

People who identify as transgender and mental health

If you only read four things:

1. The prevalence of gender dysphoria, the number of people going through gender reassignment, and the number of trans people are uncertain. Estimates for Suffolk vary from as few as ten people to over 7,500.
2. Trans people have a high incidence of mental ill health, including: anxiety, depression, self-harm. Attempted and completed suicide is more common.
3. Trans people need better access to local wellbeing and mental health services to treat comorbid mental health issues.
4. Although good quality evidence is limited, treatment (hormone or surgery) appears to improve mental health and social functioning.

Key points

Do not assume all trans people want to transition from one gender to the other. Although most trans people about their gender identity, others have a “fluid” gender identity which is neither male nor female. There is increasing interest and acceptance (particularly among younger people) of non-binary genders and gender fluidity.

Gender dysphoria describes the discomfort or distress arising when a person’s gender identity – their psychological sense of themselves – does not match the sex to which they were assigned at birth. People with intense feelings of gender dysphoria want to live and be accepted as a member of a sex other than that assigned at birth. Not all people who are gender diverse will experience gender dysphoria¹.

A person’s gender identity is entirely distinct from their sexual orientation. Trans people may be attracted to people of the opposite gender to their own identity, but this is not always the case.

The law

People who intend to transition, are doing so, or have already done so, are protected from discrimination by the Equality Act 2010². The Act also protects those associated with them, such as family members. Other protected characteristics include sex and sexual orientation.

The Gender Recognition Act 2004 allows adults to acquire a gender recognition certificate that records a change of gender and makes it legally effective.

Language

Terms may not be acceptable to all stakeholders, and meanings may change over time. The following is an alphabetical list of some of the terms that may be used:

- **Cisgender**
People whose gender identity is congruent with the sex they were assigned at birth.
- **Gender diverse**
individuals whose gender identity and/or gender role do not conform to the sex assigned to them at birth. People may not identify with the binary concept of gender.³
- **Gender dysphoria**
The discomfort or distress arising when a person’s gender identity does not match the

sex to which they were assigned at birth. Changes to gender role and expression, as well as names and pronouns may alleviate some of the discomfort.

- **Gender identity**
A person's psychological sense of themselves as male or female, or neuter. A person's gender identity is entirely distinct from their sexual orientation.
- **Gender incongruence**
A discrepancy between birth-assigned sex and gender identity. Preferred to "gender identity disorder" or "transsexualism". Gender incongruence is frequently, but not universally, accompanied by the symptom of gender dysphoria⁴.
- **Gender reassignment**
Medical intervention to adjust appearance so it aligns with gender identity.
- **LGBT**
Originally an acronym for "Lesbian, Gay, Bisexual and Transgender". Sometimes expanded to LGBTQI: Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning) and Intersex. Often now used as an umbrella term, for example by the Government Equalities Office, in whose 2018 survey respondents "could be from any minority sexual orientation (such as asexual or pansexual) or gender identity (such as non-binary or genderqueer). The survey was also open to individuals who have a variation in sex characteristics (intersex)."⁵
- **Non-binary**
"Umbrella term for people whose gender identity doesn't sit comfortably with 'man' or 'woman'. Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely."⁶
- **Sexual orientation**
A person's emotional, romantic and/or sexual preferences.
- **Trans, trans*, transgender, trans people, trans gendered people, members of the trans community**
An umbrella term to describe people identity and/or gender expression diverges in some way from the sex they were assigned at birth. This includes people with gender dysphoria.
"Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) transgender, transsexual, gender-queer (GQ), gender-fluid, non-binary, gender-variant, crossdresser, genderless, agender, nongender, third gender, two-spirit, bi-gender, trans man, trans woman, trans masculine, trans feminine and neutrois."⁶
- **Transitioning**
Changes to social role and presentation, making one's appearance as congruent as possible with self-identified gender, typically through dress but also hormonal and surgical treatment. There can be social, medical and legal changes.
- **Trans man**
A person who was assigned female at birth but has a male gender identity. Trans men and trans women may propose to transition, are in transition or have transitioned to live as the gender of their choice.
- **Trans sexualism**
A recognised disorder in the International Classification of Diseases⁷, that was regularly used in medical records. It is not a term which should be used when speaking to trans people or their families as it may cause offence.

- **Trans woman**
A person who was assigned male at birth but has a female gender identity. Both trans men and trans women propose to transition, are in transition or have transitioned to live as the gender of their choice.

What is the issue?

Trans people experience a higher incidence of mental ill health, and nearly half of them expect to be discriminated against by mental health services⁸.

Trans people have reported that mental health services often see their gender identity as a symptom of mental illness or see their mental ill health as caused by their gender identity (and so refer to a gender identity clinic not mainstream mental health services)⁸.

The NHS is clear that “*Gender dysphoria is not, in itself, a mental health condition, reflecting contemporary professional opinion*”^{4,9}.

Why is it important for Suffolk?

Gender dysphoria can lead to anxiety, depression and other mental ill health. These may be more likely to arise from social reception of the condition, or from long waiting times for support than from the condition itself^{5,8}.

The health needs of transgender people are important because:

- being trans is associated with increased mental ill health^{5,8,10,11}
- primary care, not just specialist services, need to meet the health needs of trans people
- there are indications that current services are not fully satisfactory, for example^{12,13}:
 - Suffolk GPs need better training on how to support transgender patients
 - Suffolk GPs are unable to prescribe hormone blockers, meaning monthly trips to the Tavistock Clinic (London)
 - Suffolk GPs refer young people to mental health services instead of making proper referrals to the Tavistock Clinic

The numbers

There is uncertainty about how many people in Suffolk identify as trans, experience gender dysphoria, or are undergoing gender reassignment. There are important difficulties in estimating numbers:

- conditions are not precisely defined, and the terms may be used differently by different people
- rates differ between age groups (children, adolescents, adults)¹⁴
- those presenting to services are likely to be lower than the true number due to stigma and prejudice
- prevalence may vary between areas¹⁵ and over time

The disparities between the figures indicate the difficulty of reaching reliable estimates of the numbers of trans people and prevalence of gender dysphoria. In 2015, estimates for Suffolk varied between eight and thirty trans females and between two and twelve trans males, to as many as 700 people¹⁶. Using more recent research, the numbers could range from 750 to ten times that (see [Table 1](#)).

