks, I wouldn't choose to have surgery at CX.'*

Client B

*'Haven't seen anyone yet. First appointment was around six months ahead, but had to nag them to get it. Appointment was cancelled by me due to illness, the new appointment is in another 6 months.'*

Client C

*'I chose the private route because:*

*a) I'd met many current and former patients of Charing Cross GIC, all of whom seemed to have had dreadful experiences, some for a number of years. Others, who were/had been private patients of my consultant psychiatrist were clearly being more successful in their changed gender role.*

*b) Everything I'd heard about NHS treatment indicated it would be a long, slow and more difficult "journey". I did not regard myself as needing psychiatric help and wished to complete my transition/treatment as quickly as possible, enabling me to establish myself fully in my new gender role so that disruption to my livelihood would be kept to a minimum and I would be able to start enjoying life fully, as soon as possible.'*

Client D

*'My financial situation was severely damaged by the cost of having private surgery and electrolysis. However, if I had opted for NHS treatment, I would probably still be undergoing "treatment" instead of having built a successful new life over the past three years. I would still have had to pay for the electrolysis (which, in total, has cost more than the surgery), anyway.'*

Client E

*'After waiting many years to declare my gender dysphoria, the last thing I wanted was to play long games with psychiatrists to realise what I knew was my own truth. I saw Dr Russell Reid, who treated me with respect, and made my pathway as straightforward as possible. I consider that the money spent was an actual saving over the long route through Charing Cross, as I was able to get on with my life in a shorter time, and start earning again in years less. I have no understanding of how stretching out my transition would have benefited me. The thing needed to be done, and in the shortest time possible, which was about 18 months in my case.'*

## **Needs identification from interviews**

When asked what their needs are, the answers were, despite the great variance in clients' experiences, surprisingly uniform. The needs were not in relation to obtaining triadic therapy (hormones/real life experience/surgery), as these were expected to be available through whichever route was taken. Further treatments, for example depilation through laser treatment or electrolysis, were considered essential, and it was considered grimly amusing that commissioners of treatment thought of such treatment as 'just cosmetic'.

What was talked of was the access to treatment, over and above the actual treatment given, as these were essentially similar. Comparisons were made according to the treatment given under the NHS with the private route, essentially hormone therapy and gender reassignment surgery.

Treatment over and above these treatments was universal – it is not possible to live as a woman in our society with a beard, for example. Electrolysis was considered to be the most painful and expensive part of the whole transition by many. See below for a more extensive list of the choices made by those who paid for everything, indicating the true needs of transpeople undergoing transition.

Despite the fact that everyone had their own story, and these varied greatly, there was a distinct underlying similarity in views on the process through the NHS system. This mostly concerned the Charing Cross Gender Identity Clinic, part of the West London Mental Health NHS Trust, which was almost universally considered to give not only poor treatment, but often to work against the good of the client .

A collation of the consistent views of the transpeople interviewed is as follows:

- *Clients should have the right to choose their pathway, including the psychiatrist.*
- *Support, including counselling, should be available to people going through gender transition, due to the extreme emotional challenges of such a transition.*
- *The psychiatrists at Charing Cross are unreasonable, erratic and irrational.*
- *The systems at Charing Cross are poor – paperwork often gets lost, leading to confusion and lack of continuity.*
- *Appointments are often cancelled at short notice without reason given, delaying an already lengthy process.*
- *Psychiatrists should keep to the Harry Benjamin Standards of Care; the Real Life Experience should be one year, not two, and hormones should be more available after three months.*
- *Transpeople should not be pathologised as mentally ill, and in consequence infantilised within a paternalistic system that denies them choice and respect for their rationality.*
- *There are constant delays at Charing Cross without reason given, which can add unnecessary years to the already difficult process.*
- *The psychiatrists at Charing Cross were considered to be dogmatic and fixed in their views, as if one size fits all and clients were expected to fit in with their expectations to receive treatment.*
- *Clients considered that they are not listened to at all, and simply have to take what they are given.*
- *Clients are unaware of any system for complaint, and would be hesitant of using one if it existed, due to fear of the reaction of the psychiatrist consultants, and fear of being removed from the programme.*
- *Policies are seen to be for the protection of the psychiatrists rather than for the benefit of the client.*
- *Psychiatrists should be supportive, not act as gatekeepers to treatment.*
- *Clients frequently find that they are seen by different psychiatrists, so that they feel a lack of consistency in their treatment.*

All of the above statements are made with the words used by transpeople in interview. The level of dissatisfaction with the Charing Cross GIC was very high, in essence concerning the time the treatment took and the manner in which it was given.

One person found their experience at Charing Cross to be 'fine', but chose to take the private route to surgery as the path through the GIC was taking too long, and they felt they needed to 'get on with their life'. Another followed the pathway through to surgery and found the whole process 'excellent', but objected to the time and expense of travelling to London.

What also should be considered is the time and money it takes clients to attend their appointments in West London. One anecdote tells much: A trans woman, nearing her set date for surgery - which means that she had met all the criteria for treatment - had a final appointment at Charing Cross. This was for a fifteen minute appointment. However, the appointment lasted less than five minutes, and she found it valueless and unnecessary.

To get there on time cost the client almost £40 for the train fare, plus an entire day's pay: a total of about £130. There is also the appointment cost of over £200 to Specialist Commissioning / Brighton & Hove PCT to consider.

The wastage of resources for all parties should be noted. The client's question is: *'Why can't we do this in our own community?'*

The same trans woman underwent Gender Reassignment Surgery at Charing Cross Hospital during this study. After a week she returned to Brighton, and soon it became obvious that complications had set in. After referring to her GP, and phone calls to a local surgeon skilled in this surgery, she returned to Charing Cross Hospital, by car, in pain and distress, and was seen by Mr P Thomas, Gender Reassignment Surgeon, who came to the appointment from Brighton, where he lives. There is no specialist care in the community; clients are simply left to look after themselves, backed up as always by the GP.

**These client views and experience are confirmed by the letters from Dr Alison Hermitage and Dr Susan Lipscombe which follow.**

When looking for the origin of the issue which is repeated as being the cause of great discontent with the present system, it is useful to examine the Policy Document which is the foundation of treatment in Brighton and Hove. This document encourages negative attitudes towards trans people and their treatment, and can help to why explain that the problem is simply one of access, not of the treatment itself.

This, and other related documents, are examined in Section 4.



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Dear Persia,

Thank you for the invite to contribute to your research into the process of gender reassignment.

I have been working with clients in this field for over 10 years and currently I am supporting 14 patients at various stages in the process of gender migration. (Mostly male>female transition but 1 person is transitioning female>male)

Obviously with this volume of contact with GID, I have also had volumes of correspondence with Charing Cross – none of which has gladdened my heart!

Not one of my patients having contact with the team there has had a single positive thing to say about either the process or the consultations they have had.

Almost invariably, this group has found good support from Russell Reid (Private Psychiatrist) He is extremely experienced and I have found his advice invaluable.

