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What services are available for the treatment of transsexuals in Great Britain?

AIMS AND METHOD

We conducted a questionnaire survey of all 120 health authorities and boards responsible for the commissioning of services for the assessment and treatment of transsexual people in England, Scotland and Wales, in order to identify the nature of the input offered and assess conformity to current international standards of care.

RESULTS

Eighty-two per cent of the commissioning authorities responded and confirmed that most health authorities/boards provide a full service for the treatment of transsexuals, although this would be delivered at a local level in only 20% of cases. However, 11 commissioning authorities gave confused and inaccurate responses and three other health authorities appear to hold

views on the commissioning of these specialist services that are not in keeping with the current legal situation and a recent High Court ruling, which establishes the right of transsexual people to NHS assessment and treatment.

CLINICAL IMPLICATIONS

There are discrepancies in prioritisation and provision of clinical services for this group that are not standard across Great Britain.

Transsexualism is a desire to live and be accepted as a member of the opposite gender, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic gender and a wish to have hormonal treatment and surgery to make one's body as congruent as possible with the preferred gender (World Health Organization, 1992). Gender dysphoria, gender identity disorder and transgenderism are other recognised terms for this rare disorder, the prevalence of which is estimated to be 1/34 000 for men and 1/108 000 for women (Hoenig & Kenna, 1974).

Treatment is generally sought when the person's concerns become so intense as to be judged the most important aspect of his/her daily life. The conviction that gender reassignment is the only solution is a well-established feature and the general goal of treatment is to maximise psychological well-being in the chosen gender role. The Harry Benjamin International Gender Dysphoria Association (1998) has produced standards of care for treatment that are internationally recognised.

Management includes diagnostic assessment, supportive psychotherapy, the 'real life experience' (Harry Benjamin International Gender Dysphoria Association, 1998), hormonal therapy and surgery. Initial assessment should confirm the diagnosis and ensure that the condition is not a manifestation of a major psychiatric disorder such as schizophrenia. Conventional interpretative psychotherapy is not indicated in most cases and the current approach includes information regarding possible treatment options, exploration of the person's expecta-

tions of gender reassignment, as well as more in-depth evaluation of personality and social functioning. During the real life experience, the transsexual is expected to function in the chosen gender role in all areas of his/her life, including work and personal relationships.

Hormonal therapy with the sex hormones of the opposite gender is used to induce development of secondary sexual characteristics, some of which are irreversible. Surgery includes genital reconstruction, hysterectomy, mastectomy or breast enlargement and cricothyroid cartilage surgery in men. Other components of treatment include speech therapy and hair removal. A large body of research on the outcome of gender reassignment surgery indicates that, for the majority of those who undergo this process, the result is positive (Carroll, 1999).

The rights of people with gender identity disorder to be recognised in law in their chosen gender and not to be subject to discrimination have been fought in the courts and employment tribunals. In 1995, in the case of *P v. S* and Cornwall County Council, it was recommended that the principle of equal treatment for men and women should be held to cover transsexuals (Court of Justice of the European Communities, 1996). In July 1998 the European Court criticised the UK government for not addressing legal problems and protecting the transsexual person's right to privacy, although it ruled that a violation of European law had not occurred. In December 1998 the High Court ruled in favour of three transsexual women who contested Lancashire Health



Authority's refusal to fund surgery (Royal Court of Justice, 1998). However, a number of organisations representing transsexual groups have complained that the nature of the clinical services offered to transsexuals varies considerably across Great Britain and some do not meet the standards of care established by the Harry Benjamin criteria. This study was designed to clarify the current commissioning arrangement for these specialist services.

The study

Questionnaires were sent to public health directors for each health authority/board in England, Scotland and Wales ($n=120$). They were asked if they had a local service for transsexuals and if so, whether this included psychiatric assessment, hormonal therapy and/or gender reassignment surgery. If there was no local service, they were asked to identify the tertiary clinics that they commissioned. From these initial questionnaires, tertiary gender clinics were contacted in writing and by telephone for further information.

Findings

Ninety-eight questionnaires were returned, indicating a response rate of 82%. Of the health authorities/boards that responded, 20% ($n=20$) stated that they had a complete transgender service available locally, although it was clear that not all of these centres had facilities for surgery.

Sixty per cent of the remaining health authorities/boards ($n=59$) stated that they provided no local service, but could refer elsewhere for psychiatric assessment, hormone treatment and surgery. Of these commissioning authorities, 41 referred cases to one national centre in London (Charing Cross). Seven others used established provincial centres, and seven authorities utilised a combination of specialised gender clinics in various locations.

Three health authorities/boards stated that treatment for transsexual people was a low commissioning priority for which funding was not normally provided. One reported a willingness in principle to refer for treatment but had no occasion to do so, and another confirmed that it would pay for psychiatric assessment and treatment but would fund surgery only in exceptional circumstances. A further authority confirmed that it would only fund psychiatric treatment alone and had an established policy of not paying for surgical reassignment. The implication from such a policy is that transsexual people could receive irreversible hormonal virilisation or feminisation without recourse to surgical reassignment, thereby creating a permanent pseudo-hermaphrodite state.

Six per cent of health authorities/boards who responded (6) stated that they had a local arrangement that consisted of an assessment by a named psychiatrist only, but were able to refer elsewhere for further services if indicated.