Table 1: Estimated numbers of trans people in Suffolk

Source	Year	Research geography	Suffolk estimates	
			2018	2023
Government Equalities Office ⁵	2018	UK	2,632-7,519	2,698-7,707
DSM5 in Zucker ¹⁴	2017		2,616 - 6,335	2,681 - 6,490
Reisner et al ¹⁷	2016		752 - 3,760	771 - 3,854
Van Caenegem et al ¹⁸	2015	Belgium	4,882	5,004
Clark et al ¹⁸	2014	NZ	9,394	9,629
Kuyper & Wijzen ¹⁸	2014	Netherlands	7,128	7,305
Conron et al ¹⁸	2012	USA	3,379	3,463
Glen & Hurrell ¹⁸	2012	UK	6,036	6,188
EHRC in RCN CR181 ¹⁹	2012	UK	7,519	7,707
Kennedy cited in Joseph et al ¹⁵	2010	USA	4,512	4,624
Reed cited in Joseph et al ¹⁵	2009	UK	1,504	1,541
Olyslager ²⁰	2007		752 - 1,504	771 - 1,541
De Cuypere ²¹	2007		10 - 44	10-45
Wiepjes ^{22,23}	1972-2015	Netherlands	50	51

It is not clear why people identify as trans or feel gender dysphoria. The NHS notes that the development of gender identity is multifactorial and influenced by both biological and social factors²⁴.

Although evidence is disputed²⁵, studies suggest there is a high prevalence of autism (Autistic Spectrum Disorder: ASD) in people receiving specialist services for gender dysphoria.^{24,26-28}

Incidence in the UK

In the UK, a surveillance study examined the incidence and clinical presentation of gender dysphoria in UK and Irish children and adolescents aged 4 to 15 years inclusive over a 19-month period (November 2011 – June 2013), suggesting an incidence (new cases per year) in children and adolescents aged 4-15 years (inclusive) presenting to secondary or tertiary care services of 1.6 per 100,000 in the UK.²⁴ This figure only reflected those who presented to NHS paediatric or psychological services and not those who could not, or chose not to, access this care. It therefore does not reflect the total number of children and young people experiencing gender dysphoria, as it excludes those who have not contacted the NHS, have only dealt with their GP, or who have sought private support.²⁴

Median age at presentation was 14.7 years (interquartile range 12.1-15.31 years), however the study only captured data for those presenting between their 4th and 16th birthdays, so could not show the incidence of gender dysphoria among 16 and 17 year olds, which referral trends to the Gender Identity Development Service suggest have significantly increased the overall incidence rate.²⁴

Demand has been growing for services that support children with gender dysphoria. For example, compared to 2015/16, the Tavistock and Portman NHS Foundation Trust saw a 25% increase in the number of young people referred to their Gender Identity Development Service in 2017/18 (2,519). 72% of the referrals were young people transitioning from female to male.

A psychologist at the Gender Identity Service at the Tavistock Clinic has stated:

“There is no single explanation for the increase in referral figures, but we do know in recent years that there has been significant progress towards the acceptance and recognition of transgender and gender diverse people in our society. There is also greater public knowledge about specialist gender clinics and the pathways into them”²⁹

Numbers supported locally

Analysis of hospital episode data for Suffolk residents admitted to hospital with a main diagnosis of trans sexualism (an historical medical term still used for coding hospital admissions) or gender identity disorder has been undertaken. The analysis has used the coding of the reason for a hospital admission, not demographic data: for example, these figures do not include someone who identifies as trans and is admitted to hospital for an unrelated condition such as a fall).

In the thirty-five months to February 2015, eleven Suffolk residents were admitted to hospital at least once with one of these diagnoses as the main reason for the admission. There were six admissions in 2012/13, eight in 2013/14 and five (or fewer) in the first eleven months of 2014/15. 61% of admissions were to Cambridge University Hospitals NHS Foundation Trust, and the rest were to: Imperial College Healthcare, University College London Hospitals, St George's Healthcare, Norfolk and Suffolk NHS Foundation Trust, Papworth Hospital NHS Foundation Trust. Imperial College Healthcare is the organisation responsible for gender-identity and gender-reassignment services at the Charing Cross Hospital in London. No more detailed analysis can be published (such as what treatment was provided) as the small numbers mean individuals might be identifiable.

Unmet need

It is difficult to make reliable estimates of the prevalence of gender dysphoria. This makes it hard to plan services, with two important implications:

1. The extent of unmet health need among transgender people in Suffolk cannot accurately be estimated. There are certain to be transgender people who are at present isolated and not in receipt of services, but who might benefit from them if they were available or easier to access.
2. If the range and availability of services improved, some of these under-served residents are likely to come forward seeking treatment and care. However, too little is known about the numbers of these people and their needs to reach exact conclusions about the volume of services needed.

The impact

Isolation, discrimination and delays in accessing gender identity clinics are believed to contribute to poor mental health among people who identify as transgender^{8,30-32}.

There is concern that medical professionals may pathologise the transgender experience, that is, they may:

- attribute a person's mental ill health to their transgender status and therefore refer trans people with mental ill health to a gender identity clinic rather than local mental health services⁸

- see identifying as trans as a symptom of mental illness, leading to delays in referral to a gender identity clinic^{7,8,30}

The General Medical Council (GMC) emphasises that GPs must assess, treat and refer trans patients the same as other patients. The GMC's guidance reminds GPs that the long waits for specialist appointments can be distressing, and that trans people experiencing mental ill health should be supported, including by referral to local mental health services³³.