2 of my patients have completed their gender reassignment surgery recently after 4 years of trekking to and fro for judgement by Charing Cross Psychiatrists.

All of the others who have opted for surgery have given up on the NHS and travelled to Thailand or Canada.

The difference in treatment on all levels is stark. Invariably those women who went abroad talk of a positive experience where they were treated with respect, kindness and great professionalism. Their operative results are excellent and they had very few post-op problems. (All this for about £3,000 start to finish)

Contrastingly, those who continued to operation with Charing Cross report patronising attitudes, insensitivity and no sense of caring. The operative results, I have seen so far, are far inferior to those from other countries and invariably give problems post-op

Local psychiatrists can vary widely in their knowledge about GID and seem at times to be unsympathetic and unable to empathise. However Dr Ojo and Dr Assin are very professional, kind and well informed.

Dr Vaughan is extremely helpful regarding regular physical checks on this patient group as they must have biochemical follow up. He is professional and treats my clients with respect and sensitivity. This client group are sensitive due to the hormones they are taking and fear of rejection at any point along this interminable process. (They are taking oestrogens in variable amounts or testosterone injections.)

I have found Mr Thomas to be professional and approachable with good advice on the end of a phone.

The NHS process seems to be designed to test nerve, resolve and mental strength at every opportunity rather than demonstrating understanding. There is no psychological support within this process, only adversarial roles are assigned to Psychiatrists/Psychologists.

Charing Cross frequently use the terms "female/male role" or "living in role as a woman/man". This sounds like GID patients are acting and I feel these terms should be discontinued.

GID is not about a lifestyle choice nor is it about choice at all but a compulsion to live as the person you are - come what may. "I must do or die" has often been said to me re transition and the harder and less sympathetic we make the process the more depressing it becomes to those within it.

There should be easier access to the more peripheral aspects of transition such as wigs, hair removal, speech therapy and there must be psychological *support* built in rather than judgement.

Helping someone with GID to go about their daily life without negative comment from ignorant people is vital to their continuing mental well-being and in the end of the day is what we need to achieve at a minimum.

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Persia West

16th March 2004

Dear Ms West,

You approached me on the telephone to find out my feelings about the problems transsexuals face in Brighton. I have looked after many transsexual patients and their reports differ. However, on the whole there seems to be many areas of discontent.

One of the major ones is that the centre that patients have to travel to is at Charing Cross, and there is no local provision. This provides a lot of difficulties as many patients are not working and the cost of going to and from London is not inconsiderable over a number of years.

Secondly, if people are reliant on public transport and the transport happens to be late, making them late for the appointment, they are not allowed to be seen and are dismissed as having missed their appointment through their own fault.

Another problem is the strictness of the criteria imposed by Charing Cross. This is particularly true on the working in role front, as most transsexuals may well have problems with getting jobs in their new chosen gender, before surgery, partly because of being self conscious about their bodies when going to the toilet, or in the summer wearing clothes that reveal their current gender.

I also think there is a problem with additional support for transsexuals in Brighton. There is no provision for removal of hair and of course many patients are hirsute, particularly about the face. On the positive side, the speech therapy, and in particular Linda Preston, has been superb in helping patients with this particularly difficult area, where speaking like a lady is extremely important, so that the patient can be fully accepted into society.

It would be wonderful were there a local network, and as we have the expertise in terms of excellent psychiatrists, a surgeon with a particular interest in this form of surgery, and an excellent dermatology team who can help with the hirsute problems. As I have mentioned we have excellent speech therapy, and if needs be, ENT, for shaving of the Adams apple. I do think much improvement could be made to help our transsexual population.

**Dr R Gray, Dr S M Firth, Dr S L Lipscombe, Dr G J Clifford, Dr R P Crossman, Dr R E Grimm**

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Although this is a small number of people it seems to cause an undue amount of distress to the people who have this very difficult condition. There seems to be a constant wall for transsexuals to come up against and they seem to have to jump through higher and higher hoops to get their desired result.

It would be great to get together with some of the people who have been through Charing Cross, those who are currently attending and the local specialist to see if the difficult issues that surround this group of people can be overcome at a local level.

Yours sincerely,

DR S L LIPSCOMBE

**Dr R Gray, Dr S M Firth, Dr S L Lipscombe, Dr G J Clifford, Dr R P Crossman, Dr R E Grimm**

## **SECTION 4**

### **Present provision of NHS Treatment in Brighton & Hove**

The following documents were provided by Kent Surrey & Sussex Local Specialist Commissioning and the Brighton & Hove City NHS Teaching Primary Care Trust as being those that define the treatment pathway for clients in Brighton and Hove. The documents merit examination.

#### **DOCUMENT 1 [Appendix 1]**

##### **East Sussex Health Authority Transsexualism and Gender Re-Assignment Policy**

**Dr Jennifer Bennett, Consultant in Public Health (June 1995)**

#### **DOCUMENT 2 [Appendix 2]**

##### **East Sussex, Brighton & Hove PCTs Gender Reassignment and Transexualism Policy July 1995 – Subsidiary Guidance (Draft 2) January 2004**

This document provides amendments to the 1995 Policy Document referred to above. The specialist expertise needed to write such an amendment is not indicated.

#### **DOCUMENT 3**

##### **An Assessment of Healthcare Need for Adults with Transsexualism and Gender Dysphoria in Kent Sussex and Surrey** **With highlighted comments added by Helen Goodship, May 2004**

This is the result of research carried out in 2001 by Dr Jensen, again a Consultant in Public Health, not a specialist in the field of study, although the date and the author are not mentioned on the document. This document is not included as an appendix, although relevant parts are quoted.

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#### **DOCUMENT 1 [Appendix 1]**

##### **East Sussex Health Authority Transsexualism and Gender Re-Assignment Policy**

**Dr Jennifer Bennett, Consultant in Public Health (June 1995)**

This policy document is flawed throughout, both in tone and content, and as such is a main source of the gap between client need and the high standard of specialist care allied with good intention in commissioning in this community. This document shows an incomplete understanding of many issues, and includes incorrect statements, unfounded assumptions and meaningless statistics that discredit it as a document that forms the basis of treatment for NHS clients in Brighton and Hove.

