NHS
Norfolk and Suffolk
NHS Foundation Trust

Practice guidance for

staff supporting trans service users

Working together
for better mental health

Welcome

This guidance is to help cisgender staff at Norfolk and Suffolk NHS Foundation Trust support people who identify as transgendered who use our services.

If you haven't come across the term 'cisgender' before this booklet will explain what it means.

If you only take four messages from this guidance these are the most important ones:

- Gender is often a deep part of our identity and not a choice. In a trans-hostile environment this can exacerbate mental health problems. In an accepting environment it can be the start of a journey to feeling truly at home with oneself

  Our services at NSFT are about helping people make the most of their lives. That means creating an environment that affirms the value of everyone and challenging transphobic attitudes
- We all want to be accepted for who we are and not to pretend to be someone else. Like everyone else, people who identify as trans want to live happy fulfilling lives, have a job, friends and be part of a community
- Also like everyone else, people who identify as trans are all different. Labels and categories are helpful up to a point – but the only way to find out what someone likes, loves and loathes is to ask them, to listen carefully and to respect what they say
- At NSFT we live by our values of working together for better mental health – positively, respectfully and together. If you apply these principles to your work supporting trans service users and colleagues you cannot go far wrong

cisgender

This guidance is divided into four sections for easy reference:

1. **Getting the basics right:**

   Start here to learn about the wide range of experiences that come under the term 'trans' and perhaps to unlearn some preconceptions that you might have

2. **Understanding transgender legal rights:**

   There have been significant advances in recent years. This section explains what the law says and what it means for you as a health practitioner

3. **Supporting transgender people who use our services:**

   What to think about when carrying out an assessment, collaborating on a care plan and thinking about inpatient admission needs

4. **Understanding transitioning:**

   Not all trans people want to transition surgically but some do. This section explains the care pathway and includes information about particular issues for children and young people who may identify as trans

At the back of this booklet you will find links to resources. Information is also available on the intranet, via your local Equality Lead or from the Head of Equalities and Engagement.

We also have staff guidance on supporting trans colleagues at work and this is available on the intranet.

1. Getting the basics right – concepts and language

This booklet is primarily about supporting people who identify as transgender, but the general term 'trans' refers to a wider range of experiences. In this section we talk about some language and concepts that are helpful when thinking about trans issues and supporting trans people.

The term 'tranny' is very disrespectful and should never be used in any context.

Transgender:

People who identity as transgender often have an absolute self-awareness that the gender they were assigned at birth is different to their gender identity.

So, a child who is thought by her family to be a boy, and who anatomically seems like a boy, may know from an early age that she is a girl. Or a child thought by his parents to be a girl may know that he is a boy.

Not everyone knows this instinctively from a young age, although many people do. Some people struggle with a sense of confusion and it takes time to make sense of it.

Transsexual:

In law, a transsexual person is someone who 'proposes to undergo, is undergoing or has undergone gender reassignment' (Equality Act 2010). So this is a narrower definition than transgender. Although most people who identify as transsexual might also identify as transgender, many who identify as transgender are not transsexual. Transsexual is increasingly understood to be an outdated term but it has a legal meaning.

Gender dysphoria:

Gender dysphoria means the distress that someone may experience when their gender identity is different to the gender they were assigned at birth. This distress may then lead people to want to transition so that the two are aligned. Gender dysphoria and transgender identity are not the same thing.

Cisgender:

This is a relatively new word (first coined in 1994). It means people whose gender identity / expression is the same as the gender they were assigned at birth. Most people are cisgender. The advantage of using the word cisgender in a booklet like this is that it is much quicker to use the term than to spell it out every time.

Another advantage is that it helps us all to think about who we are and to move away from a narrow concept of what is 'normal.' Most people are right-handed but nowadays we don't think of the minority of left-handed people as abnormal or inferior (although of course for many years we did). Trans people are in the minority compared to cisgender people but some people still see them as abnormal or inferior.

Transvestite:

Wearing clothes more usually worn by the 'opposite' sex is quite common but the word transvestite has very different meanings for different people. Some men wear women's clothing because they feel more comfortable or because they may find the experience arousing. But they usually identify as heterosexual men and would not identify as transgender.

