



Equality
Research
Series



Access to Health Services for Transsexual People

Eoin Collins and Brian Sheehan

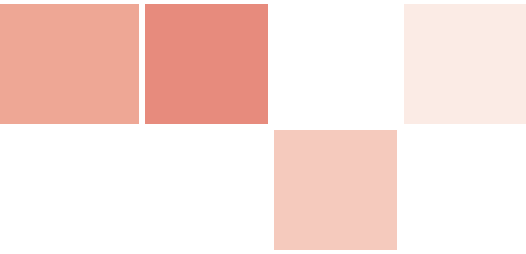


THE EQUALITY AUTHORITY
AN tÚDARÁS COMHIONANNAIS



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Eoin Collins, Nexus Research and Brian Sheehan



FOREWORD

This report seeks a new profile for transsexual people in policy making and service provision. It seeks to contribute to a new and more inclusive context for transsexual people.

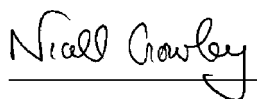
The current experience and situation of transsexual people is characterised by stigma and exclusion. They experience an invisibility in policy making. Ignorance, fear and denial are a feature of attitudes towards them. Service provision fails to acknowledge and address their needs.

The Employment Equality Acts and the Equal Status Acts provide a valuable foundation for change in this experience and situation. The gender provisions of the Employment Equality Acts have to be interpreted in the light of the Court of Justice judgement in P v S to afford protection against discrimination to transsexual people. It is the view of the Equality Authority that the gender provisions of the Equal Status Acts will be interpreted to afford protection against discrimination to transsexuals in the provision of goods and services, accommodation and education.

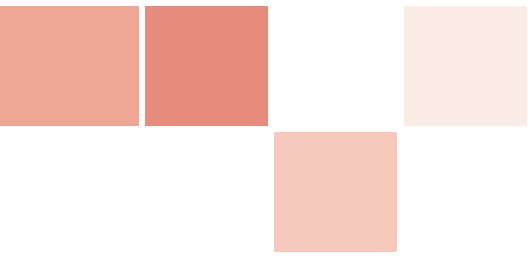
The health sector is a priority arena within which such change is required. Treatment in relation to gender reassignment and associated treatment paths is key to the quality of life of transsexual people. This report identifies anxiety, depression and the risk of suicide as possible outcomes for transsexual people from limited and inappropriate provisions in these areas.

It is hoped that this report will lead to a formal dialogue between the health sector and transsexual people. This dialogue should ensure the appropriate identification of transsexual people in health policy making. It should shape and drive a new accessibility for transsexual people to adequate and appropriate health services.

The Equality Authority is grateful to the health personnel and the transsexual people who contributed their knowledge and insights to this report. In particular, acknowledgement and gratitude is due to the Transgender Equality Network Ireland. The stimulus for this report came from the regular meetings between this group and the Equality Authority. Eoin Collins of Nexus Research and Brian Sheehan are owed a debt of gratitude for their excellent work in researching and drafting this report. They brought a level of knowledge and skill to this work that has ensured a report that has a capacity to contribute to necessary and urgent change.



Niall Crowley
Chief Executive Officer
Equality Authority
December 2004



AUTHORS' ACKNOWLEDGEMENTS

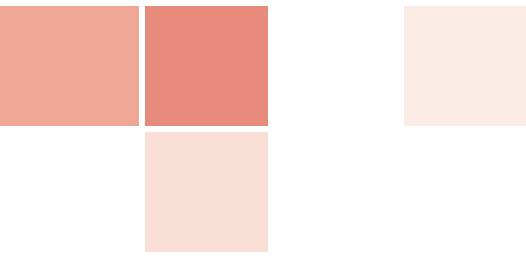
We would like to express our thanks to all those transsexual people who participated in the research. We would also like to thank all of the agencies and organisations who responded, in particular the specialist providers interviewed. Special thanks are also due to Diane Hughes, Andrea Brown, Anna Travers, Kyle Scanlon and Dr. Carol-Ann O'Brien who provided invaluable assistance and access to useful reference material.

We would also like to thank Laurance Bond and Anne Timoney of the Equality Authority for their support throughout the duration of this project.



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EXECUTIVE SUMMARY

Introduction

This report outlines the results of a study commissioned by the Equality Authority to advance understanding of the health needs of transsexual people and current health service responses to these needs in an Irish context. The Authority commissioned the research in response to representations from the Transgender Equality Network, Ireland. The specific aims of the research were

- To identify what specific health services are available to transsexual people in Ireland, including differences across health board areas, and planned future developments in this area;
- To document transsexual people's perspectives on access to health services including the perspectives of male to female and female to male transsexual people; and
- Drawing on this work, to identify recommendations in relation to transsexual people's access to health services, involving consultation and partnership between health boards, health professionals and transsexual people.

The findings of the report are presented under a number of broad chapters covering:

- The medical and legal context for transsexual people, drawing on policy and research material internationally;
- Access to transsexual health care, again from an international perspective and covering evolving standards of care and the implementation of these standards in practice;
- Policy and practice in transsexual health care in Ireland based on responses to letters sent to health boards and professional bodies and on interviews held with health professionals with expertise and experience of meeting the needs of transsexual people;
- The perspectives of transsexual people in Ireland based on the responses of seventeen transsexual people who participated in the research.

These and the concluding chapter setting out recommendations are summarised in this section of the report.

Medical and Legal Context for Transsexual People

- A key issue for transsexual people (as opposed to other groups under the broad heading of 'transgender') is the desire to live permanently in the opposite gender, for this to be facilitated by a range of medical interventions (including hormonal and surgical interventions) and for gender change to be recognised in law.
- These kind of medical treatments are now provided in many countries, including the UK where 'transsexualism' is recognised as a medical condition by the Government's Chief Medical Officer. Also, internationally recognised Standards of Care produced by the Harry Benjamin International Gender Dysphoria Association increasingly govern access to such treatments.
- Legal recognition has increased markedly, with many EU states permitting changes in birth certificates to acknowledge gender change. Ireland and the UK have been exceptions to this, although the situation in the UK is currently being revised to permit this type of change.
- Increased recognition of gender change and provision for protection against discrimination is also evidenced in a series of judgements from the European Court of Human Rights (ECHR) and European Court of Justice (ECJ) respectively.
- In Ireland, there is no provision for transsexual people to be officially recognised in the gender in which they identify. As a consequence transsexual people do not have a right to marry in their adopted gender or to change their birth certificate or to enjoy any right legally confined to the gender to which they feel they belong.
- Some protection against discrimination is afforded to transsexual people under the Irish equality legislation. This includes the Employment Equality Acts (1998 and 2004), which has to be interpreted in a manner that takes account of the judgement of the European Court of Justice that prohibits workplace discrimination against a person for a reason related to gender reassignment. The Equality Authority notes that the Equal Status Acts 2000-2004 will also have to be interpreted to provide transsexual people with protection against discrimination.

Access to Transsexual Health Care: International Context

- Health care provision for transsexual people has increasingly been governed by the internationally recognised Standards of Care for Gender Dysphoria developed by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) which require transsexual people to have a psychiatric diagnosis and ongoing supervision by a mental health professional in order to access health services along the recognised 'treatment path'. Elements of the treatment path include hormonal therapy and surgical interventions including genital reassignment.
- The HBIGDA Standards have been criticised for being too restrictive and giving too prominent a role to mental health professionals in determining access to treatments. This has led to calls for flexibility around treatment protocols to take account of differences in individual needs and circumstances, while accepting the need for psychiatric and psychological support. Standards of care have been developed however, which have argued for a shift from care based on psychiatric assessment and supervision to the informed consent of a person mentally competent to make decisions about their care.
- Health access issues identified by transsexual people have included the importance of a range of services along the recognised 'treatment path', including psychiatric assessment, hormonal therapy and surgical interventions but also non-medical services relating to gender 'transition' including speech therapy and electrolysis (for male-to-female transsexual people).

- In areas of a low population size and density, which might not justify a full gender reassignment service, emphasis has been placed on professional training and development on the issue of transsexualism, particularly among primary health care providers such as general practitioners (GPs). Also emphasised in this respect has been the need to put in place effective referral paths, and the necessary funding, for transsexual people to access further treatments including those that might only feasibly be provided outside the jurisdiction of the particular health authority.
- And finally, examples have been identified of effective and successful health service planning processes that have involved policy makers, service providers and transsexual people working in partnership.