Hate crimes

Transgender people are at a higher risk of abuse or hate crime¹⁵. Hate crime has increased in recent years⁸. According to survey data, two in five trans people (41%) and a third non-binary people (31%) experienced a hate crime or incident because of their gender identity in the previous 12 months¹⁰.

Discrimination

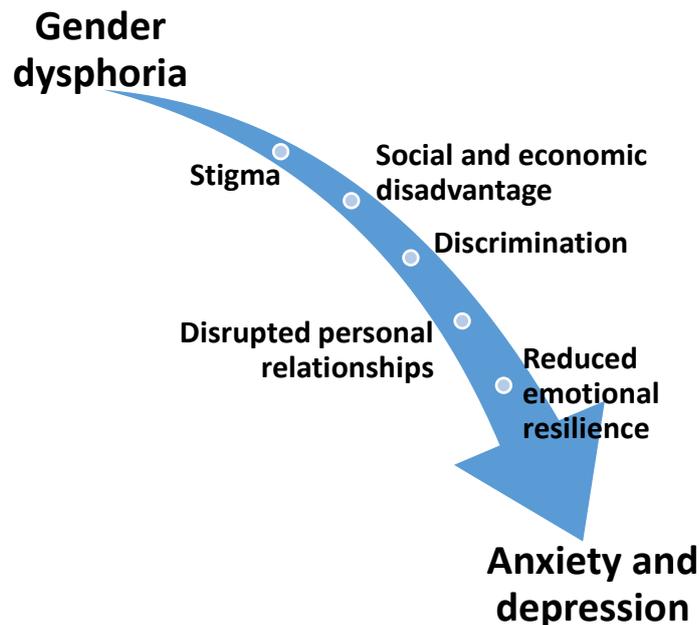
Surveys of transgender people in the UK^{5,32,34} have found:

- the average score for life satisfaction for trans people was 5.40 compared to 7.66 for the general UK population⁵ (where a high score is good)
- 67% were not open about their gender identity, fearing a negative reaction (UK)⁵
- 48% had experienced negative incidents (in the preceding 12 months) involving someone they lived with (compared to 26% cisgender LGB respondents) (UK)⁵
- Over half (53%) had experienced a negative incident (in the preceding 12 months) involving someone they did not live with (compared to 38% cisgender LGB respondents) (UK)⁵
- 57% had experienced family rejection (USA)³⁵
- only 63% had been in a paid job in the previous year (compared to 75% of the general population, and 88% of gay and lesbian people)⁵
- they were more likely to earn less than £20,000 (60%) than cisgender LGB respondents (47%) (UK)⁵
- only 38% of non-binary people (37% trans women, 34% trans men) felt comfortable being LGBT in the UK (compared to 63% of cisgender lesbian or gay respondents). Younger trans respondents were less likely to feel comfortable⁵
- up to 50% reported high levels of discrimination and harassment at work⁸
- 40% felt discriminated against when job-hunting⁸
- 30% felt excluded from workplace social networks⁸
- 18% felt they had been turned down for a job because of their gender identity⁸ (unrepresentative survey)
- 47% of transgender people in the UK had reported a negative atmosphere towards LGB&T people when they were at school (UK, compared to 35% across the EU as a whole)⁸

Transgender young people have reported parental rejection to be a particular source of stress³⁶.

Figure 1 illustrates how gender dysphoria can lead to a series of socially mediated disadvantages which concatenate to undermine mental health.

Figure 1: The relationship between gender dysphoria and mental health



Source: PHAST³⁷

It is important to note that “many young people who present to gender services are not acutely distressed”²⁴. Protective factors for trans people’s mental health may include:^{5,8,12,24,38,39}

- awareness of the possibility of gender transition,
- an accepting environment,
- access to puberty suppressing treatments for young people until they are able to take a decision to transition physiologically
- supported social transition
- psychological support
- gender-affirming medical therapy
- feeling part of an LGBT community (Pride events are seen as positive)
- receiving support, meeting people like themselves, and learning more through the internet and social media
- supportive, proactive schools

Mental health

Common forms of mental ill health

Trans people have a high incidence of anxiety and depression^{40,41}. A survey of trans people found 88% reported previous or current depression, 80% reported stress and 75% reported anxiety^{8,30}. There is a positive association between discrimination (experienced by over 40% of transgender respondents) and depression³¹.

Eating disorders

Transgender people have a high risk of eating disorders (ED) with prevalence up to 16%, higher than cisgender people⁴² (see the Mental Health Needs Assessment 2018 chapter on Eating Disorders www.healthysuffolk.org.uk/uploads/MHNA_ED_Suffolk_2018_2-0.pdf). Some transgender young people may use disordered eating to manage their body dissatisfaction: dieting can delay puberty and suppress development of sex characteristics such as breasts and menstruation^{43,44}.

Self-harm

Rates of self-harm amongst the transgender population are high^{8,45}.

53% of respondents had self-harmed at some point, with 11% currently self-harming. Self-harm reduced following transition for the majority of those who had a history of self-harm³⁰. 63% felt that they harmed themselves more before they transitioned, with only 3% harming themselves more after transition. Nearly 60% of the participants felt that there were reasons they self-harmed which related to them being trans, while 70% felt there were non-trans related reasons for their self-injury.

The reasons for self-harm which directly related to being trans included^{8,30,45}:

- gender dysphoria
- delays in getting gender reassignment treatment
- negative attitudes, including not being taken seriously by medical professionals
- not being able to access treatment or being denied treatment
- treatment complications
- struggling with coming to terms with identity or suppressing gender issues
- not understanding identity or unwilling to admit to difference
- not being accepted or experiencing negativity from others
- not having identity or gender recognised

Suicide

Trans people are more likely to attempt suicide than members of the general population^{8,45}. Over a third of trans people are said to have attempted suicide at some point in their lives, compared with only 1.6% of the general population^{30,36,46-52}.