As a critical document in service provision, the NHS is urged to swiftly update the two documents that define treatment, so that the easily available quality, client-based service that both the clients and the PCT want in place can function freely. An analysis follows.

from PAGE 2

**“4. What is transsexualism (Primary transsexualism)?**

**- Primary transsexuals are those who have consistently felt and behaved in the opposite gender role from early childhood.”**

*The definition ‘Primary Transsexual’ is given sometimes to transpeople who transition in their youth, having asserted their true gender from early childhood, and ‘Secondary Transsexual’ being those who transition in later life. These terms are themselves of doubtful value, as is any division of a range of people into two distinct categories, so many prefer not to use them at all.*

*It is notable that, as society changes, more young people declare themselves to be trans, which indicates that social conditions have a lot to do with declaration and thus the time of transition.*

*Very few transpeople over thirty years old grew up in an environment where their gender was acceptable, or had the courage to face the social and medical hostility that transition so often brought.*

**“- The criteria used to diagnose primary transsexualism: - “**

*However primary transsexualism is defined, it has never been a real criterion for treatment, as this would deny most transpeople treatment, including those who have been treated within this community.*

**“....a sense..... of being one of nature’s extant errors.”**

**“....all indications of sex differentiation being considered as afflictions and repugnant.”**

*This generalises a vast range of individuals’ feelings into categories which may be true for some, but such assumptions are simply untrue for most transpeople.*

*The words used – ‘nature’s extant errors’, ‘afflictions’, ‘repugnant’- strongly imply unacceptable deviancy from a healthy medical/social norm.*

**“It is important to distinguish this syndrome from secondary transsexuals who are suffering from a gender dysphoria syndrome which includes transvestites with severe gender strain, effeminate homosexuals and an atypical group who may be bisexual, asexual, or have impulse disorders with mild to moderate sociopathic trends.”**

*Transvestite men and homosexual men are not transsexual women; their identity is male, and they have no desire at all to undergo a gender transition.*

*To associate transpeople in this way, without evidence, with an essentially incorrect definition of secondary transsexuality that suggests ‘severe gender strain’ (what is that?) ‘effeminate homosexuals’ (an offensive stereotype), and ‘impulse disorders with mild to moderate sociopathic trends’ has no foundation in any reality, and in fact has little meaning.*

*This serves only to denigrate transpeople by enhancing a stereotype that suggests mental illness associated with perverse sexuality.*

from PAGE 3

**“5. How common is this condition?”**

**An extensive search of literature has revealed the following information.”**

*The figures in the box are meaningless; a jumble of random figures that range from 1968 in the USA (1:100,000) to the Netherlands in 1986 (1:18,000), Manchester in 1972 (1:34,000).*

*Figures used most recently (2003 / 4) by the UK parliament suggest there around 5,000 transsexual people in the UK (i.e. approximately 1:12,000) however this figure is based on government records (Passport agency and DVLA) of people who have actually requested a name and change of gender identifier with these agencies, so these figures cannot be taken as a reliable indicator of the number of people likely to require treatment.*

*Many authorities believe the true figure to be much higher and that social factors are responsible for under reporting. Some (unofficial) studies indicate that the figure could be as high as 1:500 and several intersex conditions carry incidence rates in the range of 1:1,000 to 1:2,000. (these are quoted here to give a comparison for other conditions associated with foetal development)*

*Assuming a Brighton and Hove population of 250,000 – and making no allowance for the (likely to be considerable) skewing of the figures because of the more accepting culture in the city - these figures result in a range of between 20 and 250 people.*

*Based the trans population known to the author and others in the community, it is felt that the likeliest true number of trans people in the city is in the high end of this range. There is, however, no record of this integrated section of society.*

**“6. How does this apply in East Sussex?”**

*Apart from the use of figures from (5) to create estimates, the terminology is incorrect. Male to female transsexual people are not men - they are women and the law recognises this; similarly female to male transsexual people are not women – they are men and the law recognises this.*

*This terminology denies the essence of the transsexual transition as being the truth of identity, and is offensive to transpeople. It is contrary to the essential spirit of the Gender Recognition Act, which recognises the truth of gender being within individual consciousness.*

**“7. ...treatment was first pioneered by three Danish doctors”**

*Treatment was actually pioneered in the UK in the 1950s.*

from PAGE 4

**“9. Published studies show that 70% of patients are satisfied and most report satisfactory adjustment in terms of employment and socio-psychological functioning”**

*Although it is true that the treatment is highly successful, the more recent figures have a figure of over 90% patient satisfaction.*

from PAGE 5

**“10. The Harry Benjamin International Gender Dysphoria Association drew up guidelines in 1985....”**

*Reference: ‘The Harry Benjamin International Gender Dysphoria Association’s Standards of Care For Gender Identity Disorders, Sixth Version, February 2001.’ ([www.hbigda.org/soc.html](http://www.hbigda.org/soc.html)) It may be noted from the lead page of this document that these standards of care were first introduced in 1979, and there was no revision or ‘re-endorsement’ in 1985 so it is not clear what this section of the policy document is based on.*

*Still we can look at the section headed **2. Fundamentals of Good Practice**, the standards of practice within the local policy, which were recommended and check to see if all these points are being followed in Brighton and Hove in relation to care for transpeople.*

**Frequent contact with the applicant:** *there is no provision for frequent contact with clients during the process of transition apart from assessments at the Charing Cross GIC in West London.*

**Constant monitoring.** *See above.*

**Good back-up facilities for care of those patients who become emotionally disturbed at any stage.** *The remote clinic in London that carries out assessments does not provide this, nor is it provided in the community apart from GP care.*

**Careful endocrinological supervision.** *Charing Cross GIC did not provide specialist endocrine supervision to the clients that were interviewed for this study. Neither is there provision made in the community.*

**Adequate post-surgical evaluation.** *Again, this is left to the GP, who is unlikely to have specialist experience. There is no system in place to ensure this.*

***To sum up, there is not a system in place to ensure the Fundamentals of Good Practice are actually met. Quality care is thus left to chance, despite the professional expertise in Brighton and Hove.***

**“3.Caveats**

**.....’misguided requests from applicants, should always be resisted.”**

*Naturally. This is the case in all fields of medicine. Why mention this at all, except to enhance the stereotype of the irrational nature of transpeople?*

**“11. Who will be considered for the Gender Reassignment Programme?**

**People diagnosed as primary (see box in section 4)”**

*An impossible criterion for most, and not one that has been met in the vast majority of transpeople who have undergone transition in Brighton and Hove (see above)*

**“4. People who have been referred through an NHS psychiatrist for consideration and who have NO MAJOR ADDITIONAL MENTAL ILLNESS”** (my capitals)

*This groundless and incorrect opinion that transsexualism is a mental illness has formed the approach to treatment for nine years. Gender Dysphoria is not a mental illness, neither is it necessarily linked to mental illness.*

**“13. Which centres will cases be referred to?**

**Charing Cross Gender Identity Clinic for counselling.”**

*Charing Cross GIC assesses and monitors clients, and, according to transpeople interviewed, and did not include counselling for any clients in the study group.*

**from PAGE 7**

**Appendix 1**

***Revisions of The Standards of Care were made in 1980, 1981, 1990, 1998 and 2001. There is no mention of a ‘re-endorsement’ in 1985. The ‘Synopsis’ of the Harry Benjamin Standards of Care includes statements that are not actually within the standards, and the origin of these statements, although attributed to the Standards of Care, is not indicated.***

**“Diagnostic Criteria**

**...Another mental disorder such as schizophrenia”**

*A further incorrect reference to Gender Dysphoria as a mental illness. This statement is not true of the Harry Benjamin Standards of Care, and neither is it true in fact.*