Transsexual Health Care: Policy and Practice in Ireland

From contact made with the health boards and professional medical bodies it would appear that policy and practice around meeting the health needs of transsexual people is underdeveloped in Ireland at present. In particular:

- Most of the health boards contacted regarding policy and practice around the health needs of transsexual people tended to focus on access to genital reassignment surgery abroad for which transsexual people could apply for funding under the Treatment Abroad Scheme.
- With regard to their own services, the majority of health boards refer to their provision of general mental health and psychiatric services, which it is stated, are available to transsexual people. It is not specified however, whether these general services have any particular experience or expertise around meeting the needs of transsexual people, whether there are procedures for onward referral to specialised services, or what protocols or policy framework these services operate within in relation to health provision for transsexual people.
- The small number of specialist providers identified confirmed the limited extent of developments in policy and practice around the health needs of transsexual people. To address this they put forward a number of proposals including professional training on the issue for psychiatrists and GPs, linkages to reputable gender clinics abroad and provision for the ongoing collection of epidemiological data. They also emphasised the importance of developing quality standards and procedures for treatment.
- The role of the professional bodies in driving change was highlighted, in particular that of the Irish College of Psychiatrists given that transsexualism is a recognised psychiatric condition.

Perspectives of Transsexual People in Ireland

The responses from seventeen transsexual people contacted during the course of the research indicate a very early discomfort with their birth gender and very significant barriers to accessing treatments in an Irish context, which often resulted in acute psychological distress for both them and their families. In particular:

- All but one of those contacted began questioning their gender identity before the age of 15 years, with some people stating that they felt they were the wrong gender as small children. However, most only started seeking support when aged 30 or over.
- Initial sources of support sought included GPs and counsellors, although many people report either negative reactions or else a lack of knowledge about the condition and where to refer people onwards for more specialised support.
- Seven people report being refused funding for treatments along the 'treatment path' including genital reassignment surgery, six by health boards and one person by their health insurance company.

- Barriers to accessing support and treatment included: geographic accessibility (given that specialised providers were based in Dublin); lack of information on the condition or information at health board level on treatment options and service availability and their location; and lack of family services to support partners, spouses and other family members.
- Respondents also highlight the negative impact of lack of service provision on their lives. This included depression, suicidal feelings and in some cases people accessing hormones on the 'black market' which were expensive and potentially dangerous without medical supervision.
- On the other hand, where respondents did access services that they felt were appropriate to their needs, the impact was positive in all cases. Some people describe accessing a service 'at last' as being literally life saving.
- Ideas put forward to improve services included official recognition of transsexualism as a condition requiring treatment, accessible information on the condition and how and where to access treatments, support for families and professional training and development on the condition for personnel at different levels of the health service. In providing such training, the need to ensure respect and politeness in dealing with transsexual clients was emphasised.

Recommendations

- The Department of Health and Children should develop a formal policy on transsexualism and develop broad standards of care and procedures for treatment in partnership with the relevant professional bodies including the Irish College of Psychiatrists, the Irish College of General Practitioners and the Royal College of Physicians in Ireland. Issues this policy should consider include, inter alia, the establishment of a specialist care team, the development of linkages and referral arrangements to services that cannot be provided in an Irish context and funding criteria for same and the provision of other services that could feasibly be delivered at local or regional level.
- The Department should also engage in partnership with transsexual people in identifying needs and barriers to service take-up and in developing policy and standards in this area.
- The relevant professional bodies should develop more detailed policies and standards of care for transsexual people relating to their respective professional areas and in relation to cross cutting issues including the need for health monitoring and referral along the services comprising the treatment path for transsexualism and the need for networking between relevant professionals. The feasibility of establishing a network of GPs equipped to provide initial support, onward referral and possibly ongoing hormonal therapy could usefully be examined in this context.
- In relation to transsexual people and their needs, provision should be made by the professional bodies for professional development and training taking into account the agreed standards of care and procedures for service delivery. In line with national policy development the Health Service Executive should develop strategies for meeting the health care needs of transsexual people that encompass professional training and development on the issue, the identification of services that can be provided at health board level, formal referral paths and the provision of accessible information on services and criteria for accessing them.
- The Health Service Executive and health service providers should review and/or design their policies and practices in relation to transsexual people to ensure that there is no discrimination under the Equal Status Acts 2000 to 2004 and to ensure that they effectively promote equality for transsexual people.

- Health service providers should implement effective information strategies on transsexualism and on service paths and how these can be accessed. Such strategies should include provision for the information needs of families and friends of transsexual people.
- Consultation and partnership with transsexual people will be vital to the development of policies and practices by health authorities and professional bodies that will effectively meet the needs of transsexual people.



INTRODUCTION

1.1 Background and Objectives of the Study

Transsexual people have a desire to live and be accepted as members of the opposite gender, usually accompanied by a sense of discomfort with, or inappropriateness of, their anatomic gender and a wish to have hormonal treatment and surgery to make their bodies as congruent as possible with the preferred gender (World Health Organisation, 1992). It has been shown that many transsexual people benefit from these and other treatments relating to gender reassignment and services along these lines are provided or permitted in many countries, including the majority of the States of the Council of Europe (UK Department of Constitutional Affairs, 2003)¹.

Internationally recognised standards of care governing psychological support and assessment, hormonal therapy and surgical gender reassignment for transsexual people have also been developed by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) that are widely used as a set of guidelines within the medical profession in many countries, including the UK. For those diagnosed with 'transsexualism', according to the Standards, a therapeutic regimen that includes hormonal therapy and sex reassignment surgery, when prescribed or recommended by qualified practitioners, "is medically indicated and medically necessary" (HBIGDA, 2001: 18).

In Ireland, access to and provision of these treatments, or the health needs and service requirements of transsexual people more generally, have not featured to date in key policy developments at national level. An almost complete lack of research on the issue has also meant that the health and other needs of this group of the population have remained hidden and unexplored. Nor is there any documented information on current health sector practice across health board areas in terms of understanding or responding to the needs presented by transsexual clients.

The following report outlines the results of a study, commissioned by the Equality Authority, to advance understanding in this area, following representations from members of the Transgender Equality Network, Ireland. The key objectives of the study in this respect were:

- To identify what specific health services are available to transsexual people in Ireland, including differences across health board areas, and planned future developments in this area.
- To document transsexual people's perspectives on access to health services including the perspectives of male-to-female transsexual people and female-to-male transsexual people.
- Drawing on this work, to identify recommendations in relation to transsexual people's access to health services, involving consultation and partnership between health boards, health professionals and transsexual people.

In realising these objectives it is important to note that the focus has been on the needs and service requirements of *adult* transsexual people. Gender identity issues for children and adolescents have however, been highlighted by health professionals and transsexual people during the course of the study and are referenced accordingly. However, the service needs of young people facing difficulties around gender (which may or may not be related to transsexualism) and the complex issues they raise for parents, service providers and for the young people themselves are largely beyond the scope of this current study. Nor does the study cover the service needs of other groups of people where issues of gender identity arise, such as those with intersex conditions² which can raise very different service issues.

It should be noted that at the time of the study the administrative structure of Irish health care delivery comprised ten health board organisations responsible for the delivery of health care at regional and local level. A new, unified structure is due to come into effect in January 2005 that will replace the health boards. This new organisation, the Health Service Executive, will operate at national, regional and local levels. The implications for this study are that while the findings relate to the existing health board structures, the relevant recommendations are directed to the new Health Service Executive.

1.2 Challenges

Researching the health needs of transsexual people and service responses to these presents a number of challenges. In particular:

- The level and intensity of stigma attached to issues of gender variance means that transsexual people are often hidden from and invisible to both the general population and to service providers. This not only makes it difficult to establish the extent of the transsexual population, it also makes it extremely difficult to access this population in order to develop an understanding of circumstances, needs and experiences. The capacity to understand needs is further constrained in an Irish context where, despite evidence of increased activism around the issue, there are limited resources available for representative organisations.
- There is also little evidence of any previous research in Ireland on the circumstances of transsexual people or on 'transsexualism' as an issue. Nor was there evidence at the outset of this research of any written policy or strategic documentation (nationally at least) that has referred to, included or covered the issue. So, unlike the UK for example, in Ireland it is difficult, from document search at least, to determine the official health service understanding of 'transsexualism', the type of services that might be necessary to meet transsexual people's needs or the means and criteria by which these services can currently be accessed.
- While there has been an evolving consensus at international level on medical care (and legal recognition) for transsexual people, it should be noted that this area is still the subject of considerable debate and contention. Moreover, policy and practice could not be described as fixed, but rather in the process of on-going change arising from debate between service providers and a more visible transsexual community as well as increased understanding and knowledge of the condition within the medical community.
- Another issue concerns language, terminology and definitions. In some countries, transsexual people have been seen as a particular subgroup of a wider 'transgender' population that includes people of various gender identities and presentations including Intersex people or those who cross dress with out any desire for permanent or significant gender change. While some transsexual people have self-identified as transgender in this respect, others have emphasised the very distinctive aspect of transsexual identity and the specific goal of living permanently in a new gender role. Issues of definition and terminology in this respect do lead to some confusion in the research literature in cases where 'transgender' and 'transsexual' are used interchangeably.

1.3 Approach and Methods

The challenges described above had a critical bearing on the approach and methods adopted in realising the objectives of this research. Key elements of the methods adopted in this respect are outlined in the following paragraphs.