Eleven commissioning health authorities provided responses that were characterised by a distinct lack of clarity. Four reported that there was no local service but did not have an established policy of referral to a nominated specialist centre. Two authorities indicated that they referred cases to specific surgeons but made no mention of the necessary psychiatric assessment or treatment. Three health authorities/boards stated that they referred cases elsewhere but identified centres and specialists that either did not exist or mentioned staff who had retired sometime before. Two responses indicated that there was no specific commissioning arrangement and left the matter of referral to the local psychiatrists.

In total, health authorities/boards listed 20 gender identity clinics to which they referred cases for management. When contacted by the research team, only 12 of these clinics were able to organise a complete service and six of them consisted of single-handed practitioners working in isolation from other colleagues; in contravention of the Harry Benjamin International Standard. Four of the centres contacted did not have a specialist service at all, two others consisted of a surgeon only and one offered psychotherapy without other forms of specialist input.

Discussion

From the above it can be seen that most transsexual people have access to NHS services for the treatment of gender dysphoria. However, this will only be available on a local basis to a minority (i.e. those living in the catchment areas of 21% of responding health authorities/boards). For the rest, specialist treatment involves long distance travelling to appointments that are likely to be scheduled over a fairly lengthy period of time. Specialist services that are very distant from the patients' homes may experience considerable difficulties in supervising the real life experience because of unfamiliarity with local circumstances. In those cases, transsexual people may feel that they have to 'prove' their credentials and subsequent interactions with the clinic may assume a distorted pattern, as the transsexual person may perceive the staff as representative of a barrier to be overcome rather than as a resource provided to help him/her achieve maximum psychological well-being. Also, distant services may lack knowledge of local support groups and may not be able to deliver the high level of liaison with conventional medical services, which is required post-surgery. The obvious implication from such findings is the need to consider regional structures that have sufficient catchment populations as to allow the development of specialist local expertise.

The initial assessment of transsexual people frequently takes place in primary care or generic psychiatric settings and is followed by referral to a more specialised gender clinic. The quality of initial assessment varies to the point whereby inappropriate treatments such as hormone therapy are commenced prior to the confirmation of the diagnosis. Some transsexuals are so convinced



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of the need to proceed to gender reassignment that they place significant pressure on inexperienced clinicians to prescribe hormone therapy before full multi-disciplinary assessment. Clearly there are dangers of clinicians working in isolation in this complex area. The Royal College of Psychiatrists has recently recognised the need in adolescent transsexualism for a standardised multi-disciplinary approach based on agreed criteria and has supported the development of a national consensus (Royal College of Psychiatrists, 1998). Currently, only six adult transsexual clinics appear to be established along such lines and therefore it is unlikely that treatment is delivered in a standardised manner across Great Britain. Despite this, there are a number of very good existing local initiatives that aim to provide more comprehensive and standardised services.

There is evidence of confusion among those responsible for commissioning in some health authorities/boards as to what services were available to them. Inevitably, this must translate into confusion for the service users and their doctors at the first point of contact. It may serve to alienate them further and reinforce the perception that their needs are being denied or ignored. Commissioners of health services have responsibility for ensuring that the contracted service delivers a reasonable standard of care and it is clear that this vital function is not being addressed by some health authorities.

Many health authorities/boards have different commissioning priorities that result in substantially different rates of referral from the populations served.

In the case of some health authorities, treatment of gender dysphoria was considered to be of a 'low priority' and they do not normally fund NHS surgery. Given the 1998 High Court ruling against Lancashire Health Authority's refusal to fund treatment, they may be considered to be in breach of the Human Rights Act. The cost of legal action is high and paradoxically might exceed the cost of providing the clinical service in the first place.

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Audit of case-load and case mix of higher specialist trainees in child and adolescent psychiatry[†]

AIMS AND METHOD

The aim of the audit was to ensure that the case-load and case mix for trainees in child and adolescent psychiatry met Child and Adolescent Psychiatry Specialist Advisory Committee guidelines and that trainees were seeing cases with an appropriate mix of age, gender and diagnoses. Data on case-load and case mix were analysed annually and problem areas were identified and reviewed when the audit cycle was

repeated. The audit cycle has been repeated three times.

RESULTS

Specific findings from the audit included: female trainees were seeing a high percentage of girls; male trainees were seeing a high percentage of boys; some trainees were seeing a high proportion of cases of deliberate self-harm; and there was a recent increase in the number of cases of attention-deficit

hyperactivity disorder. The first two issues were rectified as a result of the audit process; the last is being monitored.

CLINICAL IMPLICATIONS

Training needs should come before service needs. Auditing trainees' case-loads and case mixes helped best to utilise the time available for clinical work during training.

One of the consequences of the Calman reforms of postgraduate training for child and adolescent psychiatrists is shorter training (Department of Health, 1993). Of central importance to effective training is the range of clinical experience. The specific training requirements are

set out in the Child and Adolescent Psychiatry Specialist Advisory Sub-Committee (CAPSAC) advisory papers, which specify the number of cases open at one time to a trainee and the total number of cases seen in a year. The CAPSAC also expects trainees to have 'experience in

[†]See pp. 208–209 this issue.