**“Surgical (Genital and/or Breast) Sex Reassignment**

**1. The doctor who takes the burden of deciding who to refer for hormonal and surgical sex reassignment and for whom to refuse (sic) are subject to extreme social pressures and possible manipulation as to create an atmosphere in which charges of laxity, favouritism, sexism, financial gain, etc. may be made.”**

*There is nothing approximating this description of the essential nature of transpeople in the Harry Benjamin Standards of Care. This statement encourages the view that transpeople are, by nature, threatening and mentally unstable.*

*This statement is discriminatory when generalised in this fashion to include all transpeople.*

*It further maintains the stereotype of the irrational and mentally unstable nature of transpeople, giving a good understanding of why they would pay to escape from such projections and seek treatment elsewhere where there is respect for their dignity.*

***The Policy Document contains many further less significant inconsistencies and incorrect assumptions that would lead the mind of an uninformed reader to assume that transpeople are mentally ill, and need to be treated as such. This then indicates that transpeople do not have the facility to make rational choices, which in turn suggests that others might need to make those choices for them.***

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## DOCUMENT 2 [Appendix 2]

### **East Sussex, Brighton & Hove PCTs Gender Reassignment and Transsexualism Policy July 1995 – Subsidiary Guidance (Draft 2) January 2004**

This document provides amendments to the 1995 Policy Document referred to above. The specialist expertise needed to write such an amendment is not indicated.

#### **Under Section 11: Who will be considered for the Gender Reassignment Programme?**

**Criterion 3** *has been amended to read*

**“People must have been known by their GP to have a gender identity issues (sic) for at least a year before being referred to a local consultant.”**

*This means that someone who has at last declared themselves to be Gender Dysphoric to their GP, usually after some years of profound distress, must wait for a year to be referred to a local psychiatrist, then wait for one or two months for an appointment, then wait for up to nine months for a secondary appointment at the Charing Cross GIC, making almost two years for a first meaningful appointment. The Charing Cross Clinic then requires a two year Real Life Experience (RLE) – rather than the one year RLE recommended by the Harry Benjamin SOC - before surgery.*

*This makes the waiting time a minimum of four years, to be followed by ‘jumping through hoops’ in order to receive the recognised necessary treatment.*

*This would amplify their distress considerably, when surely the aim of treatment would be to diminish it.*

*This criterion would be a clear invitation to take a private route if funds were available, and would have unimaginable consequences for those who do not have funds. Such a clause would not be considered valid by anyone with understanding of Gender Dysphoria. It is an unnecessary cruelty, with no conceivable advantage for anyone, and considerable additional distress for the client in a vulnerable situation. Such an action may be considered as being detrimental to client care.*

**Criterion 8** *is amended to read*

***Patients should meet all of the following criteria ‘before being referred for assessment at a specialist gender identity clinic’;***

**Criterion 1** – *the ‘primary transsexual’ definition looked at above. It bears repeating that gender dysphoric people, although they are almost always aware of their condition since childhood, inevitably take on the role of the gender they were apparently born into – this is why there is a need for the transition.*

**Criterion 3** – *see comments above*

**Criterion 4** - *refer to the comments above in regard to mental illness.*

*The statement of Professor Louis Gooren may well be considered again at this point; ‘One of the serious obstacles to understanding Gender Dysphoria is that it is an unimaginable and inconceivable problem to those who do not have it. This distinguishes it from other forms of human suffering, for which it is much easier to generate empathy and sympathy.’*

The above analysis may provide a good understanding as to why most Transpeople leave the NHS pathway provided, or never join it at in the first place.

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A further Document is of relevance:

**DOCUMENT 3**

**An Assessment of Healthcare Need for Adults with Transsexualism and Gender Dysphoria in Kent Sussex and Surrey**  
**With highlighted comments added by Helen Goodship, May 2004**

*This is the result of research carried out in 2001 by Dr Jensen, again a Consultant in Public Health, not a specialist in the field of study, although the date and the author are not mentioned on the document.*

*It describes some limited understanding of gender dysphoria and the NHS pathway in use. The author refers to other research, which is freely available on the internet, but this is selective and often obscure and rarely relevant to the immediate situation of Transpeople in this community. It is not included as an appendix*

*The report does, however, refer to client concern and care in ways that may well be noted:*

**4.21 Primary Care**

**‘Patients are particularly vulnerable at the time of disclosure and while awaiting their first assessment at the Gender Identity Clinic. One GP described ‘trying to keep them alive’ during this stage.**

*Refer to the new requirement that in effect means that clients must wait during this vulnerable stage for up to two years – for no reason at all that is in their interest – as well as the trying and unsupported pathway then available to them. Refer again to Professor Gooren’s statement regarding empathy and sympathy.*

**‘Service users and some local clinicians expressed concern that the strong emphasis on monitoring, staff attitudes, and sheer number of people are limiting the supportive role of the clinic. *Ideally service users would like more of the service provided locally providing service users communicate well.*’ (my italics)**

**4.4 Stakeholder views on priorities.**

To summarise, in this section the author identifies:

- ***Education of all staff in the health service***
- ***Information provision on care pathways***
- ***Service links to local support groups***
- ***Identification of one local psychiatrist with interest and expertise***
- ***Develop a local service including a specialist psychiatrist, voice therapist, endocrinologist and specialist counselling***

And, in the Summary of Key Findings:

*'Stakeholders express need for greater respect and more support, particularly at disclosure and during transition'*

**These recommendations match with the findings of this Report, and have thus far not been acted upon.**

## **SECTION 5**

### **The Case for a Client-centred Care Pathway for Transpeople in Brighton and Hove**

There is one simple solution for all of the issues in the treatment for gender dysphoric people in Brighton and Hove, and that is to provide the service within this community.

**A reminder of the actions recommended in the 2001 research:**

- *Education of all staff in the health service*
- *Information provision on care pathways*
- *Service links to local support groups*
- *Identification of one local psychiatrist with interest and expertise*
- *Develop a local service including a specialist psychiatrist, voice therapist, endocrinologist and specialist counselling*

**And, in the Summary of Key findings:**

*'Stakeholders express need for greater respect and more support, particularly at disclosure and during transition'*

#### **THE PRESENT PATHWAY**

1. **General Practitioner** – the usual first step, when a client declares themselves to be transgender. The GP then refers the client to a local psychiatric service for evaluation.
2. **Local Psychiatric Consultant** – the client is then evaluated by the local psychiatrist, who is generally not expert in the field of gender. If they consider the case to merit further evaluation, the client is referred on to the Gender Identity Clinic (GIC) at Charing Cross.
3. **The Gender Identity Clinic** – this evaluates and monitors the client, setting the Real Life Experience (refer to HBIQDA), prescribing hormones and referring the client for Gender Reassignment Surgery for those who are considered gender dysphoric. Although other services are available for clients, none of those interviewed used them. The cost of and inconvenience of travel from Brighton and Hove to West London is always a consideration for clients.