International Contacts and Literature Review

Contacts were made through relevant international research networks known to the researchers and a brief review of literature identified through these contacts was then drawn up, supplemented by material identified through the internet. A key focus of this work was to identify examples of current and evolving policy and practice around determining and responding to the health needs of transsexual people, including standards of care and models of service delivery. The review also looked at research studies on access issues identified by transsexual people themselves.

Initial Contacts with Transsexual People and Direct Service Providers

Initial interviews were undertaken with a number of transsexual people in Ireland and with health professionals known to be providing relevant services to transsexual people. The latter are: a psychologist working in private practice, a hospital based consultant psychiatrist, and a consultant endocrinologist. All are Dublin based, but have provided a service to transsexual people from around the country.

These initial interviews provided an opportunity to flesh out issues such as the type of health services transsexual people are likely to require and the views of those interviewed on current provision and issues of access. These contacts also provided an opportunity to identify possible routes and approaches for eliciting the views of transsexual people more widely and for identifying approaches to ascertaining policy and provision at health board level.

Data Collection on the Perspectives of Transsexual People

At the outset of the research it had been envisaged that the most appropriate means of eliciting the perspectives of transsexual people would be through one-to-one interview. However, following initial contacts it was decided to draw up a questionnaire, which would be used to complement individual interviews. Reasons for doing this included the following:

- Drawing up the questionnaire helped establish an interview framework for looking at access issues as it allowed for consideration of the relevance of broad areas of health and medical services to transsexual people, from both a male-to-female and female-to-male perspective.
- It was clear that there were many transsexual people who might be willing to respond to a questionnaire, but who would not, for various reasons, agree to take part in an interview.
- The development of a questionnaire also provided transsexual people, some of whom were cautious about the information being asked of them, a sense of the issues the research would be covering. Providing this in written form was considered to be particularly useful given that key points of contact among transsexual people are through the internet.

The questionnaire is brief and includes questions relating to gender identity, first points of support and access to various medical and psychological services comprising internationally recognised 'treatment paths' relating to support, assessment and gender reassignment. The questionnaire also included a range of open-ended questions covering perspectives on quality of care and provision and finished by asking whether the person was interested in participating in a follow-up interview (see Appendix One for a condensed version of the questionnaire).

The cover letter to the questionnaire also outlined the procedures that would be followed to ensure confidentiality of responses- a key issue for most transsexual people. Important aspects of this were that the data collected from participants in the study would be seen by the researchers only, be stored in a

secure place, and destroyed upon the completion of the research report. It was also noted that the research would draw out issues in a general way, ensuring that no transsexual person or their service provider could be identified (a challenging task given the very limited level of service development in the country and the small number of health professionals involved).

As already noted, an important challenge in researching the needs of transsexual people is that the population is small and, due largely to the intensity of stigmatisation, hard to reach. In addition, it was considered important, given the terms of this study, to include the perspective of male-to-female and female-to-male transsexual people and the perspective of transsexual people across different health board areas. In order to address these issues, questionnaires were distributed through a range of channels including:

- Web based networks such as the Irish T Yahoo User Group, Irish Trans and international web based networks to which Irish transsexual people subscribe.
- Lesbian organisations' mailing lists (which are used by some female-to-male and male-to-female transsexual people).
- Health service providers to transsexual people in Ireland
- Methods of 'snowball' contact where transsexual people interviewed were asked to pass on information on the research (including the questionnaire) to others.

Fifteen people responded to the questionnaire, four of whom were interviewed in more depth subsequently. Detailed interviews were also undertaken with an additional two transsexual people who had not filled in the questionnaire but who were interested in participating in the research, bringing the total number of transsexual people participating in the study to seventeen.

A further five questionnaires were returned by people who indicated they were not from Ireland and had no links with the country, but had accessed the questionnaire on the internet. Regrettably these questionnaires had to be excluded from the analysis as the study is focused on Ireland.

Assessing Policy and Provision

Having identified the broad areas of health and medical needs through literature review and direct contact with direct service providers and transsexual people themselves, a one page questionnaire was drawn up and sent to the Chief Executive Officers of each of the health boards in the country. Letters were also sent to the Irish College of Psychiatrists, the Royal College of Physicians of Ireland and the Irish College of General Practitioners to assess policy and practice regarding transsexualism within their respective professional bodies.

1.4 Structure of the Report

In presenting the findings from this research, the report is structured as follows:

- Chapter two provides a general overview of the medical and legal context for transsexual people. This includes an outline of policy and research material covering: how transsexualism is defined; estimates of prevalence; and the type of medical treatments provided for both male-to-female and female-to-male transsexual people. The chapter also provides an overview of relevant legal developments in Ireland and internationally such as legal recognition of gender change and anti-discrimination protections.

- Chapter three provides a detailed description of the protocols relating to the identification of transsexualism and access to treatments. The chapter also outlines the results of research identified through the review of international literature covering issues such as the perspectives of transsexual people relating to health care. Examples of policies and practice internationally relating to transsexual health care are also documented, including examples of service planning that has provided for greater involvement of transsexual people in the planning process.
- Chapter four outlines the current situation in relation to health care policy and provision for transsexual people in Ireland. This is based on responses from letters sent to the health boards and to relevant professional bodies. The chapter also draws on consultations held with medical personnel in Ireland (with specialist knowledge of transsexual health issues) to outline gaps in current provision and to put forward suggestions for enhanced services in the future.
- Chapter five looks at the perspectives of transsexual people in Ireland based on interviews and responses to the questionnaire. Issues covered include when people first started questioning their gender identity, which services they sought support from and their experiences of this support. It goes on to look at the health services they are currently accessing, barriers to accessing services and the impact on their lives of health services they considered appropriate or inappropriate to meeting their needs.
- Finally, chapter six concludes with a summary of research findings and sets out recommendations on provision of and access to transsexual health care.

MEDICAL AND LEGAL CONTEXT FOR TRANSSEXUAL PEOPLE

There have been significant developments internationally in terms of understanding, recognition and provision around the health needs of transsexual people. This chapter provides a brief overview of some of these developments. These include the increased acknowledgement of the distinctiveness of transsexual people's identity (with associated terminology to describe this identity), recognition of transsexualism as a medical condition and the provision of a range of surgical and hormonal treatments to facilitate gender change.

More broadly, the chapter also outlines developments outside the medical/health area that support and facilitate gender change. Key in this respect has been legal changes, particularly at EU and Council of Europe level, that recognise the right to change gender and to be protected against discrimination.

2.1 Definitions and Terminology

Transsexual people are often considered a subgroup of a wider population of people of different gender identities and presentations, increasingly referred to under the umbrella term of 'transgender'. These include 'intersex' people (previously known as hermaphrodites), transvestites or cross dressers (who have no wish to change their biological sex) and transgenderists (who may express a wish for hormones but not genital reassignment surgery) (Ontario Human Right Commission, 1999). A fuller description of these and other relevant terms and definitions are outlined in the Glossary at the end of the report.

While recognising commonalities on some issues and the value of increased recognition of the right to express gender variance for all groups, many transsexuals have emphasised the distinctiveness of transsexual people's identity and needs. Paramount in this respect, is the overwhelming desire to permanently fulfil their lives as members of the opposite sex and for this to be facilitated through a range of treatments that can include hormones and surgery (Israel and Tarver, 1997; World Health Organisation, 1992; Inter-Departmental Working Group on Transsexual People, 2000).

A recent paper setting out the policy position of the UK Government on transsexualism and transsexual people (Department of Constitutional Affairs, 2003) attempts to clarify issues of terminology by putting emphasis on what transsexualism is not. Transsexualism, it is stated:

- "Is not cross-dressing for sexual pleasure, psychological comfort or compulsion
- It is not an orientation towards people of the same sex
- It has nothing to do with drag queens

- Transsexual people do not choose their gender identity. Transsexualism is an overpowering sense of different gender identity rather than any sexual orientation: transsexual people may be heterosexual, gay/lesbian or celibate
- It is not a mental illness. It is a condition considered *in itself* (author's italics) to be free of other pathology (though transsexual people suffer depression or illnesses like everyone else)" (2003:3)

As to the causes of transsexualism, the European Court of Human Rights has stated that:

"It remains the case that there are no conclusive findings as to the cause of transsexualism and in particular, whether it is wholly psychological or associated with physical differentiation in the brain. The expert evidence in the domestic case of *Bellinger v Bellinger* was found to indicate a growing acceptance of the findings of sexual differences in the brain that are determined pre-natally, though scientific proof for the theory was far from complete. The Court considers it more significant however that transsexualism has wide international recognition as a medical condition for which treatment is provided in order to afford relief" (European Court of Human Rights, *Goodwin v The United Kingdom*, quoted in Barry, 2004).

2.2 Prevalence

While there is very limited information with which to establish the precise prevalence of transsexualism, the most recent prevalence information from the Netherlands is 1 in 11,900 males and 1 in 30,400 females (HBI-GDA, 2001). These estimates, according to the Report of the Interdepartmental Working Group on Transsexual People in the UK (2000), are supported by a study carried out in primary care units in Scotland which estimated the prevalence in men over 15 years at 1: 12,400 with an approximate sex ratio of one to four in favour of male to female patients (Interdepartmental Working Group on Transsexual People, 2000).