Gender-based discrimination, stigma, hate crimes (including violence) and limited access to health services may make trans people more vulnerable to suicidal ideation³¹. Suicide attempts are associated with higher rates of depression, anxiety and substance abuse^{47,50}.

Suicide attempts appear to occur more frequently among transgender adolescents and young adults than among older age groups⁵⁰.

Suicidal thoughts and attempts may reduce post-transition.³⁰

Substance misuse

Research suggests the prevalence of smoking, and of alcohol and drug misuse may be higher for trans people than the general population^{8,35,53}.

Trans survey respondents have commented they misuse drugs and alcohol as a coping mechanism, particularly to deal with discrimination and with the waiting times to access gender identity clinics⁵.

Interventions: evidence base and best practice

Not all trans people wish to transition medically, for example to receive hormone treatment or undergo surgery. There is evidence that medical professionals may not recognise the range of transgender experience, including identification as non-binary, leading to trans people feeling they have to “fit” expectations.^{8,10,30}

Feelings of gender dysphoria may not persist into adulthood: studies of prepubertal children experiencing gender dysphoria suggest it persists into adolescence or adulthood for 2-30% of people assigned as male at birth and 12-50% of people assigned female²⁴. Rates of gender dysphoria continuing into adulthood from adolescence are believed to be higher²⁴.

Research to support the use of hormone treatments and gender reassignment surgery is of low reliability. More research of a higher quality is required as lack of evidence does not mean lack of effectiveness. Research looking at the potential psychological and emotional wellbeing benefits of treatments and surgery may fail to consider other ongoing factors, such as the impact of discrimination and prejudice against pre- and post- transition transgender people⁵⁴. For example, fewer depressive symptoms were found in people with greater self-acceptance of their transgender identity (lack of self-acceptance may be increased by exposure to prejudice)³¹.

Delays in getting desired treatment

Recent research reviews^{8,31}, found that trans people feel delays in access to gender identity clinics contribute to their mental ill-health.

Delays in treatment may increase the risk of substance misuse⁵, self-harm³⁵ and suicidal ideation³¹ among trans people.

Transitioning

There was some evidence that mental health improves post-transition²⁴, and where it did not, this was attributed to lack of support (including from friends and family), or from unrelated events³⁴.

A 2015 literature review of mental health and gender dysphoria⁴⁰ found longitudinal studies showed an improvement in mental health after gender-confirming medical interventions, with scores becoming in line with the general population.

A qualitative study found social and/or medical transitioning is an important protective factor against suicide⁵¹.

A survey found self-harm reduced following transition for the majority of those who had a history of self-harm³⁰. 63% felt that they harmed themselves more before they transitioned, with only 3% harming themselves more after transition.

Hormone therapy

A 2016 systematic review of the effects of hormone therapy on the psychology and quality of life of trans people, identified three suitable studies published before 2014, of low-quality evidence. Two found statistically significant reductions in depression, sleep problems, anxiety and phobias, while none could sufficiently evidence an improvement in quality of life⁵⁵. One of the included studies found that, with hormone treatment, most study participants (85.6%) had no psychiatric comorbidity, and that the treatment had a positive effect on patients with subthreshold symptoms (e.g. 50% to 17% anxiety, 42% to 23% depression).⁵⁶

A 2010 review of twenty-eight low quality studies on the impact of hormonal therapy and sex reassignment surgery⁵⁷ showed hormone therapy was likely to improve feelings of gender dysphoria (80%, 95% CI 68 to 89; eight studies; $I^2=82%$), psychological symptoms (78%, 95% CI 56 to 94; seven studies; $I^2=86%$), quality of life (80%, 95% CI 72 to 88; 16 studies; $I^2=78%$) and sexual function (72%, 95% CI 60 to 81; 15 studies; $I^2=78%$).

A retrospective review⁵⁸ of electronic health records from a health center (sic) in Boston USA 2010-2015, found access to gender-affirming hormones at a younger age protected against alcohol misuse. It is unclear whether patients who had an existing alcohol use disorder were less likely to be given hormones, or whether using hormones at a younger age reduced gender dysphoria and therefore reduced the need for coping mechanisms such as alcohol use.

Surgery

A recent (2017) review of transgender literature⁵⁹ found surgery was the most popular topic for articles (440, 18.3%). However, few (6%) considered patient satisfaction and quality of life following surgery, and patients were usually only followed-up within a year of surgery. The review identified gaps in monitoring the psychosocial outcomes of surgery, and in the evaluation of “patients’ goals and expectations” of surgery⁵⁹.

A 2019 literature review on facial surgery⁶⁰ found only two studies considering the outcomes of facial masculinisation operations (seven subjects), summarised as “generally satisfied”.

A 2019 review of the impact of gender-affirming surgery in children and young people⁶¹ identified five studies, reporting reduced gender dysphoria or satisfaction with the surgery for transgender males. However, all the studies had limitations, for example, four of the five had small (or “very small”) sample sizes, and no conclusions could be drawn on the benefits of male to female surgery in those under 18.

A review of electronic health records⁵⁸ showed gender-affirming treatment is associated with better mental health. People who had received surgery were more likely to be older, and have a higher income than those who had not received surgery. However, the study could not show whether people with financial security and “psychosocial stability” found it easier to access surgery, or whether gender-affirming surgery led to higher quality of life and improved functioning (and therefore to higher income).

A 2002 review⁶² found that gender reassignment surgery may benefit some trans people who have satisfied recognised diagnostic and eligibility criteria, and who have received recognised standards of care for surgery, but there was insufficient evidence to support the efficacy of gender reassignment surgery for specific subgroups of persons selected for surgical intervention. The quality of the evidence was poor: there was only a small number of studies, they had unreliable study designs and methodological limitations. More research is required.