People assigned as men who are transitioning to women will usually wear women's clothing, and similarly people who were assigned as women at birth who are transitioning to men will usually wear men's clothing (depending on where they are in their journey and what they prefer). The aim is simply to align physical appearance with internal identity. There is usually no inherent sexual aspect here and the ideal outcome for most would be simply to walk down the street and not be noticed.

Drag:

In the gay community there has been a long tradition for some men to dress in drag for entertainment. There is rarely any sexual or identity component to drag. The intention is not to be able to pass as a woman and the feminine image is usually taken to an extreme as part of the entertainment. This can cause tensions within the LGB&T community because of the risk of gender stereo-typing.

There is an increasing alternative scene of 'drag kings' who are women (sometimes but not always lesbian women) who dress as men and as for 'drag queens' this is for entertainment.

Non-binary:

The idea of the 'opposite sex' is sometimes called a binary description because it implies that there are only two choices. This may seem self-evident but it isn't true. It may not be a common experience but some people find that their gender identity is not fixed and it changes over time. Some people don't feel particularly male or female or masculine or feminine – their experience is that these terms just don't particularly make sense for them. They may describe themselves as non-binary. Some people may prefer the title 'Mx' and use pronouns such as they / their. Others may use 'hir' or 'ze'. It is always appropriate to ask someone who identifies as non-binary what pronouns they prefer.

Intersex:

Some people are born with reproductive or sexual anatomy that doesn't seem to fit what might be considered typical. Sometimes this is clear at birth but for some people it is only evident when they reach puberty. Then it is noticed that their internal reproductive organs are inconsistent with their external sexual characteristics.

The term hermaphrodite is not in modern use because it is based on the idea of having both male and female reproductive organs which is not physiologically possible.

Sexual orientation:

There is less confusion nowadays about what it means to be lesbian, gay, bisexual (LGB) or heterosexual. Changes in social attitudes mean that most people now have LGB family and friends.

Where people do still get confused is in understanding that sexual orientation and gender identity are completely independent of each other.

The following diagram illustrates this. All combinations are possible and of course even these labels are misleading because people can change over time and we don't fit neatly into boxes in the way the diagram implies.

	Lesbian / Gay	Bi	Heterosexual	A-sexual*
Cisgender Woman / Cisgender Man				
Non-binary				
Trans Man				
Trans Woman				

***A-sexual. Many people find that sexual feelings of any kind don't play a part in their lives and describe themselves as a-sexual.**

A further dimension which is not shown on the diagram above is masculinity / femininity. Masculinity and femininity are mostly socially defined. They vary from culture to culture and over time. However, some boys (from a very early age) and men are comfortable identifying as feminine and can be heterosexual or gay, cisgender or trans. The same applies to girls and women. Although we are tempted to try to pigeon-hole people, in reality humans are infinitely variable.

Risks to wellbeing for trans people

Awareness about transgender identity is important for mental health practitioners because trans people have a much higher rate of suicide and self-harm, including harmful substance misuse, than the general population. These raised levels of mental distress are not because gender dysphoria is a mental illness – it is not. It is because of the level of hostility and violence amongst intolerant families, communities and faiths.

"I was waiting for my partner who was attending an outpatient appointment and the only other person in the waiting room took out their phone and started to take pictures of me.

I felt extremely uncomfortable and spoke to the receptionist about it. They didn't know what to do and so did nothing."

Abuse and violence

The level of transphobic abuse and violence in the UK is a significant problem which can directly impact on the mental wellbeing of people who are targeted. Accurate figures are hard to obtain and many transgender people describe experiencing chronic low level abuse (name-calling, glaring, spitting) which they do not report.

Reports of serious assaults have increased significantly in recent years, partly because police attitudes have changed and so responses are more appropriate.

Internationally, a transgender murder is estimated to be reported on average every 29 hours (most are not reported or defined as transphobic and so are not recorded).

"I lived in an area where all the GPs said that my request to be referred to a Gender Identity Clinic was inconsistent with their religious beliefs.

I had to change my GP several times before I found one who was not transphobic. Only then could I get the support I needed"

Religious prejudice

Although almost all the major religions have moderate members who are not transphobic, most mainstream religious belief systems are hostile to transgender people. At NSFT, our spiritualty strategy is clear; equality comes first. Anyone who discriminates unfairly against transgender people may face a disciplinary investigation.