A range of caveats needs to be emphasised in calculating prevalence however. With the level of stigma attached to transsexualism (and gender variance more generally) and very uneven health service responses, there is likely to be differences between the known and actual prevalence of the condition. Known prevalence in this respect has been shown to rise with increased 'tolerance' of the issue among the medical profession and the wider population and where services are available and accessible (Suffolk Health Authority, 1994: 7). Recorded prevalence also rises over time as more people seek treatment and as more have received gender reassignment surgery (1994: 7).

The Harry Benjamin International Gender Dysphoria Association (HBI-GDA) also puts forward a number of observations, which it is suggested may increase reported prevalence. These include the fact that gender problems are occasionally diagnosed when patients are seen with anxiety, depression, bipolar disorder, substance abuse and other issues of this nature.

The HBI-GDA Standards also note that gender variance among female bodied individuals tends to be relatively invisible to the culture, particularly to mental health professionals and scientists (2001:2). Again, where targeted services have been developed prevalence data changes. For example, the male to female ratio was originally thought to be 8:1, but with increasing recognition of, and treatment for female-to-male transsexual people more of this group have come to the attention of the medical profession (Suffolk Health Authority, 1994).

2.3 Health Service Provision

The provision of hormones, surgery and other services related to gender reassignment is now standard practice in many countries. The mainstream gender reassignment process in the UK for example is typically divided into three main stages, broadly following international protocols laid down by the Harry Benjamin International Dysphoria Association (Interdepartmental Working Group on Transsexual People, 2000). These are:

- Social gender role change: when transsexual people change their name and inform their family and friends of their plans to live full-time in the chosen gender role
- Hormonal gender reassignment: when people, who after psychiatric assessment are considered suitable, are offered cross gender prescriptions
- Surgical reassignment: after completion of two years of a 'real life test' of living in the new gender role

This process, as noted in the Report of the Interdepartmental Working Group on Transsexual People in the UK, has implications for a range of services. The precise form of service intervention will also depend on the particular needs and characteristics of the individual transsexual person. Services can encompass:

- Counselling
- Psychiatric assessment and referral
- Electrolysis and laser epilation
- Speech therapy
- Hormone therapy
- Surgery

The form of intervention and service required will differ for male-to-female and female-to-male transsexual people. For example, male-to-female transsexual people will normally be prescribed oestrogens and female-to-male people will be given various testosterone, known as androgens (Interdepartmental Working Group on Transsexual People, 2000: 28).

For male-to-female people, surgery will usually involve the removal of the testes, the dissection of the penis and the creation of a pseudo-vagina. Other procedures can include facial feminisation surgery, breast implants, electrolysis or laser treatment for the removal of facial or bodily hair and speech therapy or surgery to alter voice pitch.

Surgery for female-to-male transsexual people is more complex, including the construction of male external genitalia, a mastectomy to reduce the breasts and to construct a male chest and a hysterectomy to remove the uterus and the ovaries (Interdepartmental Working Group on Transsexual People, 2000:29).

2.4 International Legal Context

Legal recognition of gender change has increased markedly in the past few decades. Many of member the states of the European Union for example, with the exceptions of the UK and Ireland, now permit changes in birth certificates to reflect reassigned sex. The situation is now changing in the UK where at the time of writing the Government sponsored Gender Recognition Bill which was before the Houses of Parliament sets out the criteria and a process of assessment for the issuance of a "gender recognition certificate". A person granted such a certificate will be entitled to a new birth certificate reflecting the acquired gender and this will also allow them to marry someone opposite to their acquired gender (Department of Constitutional Affairs, 2004).

Legal change in the UK follows a succession of judgements from the European Court of Human Rights and the European Court of Justice, where the current legal treatment of transsexual people has been held to be contrary to the European Convention on Human Rights and/or European Community Law. The key areas covered in these cases have been employment rights, the right to privacy and the right to marry.

Employment and Marriage Rights: The European Court of Justice

In the case of P-v-S and Cornwall County Council (1996), the European Court of Justice held that Article 5(1) of the original Gender Equal Treatment Directive precludes dismissal of a transsexual person for a reason related to gender reassignment. For the purposes of discrimination between men and women in the fields covered by the Directive, a transsexual person is to be regarded as having the identity of the gender to which he or she has been reassigned (Barry, 2004: 4).

More recently, this Court has ruled that national legislation which denies transsexuals the right to marry is contrary to Community law if the effect of this is to deprive them of any entitlement to a survivor's pension. This was the ruling in the case of KB v National Health Service Pensions Agency (2004) where the female applicant complained that the denial of a widower's pension to the female-to-male transsexual person, with whom she had celebrated what would have been a marriage had it been possible, constituted sex discrimination contrary to Article 141EC.

Marriage Rights and Privacy: European Court of Human Rights

Of particular relevance to current legal change in the UK has been the judgements of the European Court of Human Rights in the cases of Goodwin-v-The United Kingdom and I-v-United Kingdom, where the UK was found to have breached Article 8 and Article 12 of the European Convention on Human Rights, that is, the right to respect for private life and the right to marry. In these cases the applicants had undergone gender reassignment surgery provided by the National Health Service and lived in society as females, although for legal purposes as males. Each applicant complained about the lack of legal recognition for her post-operative sex and about the legal status of transsexual people in the UK.

According to the Court in these judgements:

“...In the twenty first century the right of transsexuals to personal development and to physical and moral security in the full sense enjoyed by others in society cannot be regarded as a matter of controversy requiring the lapse of time to cast a clearer light on issues involved. In short, the unsatisfactory situation in which post-operative transsexuals live in an intermediate zone, not quite as one gender or the other, is no longer sustainable” (Quoted in Barry, 2004)

The Court did not underestimate the difficulties or the important repercussions which any major change in the system will inevitably have, not only in the field of birth registration, but also in the areas of access to records, family law, affiliation, inheritance, criminal justice, employment, social security and insurance. It concluded:

“No concrete substantial hardship or detriment to the public interest has indeed been demonstrated as likely to flow from any change to the status of transsexuals and as regards other possible consequences the Court considers that society may reasonably be expected to tolerate a certain inconvenience to enable individuals to live in dignity and worth in accordance with the sexual identity chosen by them at great personal cost” (Quoted in Barry, 2004)

Access to Health Care

Access to health care has been the subject of litigation also. In the UK for example, three transsexual people who were refused funding for gender reassignment surgery by the North-West Lancashire Health Authority won their case against this refusal in the High Court in 1998 (R v North West Lancashire Health Authority Ex parte Miss A, D and G). The ruling found that it was for the Health Authority, not the Court, to allocate resources within its limited budget. However, the decisions to refuse funding in these instances were found to be “unlawful and irrational” as they were “arrived at without consideration of relevant matters such as the question of what constitutes proper treatment of what is recognised as the illness involved in gender dysphoria or transsexualism”.

This ruling was subsequently upheld on appeal where the appeal court found the policy of the Health Authority as being flawed in two important respects:

“First, it does not in truth treat transsexualism as an illness, but as an attitude or state of mind which does not warrant treatment. Second, the ostensible provision that it makes for exceptions in individual cases and its manner of considering them amount effectively to the operation of a ‘blanket policy’ against treatment for the condition because it does not believe in such treatment” (Appeals Court, 1999).

Accordingly, the appeal court judge (Auld L.J.) found that the Health Authority should reformulate its policy to give proper weight to its acknowledgement that transsexualism is an illness, apply that weighting when setting its level of priority for treatment and make effective provision for exceptions in individual cases from any general policy restricting the funding of treatment for it (Appeals Court, 1999).

2.5 The Legal Situation in Ireland

The legal context for transsexual people in Ireland is outlined in a paper by Eilis Barry, Legal Advisor to the Equality Authority entitled *Transsexualism and Gender Dysphoria: The Legal Context* (Barry, 2004). The paper notes that under the current law in Ireland there is no provision allowing transsexual people to be officially recognised in the gender in which they identify. This, it is noted, has many consequences including the following:

- Transsexual people cannot marry in their adopted gender
- Transsexual people are not currently entitled to have their birth certificates revised
- It may be necessary to reveal the gender specified on the person’s birth certificate when applying for a new job
- Transsexual people may worry that if they do not disclose their legal gender for insurance purposes, that this may amount to fraud
- Transsexual people are not entitled to enjoy any right legally confined to persons of the gender to which they feel they belong

However, a degree of protection is afforded to transsexual people under both the Employment Equality Acts (1998 and 2004) and the Equal Status Acts (2000 to 2004), particularly in the light of the judgement of the European Court of Justice in *P v S* (Barry, 2004). The Employment Equality Acts prohibit discrimination in employment on the basis of nine grounds including gender. The gender provision of the Acts now have to be interpreted in the light of the *P v S* judgement which precludes dismissal of a transsexual person for a reason related to gender reassignment.