The limitations of this service are:

- Specialist endocrine and physiological evaluation do not take place.
- There is no support either during monitoring appointments or in the long spaces between. Appointments are often cancelled without reason, with a long wait for the next.
- There is no information supplied as to time taken for treatment, what will happen, reasons for action or non-action. There is no guidance, only control.
- Many clients take to the private route and abandon the service at Charing Cross, considering it a waste of their own time and money, as well as the scarce finances of the PCT.

## THE NEED FOR CHANGES

Everyone I talked to – the transpeople in transition who are the clients of the local care pathway to be based on, the GPs and other medical professionals who deal with transpeople in transition on a daily basis, and those people who support them through counselling or a help line – speaks with one voice. Note the views of transpeople, and how they are reflected in the opinions of Dr Hermitage and Dr Lipscombe.

THE PRESENT POLICY DOCUMENT IS UNACCEPTABLE AND NEEDS TO BE COMPLETELY RE-WRITTEN WITHIN A CLOSE TIME-FRAME , WITH REFERENCE TO THOSE WHO ARE QUALIFIED TO WRITE IT, AND MUST HAVE REAL INPUT FROM THE LOCAL TRANSCOMMUNITY.

As a reference it is recommended to look at a contemporary publication that demonstrates how far social attitudes have moved on. ***Employing Transsexual People – Guidance*** is published by the **Equality Challenge Unit for Higher Education**. Although this focuses on employment rather than medical treatment, the vastly different tone from the Policy Document which has been analysed above may be good guidance in attitude and approach for a new and acceptable policy. <http://www.ecu.ac.uk/publications>

The system needs to change, and change in essence, not just cosmetically.

That the Brighton & Hove City NHS Primary Care Trust funded this study, through Spectrum (the Brighton and Hove Lesbian, Gay, Bisexual and Transgender Forum) merits respect. This support is a statement not only of awareness of dissatisfaction within the client group, but also the willingness to look at what the cause may be, and to listen to a possible solution.

As the previous study showed, in the few areas that focused on the needs of the client group, what transpeople want is simple: respect, courtesy, understanding and care.

It may be noted that when transpeople paid for private psychiatric assessment, their choice was without exception Dr Russell Reid, who they found professional, empathetic, supportive and positive about making their transition as painless as possible. His approach is client-based, and this was recognised in the way transpeople recommend his services to others.

Trans people want to be informed of what is happening to them, and be treated like adults who can make their own choices. And they don't want to take long, expensive journeys to a clinic in West London that makes them 'jump through hoops' to access treatment they have a legal right to. And they want to be treated in their own community, in Brighton and Hove.

The question here is not why should they be treated in their own community, the question is why they should not be.

The answer is simple and evident, and fits well with the current approach to treatment within the NHTS as a whole and it also respects their own right to choose their own treatment pathway.

## **An Integrated Local Gender Service**

Brighton and Hove already has everything we need to make a fine Integrated Local Service. The players are in place, and are in fact already active. All that is needed is to integrate what already exists. It is unnecessary to send people to West London to a clinic which is almost universally disliked, and which costs both the client group and the PCT highly.

Some of the experienced medical professionals who are already providing an excellent local service have been interviewed. This list is not exclusive; there are others with equal skill, understanding and compassion within this community. But these are the medical professionals I have interviewed, and who all see the value in a local integrated service.

### **General Practitioners**

**Dr. A. Hermitage**

**Dr. S. Lipscombe**

Both have extensive experience of clients undergoing gender transition over some years, and their professional understanding and care with the client group attracts others. They both have issue with the present system, and support the concept of a Local Integrated Gender Service.

### **Consultant Endocrinologist**

**Dr. N. Vaughan**

with many years experience of the endocrine issues surrounding gender transition. Almost certainly one of the most experienced Endocrinologists in the country in this specialist area. He already takes Transpeoples' referrals from GP's, has done for some years, and is willing to join an integrated service.

### **Consultant Psychiatrist**

**Dr. T. Ojo** – A Specialist Consultant Psychiatrist in the field of Sexuality and Relationships, dealing with gender issues at the York Clinic at Guy's Hospital in London since 1996. Has followed through complete gender transitions from first assessment to surgery.

He sometimes sees clients in Brighton and Hove for the initial assessment, and it is from the clients themselves that he was recommended to me, as a psychiatrist who 'knows who we are, knows all about Gender Dysphoria.'

Dr Ojo agreed with the principle of a total integrated service in Brighton and Hove. He has a special interest in this area, and is very interested in being involved in the creation of the Integrated Local Gender Service. He is the choice of local Transpeople who have met him, and has impeccable qualifications and experience, along with a modern, respectful approach to Transpeople.

### **Gender Reassignment Surgeon**

**Mr P Thomas** – Mr Thomas is a Consultant Urologist and expert in Gender Reassignment Surgeon, male to female. He performs this surgery at this time at the Charing Cross Hospital on referral from the Gender Identity Clinic, and is considered one of the leading GRS surgeons in this country. He stated his interest in, and willingness to co-operate with a Local Integrated Gender Service.

Mr Thomas performs GRS for private patients at the Sussex Nuffield Hospital in Woodingdean on the outskirts of Brighton and Hove.

### **Voice Therapist**

**Lynda Preston** is a professional voice therapist who has long experience with Transpeople. She sees around 6 clients from this group per year, and shows concern that support for what she sees as a 'highly vulnerable group' is 'non-existent'. She is supportive of a Local Integrated Gender Service, and willing to contribute to it.

### **Counselling**

Although no counsellor working within the NHS system was identified, there are counsellors who work in Brighton and Hove who have extensive experience with gender dysphoria.

### **Additional Resources for a LIGS in Brighton and Hove include**

#### **The Clare Project – A Self-Help Group for People with Gender Issues**

One of the most successful and long-running groups of this kind in the country. It meets monthly and gives practical information, support and sense of belonging, mostly for transpeople. It has a bursary fund which supports counselling for transpeople.

## **A Specialist General Practitioner or Nurse for the Integrated Gender Service**

All of the above are already working with transpeople in transition, and have good experience. To be integrated, joined up and working together, there needs to be a single point of reference, and the suggestion is that this is provided by a Specialist GP, in time, with a Specialist Nurse, of at least Level G, who would work part time sooner. There are many nurses in this community with direct experience of transsexual medical issues, due to Gender Reassignment Surgery being practised in this city for many years. The nurse's function would be:

- **To inform** to inform GP's and other service providers about services available (see above) and how to access them; to inform clients about the Gender Service and what it can provide, as well as to guide them in the right direction.
- **To monitor** physical health, keep an eye on emotional health, *be there* as a point of contact for clients, inform GP's and other service providers on progress and problems.
- **To run a Drop-In clinic** for a couple of hours a week, modelled on the service in Glasgow, for clients to come in for information, have an eye kept on them, feel supported and remove the sense of isolation which is common at present.
- **To Provide Post-Surgical Care** – removal of sutures, checking on conditions, making contact with GP's, surgeon etc, if need be.
- **To maintain Current Information regarding a range of gender issues**, with routes for treatment, with for example intersexuality, or young people who identify as trans.