A systematic review from 1998 found one controlled study comprising 40 participants, and 11 non-controlled studies comprising 519 participants⁶³. The controlled study reported that, after two years, trans people who had undergone gender reassignment surgery were significantly more active in visits to family and friends, eating out, sport in company and sexual interest. They had significantly reduced scores on the psychoneurotic index, which measures free-floating anxiety, phobic anxiety, obsessiveness, somatic anxiety, depression and hysteria, although the clinical significance of this was not reported. Positive outcomes in the non-controlled studies were reported in cosmetic appearance, sexual functioning, self-esteem, body image, socio-economic adjustment, family life, social relationships, psychological status and satisfaction. However, little could be reliably concluded from these studies because they all had serious methodological limitations. Surgery and society have changed significantly in the past twenty years⁴⁰.

Physical postoperative complications include haemorrhage, urethral stenosis, urinary incontinence, rectal fistula, vaginal stenosis and erectile tissue around the urethral meatus. The incidence of these events varied between the studies and there were high rates of loss to follow-up.

New problems may emerge following reassignment surgery, such as loss of job, family, partner, children or friends. Some people are forced to move away from their familiar environment and, despite being confident in their gender role, may have difficulty with social adaptation and acceptance by others. The extent of these problems has not been recorded in the published studies.

What are we doing?

Primary care

Suffolk GPs reportedly vary in their awareness of gender dysphoria and how to manage it. Patients are not always given appropriate support and referral, and there are problems with primary care staff using the correct name, gender and title. Some will not prescribe hormones or arrange blood tests, and some are reluctant to refer patients for specialist assessment¹⁶.

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

1. Referring patients

The GP should consider whether any co-existing conditions, health issues (mental or physical), or risk and vulnerability factors need to be taken into account.

Many Suffolk GPs are not equipped to support young transgender individuals. Healthwatch Suffolk found that children and young people who are questioning their gender or going through a transition need access to a GP trained specifically to support them¹².

Currently (2018) in Suffolk, GPs refer people with gender dysphoria to a local mental health professional, who in turn refers them to a gender identity clinic. This may be valuable in enabling access to wider support, and assessing whether there are other mental health issues, but is not required or specifically recommended by national guidance⁶⁴, is likely to cause further delays in treatment, and risks pathologizing the condition.

2. Providing and monitoring treatment

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

In 2013, clinicians prepared a guide to gender dysphoria services for primary care staff⁶⁵. Their key recommendations were to:

- refer early and swiftly to a reputable gender service
- support the treatment recommended by the gender service
- get pronouns right; if in doubt, ask discreetly
- be particularly mindful of medical confidentiality
- avoid misattributing commonplace health problems to gender

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

Other services

Assessment before referral to a gender identity clinic

The UK Intercollegiate Good Practice Guidelines for the Assessment and Treatment of Adults with Gender Dysphoria for specialist services were published in 2013¹⁹: "Gender dysphoria may be confirmed in different ways, for instance by engaging in a period of therapy with a counsellor,

psychotherapist, psychologist or a psychiatrist. This can take place in either primary or secondary care settings.”

In Suffolk, referred patients are seen by a clinician from a community mental health team without specialist knowledge or expertise in the condition. This is a less satisfactory approach.

It is possible for any GP to refer trans people to a Gender Identity Clinic⁵. In England there are seven adult Gender Identity Clinics and one for children and young people. 80% of trans people in the UK found accessing specialist services was not easy, mainly because the wait was too long (71% of respondents in the East of England, second to the South East 75%), although nearly a third (28%) of people in the East of England answered that their GP did not know where to refer them⁵. Suffolk’s transgender community report similar issues¹⁶.

Treatment of mental health problems

People with gender dysphoria may experience concurrent mental health problems, such as anxiety, depression and self-harm. These may be coincidental or linked to their gender status.

Trans people and people with gender dysphoria would be assisted by better access to local mainstream mental health services for mental health problems not requiring specialised skills³³. However, they seem to find local services hard to access, with reports that local services are reluctant to treat them or to signpost them to the gender identity clinic¹⁶. Recent research from Healthwatch Suffolk¹² included feedback from trans people that:

“Mental Health services should understand that problems with mental health may not all be rooted in transgender. Generalised support may also be needed”.

Gender identity clinics are highly specialised and generally do not provide treatment for common mental health disorders (CMD). Some people seeking gender reassignment will not disclose psychological distress to staff at a gender identity clinic, as they believe that disclosure will delay or prevent treatment.

NHS England says “Some, but not all, patients may require formal psychiatric intervention to assist with psychiatric comorbidities and in such cases shared care may be appropriate”⁶⁴. The document notes that “If significant medical or mental health concerns are present, they must be reasonably well-controlled”.

Norfolk and Suffolk Foundation Trust (NSFT) have recently produced guidance for their staff on meeting the needs of trans service users.