Getting the basics right – your role

If you are a trans member of staff you may be interested in a booklet on supporting other trans staff - available on the intranet.

This section assumes that you are a cisgender practitioner.
A good starting place is self-reflection.

- How do you feel about supporting someone who identifies as transgender?
- What did your upbringing teach you about gender, masculinity, femininity, male and female?
- What religious or political beliefs (if any) do you hold about gender?

You may not have thought much about this before but most people in western societies (and elsewhere) are given quite narrow ideas about gender. The concept of gender is usually based on primary sexual characteristics; whether people are born with a penis or a vagina or in genetic terms whether they have XX or XY chromosomes.

From birth we are also immersed in social norms about what it means to be masculine, feminine, a good boy or a nice girl.

Of course some people have always been born with indeterminate physical gender characteristics. Nonetheless, such is the power of our cultural assumptions about gender that a doctor will often allocate one or other gender to someone born with intersex characteristics and hope for the best.

Forcing of individuals' identities into male or female with no other options is sometimes called a 'binary' approach. For many people this works out fine. But for some people it is an unhelpful concept. They may not feel that their birth-assigned gender matches their identity and their gender identity might be fluid or non-existent.

If you are unable to work with a transgender service user with an affirming, accepting mind-set then you should not work with them as you may do them psychological harm.

You should discuss this in supervision and work towards a resolution of your problem. The service user's needs must be put at the centre of any allocation decision.

Reflective practice is important in mental health work because we need to be conscious of our own reactions in order to be able to work effectively with other people and support their recovery.

If you have the same gender identity as you were allocated at birth and are comfortable with this (that is, you are cisgender) you may not have thought about this much before.

For people who have never had to think about their gender identity, the idea of not being sure or being sure that you have been allocated the wrong gender can seem confusing, fascinating or disturbing. But these reactions only tell us about the experience of ourselves as cisgender people – as cisgender people we need to recognise these reactions as our own and not project them onto the people we are here to support.

2. Understanding transgender legal rights

There are two main pieces of legislation to consider.

The right to gender recognition - the Gender Recognition Act (2004)

After over a decade of campaigning by transgender people and their supporters, the Gender Recognition Act (2004) (effective from 2005) provided a limited set of rights for transgender people. It enables people to change their legal gender in the UK and to be issued with a new birth certificate.

Transgender people do not need to have undergone gender reassignment surgery but they do need to have lived as the 'appropriate' gender for two years and provide evidence to a Gender Recognition Panel before a Gender Recognition Certificate can be granted.

This process has been criticised by transgender rights groups as humiliating, overly bureaucratic and too narrow. There is only a choice of male or female and no recognition of non-binary identities.

Detailed information about the legal process of gender recognition is beyond the scope of this guidance but is available here: www.gov.uk/apply-gender-recognition-certificate/overview. This site also explains the position for married or civil partnered people who plan to transition. Many transgender people simply live as they wish and do not pursue a Gender Recognition Certificate. Other countries allow self-declaration rather than using a panel approach.

"I was put on a male ward and when I said I was not happy with this, they pulled the curtains round the bed 'to give me privacy'.

During my stay I think every porter, nurse and doctor in the building must have found one excuse or another to just 'look in' for some reason or another.

I was made to feel like I was in a freak show or a zoo. It was a degrading, and dehumanising experience that I would not have thought possible in the NHS."

The Gender Recognition Act is now widely viewed as outdated because it relies on a medical diagnosis of gender dysphoria. Many other countries (including Netherlands, Ireland, Argentina, Malta) rely on self-identification. There is no legal recognition for non-binary gender identities under the Gender Recognition Act although the Women and Equalities Committee on Transgender Equality (2015) recommended that the government address this in the future.

S.22 of the Gender Recognition Act (2004). The right to privacy.

For the purposes of the Data Protection Act (1998), information related to the gender recognition process is "protected information" and this protects the privacy of transsexual people under Article 8 of the ECHR.

As a mental health practitioner it is important to understand it is a criminal offence for you to disclose that a transgender person was assigned a different gender at birth without their agreement. This right to privacy is limited to people covered by the Gender Recognition Act and there are some exceptions (for example to prevent a crime).

However, protecting the confidential information of all the people we support is an important part of our work as NHS staff. This apples to trans people who do not have a Gender Recognition Certificate too.