The Employment Equality Acts also prohibit discrimination on the basis of disability. However, there have been no decisions yet as to whether transsexualism comes within the definition of a disability.

The gender provision of the Equal Status Acts 2000 to 2004 will also have to be interpreted to afford protection to transsexual people (Barry, 2004). The Equal Status Acts provide for some exceptions in the provision of goods and services, accommodation and education. The Equal Status Acts also cover the same nine grounds as the Employment Equality Acts (1998 and 2004). However, the Equal Status Acts do not explicitly apply to functions of the State that do not come within the definition of a service. Key matters of interest to transsexual people such as amending birth certificates and the right to marry may relate more to the functions of the State and therefore it is not certain that the Acts can afford protection in these areas (Barry, 2004).

2.6 Summary

Significant points emerging from this overview of the medical and legal context for transsexual people internationally include the following:

- A key issue for transsexual people (as opposed to other groups under the broad heading of 'transgender') is the desire to live permanently in the opposite gender, for this to be facilitated by a range of medical interventions (including hormones and surgical interventions) and for gender change to be recognised in law.
- These kind of medical treatments are now provided in many countries, including the UK where 'transsexualism' is recognised as a medical condition by the Government's Chief Medical Officer. Also, internationally recognised Standards of Care produced by the Harry Benjamin International Gender Dysphoria Association increasingly govern access to such treatments.
- Legal recognition has increased markedly with many of the EU states, but not Ireland or the UK, permitting changes in birth certificates to acknowledge gender change, although the situation in the UK is currently being changed.
- Increased recognition of gender change and provision for protection against discrimination is also evidenced in a series of judgements from the European Court of Human Rights (ECHR) and European Court of Justice (ECJ) respectively.
- In Ireland, there is no provision allowing for transsexual people to be officially recognised in the gender in which they identify. As a consequence, transsexual people do not have a right to marry in their adopted gender or to change their birth certificate or to enjoy any right legally confined to the gender to which they feel they belong.
- Some protection against discrimination is afforded to transsexual people under the Irish equality legislation. This includes the Employment Equality Acts (1998 and 2004), which have to be interpreted in a manner that takes account of the judgement of the European Court of Justice that prohibits workplace discrimination against a person for a reason related to gender reassignment. The Equal Status Acts 2000-2004 can also be interpreted to provide transsexual people with protection against discrimination.

ACCESS TO TRANSSEXUAL HEALTH CARE: INTERNATIONAL CONTEXT

A growing body of research and policy literature is now discernible setting out key issues in relation to accessing health services by transsexual people. As mentioned in the previous chapter, this includes evolving standards of care governing access to medical treatments such as those put forward by the Harry Benjamin International Gender Dysphoria Association (HBIGDA). It also includes research directly focused on accessing health care from the perspective of transsexual people themselves. Provision for transsexual people has also been made more explicit in health policy documentation in a number of countries and a number of relevant documents have been identified which provide insights into issues that arise in planning health services for transsexual people in very different service environments (for example, in terms of population size or different legal contexts).

While it is not possible to present a fully comprehensive summary of this literature in the context of this study, the references contained in this chapter provide useful information on the policies now driving provision in this area as well as illustrating issues of concern raised by professional health care providers and transsexual people alike.

The chapter begins with a description of the HBIGDA Standards of Care and also of other practice guidelines and services protocols. It goes on to document examples of research focusing on the perspectives of transsexual people in accessing health care including perspectives on what comprises a quality health service. The final section documents examples of policy development and service planning for transsexual health care, including models of provision in different services environments. The latter includes examples of service planning approaches involving working partnerships between health care providers and transsexual people themselves.

3.1 Standards of Care

Harry Benjamin International Gender Dysphoria Association

Medical interventions for transsexual people, as noted in the introduction to this report, have increasingly been influenced by the internationally recognised Standards of Care for Gender Identity Disorders developed by the Harry Benjamin International Gender Dysphoria Association (HBIGDA, 2001)³. These standards focus on psychological assessment/diagnosis of gender identity disorders and prescribe one or more elements of 'triadic therapy': real-life experience, hormone therapy and surgery.

The general goal of psychotherapeutic, endocrine or surgical therapy for persons with gender identity disorders, according to the Standards, is lasting personal comfort with the gendered self in order to maximise overall psychological well-being and self fulfilment (2001: 1). Such a therapeutic regimen, it is stated:

“...when prescribed or recommended by qualified practitioners, is medically indicated and necessary. Sex reassignment is not ‘experimental’, ‘investigational’, elective, ‘cosmetic’ or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound gender identity disorder” (2001: 18)

The diagnostic criteria used in the Standards are derived from DSM IV (American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Health Disorders) which has replaced the term ‘transsexualism’ with ‘gender identity disorder’, and the World Health Organisation’s ICD-10, which gives equivalent criteria for transsexualism. Three criteria are identified in this respect by the World Health Organisation for a diagnosis:

- “The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment;
- The transsexual identity has been present persistently for at least two years;
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality” quoted in (HBIGDA, 2001:5)

The Standards then set out specific eligibility criteria for accessing different treatments given “the medical and social risks” involved. In particular:

- For hormone therapy a person must be above 18 years of age and have a demonstrable knowledge of what hormones can do and cannot do and their social benefits and risks. They must also have either a documented ‘real-life experience’ of living in the new gender for at least three months prior to the administration of hormones or a period of psychotherapy of a duration determined by a mental health professional (usually a minimum of three months).
- For genital reassignment surgery, criteria include a requirement that the person be the legal age of majority in their country, have had 12 months of continuous hormonal therapy and 12 months of successful continuous real-life experience. If required by the mental health professional, the person must have ‘regular responsible participation’ in psychotherapy during the course of the ‘real life experience’. They must also have demonstrable knowledge of the cost, required lengths of hospitalisations, likely complications and post-surgical rehabilitation requirements of various surgical approaches (HBIGDA, 2001).

The Standards also cover the responsibilities and credentials of professionals providing specialised care to transsexual people including mental health professionals, surgeons and prescribing physicians. It is recommended that surgeons undertaking different procedures (including genital reassignment surgery) should have a chance to speak at length with their patients to satisfy themselves that the patient is likely to benefit from the procedures. Ideally, the Standards suggest, the surgeon should also have a close working relationship with the other professionals who have been actively involved in the patient’s psychological and medical care. It is stated that this is best accomplished by belonging to an interdisciplinary team of professionals who specialise in gender identity disorders” (2001: 19).

The Standards finish with a section on ‘post-transition follow-up’, recommending long-term follow-up with the surgeon, prescribing physician and the mental health professional (2001: 22).

‘Transgender Care’, Israel and Tarver

While the importance of the HBIGDA Standards of Care in advancing service provision for transsexual people has been widely recognised, the restrictions imposed by them or cases where eligibility criteria for treatments are even more rigorous than those set out in the Standards have been the subject of some contention. Other standards and guidelines in this respect have been developed with a view to giving transsexual people a greater say in identifying and accessing treatments, while at the same time providing adequate guidance and protection for medical and mental health professionals (Looking Glass Society, 1998).

For example, *Transgender Care: Recommended Guidelines, Practical Information and Personal Accounts* (Israel and Tarver 1997), is put forward as a comprehensive resource for consumers and professionals concerning the psychological, hormonal, surgical and social support of transgendered identified individuals. Recommended guidelines in this respect are specified under chapter headings relating to service areas such as mental health services, transgender hormone administration, aesthetic surgery, genital reassignment and provision for transgender youth. Guidelines are also developed for these services in dealing with factors such as cultural diversity and other health concerns such as HIV/AIDS.

The authors of *Transgender Care* support the continued use of key criteria for treatment posited by the HBIQDA Standards, such as requirements for 'real-life experience' or 'real-life tests' for accessing particular procedures or services. They further state in this respect that 'no known competent service provider' has voiced support for the removal of the real-life test and other treatment protocols and for the provision of hormones or surgery 'on demand'. Real life tests and other care protocols do, in their view, achieve a number of important goals. In particular, they:

- Prevent inappropriate or unprepared individuals from undergoing hormone administration or surgical procedures;
- Provide surgeons, professionals and insurance companies with protection against negative outcomes in malpractice suits initiated by dissatisfied or regretful post surgical patients;
- Protect non-transsexual and unprepared individuals from undergoing hormone administration or surgical procedures and incurring physical, psychological or social damage (1997: 12).

However, the authors do stress that a number of principles should not be overlooked in the development and application of protocols such as those put forward in the HBIQDA standards. For example, care providers are advised not to interfere unnecessarily in the lives of transgender people or to set protocols that do not allow such individuals "the same right of self-determination of gender identity routinely extended to non-transgender individuals" (1997: 11). Nor should professionals, it is noted, erect unrealistic protocols as barriers to further treatment. Examples cited of such barriers are inflexible treatment protocols that require a successful 'real life experience' of living in the new gender role before the administration of hormones or minimal aesthetic surgery that would give the person some chance of 'passing' in such a role. This can be particularly difficult for people whose physical attributes are clearly incongruent with their developing gender role and can expose them to ridicule, derision or physical violence (1997: 11).

