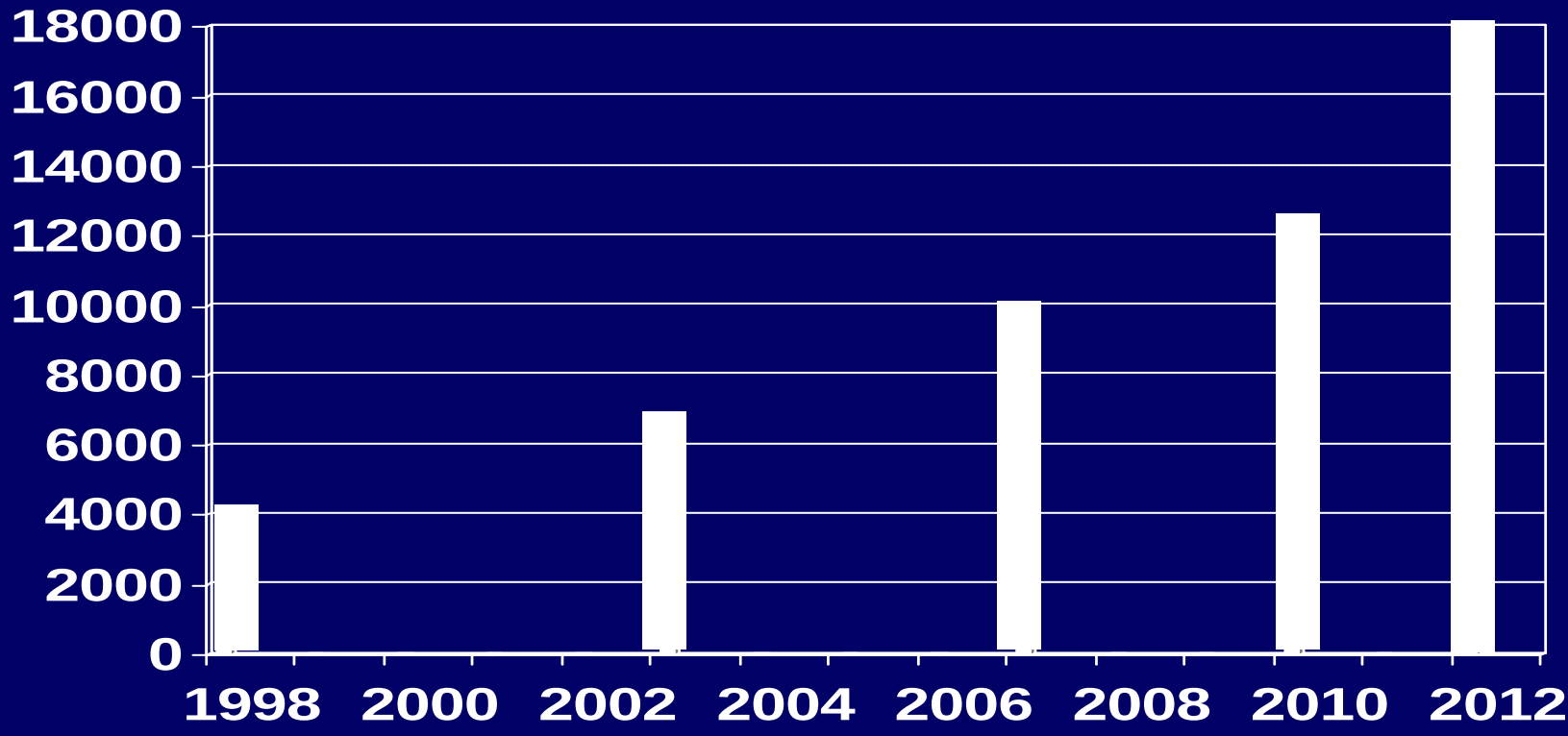
Transgender Healthcare

GLA

gender identity
research &
education society

September 2013

Number of adults seeking medical care – 1998-2012 – rise of 20+% p.a.



EHRC - 1% in 10,000 cohort have protected characteristic of gender reassignment;

child and adolescent group - 30+% rise p.a.

Young people STILL going to USA, and now Germany for treatment

puberty suppressed hormones only given according to a limited research protocol that leaves many young trans people not receiving timely and appropriate treatment.

UK slow to treat older 14+ children; 17+ get nothing; transfer to adult services badly managed.

Good stuff!
The Report by Secretariat May 14 2013 to World Health Organisation's Executive Board:

- "With regard to gender identity, the Working Group has recommended:
  - abandoning a psychopathological model of transgender identity
  - in favour of a model that reflects ***current scientific evidence*** and best practice…".