Protection from discrimination – the Equality Act (2010)

Under the Equality Act (2010), gender reassignment is a protected characteristic. This is using the narrower term of transsexual rather than transgender.

The government created the concept of a protected characteristic to recognise the fact that some groups face unfair discrimination and need legal protection.

It is against the law to discriminate against transsexual people in employment or in the provision of goods and services. The protection applies to everyone and there is no need to be under medical supervision. It also applies to the family, friends and colleagues of transsexual people.

Confidentiality

"Disclosing someone's trans status or history without permission or cause is, in some cases, a criminal offence. You should always gain consent before disclosing this information, with permitted exceptions only when it is not possible to gain consent and is essential for the delivery of services, for example the emergency care of an unconscious person, and only to the staff who need to know to effectively deliver relevant care ."

Fair care for trans patients. RCN (2016)

NSFT, as a public authority, also has duties towards transsexual people under the Equality Act. Remember that the Equality Act uses a definition of transsexual as someone who 'proposes to undergo, is undergoing or has undergone gender reassignment'.

We have to have due regard to the need to "eliminate discrimination, harassment and victimisation against transsexual people, to advance equality of opportunity and foster good relations between transsexual people and others." This means that we need to think about any potential negative impact on transsexual people in the way that we run all of our services.

In line with our Trust's values, we respect the wishes and preferences of transgender people even where the law does not provide specific protection because they are not transsexual.

Wider protection from hate incidents or hate crimes

There are no specific hate crimes but any criminal offence can be a hate crime if it is directed towards a transgender person because of their protected characteristic. If a court finds that a crime was motivated by transphobic hate then the judge can impose a tougher sentence against the perpetrator. More information is available on hate incidents and hate crimes at the Citizens Advice Bureau site: https://www.citizensadvice.org.uk/discrimination/hate-crime/sexual-orientation-and-transgender-identity-hate-crime/ Details of Norfolk and Suffolk Constabulary hate crime units are given on their websites.

3. Supporting transgender people who use our services

We have specific legal duties to people who are transsexual and we want to extend this approach to all transgender people in order to be consistent with our values.

Names, pronouns and health records

- There is no such concept as a "legal name" in UK law. We are all entitled to be known by any name that we choose so long as there is no fraudulent intention. People can use more than one name
- There is no legal requirement to provide a Gender Recognition Certificate (GRC), or a new birth certificate in order for a change of gender to be recorded in NHS records. You should not ask to see someone's GRC
- As practitioners we always choose language that our service users and colleagues will find respectful
- Ensure that you always use the right pronouns and names for the individual. So, for someone who has transitioned from male to female, make sure that you say and write 'she' and 'her'. Similarly, for someone who has transitioned from female to male, make sure that you say and write 'he' and 'his'
- Although progressive thinking about gender now includes 'non-binary', there is no legal recognition for this status yet and you will not be able to record 'non-binary' on Trust databases. This will not come as a surprise to a service user who identifies as non-binary. Use this as an opportunity for a helpful discussion about their identity and the words that they would prefer that you use. Some people may prefer the title 'Mx' and use pronouns such as they/their. Others may use 'hir' or 'ze'. It is always appropriate to ask someone who identifies as non-binary what pronouns they prefer

Mental wellbeing

It important not to jump to the conclusion that someone who approaches mental health services for help and identifies as transgender has a mental health problem is related to their gender identity.

It might not be. It might be. Or it could be a bit of both.

As we have already discussed, labels and boxes are convenient but also limiting. As mental health practitioners we know this applies to mental health issues too.

Almost everyone you see as a mental health practitioner has some sort of mental health problem. If you don't know any trans people in your personal life, and you only meet trans people who are mental health service users, you may wrongly conclude that all trans people have mental health problems. This is an easy logical error to make but it is nonetheless wrong-headed. Most people who identify as transgender don't have mental health problems, don't use mental health services and you just haven't met them.