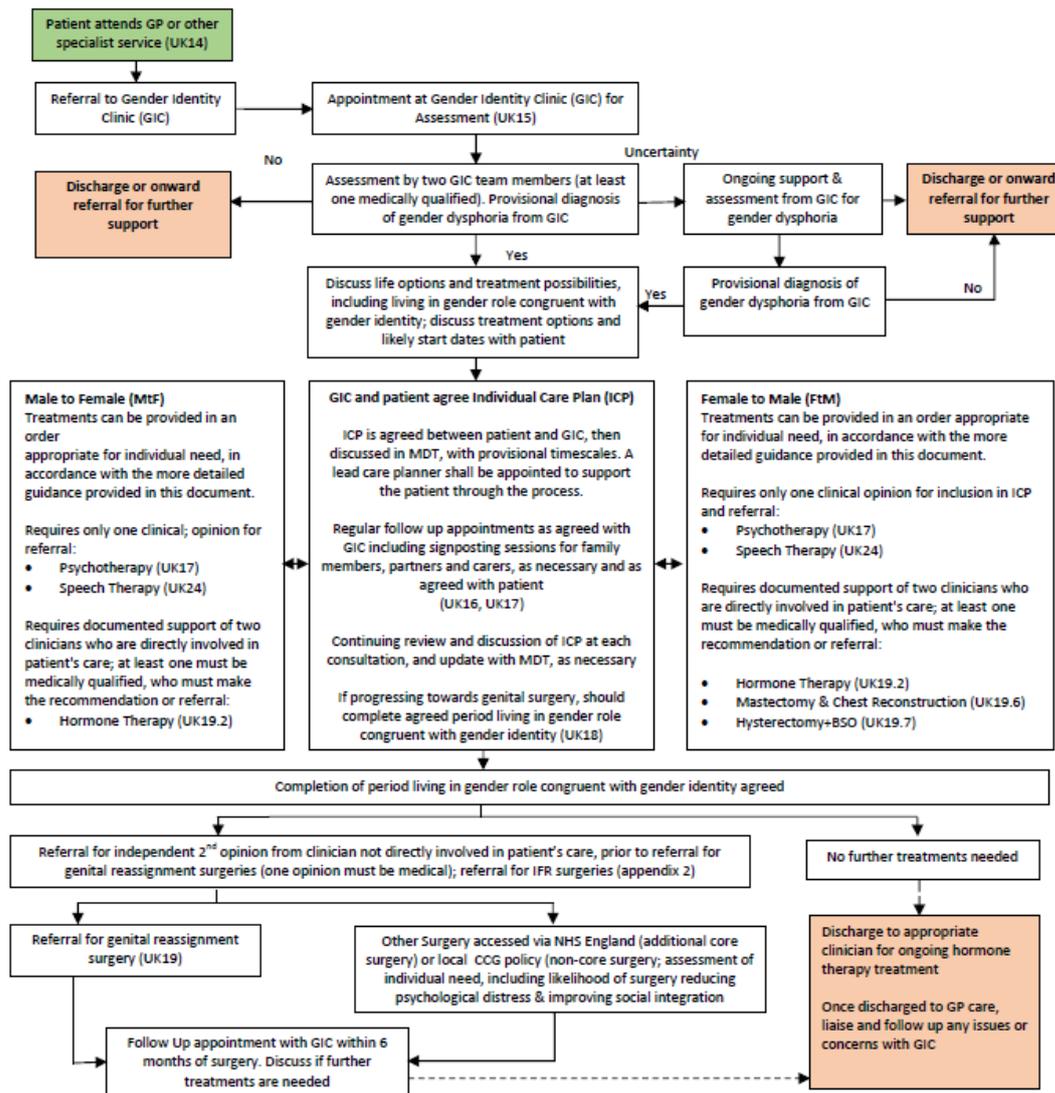
Tertiary services

Tertiary services provide gender identity clinics, where people with gender dysphoria can receive more specialised assessment, hormonal treatment and gender reassignment surgery.

These services are commissioned by NHS England, based on an interim gender dysphoria protocol and service guideline 2013/14⁶⁴. [Figure 2](#) illustrates the model of care that NHS England commissions.

56% people from the East of England (53% UK), who used Gender Identity Clinics were positive about the service, while 25% rated them mainly or completely negative (23% UK).⁵

Figure 2: NHS gender identity services



Source: NHS England⁶⁴

Adult patients from Suffolk are referred to the gender identity clinic at the Charing Cross Hospital in West London.

Patients under 18 are referred to the Tavistock and Portman Clinic, London for assessment and then to University College London Hospital for possible hormone blocking treatment. The hormone blockers are used to stop the onset of puberty or diminish its progress, giving time for further assessment and reflection before a decision is made about gender alignment.

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

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

Tertiary treatments in a gender identity clinic include:

- hormonal treatment to render the patient's appearance more congruent with their intended gender
- a period of living in the gender role congruent with the individual's gender identity, referred to as real-life experience, before the provision of genital reassignment surgery. This typically lasts one to two years. Patients who elect not to have surgery may continue hormone therapy
- gender reassignment surgeries to provide sexual anatomy as close as possible to that of the intended gender

Local support

Suffolk Lesbian, Gay, Bisexual and Trans Network (www.suffolklgbtnetwork.org.uk) run a group for adult trans people: Gender Xplored has monthly meetings and a Facebook page (www.suffolklgbtnetwork.org.uk/genderexplored).

Outreach youth (outreachyouth.org.uk), based in Ipswich, provide LGBT*Q+ youth groups and one-to-one support.

Gender dysphoria has a severe impact on family members¹⁹. They may feel that a change of gender is such a large step that it constitutes the loss of the relative that they loved. Trans* Families ([outreachyouth.org.uk/lgbtq-youth/trans support](http://outreachyouth.org.uk/lgbtq-youth/trans-support)) is a co-produced project to support parents and carers of trans children that started in 2017 and has engaged with over twenty Suffolk families.

Local awareness raising and professional education

Following the original Groups At Risk Of Disadvantage: transgender community needs assessment (2015)¹⁶, the community worked with Public Health and other stakeholders to address identified issues, including: mapping local referral pathways, providing support for the social context of transition, and creating the Suffolk gender identity hub. The original health needs action plan has been updated⁶⁶.

Public Health Suffolk maintains the Suffolk gender identity hub (www.healthysuffolk.org.uk/advice-services/adults/transgender-hub), providing information and support aimed at trans people, their friends and families, and health professionals or managers.

What else could we do?

More information is needed:

- The epidemiology of gender dysphoria is not well understood.
- Research into the impact of treatments for gender dysphoria is of low reliability.

Recommendations

Work remains to:

1. Improve the knowledge and understanding of staff working in universal services.
2. Increase understanding of referral rates and support services
3. Provide good quality, up to date information for trans people and their families.