- Inst Mental Health (US) and the Chair of DSM-IV criticised DSM-5 for not taking account of up-to-date brain research

Good stuff!
WPATH on ICD

- Transsexualism in ICD10 under Mental and Behavioural Disorders.
- WPATH recommends new text and reposition in ICD 11
- Gender incongruence of childhood (? removed because no physiological treatments required - or retained so that support for families and gender dysphoric children provided).

Good stuff!
UK clinicians on ICD 11

- In response to joint statement of Dr Bouman and Professor Wylie (Nottingham and Sheffield GICs), supporting move to different category and change of terminology for transsexualism -

- Charing Cross put out statement:

  We support:
- renaming Transsexualism, to the less contentious Gender Dysphoria, Gender Incongruence or similar;

- the diagnosis itself should be in a category aligned with gender identity, sexual or reproductive conditions

- rather than that section specifically designated mental health."

Good stuff!
UK SoC description/diagnosis (strongly influenced by WPATH)

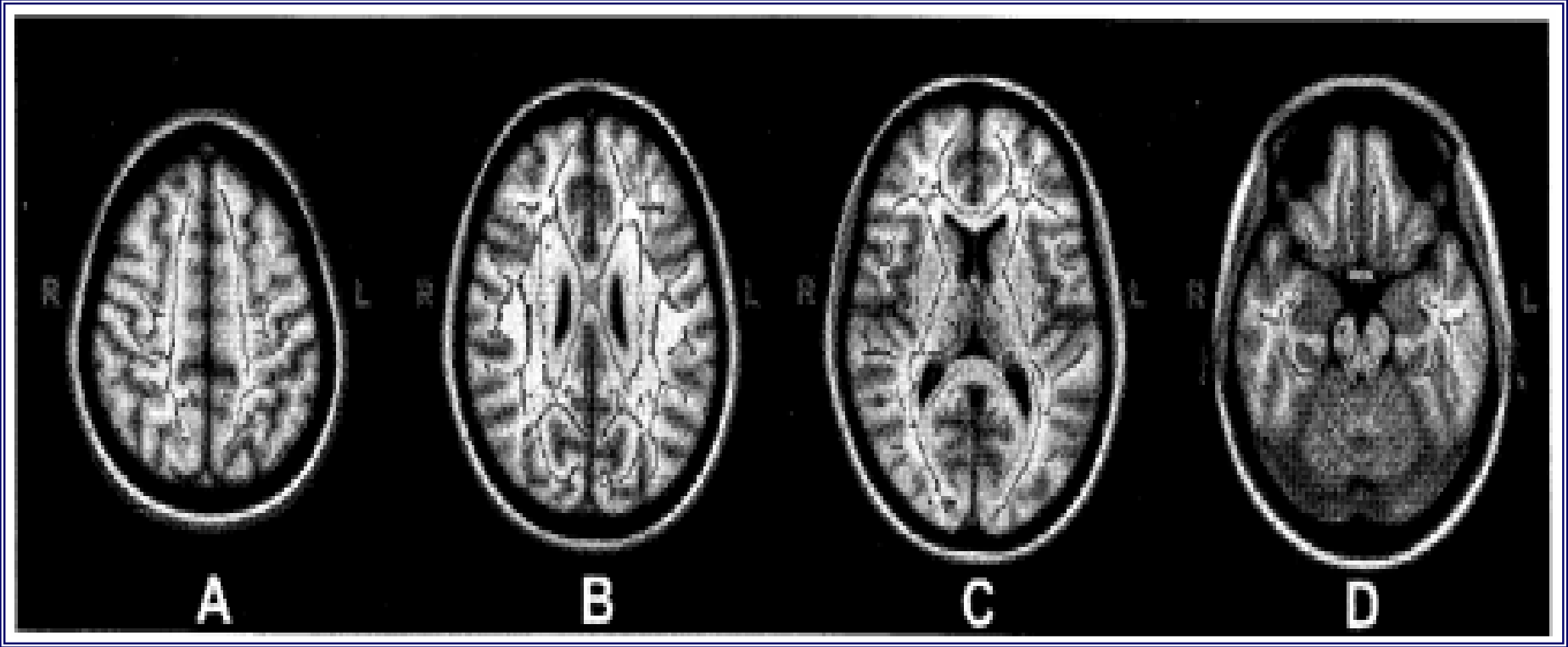
"The expression of gender characteristics that are not stereotypically associated with one's assigned sex at birth, is a common and culturally diverse human phenomenon that should not be judged as inherently pathological or negative"

Response to WHO's 'brain science' model

Nerves work like electric wiring; insulation of nerves enables conductivity

In the body, the insulation is a white, fatty sheath. Passage of nerves through brain make distinct male and female patterns (white matter)

Scans: white matter in living, untreated subjects



Trans women significantly different from both male and female controls in A,B,C and D

Trans men consistent with male controls in A,B,C, not D

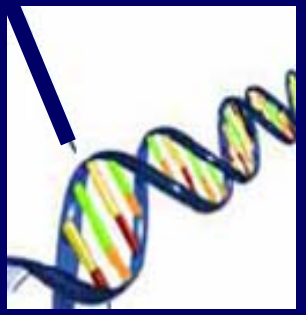
Hare et al, 2008

- Gene (section of DNA) 'Androgen receptor' governs how the body responds to testosterone

- Trans women:

  repeat sequences of this gene compared with
  - non-transsexual male control subjects

- Person with this modified gene would not respond typically to testosterone



dichotic listening – hard wired

Men have Right Ear Advantage

Women have Left Ear Advantage, but more balanced hearing between the R and L ears

Trans women have LEA, so hearing is like other women's – not like men's.