As a starting point, it may be helpful to think about mental health and transgender issues from three perspectives:

- Most people who identify as transgender have no mental health problems

  They may (or may not) want support from the NHS to transition using hormones and / or surgery so that their gender identity matches their gender appearance. They might describe themselves as having a naturally occurring condition that needs NHS help but that is not the same as seeing themselves as ill or having a mental disorder. An analogy might be pregnancy and childbirth. Most mothers use the NHS to help with child birth but no-one would describe those women as ill

- Some people who identify as transgender may experience mental health problems because they have grown up or live in a transphobic family or community

  Growing up with people who you know would reject you if they knew who you really were can make self-acceptance very difficult. A lack of positive role models may feed feelings of isolation, guilt and depression

  Worries about rejection may lead to anxiety. Internalised transphobia can affect self-esteem. A lack of positive self-worth may lead to personality based problems and these may include self-harm, substance misuse and difficulty sustaining positive relationships. But these problems would not have arisen in a loving, accepting environment

- Some people who identify as transgender will experience mental health problems simply because mental health problems are so common.

  There is nothing intrinsic about being transgender that makes people immune from the same mental health problems that affect everyone else. In practice someone who is depressed may attribute this to their feeling about their transgender identity, but when not depressed they might see things differently and feel positive about their identity

"Although many of the professionals who work at a Gender Identity Clinic (GIC) are psychologists and psychiatrists, they are all absolutely clear that they do not see gender dysphoria as a mental illness".

Charing Cross GIC booklet for patients

So it is important not to jump to the conclusion that someone who approaches mental health services for help, and identifies as transgender, has a mental health problem that is related to their gender identity.

It might not be. It might be. Or it could be a bit of both.

Assessment skills

You may already know that someone identifies as transgender before you see them, or they may disclose this to you when you meet them. It may or may not come a surprise.

As you know already, every assessment is different and there is no single approach but here are some tips.

- Even if you are an experienced practitioner you may feel a little de-skilled in this situation but you don't need to. You already have the skills you need to carry out a therapeutic assessment
- Put the person at ease. Remember that mental health services have a very variable track-record on LGB&T rights and so the person you are seeing may be worried that they are about to be judged or discriminated against
- Everyone can expect to feel safe and to know that we take an affirmative approach to their identity. Remember that the person you're seeing is not telepathic so you have to actually say something in your own words that makes this clear. This is part of the practitioner's role

- Discuss confidentiality. What does the person you are seeing want in terms of boundaries? Does their GP know? Are they supportive? Share what you are going to record on the healthcare record (as is good practice for all work) and check whether they are happy with the entry
- Discuss preferred names and pronouns
- Carry out a holistic assessment as you would normally and don't slip into the mistake of "assessing a transgender person". You're assessing someone who has many facets. They may have close friends, families, a spouse – all of whom form part of the total picture. They may have a spiritual life which is a source of strength. They will have lots of strengths and interests. They happen to be transgender and this may or may not be relevant
- If someone is confused about their gender identity and that is clearly their main concern then mental health services are probably not appropriate. There are specialist voluntary agencies and resources far more able to help people think through their confusion. As an assessor your role is to help the person understand that their confusion is very common and not a mental disorder. This may be a huge relief although of course it could add to their confusion if they were hoping that a medical model would provide clarity. Instead you can signpost them to some of the resources listed at the back of this booklet

Care planning

"Being trans is not inherently problematic for the individual –the problems mostly arise out of the reaction of others and the consequent experience of stigma, with all the effects that that has for the health of the individual. Much of the support needed by trans people is about developing coping strategies to be themselves in a hostile world.

NHS organisations can strive to be the first place in society where such coping strategies become unnecessary."

Trans – A practical guide for the NHS (2008)

Just as for carrying out an assessment, you already have skills in co-producing care plans with service users.

Care planning is no different when working with someone who identifies as transgender. It is based in the assessment and follows from what people want to achieve from their contact with our services and in their wider life.

Here are some points to note:

- For someone seeking surgery, their mental state will be part of the pre-referral process. This means that a local mental health practitioner, often a psychiatrist, will see someone to rule out an underlying mental disorder before a referral to the Gender Identity Clinic. This assessment requires a specialist skill set and is a separate care pathway and is not part of your role
- Having had previous treatment for a mental health problem does not rule out a referral to a GIC, nor does it rule out surgery if that is appropriate. However, because surgery is irreversible, great care is taken to avoid a mistake. This means that there may be something of a dilemma for someone who is likely to want to seek surgery in how open they may feel they can be about their mental health problems. Recognising this dilemma and opening up a discussion about it may be helpful in deepening rapport and drawing up a meaningful care plan
- If relevant to the assessment, you might want to signpost people to voluntary organisations and support groups available for trans people. They can provide peer-support and advice on a wide range of topics. Support is also available for spouses and family

Inpatient care

It is much easier to provide supportive inpatient care if this is planned in advance. When someone is in a crisis it can be hard to think clearly. If the person you are working with has been an inpatient before, or might need admission in the future, it is a good idea to discuss their wishes and needs before a crisis and to agree what to record in their health record.