Other issues of concern are drawn out in a series of essays contained in *Transgender Care* written by service providers and transgender people themselves. In an article on the ethical implications for psychotherapy, a psychotherapist writes of the potential for the relationship between the mental health professional and the transsexual client to be distorted when the former (in line with the HBIQDA Standards) is not just providing support for the client but is also effectively a gatekeeper to different treatments (including genital reassignment). The relationship can become one in which the client, eager to proceed with the desired medical procedures, actually fears rather than trusts the therapist. One suggestion for the resolution of this dilemma of the conflicting demands of healer, evaluator and gatekeeper, is the possibility of diversifying functions between the mental health professionals involved in client care (Anderson, 1997: 189).

Health Law Standards of Care

Some people have had a more fundamental objection to the HBIQDA Standards, rejecting the psychiatric diagnosis of the condition in the first place, the requirement for "real life tests" and the central role given to mental health professionals in determining access to treatments. *The Health Law Standards of Care for Transsexualism*, also known as the ICTLEP Guidelines (Health Law Project, 1993) were developed with these concerns in mind ⁴.

These standards represent a shift in approach to transsexual medicine, from treatment based on the assessment and diagnosis of a medically classifiable disorder, as in the HBGDA Standards, to the informed consent of a person mentally competent to make decisions about their care. This approach (and the contrast with the HBGDA Standards or those suggested by Israel and Tarver) is evidenced in the standards proposed for accessing specific treatments such as hormonal therapy and various surgical interventions. For example, with regard to surgery the standards propose that surgeons participating in transsexual health care shall provide sex reassignment surgery to the patients requesting a change in their sexual appearance subject only to:

- The surgeon's reasonable belief that the surgery will not aggravate pre-existing health conditions
- The surgeon's reasonable determination that the patient has been under hormonal sex reassignment therapy for at least one year
- The patient's signature of an informed consent and waiver of liability form. If the patient is married, the surgeon may not require divorce but may require the spouse to sign a waiver of liability form (1993: 2)

The Health Law Standards also set out a number of principles informing this practice. On the one hand, from the transsexual perspective, a key principle concerns "the right of a person to express their gender identity through changes to their physical appearance, including the use of hormones and reconstructive surgery". On the other hand, service providers are also deemed to have "a right to charge reasonable fees for their services, to be paid in advance and to require a waiver of all tort liability except negligence" (1993: 1).

3.2 Research on Perspectives of Transsexual People

While research on transsexualism and issues of gender identity more broadly has increased markedly, there would still appear to be, from the review of literature undertaken in this instance, very limited research on health access issues from the perspective of transsexual people themselves. A number of studies were identified however, which do highlight the views of transsexual people on what they consider to be appropriate health care and the factors facilitating or blocking access to such services.

For example, *Community Survey: Transition and Cross Services in BC* (Goldberg et al, 2003) is part of a series of research reports undertaken jointly by members of the transgender community in British Columbia and the Vancouver Coastal Health Authority to inform the development of transgender services. This particular report draws together the results of a survey of 194 transgender and transsexual people in the Vancouver region. Of these survey respondents, 72% reported having difficulty in accessing transition/cross-dressing services. Key barriers in order of importance were financial expense, no services available locally, being waitlisted for services, lack of knowledge of service provision, difficulty with the service approach and fear of loss (including family and friends).

The main service requirements of respondents, in order of stated need were:

- Hormones
- Counselling
- Surgery
- Referral/information
- Peer support
- Diagnostic assessment
- Electrolysis

- Services relating to appearance
- Speech therapy

In locating these services, the most important point of contact was referral from the individual's general practitioner (GP), followed by friends and referral from a specialist service. GP's consequently featured centrally in respondent's views on quality of care. In this respect Goldberg et al (2003) suggest:

- Communication to GPs to enable appropriate referrals
- The development of clinical pathways for GPs to improve the care provided at the first point of contact
- Inclusion of transgender medicine in the health sciences curriculum
- Continuing education for GPs and other providers on transgender medicine

A broader set of issues are raised in *Access to Health Care for Transgendered Persons in Greater Boston* (ISI, and GLBT Health Access Project, 2000) which is a US study based on four focus groups comprising 40 transsexual and transgendered participants from the Greater Boston area. The groups were divided among individuals who transitioned from male-to-female (MTF) and female-to-male (FTM), then further broken into age groups, 25 and under and 26 and over. According to the authors, transsexual and transgendered individuals were recruited and trained to run the focus groups in order to help participants feel more comfortable and expressive.

With regard to health issues, individuals in all groups emphasised their need not just for specific services such as hormone treatment, sex reassignment surgery or mental health services, but also general health services in common with the rest of the population. Access to the latter, it was emphasised could be greatly diminished because of negative reactions to transsexual people or due to fear of their transsexualism being revealed and disclosed to others. In this respect, participants from all groups reported experiencing humiliating treatment from providers and outright refusal to provide services in some cases. As one person put it:

“I can't even make it through the front door without staff staring at me, laughing at me or whispering”(2000: 18)

When asked to establish what they considered to be quality health care, responses included the following:

- In all four groups participants agreed that quality health care hinged on providers willingness to listen, learn and to allocate time to discuss conditions and issues unique to transsexual and transgendered people.
- Some participants said that the quality of care is greatly helped by access to a continuity of providers and consistency in policies for health care.
- In one male-to-female group, participants noted that a health care experience included not only one's interaction with a provider, but also their interaction with receptionists and other staff during the medical visit.
- A provider's acceptance of one's self identification was also considered a key aspect of quality health care, including being addressed according to the specified pronoun preference.

Accessing health services was considered to have two components, that is, firstly locating providers who were knowledgeable about transsexual and transgendered people and health issues and secondly, paying for specific services. In this respect:

- There were a variety of first points of contact when seeking to locate providers knowledgeable about the issue, including medical centres, internet, and transgendered community sources.
- In all groups, participants expressed fear of disclosing their transsexual identity to insurers for fear of facing exclusions in or loss of their health care coverage. Also noted was that while insurance often covered basic services, coverage was not available for endocrinology or hormone therapy.

With regard to specific services such as hormone therapy, a key concern for many participants was that inconsistent implementation of standards across the health system had limited their access to such a service. Concern was expressed as to the amount of therapy and examinations required to obtain hormones. As one participant put it “Health care providers want too much from you to give you so little” (2000: 12). Many participants in the male-to-female group in particular spoke of having taken hormones without supervision in this context, which posed a serious risk for their overall health.

3.3 Healthcare Policy and Practice

While specialised health services following the Harry Benjamin Standards of Care now exist in many countries, broader policies and practice directly relevant to accessing these services are often undeveloped and unevenly applied. There is also very limited evidence of policies or practice being articulated in formal, written policy documentation. In the UK for example, the main NHS centre for providing care for adult transsexual people is at Charing Cross in London with smaller scale services being provided in Leeds, Leicester, Newcastle and Bristol⁵. However, health authorities throughout the UK (broadly equivalent to the health boards in Ireland) play a key role in relation to accessing these and other services relevant to transsexual people. This relates to their role as funders of treatment such as surgery or hormonal therapy, as providers of psychiatric support and assessment and as first points of contact for many transsexual people.

Nevertheless, in a recent survey of 120 health authorities in the UK policy and provision across different health authorities was found to differ markedly (Murjan et al, 2002). Only 20% of the authorities surveyed had a complete service for transsexual people locally although it was clear that not all of these centres had facilities for surgery. Sixty percent stated that they provided no local service but could refer elsewhere for psychiatric assessment, hormone treatment and surgery, while a small number of authorities reported having no local service and no policy of referral to an established gender identity specialist service (Murjan et al, 2002: 211).

With regard to funding, three authorities 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, while another confirmed that it would only fund surgery in exceptional circumstances. A further authority confirmed that it would only fund psychiatric treatment alone and had an established policy of not paying for surgery (ibid.).

Given that only 20% of the authorities provided a comprehensive service for transsexual clients, Murjan et al note that for many transsexual people, specialist treatment involves long distance travelling to appointments that are likely to be scheduled over a fairly lengthy period of time. As a result:

- Specialist services that are very distant from the patient’s home may experience considerable difficulties in supervising the real life experience [required of transsexual people under the HBGDA Standards of Care] because of unfamiliarity with local circumstances.
- Distant services may also 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 implication of these findings, it is suggested, is the need to consider regional structures that have sufficient catchment populations so as to allow the development of specialist local expertise (2002: 211).