### **Costs**

The limited funds available for treatment through the NHS are well understood. It is beyond the capacity of this study to give detailed estimates of costs of a Local Integrated Gender Service, but some comments might be guidance for an approach of commissioners, if the will to provide the service is created.

At this time, costs to the PCT/Specialist Commissioning have to be in services provided for this client group. These are:

- Initial consultation with a local psychiatrist, through South Downs NHS Trust
- Assessment and monitoring at the Charing Cross Gender Identity Clinic
- Gender reassignment surgery, either at Charing Cross or University Hospital in London.

If the service is local, then there is no need for a second assessment at Charing Cross. The saving is on the initial assessment at Charing Cross for each client, which is £460. Further consultations at Charing Cross cost £235 for 15 minutes. The entire time taken over client's assessment may be years longer than need be, adding to overall cost yet again. Further services such as breast augmentation that are at present permitted within the policy for trans women can be performed locally.

Other services, such as counselling – so often regarded as an essential option during the transition – electrolysis, tracheal shave and so on, can be considered at the time of writing the new policy document, in consultation with the professional resources listed above.

Although it is impossible to calculate the savings from not using the Charing Cross GIC, they must be significant. The first assessment at £458 for one hour and further assessments at £242 simply have to be way over the cost of similar services through the Southdowns NHS Trust, as mentioned above. Also, the likelihood is that the entire process will be significantly shorter, and there is no clear need for a second assessment as at Charing Cross for a further £458. And this does not take into account the enormous cost to the clients, which has not been considered so far.

A further point to bear in mind is that many clients interviewed drop out of the system during their assessment at Charing Cross. Although this may be considered to be evidence of the effectiveness of the stringent system at Charing Cross, weeding out those who might have made a terrible mistake, in fact it is evidence of a further waste of time and public money, as most of them simply run out of patience and take the private route.

## **CONCLUSION**

The main problem that lies between the aspirations for high quality care at the PCT, the needs of the client group, and the team of excellent local medical professionals is simply one of access. At this time, the focus on the Policy Document and the approaches to treatment it inspires – feeding into the Charing Cross Gender Identity Clinic and its unyielding focus on assessment - denies wider and better service, and drives way a significant number of clients.

A Local Integrated Gender Service – based around the new policy document - should not be within the same cost band as the present system, as well as being completely satisfactory, a model of Good Practice that satisfies clients and medical practitioners in Brighton and Hove. It would also diminish the present wastage of limited funds. So many clients drop out of the barely tolerable present system to take a private route, thereby wasting their own time and money, as well as the public funds spent on expensive services at Charing Cross GIC that come to nothing.

It was evident from the outset of preparing this Report that there is little understanding of the true nature of Gender Dysphoria and the medical aspect of its alleviation. Clearly there needs to be essential education for those who deal with this field – even reading this Report would be a good beginning.

Transpeople's needs are, first and foremost, to be treated appropriately and with respect, that the medical treatment they merit is delivered in a manner which respects their dignity. In other words, that access to treatment is made simple; and that clients no longer have to suffer the indignities of 'jumping through hoops'.

It is recommended that action is taken soon, as the turned tide in the transsexual legal and social situation means that more transpeople are finding their own voice, and are willing to act accordingly to claim their legal rights.

**Persia West** – October 2004

## Suggested Internet Links for Further Information

[www.hbigda.org/soc.html](http://www.hbigda.org/soc.html)

**The Harry Benjamin International Gender Dysphoria Association Standards of Care**, referred to in the text of the Report.

[www.ecu.ac.uk/publications](http://www.ecu.ac.uk/publications)

**'Employing Transsexual People – Guidance'** is published by the **Equality Challenge Unit for Higher Education**. Although this focuses on employment rather than medical treatment, the tone of this contemporary publication demonstrates how far social attitudes have changed. It may help to provide good guidance in attitude and approach for a new and acceptable policy.

[www.gendertrust.org.uk](http://www.gendertrust.org.uk)

**The Gender Trust** is the UK National Charity that deals with gender issues. This site contains good information regarding the issues dealt with in the report, as well as containing links to other sites which have a mine of information on any topic imaginable. The Gender Trust is based in Brighton and Hove.

[www.pfc.org.uk](http://www.pfc.org.uk)

**Press for Change** is the UK campaign for respect and equality for all Transpeople. This large site is a mine of information, particularly concerning the law.

<http://ai.eecs.umich.edu/people/conway/TSuccesses/TGallery1.html>

This website is run by trans woman **Professor Lynn Conway**, - Computer Scientist, Electrical Engineer, Inventor, Research Manager, Engineering Educator.

# APPENDIX 1

EAST SUSSEX HEALTH AUTHORITY

TRANSSEXUALISM AND GENDER  
REASSIGNMENT POLICY

**with Appendix I,  
Synopsis of the Harry Benjamin Standards of Care**

June 1995

EAST SUSSEX  
HEALTH AUTHORITY  
  
TRANSSEXUALISM  
  
AND  
  
GENDER REASSIGNMENT  
  
POLICY

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**June 1995**

## **EAST SUSSEX HEALTH AUTHORITY**

### **TRANSSEXUALISM AND GENDER REASSIGNMENT**

#### **1. Who this policy is for?**

GP's, urologists, psychiatrists, endocrinologists, behaviour therapists and clinical psychologists wishing to provide care in the primary care setting in East Sussex and secondary care in hospitals contracted to undertake this treatment for the East Sussex Health Authority.

This policy provides guidance for GP's and Consultants (in particular, psychiatrists and urologists) on the issues involved in the purchase of services for individuals wishing to change their gender.

#### **2. How has this policy been developed?**

This document was drawn up following consultation with all interested parties including two consumer organisations, relevant clinicians (psychiatrists and urologists) and GPs.

#### **3. How will the target audience be informed?**

Surgeons, psychiatrists and GPs have already contributed to discussions on the needs assessment document on which this policy is based. They will formally be circulated via Health Commissioners with this policy document after its acceptance by the Health Authority.

#### **4. What is Transsexualism (Primary Transsexualism)?**

Cross gender can occur from male to female or female to male. The ration of male to female compared with female to male is 3: 1.

Primary Transsexuals are those who have consistently felt and behaved in the opposite gender role from early childhood.

#### **The criteria used to diagnose primary transsexualism:**

- 1. A sense of belonging to the opposite sex, of having been born into the wrong sex, of being one of nature's extant errors.***
- 2. A sense of estrangement from one's body, all indications of sex differentiation being considered as afflictions and repugnant.***
- 3. A strong desire to resemble the opposite sex physically via therapy, including surgery.***
- 4. A desire to be accepted by the community as belonging to the opposite sex.***

It is important to distinguish this syndrome from secondary transsexuals who are suffering from a gender dysphoria syndrome which includes transvestites with severe gender strain, effeminate homosexuals and an atypical group who may be bisexual, asexual, or have impulse disorders with mild to moderate sociopathic trends.

