

Summary

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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INTRODUCTION

The Report was funded by the Brighton & Hove City NHS Primary Care Trust (PCT) because it is known that many transsexual (trans) people choose to pay for their medical treatment despite great financial sacrifices and the availability of a free-to-user pathway through the NHS.

This indicates profound dissatisfaction with the treatment offered, which suggests that the PCT may not be commissioning treatment to the standard to which it aspires, and that the client group may not be receiving the treatment it merits.

The Report is in five sections plus Recommendations, summarised below:

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. At its extreme, when the anguish this creates is intolerable, it is called transsexualism.

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, 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, and simple happiness. Transpeople more often than not become more socially integrated, more effective, and contribute more to society due to the integration of their own being. Additionally, the long-term distress caused by Gender Dysphoria diminishes, so that stress related illness is greatly reduced.

The essence of medical intervention - which is part of a greater personal and social transition – consists of hormone treatment (oestrogen for trans women, testosterone for trans men), and surgery to modify the primary and secondary sexual characteristics of the body. This enables the individual to have the body and life which are in alignment with their inner sense of identity – diminishing distress and enhancing personal integration.

These treatments are available through the NHS, but this research demonstrates that the **access** to this treatment is unnecessarily long and arduous, and is supplied in a manner which increases rather than diminishes the suffering of the individual.

Section 3

What do Transpeople think about present care provision?

***“If they really understood us, they wouldn’t treat us like this”
Trans woman at The Clare Project, Brighton and Hove, April 2004***

Most transpeople interviewed either never began on the NHS pathway – having investigated its qualities in advance – or abandoned it, due to direct experience of those qualities, to take the private medical route.

The major dissatisfaction lies with the attitude and organisation of the Charing Cross Gender Identity Clinic (GIC) in West London, to which all Gender Dysphoric clients from Brighton & Hove are sent for the assessment which eventually leads to medical intervention.

This assessment is in the hands of psychiatrists, who are often perceived as ‘gatekeepers’ to treatment which is medical not psychiatric in nature. As such, they have a power over clients in distress that is often perceived to be used inappropriately, and is often seen to cause further distress.

Quotes from the client group include:

“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, but the new appointment is in another 6 months time.”

“I chose the private route because 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. 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.”

“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.”

Consistent comments include:

- *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, and there can be constant unexplained delays, which can add unnecessary years to the already difficult process.*
- *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.*
- *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 these expectations in order 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 hesitate to do so, due to fear of the reaction of the consultant psychiatrists, and fear of being removed from the programme.*

These observations are confirmed and backed up by letters from two local General Practitioners who have long experience with transpeople in transition.

“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 the 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.”

Dr Alison Hermitage

“I have looked after many transsexual patients and their reports differ. However, on the whole there seems to be many areas of discontent.

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.”

Dr Susan Lipscombe

Section 4

Present provision of NHS Treatment in Brighton & Hove

When investigating the causes for dissatisfaction with treatment for transpeople in Brighton and Hove, it became clear that despite the existence of experienced and compassionate local medical professionals, the intention of the PCT to provide quality service, and the needs of transpeople, there is an obstacle to joining all this together.

At present, the key to understanding prevailing attitudes and beliefs about transpeople comes from the Policy Document that defines their treatment.

East Sussex Health Authority Transsexualism and Gender Re-Assignment Policy

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

The Report analyses this Policy Document – and the subsidiary guidance written in January 2004 - at length. The 1995 Policy Document defines transpeople as mentally ill more than once – without evidence to support this claim. It contains factual errors, meaningless statistics, and misleading assumptions.

A section of this analysis gives a good idea of the whole. The 1995 Policy Document's Appendix is titled:

‘Synopsis of the Harry Benjamin Standards of Care: The
Hormonal and Surgical Reassignment of Gender
Dysphoric Persons 1979 (re-endorsed 1985)’

Revisions (not re-endorsements) of the Standards of Care were made in 1980, 1981, 1990, 1998 and 2001 - not 1985, and nowhere is there a mention of re-endorsements.

The Appendix, which purports to be a ‘Synopsis’ of the Harry Benjamin Standards of Care, includes statements that are not actually within the Standards, and so the origin of these statements – although they are attributed to the Standards of Care - is not indicated. For example:

“The doctor who takes the burden of deciding who to refer 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.”

There is nothing approximating this description of the essential nature of transpeople in the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders – whose Overarching Treatment Goal is “lasting personal comfort with the gendered self in order to maximize overall psychological well-being and self-fulfilment.” In contrast the East Sussex Policy Document's statement encourages the view that transpeople are, by nature, threatening and mentally unstable.

Such a statement is discriminatory when generalised to include all transpeople, creating a stereotype of irrationality and mental instability within this group. It is inconceivable to imagine a policy document making such statements about black or Jewish people. Why should it be tolerated for transpeople?

The analysis of the Policy Document merits close reading. The attitudes ingrained in it fit well with those of the Charing Cross Gender Identity Clinic described not only by the client group, but also by two General Practitioners who deal with them frequently.

The tone of the document does much to explain the profound dissatisfaction with the current treatment pathway, why the PCT may not be commissioning treatment to the standard to which it aspires, and why the client group may not be receiving the treatment it merits.

Section 5

The Case for a Client-centred Care Pathway for Transpeople in Brighton & Hove

In Brighton and Hove in 2004 we have an 'A team' of medical professionals who have good and long experience of Gender Dysphoria. All of them have been interviewed and have seen the value of a Local Integrated Service to give transpeople the high quality of treatment they, as all clients equally, merit.

There are two General Practitioners, a Consultant Endocrinologist, a Consultant Psychiatrist with specialist experience, a Gender Reassignment Surgeon, and a Voice Therapist who have showed interest in creating a better service, based locally. Such a service, which should cost no more than the present service, could change the focus of treatment from arduous psychiatric assessment in a remote clinic which denies other professional intervention in this community, to a more complete service at home.

The present system denies clients access to excellent local service. It only needs 'joining up'.

The main problem may be found in resistance to change. Old attitudes, as found in the defining Policy Document that has provided the single education on the issues described in the Report, still lean towards punitive harshness for transpeople, and are hard to change.

The social and legal changes, which have already begun to change the lives of transpeople and give them the human dignity and rights they merit, mean that the time has now come to embrace compassion and reality.

RECOMMENDATIONS

The current Policy Document should be swiftly replaced, not re-written. The new document should be written with the contribution of the local medical experts who are named in the Report, with input from community groups.

This new document should then lead to the creation of a **Local Integrated Service** to handle all gender issues, based around a Specialist General Practitioner or a Specialist Nurse. Education for medical professionals on the realities of treatment for transpeople should be encouraged.

Concerns should be focused first on the client group, with PCT policies and actions based on the client group's needs. The clients should be treated with respect, and their dignity should be observed, with reference to the Gender Recognition Act 2004, which brings the definition and status of transpeople in the United Kingdom into the twenty-first century.

Access to treatment – the underlying issue in this report – should be made swift and simple, and treatment supplied locally, with understanding and respect. The issue should no longer be treated as a mental health issue, because it is not.