A key consideration is the choice of male or female bed as we have moved away from mixed sex inpatient accommodation over recent years.

"All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms. Women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. Consideration should be given to the particular needs of transgender patients".

CQC Assessment of same-sex accommodation – mental health (2015)

As a general rule, if someone has started to transition then they should be admitted to their stated preferred gender ward. So, someone who is transitioning from female to male should be admitted to a male ward and someone transitioning from male to female should be admitted to a female ward. CQC guidance is not specific other than emphasising the need to promote safety and dignity for all patients including transgender patients.

Risk assessment considerations

Potential risks for trans patients and to other patients should be considered, mindful of the need to preserve confidentiality. Examples of risks to be considered and mitigated include:

- Transphobic abuse or assault by other patients towards the trans service user
- Sexual assault or unwanted sexual attention towards the trans service user
- Disinhibited behaviour by the transgender service user which puts their dignity or safety at risk
- Disinhibited behaviour by the transgender service user which puts other patients at risk of sexual or physical assault

Options for mitigating risk

In our newer wards where there every room has an en-suite bathroom then issues of privacy and dignity can be minimised more easily. Women-only lounge areas provide safe areas for trans women.

Where there is a choice of single or shared bedrooms, offering a single room may well be the preferred option. The RCN advise, "Patient placement should be based on both asking the patient for their preference, and on gender presentation."

A shared bathroom also presents potential risks. Depending on the circumstances, a trans patient may be vulnerable to abuse or other patients may feel unsafe. Increasing staff awareness and availability around shared bathroom areas especially at busier times (for example: mornings and evenings) may help everyone feel safe.

If setting boundaries with other patients is not effective in preventing transphobic abuse then police involvement may be helpful. Just as in tackling racist abuse, a uniformed officer may be able to change the dynamic and it makes clear what our own expectations are.

Not challenging abuse is the same as tacitly condoning it.

Practice considerations

Trans women may need access to shaving toiletries and privacy to shave. This needs sensitive handling to avoid embarrassment and protect dignity. Trans men, if they have retained a uterus, may have raised risks of cervical cancer due to their hormone therapy.

Trans women may need prostate examination for certain conditions. As a generation of transgender people grow older new issues arise. Surgical techniques have changed over time and advice from a specialist surgeon may be needed before attempting procedures such as catherisation.

Dementia may affect memory recall and someone may access memories from their pre-transition years causing confusion and distress.

4. Understanding transitioning

This section of our guidance is taken from the NHS Choices website: www.nhs.uk/Conditions/Gender-dysphoria/Pages/Treatment.aspx

Treatment for gender dysphoria aims to help people with the condition live the way they want to, in their preferred gender identity.

What this means will vary from person to person, and is different for children, young people and adults. The specialist Gender Identity Clinic (GIC) care team will develop an individual treatment plan that's tailored to the person's needs. There are seven GICs in the country and three Trusts that provide surgery. Waiting times for Gender Identity Clinic appointments and for surgery are getting longer as more people feel confident to come forward (25 – 30% increase per year).

Gender identity services for children and young people

If a child is under 18 and thought to have gender dysphoria, they'll usually be referred to a specialist child and adolescent Gender Identity Clinic (GIC). The main clinic for young people is the Tavistock Clinic in London. GPs can refer young people directly to the Tavistock: http://gids.nhs.uk . Their website has a wide range of information for young people, parents and professionals.

Staff carry out a detailed assessment of the child, to help decide what support they need.

Depending on the results of this assessment, the options for children and young people who may have gender dysphoria can include:

- family therapy
- individual child psychotherapy
- parental support or counselling
- group work for young people and their parents
- regular reviews to monitor gender identity development
- hormone therapy (see below)

The child's treatment should be arranged with a multi-disciplinary team (MDT). This is a group of different healthcare professionals working together, which may include specialists such as mental health professionals and paediatric endocrinologists (specialists in hormone conditions in children).