## 5. How common is this condition?

### Prevalence

Estimation of the prevalence of transsexualism is a difficult task. An extensive search of literature has revealed the following information.

<b>COUNTRY</b>	<b>DATE</b>	<b>MALE TO FEMALE</b>	<b>FEMALE TO MALE</b>
Netherlands	1980	1: 45,000	1: 200,000
Netherlands	1986	1: 18,000	1: 54,000
UK (Manchester)	1972	1: 34,000	1: 108,000
USA	1968	1: 100,000	1: 400,000
Sweden	1968	1: 37,000	1: 103,000

In 1972 a conservative estimate of 537 male transsexuals and 181 female transsexuals over the age of 15 in England and Wales was made.

The change in numbers over the years is not likely to be due to a change in the incidence of transsexualism, but is more probably due to the growing awareness of the syndrome amongst doctors and the general public, and perhaps a shift in the climate of opinion whereby the transsexual is more likely to be overt.

## 6. How does this apply to East Sussex?

### Prevalence in East Sussex

<b>MALE TO FEMALE</b>		<b>FEMALE TO MALE</b>	
<b>Population 15+</b>	<b>:275,400</b>	<b>Population 15+</b>	<b>:320,800</b>
<b>Prevalence</b>	<b>:15 men</b>	<b>Prevalence</b>	<b>:6 women</b>

*Based on estimates in Netherlands (1986) see above.*

However, it is known that a much larger number of transsexuals live in East Sussex. 1

## 7. What is the purpose of the treatment and what does it involve?

The purpose of treatment is to improve the quality of life for transsexual patients.

Treatment was first pioneered in 1962 by three Danish doctors when they agreed to the request for hormonal and surgical treatment so that a male transsexual might live as a woman.

Gender identity clinics were created, staffed by surgeons, psychiatrists, speech therapists, and others. There are very few private or NHS clinics in England.

There exist the following consecutive stages in the process: psychotherapy: hormone therapy: surgery: psychotherapy: and life long monitoring and support.

All referrals require initial consultant psychiatric assessment, locally, through the NHS. Referral is then made to a specialist psychiatrists for a detailed psychological assessment, which could last one year, before starting hormone therapy.

Then hormone treatment is started. The prescription of feminising or masculinising drugs carries considerable dangers and must be overseen by a consultant and general practitioner. About two years later, if adjustment is successful and the person wishes to have the ultimate step, surgery is carried out.

Follow up at the clinics should continue after surgery and the continuation of hormonal treatment must be carefully monitored,

## **8. What exactly is sex re-assignment?**

### **i) Hormonal Sex Reassignment**

This involves administration of androgens to females and oestrogens and/or progesterones to male phenotypes for the purpose of effecting bodily changes to approximate the physical appearance of the opposite sex.

### **ii) Surgical Sex Reassignment**

This involves surgery to the genitalia, breasts and other parts of the anatomy for the purpose of physically altering the body to the appearance of the other sex.

Surgery may include mastectomy, reduction mammoplasty, augmentation mammoplasty, castration, orchidectomy, penectomy, vaginoplasty, hysterectomy, salpingectomy, vaginectomy, oophorectomy and phalloplasty.

In addition non-genital surgical reassignment refers to all other procedures commonly carried out to nose, throat, chin, cheeks, hips, etc.

## **9. What is the outcome of treatment?**

Published studies show that 70% of patients are satisfied and most report satisfactory adjustment in terms of employment and social-psychological functioning. Evaluation of outcome was conducted in terms of.:

- a) subjective wellbeing
- b) self perception
- c) personal satisfaction and behaviour in the new gender
- d) integration into the gender role
- e) confidence in the new gender

- f) satisfaction with the new anatomical arrangements.

However, some patients requested a surgical reversal to their former gender and others committed suicide. A recent study (1994) from Leeds confirmed this improvement in the quality of life for the majority of patients who completed surgery.

## **10. Important Consideration**

### **1. Standards for Treatment**

The Harry Benjamin International Gender Dysphoria Association drew up guidelines in 1985 and these should be followed by all providers who offer these services. The Health Authority's recommended providers have contributed to these and accept them. (Shortened version shown as Appendix 1)

### **2. Fundamentals of Good Practice**

Include:

- a) frequent contact with the applicant
- b) constant monitoring
- c) good back-up facilities for care of those patients who become emotionally disturbed at any stage
- d) careful endocrinological supervision
- e) adequate post-surgical evaluation

### **3. Caveats**

Urgent processing through gender re-assignment programmes, often under misguided requests from applicants, should always be resisted. Gender re-assignment procedures require good liaison between professionals in several specialities.

Appendix II shows a flow chart of the normal referral patterns.

## **11. Who will be considered for the Gender Reassignment Programme?**

1. People diagnosed as primary (see box in section 4).
2. People primarily aged between 25-55 years of age (at age of surgery).
3. People known to their GP for one year.
4. People who have been referred through an NHS psychiatrist for consideration and who have no major additional mental illness.
5. People who have been referred by a local NHS psychiatrist to a specialist gender identity clinic where care is overseen by a specialist psychiatrist for two years.

6. People who have been permanent residents of East Sussex for the last two years.

7. People are expected to enter an NHS programme via the GP involving local NHS psychiatrists, referral on to specialist psychiatrists and finally, if needed, surgery (as per attached flow chart, Appendix II).

8. All the above criteria should be met.

**12. How will cases be prioritised?**

- By a specific panel set up to review cases.
- If on any occasion more cases are deemed suitable for surgery than resources available for that year, then cases will be approved on a priority basis within the available budget. Cases not approved will go forward for consideration for funding from the next year's budget, as determined by the Review Panel.

**13. Which centres will cases be referred to?**

- Charing Cross Hospital Gender Identity Clinic for counselling.

**14. Monitoring and Evaluation**

- Total numbers of cases and annual costs to be monitored by the ECR Policy Group six monthly.
- Feedback from providers will be required and reviewed.

**15. Resources**

- Up to four cases of gender reassignment surgery will be funded annually, if resources are available.

APPENDIX I

**SYNOPSIS OF THE HARRY BENJAMIN STANDARDS OF CARE: THE  
HORMONAL AND SURGICAL REASSIGNMENT OF GENDER  
DYSPHORIC PERSONS 1979 (RE-ENDORSED 1985)**

(Amended for use in East Sussex 1994 by Dr Jenny Bennett)

These are minimal standards.

1. Persons recommending sex reassignment surgery or hormone therapy should have documented training and experience in this field (general psychotherapy, sex therapy and gender counselling).