Examples of Service Policy and Planning

Uneven policy development and under-provision of services is likely to change in the UK following the 1998 case taken against North West Lancashire Health Authority by three transsexual people who had been refused funding for gender reassignment surgery. The decisions of the Authority in these instances (as outlined in section 2.4 of this report) were found to be “unlawful and irrational” as they were “arrived at without consideration of relevant matters such as the question of what constitutes proper treatment of what is recognised as the illness involved in gender dysphoria or transsexualism” (Appeals Court 1999). The result of this case consequently is that it is now illegal for a health authority in the UK to impose a blanket ban on funding medical treatment for the purposes of gender reassignment.

Following this judgement, the North West Lancashire Health Authority (now part of the Wyre Primary Care Trust) developed a *Policy on the Commissioning of Services for People with Gender Identity Problems*. This policy, one of the few written policies on this issue identified in the course of this research, was originally put forward as a consultation document and amended in a series of drafts following representations from groups such as Press for Change (PFC), the leading campaigning organisation for transsexual people in the UK. The evolving policy and evaluations of different drafts provided by Press For Change (available on the Press For Change website, www.pfc.org.uk), provide very useful pointers on the issues involved in making services accessible to transsexual people on an equal basis to those with other medical conditions.

Another significant written strategy document identified in the context of the UK is an internal report produced by Suffolk Health Authority in 1994. Entitled *Transsexuals and Sex Reassignment Surgery*, the report provides an overview of transsexualism and then goes on to put forward a suggested ‘management scheme’ following the standards set down by the Harry Benjamin Gender Dysphoria Association⁶. The report also covers issues such as the technical aspects of surgery and factors associated with successful outcomes. It then finishes by considering different purchasing options with regard to provision, such as:

- *No specialist psychiatric care or sex reassignment surgery.* The downside of this, it is stated, is that non-specialised psychiatric care is difficult to implement given the complexity of the condition. This could lead therefore to people undergoing surgery who may not have been really suitable.
- *Specialist psychiatrist care (purchased at a specialised gender identity clinic) but no sex reassignment.* Here it is noted people might not avail of psychiatric care if it is known from the outset that surgery would not be provided.
- *Unconditional purchase of specialist psychiatric care and sex reassignment surgery.* This, it is suggested, could lead to over subscription of the service, for example by people who might move into the area to benefit from this liberal purchasing policy.

Interestingly, even though this report is written before the 1998 case where the option of a blanket ban on provision would now be unlawful, the report came down in favour of another option: “conditional purchase of specialised psychiatric care, surgery and hormonal therapy”. This option, it is noted would “provide the best care for the population of transsexuals in Suffolk” (Suffolk Health Authority, 1994).

Involving Transsexual People in Service Planning: The Case of Vancouver

In other countries more extensive examples of policy development around transsexual/transgender health care were identified, often with greater involvement of the client group. A significant example in this respect was the case of Vancouver, Canada, referred to in the previous section. This involved a joint planning exercise by the Vancouver Coastal Health Authority and members of the transgender community to provide an alternative model of care for transsexual/transgendered people in British Columbia following the closure of the Gender Dysphoria Clinic in Vancouver Hospital and Health Sciences Centre. The actions undertaken as part of this exercise included a comprehensive survey of

the transgender population (issues arising from this are outlined in section 3.2 above), which included basic demographic information such as location, age, education, ethnicity, gender identity and household income. It went on then to examine service needs and to elicit views on different service options to meet these needs.

These planning actions also included the preparation of the report *Transition and Crossdressing Service Delivery: A Review* (Goldberg, 2003), which provides an extensive overview of international literature on health needs relating to gender transition and cross-dressing. This includes:

- A systematic comparison between the HBIQDA Standards of Care and alternatives such as the Health Law Standards (referred to in section 3.1 above).
- A discussion around different approaches to meeting the needs of adolescents with gender identity disorders, including the HBIQDA Standards, standards on this matter issued by the Royal College of Psychiatrists and other standards, guidelines and research including *Transgender Care* by Israel and Tarver.
- A review of the approaches adopted by gender identity clinics, programmes or other specialised services for transgendered people around the world and the nature and scope of services provided.

One of the findings in this review of international practice is a key divergence between the medical/prescriptive model followed by many gender identity clinics and the harm reduction/client directed model followed by some services. This reflects in many respects the divergence between the HBIQDA and the Health Law Standards referred to in section 3.1 above, in particular:

- The medical/prescriptive approach emphasises practitioner responsibility to screen out people who are 'unsuitable' candidates for gender transition (to protect from future regrets) and practitioners typically employ various psychological tests to arrive at one of the diagnoses in the DSM-IV or ICD-10. While some clinics using this approach follow the HBIQDA Standards of Care closely in this respect, many were also found to follow more restrictive standards.
- The harm reduction/client directed approach, Goldberg notes, is emerging as an adaptation of harm reduction practices that have been used to ensure access to non-judgemental health care by drug users. In this framework, the practitioners role in relation to transgender health care is to assist transgendered people to get the resources they need to make fully informed decisions about gender transition, to employ strategies to reduce the negative consequences of medically unsupervised hormone use and to promote regular use of health care services. Services along these lines are often provided in community-based settings (although not always) and while some practitioners do follow the HBIQDA Standards of Care "others reject them as an oversimplified response to the realities of clients' complex identities and needs" (Goldberg, 2003: 11).

While these approaches are philosophically quite different, in practice some programmes, Goldberg notes, combine elements of each (2003: 11).

The Goldberg review and the survey of transgendered people in the Vancouver region, informed a final document in the planning process, *Recommendations for a Transgender Health Program* (Kopala, 2003). This report further elaborates on the conclusions and recommendations of the survey of transgendered people which broadly focused on:

- *The Planning Process.* Where it was emphasised that community consultation should be ongoing throughout the service planning phase and ongoing service user involvement should be actively encouraged in any new services. It was stressed in this instance that the partnership between the Health Authority (Vancouver Coastal Health Authority) and service users had been very successful and should continue as a mechanism for service delivery planning, with an invitation to health professionals to contribute their expertise.

- *Service Delivery.* Where it was recommended that future service delivery should be based on the HBIGDA Standards of Care. Also, given that many transsexual people did not live in a densely populated area such as Vancouver, a ‘blended’ model of service delivery was proposed involving a centralised transgender health centre, an informal network of practitioners and an expansion of existing health programmes to include a transgender-specific component.
- *Professional Training and Development.* In line with the proposed structure of delivery, it was stressed that strategies should be developed to increase the pool of professionals able to offer health and social services to transgendered people and their families. Strategies should also be developed to improve the ability of GPs, as primary points of entry into the health system, to properly assist people needing referrals to specialised transition/cross-dressing services (Goldberg et al, 2003: 26).

The final report by Kopala (2003) elaborates on these broad recommendations including detailed proposals around structures for delivery, planning and evaluation, promoting awareness of services available and promoting awareness more generally both within the medical community and in the wider society.

3.4 Summary

In looking at access to health services, key issues which have emerged from the review of policy and research internationally are as follows:

- Health care provision for transsexual people has increasingly been governed by the internationally recognised Standards of Care for Gender Dysphoria developed by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) which require transsexual people to have a psychiatric diagnosis and ongoing supervision by a mental health professional in order to access health services along the recognised treatment path. Elements of the treatment path include hormonal therapy and surgical interventions including genital reassignment.
- Concern has been expressed by some people that the HBIGDA Standards are too restrictive and give too prominent a role to mental health professionals in determining access to treatments. This has led to calls for flexibility around treatment protocols to take account of differences in individual needs and circumstances, while accepting the need for psychiatric and psychological support. Standards of care have been developed however, which have argued for a shift from care based on psychiatric assessment and supervision to care provided based on the informed consent of a person mentally competent to make decision about their treatment.
- Health access issues identified by transsexual people have included the importance of a range of services along what has been described as the service path, including psychiatric assessment, hormonal therapy and surgical interventions but also non-medical services relating to gender ‘transition’ including speech therapy and electrolysis (for male-to-female transsexual people).
- In areas of a low population size and density, which might not justify a full gender reassignment service, emphasis has been placed on professional training and development on the issue of transsexualism, particularly among primary health care providers such as GPs. Also emphasised in this respect has been the need to put in place effective referral paths (and the necessary funding) for transsexual people to access further treatments including those that might only feasibly be provided outside the jurisdiction of the particular health authority.
- And finally, examples have been identified of effective and successful health service planning processes that have involved policy makers, service providers and transsexual people working in partnership.

TRANSSEXUAL HEALTH CARE: POLICY AND PRACTICE IN IRELAND

From the initial review of policy documentation in Ireland no evidence was found of the health needs of transsexual people, and service responses to these needs, having been articulated in formal written policy statements at national or at health board level. Nor was it very clear how information on policy and practice could be easily accessed, for although transsexualism has been identified internationally as a psychiatric condition, relevant service responses cover a range of functional areas within the health sector, both within health boards and including services provided outside of health board provision such as the services of GPs.

It was decided in this context to write seeking information on policy, practice and planned provision in the future to:

- The Chief Executives Officers of each of the ten health boards, in expectation that this would provide the best means of eliciting information on overall policy and practice covering different internal policy and functional areas.
- Relevant professional bodies, including the Irish College of Psychiatrists, the Royal College of Physicians of Ireland and the Irish College of General Practitioners.