History: National Commissioning - Interim document started Aug 1st 2013:

- June: Stakeholder Engagement consultation;
  (Scottish Protocol introduced and promised as Interim Protocol)

- July: Clinicians wrote Service Specification plus SoC – hybrid document; departs from Scottish protocol (nonetheless was approved by Clinical Priorities Advisory Group)

- Service Specification intended to be 'informed by' the WPATH standards of care
- and to conform to UK RCPsychs (Intercollegiate) standards of care

- It does not!

NHS (England) Clinical reference groups (CRG) writing new Service Specifications to replace Interim Protocol

- Gender reassignment CRG (1 of 74 specialised services)

  - Chair Dr John Dean (lead at Exeter GIC – not psychiatrist)
  - NHS England commissioners 2
  - Clinicians 17
  - Patients, carers, patient reps 4 (promised “parity of esteem”, but in the event of a vote, stakeholders clearly out-numbered)

  - Stakeholders’ Engagement members are not present at CRG meetings

National Commissioning Board

- Despite growth in numbers seeking treatment, “NO NEW MONEY” for specialised services
- Waiting lists ➔ longer delay (?undue delay)
- Alternative local network providers with greater GP involvement?
- Achievable long-term, but will be slow to implement. Better value for money; less stress; less delay.

NOT funded by National Commissioning must persuade CCG/ ?Area Teams – Individual Funding Request (IFR)

- Breast augmentation (trans women)
- Tracheal shave
- FFS
- *Extra* facial hair removal
- Gamete storage
- More psychological support

National Commissioning funds

- Psychological (psychiatric?) assessment
- Psychological support/counselling (how much?)
- Hormone therapy
- Genital surgery (including hyst/oophorectomy)
- Chest reconstruction (trans men)
- Facial hair removal (limited – under discussion ?hormone support)
- Donor site hair removal
- Speech and language therapy

Problems – Clinicians Current Interim Protocol

- Duration of time in role ‘typically 12-24 months’ (UK SoC say: *usually at least 12 months*)
- Period in role can be extended….(*Can’t be extended unless for demonstrable clinical reasons)*
- No early referral for hair removal from donor site (*this is not compliant with UK SoC*)
- Only GICs mentioned throughout, despite saying local service possible (*UK SoC include ‘network’ throughout the document)*
- Individual Care Plans agreed before patient can access treatment (*can be misused to coerce patients to follow a particular pre-determined route*; *prevents flexibility - hormones not included in ICP?*)

Problems continued:

- 2 referrals for hormone therapy (*UK SoC/ WPATH – one referral)*
- 2 referrals for chest reconstruction (trans men) *(despite UK SoC and WPATH and Opinion from Counsel - requiring only one*)
- *Independent* opinion (i.e. from psychiatrist in *another* GIC, therefore 3 opinions for genital surgery (*UK SoC require 2*)
- Extent of 'policing': specific demands and monitoring of time in role (*breach of human rights?)*
- No mention of equality and human rights legislation, or NHS Constitution: "no decision about me, without me" (*This should be repeated on every separate document)*

More good stuff !
Gender nonconformity in UK SoC

- “There is a growing recognition that many people do not regard themselves as conforming to the man/woman binary divide, and that this will impact on their treatment.
- Self-descriptions include: pan-gender, poly-gender, neutrois and gender queer.
- A few people who ...see themselves as non-gendered, may require gender neutralising treatments...”

More good stuff!

Hormone therapy in UK SoC

- 1.4

  The fact that these medications are, in the main, not licensed for this use, is not a reason to withhold this treatment;

- Religious beliefs or cultural mores must not be used to withhold, withdraw or denigrate treatment.

More good stuff! eligibility for hormones

- "…administration of hormones is
  - not contingent upon role change and
  - patients should not have to take this step or
  - be obliged to make a commitment to it…";
- "treatment may not be withheld or withdrawn because the individual…chooses not to change the gender role full-time, or at all";
- "bridging prescriptions" may be given to those who are self-prescribing;
- [official name change] is not obligatory, and treatments should not be made contingent upon it.

Thomas Beattie

ENJOY!

Thank you