***2. Hormonal or surgical sex reassignment on demand (i.e. justified simply because the patient has requested such procedures) is contra-indicated.***

3. GPs who decide in favour of recommending hormonal or sex reassignment share the moral responsibility for that decision with the physician, psychiatrists, behaviour therapist and/or surgeon who accepts that recommendation.

4. The basis of the recommendation should in part be based on the diagnostic criteria for transsexuals - this should have been present for at least two years.

**Diagnostic Criteria**

- *Sense of discomfort and inappropriateness about ones anatomic sex.*
- *Wish to be rid of ones own genitals and live as a member of the other sex.*
- *The disturbance has been continuous (not limited to periods of stress) for at least two years.*
- *Absence of physical intersex or genetic abnormality. These people would automatically get treated if they so wished.*
- *Not due to another mental disorder such as schizophrenia.*

5. Hormonal Sex Reassignment

1 ) This is both therapeutic and diagnostic.

2) The doctor who starts this therapy should have known the patient for at least 3 months. Hormonal therapy should precede surgical reassignment.

3) Irreversible effects such as breast growth and infertility in Male to Female and infertility, hair growth, voice deepening and clitoral enlargement in Female to Male may occur and must be explained to patients.

4) Patients must be monitored by a physician in addition to the GP in order to ensure that an overview of SGPT in persons receiving Testosterone; SGPT, bilirubin, triglycerides and fasting glucose in persons receiving oestrogens is carried out. Also routine blood chemistry and physical examination must be carried out on a regular basis, i.e. yearly.

#### **Surgical (Genital and/or Breast) Sex reassignment**

1. The doctor who takes the burden of deciding who to recommend for hormonal and surgical sex reassignment and for whom to refuse are subject to extreme social pressures and possible manipulation as to create an atmosphere in which charges of laxity, favouritism, sexism, financial gain, etc. may be made.

2. The principle of a peer review and a co-ordinated decision by at least three professionals; GP, clinical psychologists/psychoanalyst/psychiatrists with a specialist interest in this area and surgeon is essential to safeguard the long term health of the patient.

3. The psychiatrist who makes a recommendation for surgical reassignment must have overseen the care of the patient for two years prior to the recommendation.

4. Genital sex reassignment shall be preceded by a period of at least twelve months during which time the patient lives full time successfully in the social role of the genetically other sex.

5. A comprehensive genito-urinary tract examination may be needed in order to exclude any genito-urinary disorder which may complicate later surgery.

6. The surgeon performing the surgical genital sex reassignment should receive written recommendations from at least one other consultant, and should satisfy himself that the patient has a GP who can take a longer term overview of the patients progress.

7. Special problems for such patients include financial difficulties and the need for post reassignment therapy whether this be psychological, hormonal, or surgical.

8. Informed consent must be obtained from the patient for the surgery, and the patients should be over the age of 21 years.

9. The privacy of the medical record of sex reassignment patients shall be safeguarded according to procedures in use for any other patient group.

## APPENDIX 2

**East Sussex, Brighton & Hove PCTs  
Gender Reassignment and Transsexualism  
Policy  
July 1995**

**Subsidiary Guidance (Draft 2)  
January 2004**

**East Sussex, Brighton & Hove PCTs  
Gender Reassignment and Transexualism Policy  
July 1995**

**Subsidiary Guidance (Draft 2)  
January 2004**

This guidance has been produced to update the sections of the policy relating to provision of the service, where these are out of date, or to clarify the wording in some respects. The changes were agreed in principle by the PCTs in December 2003. The numbering refers to paragraphs in the 1995 version of the policy.

*The successor organisations to the Health Authority are the Primary Care Trusts in East Sussex, Brighton & Hove, which adopted the 1995 policy.*

**Section 8(ii): Surgical Sex Reassignment**

This describes gender reassignment services in general, and should not be read as implying that all the procedures listed will be funded.

**Section 11: Who will be considered for the Gender Reassignment Programme?**

Criterion 2 (relating to age at surgery) is to be disregarded

Criterion 3 has been amended to read:

People must have been known by their GP to have had a gender identity issues for at least a year before being referred to a local consultant.

Criterion 5 has been amended to read:

People who have been referred to a specialist NHS gender identity clinic, where care is overseen by a specialist psychiatrist.

Criterion 6 has been amended to read:

People who are registered with a GP practice belonging to one of the Primary Care Trusts in East Sussex, Brighton & Hove.

Criterion 8 is amended to read

Patients should meet all the following criteria **before being referred for assessment at a specialist NHS gender identity clinic:**

- Criterion 6, as revised above
- Criterion 3, as revised above
- Criterion 1
- Criterion 4

Patients should meet all the following criteria **before being referred for surgery**:

- Criterion 6, as revised above
- Criterion 4
- Criterion 5, as revised above
- Criterion 7

### **Section 12: How will cases be prioritised ?**

This section will be deleted and replaced as follows

Provided the patient has met all the criteria for surgery in section 11, and has been recommended for surgery by two consultants at a specialist NHS gender identity clinic, the following procedures will be funded:

Male to female: castration, orchidectomy, penectomy, vaginoplasty.  
Augmentation mammoplasty will be funded, if specifically recommended by a specialist NHS gender identity clinic.

Female to male: mastectomy, reduction mammoplasty, oophorectomy, salpingectomy, hysterectomy, vaginectomy, phalloplasty.

Procedures not listed above will not routinely be funded.

The Gender Reassignment Policy will take precedence over the East Sussex Cosmetic Surgery (Aesthetic Surgery) Policy.

The PCTs in East Sussex have appeals processes to hear appeals and review decisions where treatment is not funded.

### **Section 13: Which centres will cases be referred to?**

This section will be amended as follows.

All patients will be referred first to the **NHS mental health services in East Sussex, Brighton & Hove**.

After initial assessment they will be referred to the **West London Mental Health Trust** (known as 'Charing Cross') Gender Identity Clinic.

The following Male to Female surgical procedures will be carried out by **Hammersmith Hospitals NHS Trust** (Charing Cross Hospital):  
castration, orchidectomy, penectomy, vaginoplasty

The following Female to Male surgical procedures will be carried out by **UCL Hospitals NHS Trust**:  
vaginectomy, phalloplasty

The following procedures will be carried out by the **local NHS Trusts**, but only if the patient has been referred by the Gender Identity Clinic:

Male to Female: augmentation mammoplasty

Female to Male: mastectomy, reduction mammoplasty, oophorectomy, salpingectomy, hysterectomy

No surgical procedures should be undertaken unless all criteria for surgery in Section 11 are met, nor should patients be placed on a waiting list for surgery

**Private referrals**

No referrals for surgery will be accepted from private consultants. Only referrals from the West London Mental Health Gender Identity Clinic will be accepted.

**Section 14: Monitoring and Evaluation**

The first sentence will be amended as follows:

Total number of cases and annual costs to be monitored routinely by the designated commissioner.

**Section 15: Resources**

This section is out of date and will be disregarded.