Most treatments offered at this stage are psychological, rather than medical or surgical. This is because the majority of children with suspected gender dysphoria don't have the condition once they reach puberty. Psychological support offers young people and their families a chance to discuss their thoughts and receive support to help them cope with the emotional distress of the condition, without rushing into more drastic treatments.

About hormone therapy for children and young people

If the child has gender dysphoria and they've reached puberty, they could be treated with gonadotrophin-releasing hormone (GnRH) analogues. These are synthetic hormones that suppress the hormones naturally produced by the body.

Some of the changes that take place during puberty are driven by hormones. For example, the hormone testosterone, which is produced by the testes in boys, helps stimulate penis growth.

GnRH analogues suppress the hormones produced by the child's body. They also suppress puberty and can help delay potentially distressing physical changes caused by their body becoming even more like that of their biological sex, until they're old enough for the treatment options discussed below. GnRH analogues will only be considered for the child if assessments have found they're experiencing clear distress and have a strong desire to live as their gender identity.

The effects of treatment with GnRH analogues are considered to be fully reversible, so treatment can usually be stopped at any time after a discussion between the parent, their child and the GIC MDT.

Transition to adult gender identity services

Teenagers who are 17 years of age or older may be seen in an adult gender clinic. They are entitled to consent to their own treatment and follow the standard adult protocols.

By this age, doctors can be much more confident in making a diagnosis of gender dysphoria and, if desired, steps can be taken towards more permanent hormone or surgical treatments to alter the child's body further, to fit with their gender identity.

Adult gender identity services

Adults with gender dysphoria should be referred to a specialist adult gender identity clinic (GIC). As with specialist children and young people GICs, these clinics can offer ongoing assessments, treatments, support and advice, including:

- Mental health support, such as counselling
- Cross-sex hormone treatment (see below)
- Speech and language therapy – to help alter the voice, to sound more typical of the gender identity
- Hair removal treatments, particularly facial hair
- Peer support groups, to meet other people with gender dysphoria
- Relatives' support groups

For some people, support and advice from a clinic are all they need to feel comfortable in their gender identity. Others will need more extensive treatment. The amount of treatment someone chooses is their decision.

Hormone therapy

Hormone therapy for adults means taking the hormones of the person's preferred gender. Hormone therapies carry risks as well as benefits and these are summarised on the www.nhs.uk/Conditions/Gender-dysphoria/Pages/Treatment.aspx website. Because of the risks GP monitoring is always part of the care package.

A trans man (female to male) will take testosterone (masculinising hormones)
A trans woman (male to female) will take oestrogen (feminising hormones)
The aim of hormone therapy is to help the person feel more comfortable with themselves, both in terms of physical appearance and how they feel. These hormones start the process of changing the body into one that is more female or more male, depending on the person's gender identity. Hormones usually need to be taken indefinitely, even if someone has genital reconstructive surgery.

Hormone therapy may be all the treatment needed to enable someone to live with their gender dysphoria. The hormones may improve how they feel and mean that they don't need to start living in their preferred gender or have surgery.

Changes in trans women

For a trans woman, changes from hormone therapy may include:

- The penis and testicles getting smaller
- Less muscle
- More fat on hips
- Breasts becoming lumpy and increasing in size slightly
- Less facial and body hair

Hormone therapy won't affect the voice of a trans woman. To make the voice higher, trans women will need voice therapy and, rarely, voice modifying surgery.

Changes in trans men

For a trans man, changes from hormone therapy may include:

- More body and facial hair
- More muscle
- The clitoris (a small, sensitive part of the female genitals) getting bigger
- Periods stopping
- An increased sex drive (libido)

The voice may also get slightly deeper, but it may not be as deep as other men's voices.

Social gender role transition

If someone wants to have genital reconstructive surgery, they will usually first need to live in their preferred gender identity full time for at least a year. This is known as "social gender role transition" (previously known as "real life experience" or "RLE") and it will help in confirming whether permanent surgery is the right option.

It is possible for anyone to start their social gender role transition as soon as they're ready, and people often do this after discussing it with their GIC care team, who can offer support throughout the process.