Related mental health needs assessments

- Eating Disorders (www.healthysuffolk.org.uk/uploads/MHNA_ED_Suffolk_2018_2-0.pdf)
- Self-harm (www.healthysuffolk.org.uk/uploads/MHNA_Self-harm_Suffolk_2018_2-1.pdf)
- Learning disabilities and mental health (www.healthysuffolk.org.uk/uploads/MHNA_LD&MH_Suffolk_2018_2-0.pdf)

Useful links

- NHS. Gender dysphoria. *NHS Choices* (2016). Available at: www.nhs.uk/conditions/gender-dysphoria/. (Accessed: 1st May 2018)

References

1. WPATH World Professional Association for Transgender Health. Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People. 118 (2011). Available at: <https://www.wpath.org/publications/soc>. (Accessed: 24th May 2018)
2. *Equality Act 2010*. 251 (2010).
3. Royal College of Psychiatrists. *Supporting transgender and gender-diverse people*. (2018).
4. NHS England. *Gender Identity Services for Adults (Non-Surgical Interventions)*. (2018).
5. Government Equalities Office. *National LGBT Survey: Research report*. (2018).
6. Stonewall. Glossary of terms. Available at: <https://www.stonewall.org.uk/help-advice/glossary-terms>. (Accessed: 14th August 2018)
7. World Health Organization. ICD-10 Version: (2016). Available at: <http://apps.who.int/classifications/icd10/browse/2016/en>. (Accessed: 23rd March 2018)
8. National Institute of Economic and Social Research, Hudson-Sharp, N. & Metcalf, H. Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence. 162 (2016). Available at: <https://www.niesr.ac.uk/publications/inequality-among-lesbian-gay-bisexual-and-transgender-groups-uk-review-evidence>. (Accessed: 9th July 2018)
9. NHS England. *Gender Identity Services for Adults (Surgical Interventions)*. (2018).
10. Stonewall. *LGBT in Britain - Trans Report*. (2018).
11. Assembly, L. & London Assembly. *Supporting mental health for all*. (2018).
12. Healthwatch Suffolk. *Response to the House of Commons Women and Equalities Committee Health and Social Care and LGBT Communities Inquiry (Presentation of evidence)*. (2018).
13. Torjesen, I. Trans health needs more and better services: increasing capacity, expertise, and integration. *BMJ* **362**, k3371 (2018).
14. Zucker, K. J. Epidemiology of gender dysphoria and transgender identity. *Sexual Health* **14**, (2017).
15. Joseph, A., Cliffe, C., Hillyard, M. & Majeed, A. Gender identity and the management of the transgender patient: a guide for non-specialists. *J. R. Soc. Med.* **110**, 144–152 (2017).

16. Public Health Action Support Team. *Transgender Community*. (2015).
17. Reisner, S. L. *et al.* Global health burden and needs of transgender populations: a review. *The Lancet* (2016). doi:10.1016/S0140-6736(16)00684-X
18. Winter, S. *et al.* Transgender people: health at the margins of society. *Lancet* **388**, 390–400 (2016).
19. Royal College of Psychiatrists. *Good practice guidelines for the assessment and treatment of adults with gender dysphoria CR181*. 60 (2013).
20. Olyslager, F. & Conway, L. On the Calculation of the Prevalence of Transsexualism. in *WPATH 20th International Symposium* (2007).
21. De Cuypere, G. *et al.* Prevalence and demography of transsexualism in Belgium. *Eur. Psychiatry J. Assoc. Eur. Psychiatr.* **22**, 137–141 (2007).
22. Wiepjes, C. M. *et al.* The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets. *J. Sex. Med.* **15**, (2018).
23. Kesteren, P. J. M. van, Asscheman, H., Megens, J. A. J. & Gooren, L. J. G. Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clin. Endocrinol. (Oxf)*. **47**, 337 (1997).
24. NHS England. *NHS Standard contract for Gender Identity Development Service (GIDS) for Children and Adolescents*. (2016).
25. Turban, J. L. & van Schalkwyk, G. I. “Gender Dysphoria” and Autism Spectrum Disorder: Is the Link Real? *J. Am. Acad. Child Adolesc. Psychiatry* **57**, 8–9.e2 (2018).
26. Glidden, D., Bouman, W. P., Jones, B. A. & Arcelus, J. Gender Dysphoria and Autism Spectrum Disorder: A Systematic Review of the Literature. *Sex. Med. Rev.* **4**, 3–14 (2016).
27. Van Der Miesen, A. I. R., Hurley, H. & De Vries, A. L. C. Gender dysphoria and autism spectrum disorder: A narrative review. *Int. Rev. Psychiatry* **28**, 70–80 (2016).
28. Janssen, A., Huang, H. & Duncan, C. Gender Variance Among Youth with Autism Spectrum Disorders: A Retrospective Chart Review. *Transgender Heal.* **1**, 63–68 (2016).
29. Tavistock & Portman NHS Foundation Trust. GIDS referrals increase in 2017/18. (2018). Available at: <http://gids.nhs.uk/news-events/2018-05-16/gids-referrals-increase-201718>. (Accessed: 4th June 2018)
30. McNeil, J., Bailey, L., Ellis, S., Morton, J. & Regan, M. *Trans Mental Health Study 2012*. (2012).
31. Su, D. *et al.* Mental Health Disparities Within the LGBT Population: A Comparison Between Transgender and Nontransgender Individuals. *Transgender Heal.* **1**, 12–20 (2016).
32. Carmel, T. C. & Erickson-Schroth, L. Mental Health and the Transgender Population. *J. Psychosoc. Nurs. Ment. Health Serv.* **54**, 44–48 (2016).
33. General Medical Council. Trans healthcare. Available at: <https://www.gmc-uk.org/ethical-guidance/ethical-hub/trans-healthcare#trans-health>. (Accessed: 2nd May 2018)
34. National Institute of Economic and Social Research, Hudson-Sharp, N. & Metcalf, H. Inequality among lesbian, gay bisexual and transgender groups in the UK: a review of evidence. 162 (2016). Available at: <https://www.niesr.ac.uk/publications/inequality-among-lesbian-gay-bisexual-and-transgender-groups-uk-review-evidence>. (Accessed: 9th July 2018)
35. Grant, J. M. *et al.* *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. (2011).
36. Grossman, A. H. & D’Augelli, A. R. Transgender youth and life-threatening behaviors. *Suicide Life-Threatening Behav.* **VO - 37** 527 (2007).
37. PHAST CIC. Taking action to improve population health and increase equality. Available at:

- <https://www.phast.org.uk/>. (Accessed: 3rd May 2018)
38. Connolly, M. D., Zervos, M. J., Barone, C. J., Johnson, C. C. & Joseph, C. L. M. The Mental Health of Transgender Youth: Advances in Understanding. *J. Adolesc. Heal.* **59**, 489–495 (2016).
 39. Healthwatch Suffolk. *My health, our future: Understanding children and young people's mental health in Suffolk.* (2019).
 40. Dhejne, C., Van Vlerken, R., Heylens, G. & Arcelus, J. Mental health and gender dysphoria: A review of the literature. *Int. Rev. Psychiatry* **28**, 44–57 (2016).
 41. Mizock, L. Transgender and Gender Diverse Clients with Mental Disorders: Treatment Issues and Challenges. *Psychiatr. Clin. North Am.* **40**, 29–39 (2017).
 42. Schaumberg, K. *et al.* The Science Behind the Academy for Eating Disorders' Nine Truths About Eating Disorders. *Eur. Eat. Disord. Rev.* **25**, 432–450 (2017).
 43. Giordano, S. Eating yourself away: Reflections on the 'comorbidity' of eating disorders and gender dysphoria. *Clin. Ethics* **12**, 45–53 (2016).
 44. Jones, B. A., Haycraft, E., Murjan, S. & Arcelus, J. Body dissatisfaction and disordered eating in trans people: A systematic review of the literature. *International Review of Psychiatry* (2016). doi:10.3109/09540261.2015.1089217
 45. Marshall, E., Claes, L., Bouman, W. P., Witcomb, G. L. & Arcelus, J. Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature. *Int. Rev. Psychiatry* **28**, 58–69 (2016).
 46. Clements-Nolle, K., Marx, R., Guzman, R. & Katz, M. HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: implications for public health intervention. *Am. J. Public Health* **91**, 915–921 (2001).
 47. Clements-Nolle, K., Marx, R. & Katz, M. Attempted Suicide Among Transgender Persons: The Influence of Gender-Based Discrimination and Victimization. *J. Homosex.* **51**, 53 (2006).
 48. Kenagy, G. Transgender health: findings from two needs assessment studies in Philadelphia. *Health Soc. Work* **30**, 19–26 (2005).
 49. Whittle, S., Turner, L., Al-Alami, M., Press for Change & Manchester Metropolitan University. *Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination.* (2007).
 50. Xavier, J. *et al.* *The health, health-related Needs, and Lifecourse Experiences of Transgender Virginians.* (2007).
 51. Adams, N., Hitomi, M. & Moody, C. Varied Reports of Adult Transgender Suicidality: Synthesizing and Describing the Peer-Reviewed and Gray Literature. *Transgender Heal.* **2**, 60–75 (2017).
 52. Braveman, P. Health disparities and health equity: concepts and measurement. *Annu. Rev. Public Health* **27**, 167–194 (2006).
 53. Rooney, E. *All Partied Out? Substance Use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community.* (2012).
 54. Veale, J. F., Watson, R. J., Peter, T. & Saewyc, E. M. Mental Health Disparities Among Canadian Transgender Youth. *J. Adolesc. Heal.* **60**, 44–49 (2017).
 55. White Hughto, J. M. & Reisner, S. L. A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals. *Transgender Heal.* **1**, 21–31 (2016).
 56. Colizzi, M., Costa, R. & Todarello, O. Transsexual patients' psychiatric comorbidity and positive effect of cross-sex hormonal treatment on mental health: Results from a longitudinal

- study. *Psychoneuroendocrinology* **39**, 65–73 (2014).
57. Murad, M. H. *et al.* Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clin. Endocrinol. (Oxf)*. **72**, 214–231 (2010).
 58. Beckwith, N., Reisner, S. L., Zaslou, S., Mayer, K. H. & Keuroghlian, A. S. Factors Associated with Gender-Affirming Surgery and Age of Hormone Therapy Initiation Among Transgender Adults. *Transgender Heal.* **2**, 156–164 (2017).
 59. Wanta, J. W. & Unger, C. A. Review of the Transgender Literature: Where Do We Go from Here? *Transgender Heal.* **2**, 119–128 (2017).
 60. Sayegh, F. *et al.* Facial Masculinization Surgery and its Role in the Treatment of Gender Dysphoria. *J. Craniofac. Surg.* **30**, 1339–1346 (2019).
 61. Mahfouda, S. *et al.* Gender-affirming hormones and surgery in transgender children and adolescents. *Lancet Diabetes Endocrinol.* **7**, 484–498 (2019).
 62. Day, P. *Trans-gender reassignment surgery.* (2002).
 63. Best, L. & Stein, K. *Surgical gender reassignment for male to female transsexual people.* (1998).
 64. NHS England. Interim gender dysphoria protocol and service guideline 2013/14. 29 (2013). Available at: <https://www.england.nhs.uk/2013/10/gender-protocol/>. (Accessed: 1st May 2018)
 65. *Gender dysphoria services: a guide for General Practitioners and other healthcare staff.* (2013).
 66. Public Health Suffolk. Suffolk transgender communities - action plan update. *Suffolk Groups at Risk of Disadvantage Health Needs Assessment* (2019). Available at: <https://www.healthysuffolk.org.uk/uploads/Transgender.pdf>. (Accessed: 5th June 2019)