The length of the transition period recommended can vary, but it's usually one to two years. This will allow enough time to have a range of experiences in their preferred gender role, such as work, holidays and family events.

Surgery

Once someone has completed their social gender role transition and they, and their GIC care team, feel ready, they may decide to have surgery to permanently alter their sex. Further details about surgical options is available at: www.nhs.uk/Conditions/Gender-dysphoria/Pages/Treatment.aspx

Life after surgery

After surgery, most trans women and men are happy with their new sex and feel comfortable with their gender identity. One review of a number of studies that were carried out over a 20-year period found that 96% of people who had genital reconstructive surgery were satisfied.

Despite high levels of personal satisfaction, people who have had genital reconstructive surgery may face prejudice or discrimination because of their condition. Treatment can sometimes leave people feeling:

- Isolated, if they're not with people who understand what they're going through
- Stressed about or afraid of not being accepted socially
- Discriminated against at work

There are legal safeguards to protect against discrimination (see section 2 in this booklet) but other types of prejudice may be harder to deal with. They can contribute to depression and anxiety.

Sexual orientation after surgery

Once transition has been completed, it's possible for a trans man or woman to experience a change of sexual orientation. For example, a trans woman who was attracted to women before surgery may be attracted to men after surgery. However, this varies greatly from person to person, and the sexual orientation of many trans people doesn't change.

Some trans men or women going through the process of transition may not know what their sexual preference will be until it's complete. However, for many people, the issue of sexual orientation is secondary to the process of transition itself.

Useful resources – national

www.gires.org.uk
Gender Identity Research and Education Society

www.gendertrust.org.uk
Gender Trust – The Gender Trust is a listening ear, a caring support and an information centre for anyone with any question or problem concerning their gender identity, or whose loved one is struggling with gender identity issues

www.stonewall.org.uk
Stonewall charity providing advice and information on LGB&T issues

www.pfc.org.uk
Press For Change – Transgender law group

Useful resources – local

www.oasisnorfolk.com
Oasis – Norfolk based transgender support and social group

www.norwichpride.org.uk
Norwich Pride

www.suffolklgbtnetwork.org.uk
Suffolk LGBT network

About the authors:

Julia Barber

I am 71 years old and have been aware that I was transgender from the age of seven. Due to attitudes towards transgender in the fifties and subsequent pressure from my employer

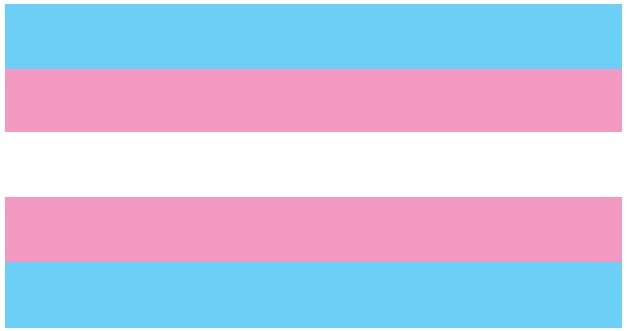
I transitioned at age 60. Within three years I had undergone surgery to become the person I am. I regard myself very fortunate to still be with my wife of over forty years but have been disowned by the rest of my family. Transitioning did save my life.

Jenny Carlisle

I have been aware that I was suffering from Gender Dysphoria from a very early age and had Gender Reassignment Surgery in 2004, I work as a Staff Nurse for Norfolk and Norwich Foundation Trust and also I am a Equality and Diversity lead.

Robert Nesbitt

I'm NSFT's Company Secretary and the lead executive team member for equality and diversity. I'm also the chair of our LGB&T employee network.



These are the colours of the trans flag.

We fly the flag at Hellesdon Hospital to recognise transgender memorial day on Monday 20 November.

Norfolk and Suffolk NHS Foundation Trust values and celebrates the diversity of all the communities we serve. We are fully committed to ensuring that all people have equality of opportunity to access our service, irrespective of their age, gender, ethnicity, race, disability, religion or belief, sexual orientation, marital or civil partnership or social and economic status.

Patient Advice and Liaison Service (PALS)

NSFT PALS provides confidential advice, information and support, helping you to answer any questions you have about our services or about any health matters.

IN TRAN communication for all

If you would like this leaflet in large print, audio, Braille, alternative format or a different language, please contact PALS and we will do our best to help.

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