Replies were received from all but one of the health boards. Letters to the professional bodies led to subsequent interviews with the Chair of the Irish College of Psychiatrists and, through the Royal College Physicians, with a consultant endocrinologist in the Eastern Region Health Authority known to be the principal provider of hormonal therapy to transsexual people in Ireland. Interviews were also held with two other professionals identified as having some experience and expertise in meeting the needs of transsexual people within their particular professional area. These were a consultant psychiatrist and a psychologist in private practice, both in Dublin. The results of these consultations are outlined in this chapter.

4.1 Services Provided at Health Board Level

Most of the replies from the health boards tended to focus on access to gender reassignment surgery, which, it was noted, is not available in Ireland. Six health boards stated that transsexual people can apply for funding for such surgery under the Treatment Abroad Scheme (E1 I2); four reporting that they had received applications (although very infrequently) and three boards noting that they had funded surgery under the scheme (there were no reports of refusals in this respect). Two boards stated that they had never received requests for funding. It was not apparent however, whether other surgical interventions related to transsexual care (for example cosmetic/aesthetic surgery such as facial feminisation) were included under the term gender reassignment (which commonly denotes genital surgery) and whether

these are available in Ireland or accessible under the Treatment Abroad Scheme.

The Southern Health Board provided more detailed information on the application of the Treatment Abroad Scheme in relation to gender reassignment. It notes there is a policy and procedure in place for the provision of treatment abroad and certain criteria have to be fulfilled before an application can be processed under this scheme. One of the criteria includes “urgent medical necessity for treatment”, but that this issue has to be determined individually in every case. The Southern Health Board does however, “recognise Gender Dysphoria as an illness that requires treatment”, the only health board to have explicitly stated such a policy position. This Board also has a procedure in place when assessing the individual merits of an application for funding, including assessment by a consultant psychiatrist, referral to a recognised centre dealing with gender identity disorders (Charing Cross Hospital in London is the centre recognised by the Board) and then assessment of the application by the Board’s medical referee.

With regard to other services, the majority of health boards refer to their provision of general mental health and psychiatric services, which, it is stated, can be accessed by transsexual people. In only one case however, is it specified that specialist services are available in this respect. This is the East Coast Area Health Board, which notes that where specific specialist counselling is required, transsexual people are referred to a consultant psychiatrist in St. Patrick’s Hospital in Dublin.

One health board refers to other services such as endocrinology and urology, which it is noted are “within the scope of in-house expertise” and accessible to transsexual clients upon referral. However, it is not stated whether these general services have any particular experience or expertise around meeting the needs of transsexual clients, whether there any procedures for onward referral to specialised services or what protocols or policy framework these services operate within with regard to such clients.

4.2 Policy and Planning

Service providers interviewed acknowledged that policy around the health needs of transsexual people is broadly underdeveloped in Ireland at present. The Irish College of Psychiatrists for example, does not have a formal policy on the issue, although it was noted that some policy development has taken place in the Royal College of Psychiatrists in the UK, to which the Irish College is affiliated. To date this policy development has related to younger people, with the production of the Council report *Gender Identity Disorders in Children and Adolescents: Guidelines for Management* in 1998. The Royal College has more recently established a working group on gender identity issues, which will have an input from the Irish College.

At health board level, as indicated above, the Southern Health Board was the only Board to explicitly state that it recognises gender identity as an illness that requires treatment, although most boards did accept applications from transsexual people under the Treatment Abroad Scheme. Policy around the broader range of services relevant to transsexual care, and recognition of the treatment protocols and specialist knowledge needed in relation to such provision, was less apparent.

Two boards did state however, that the needs of transsexual people will be taken account of in future service planning. The Mid-Western Health Board states in this respect that the Board “is conscious of the need to formulate formal pathways and procedures relative to the range of services and interventions that may be required by transsexual people”. This work, it notes, has commenced. And the Midland Health Board states that the Board is currently developing a strategy on sexual health that will take into account the needs of transsexual people, although the Board does not currently have any plans to change existing service provision.

4.3 Specialist Providers

Three health care providers as noted, were identified in the course of the project as having expertise and experience of dealing with transsexual care in the context of their respective professional areas: psychology, psychiatry and endocrinology. While these professionals do not comprise a formal specialist team, they have increasingly co-operated in meeting the needs of their transsexual clients

and comply with internationally recognised standards of care.

Mental health services provided have included the provision of psychiatric assessment and referral of carefully assessed individuals onwards for hormonal treatment and surgical interventions in recognised gender identity clinics in the UK. The consultant endocrinologist has fifty patients currently, with one or two new patients each month. Therapy is provided in line with international protocols, where factors determining treatment include:

- That it is safe to start treatment given the medical condition and history of the patient
- That the patient has a psychiatric diagnosis
- The patient understands the consequences of taking hormones
- The patient will comply with the treatment prescribed to them

Policy and Future Provision

In interviews with these professionals, it was acknowledged that specific health care provision for transsexual people is very underdeveloped in Ireland at present. However, it was noted that the experience of responding to needs to date does allow for a consideration of gaps in provision and for the identification of elements of a system that would enhance and make services more effective in the future.

These providers emphasised that a key element of such a service is the development of a specialised care team for transsexual people. Given the likely prevalence of transsexualism (based on current estimates internationally) this could be a small team of professionals encompassing mental health and endocrine services and could operate at national level, taking referrals from different parts of the country. The team could also liaise closely with surgeons outside the country in terms of patient care, and with surgeons in Ireland with respect to procedures that could feasibly and cost effectively be carried out in this jurisdiction.

Issues identified in terms of supporting this team included:

- The need for a larger number of psychiatrists with a knowledge of transsexualism, including diagnostic criteria, treatment protocols, standards of care and services available. This, it was noted, would allow for informed second opinion in assessment and diagnosis and would allow for greater accessibility if such a professional capacity was available in different regions.
- The importance of ensuring effective linkages with a major gender centre or clinic (in the UK) including provision for ongoing liaison, evaluation and follow-up of clients.
- The need for comprehensive and quality standards and procedures for treatment and review around hormonal therapy. This would be especially helpful to GPs called on to prescribe hormones for transsexual clients.
- Provision for post-surgical care and follow-up. Effective links with a gender clinic abroad would be an important element in supporting follow-up care in this respect. Also mentioned was the need to highlight the importance of post-operative care amongst the transsexual population, especially those who have had no contact at all with Irish service providers and who have accessed services privately abroad.
- Provision for and access to proper epidemiological data so policies and services can be informed by reliable information on the extent of transsexualism and outcomes of different approaches and procedures.

The population and likely prevalence of transsexualism might not justify the development of specialist teams in each health board area. However, it was noted by some of the providers interviewed, that much could be done to facilitate transsexual people's access to specialised care at national and international levels and to provide those services which could feasibly and cost effectively be delivered locally. Mentioned in this respect were:

- The role of GPs who often comprise a key first point of contact for transsexual people. At the very least, a system for referring on clients to specialised provision was highlighted, but also the role GP's could play in relation to aspects of care such as ongoing as opposed to initial hormonal therapy.
- The role of the health boards in terms of funders of treatment and in communicating the eligibility criteria of such funding as well as other information on treatment options to transsexual people in their areas. Health board psychiatrists could also play a role in this respect.
- Other services relating to transsexual needs which could feasibility be provided at local level. These include services essential for passing in the new gender role such as electrolysis and speech therapy.
- Provision for on-going monitoring of the 'real-life test', which was considered difficult if services are based in Dublin. The potential role of health board psychiatrists was mentioned in this respect.

Other issues identified included gender identity issues arising among children and adolescents. While it was recognised that this raised many additional service and ethical issues, it was also stressed that issues of gender identity among children were arising within psychiatric practice and policy and provision for responding was undeveloped. Provision in this respect was clearly relevant to adult transsexual people, given that gender identity problems can arise very early in their lives.

And finally, it was stated that the professional bodies could play a significant role in driving future provision, not least the psychiatric profession, given that transsexualism is classified as a psychiatric condition.

4.4 Summary

From contact made with the health boards and professional medical bodies it would appear that policy and practice around meeting the health needs of transsexual people is underdeveloped in Ireland at present. In particular:

- Most of the health boards contacted regarding policy and practice around the health needs of transsexual people tended to focus on access to genital reassignment surgery abroad for which transsexual people could apply for funding under the Treatment Abroad Scheme.
- With regard to services, the majority of health boards refer to their provision of general mental health and psychiatric services, which it is stated, are available to transsexual people. It is not specified however, whether these general services have any particular experience or expertise around meeting the needs of transsexual people, whether there are procedures for onward referral to specialist services, or what protocols or policy framework these services operate within in relation to health provision for transsexual people.
- The small number of specialist providers identified confirmed the limited extent of developments in policy and practice around the health needs of transsexual people. To address this they put forward a number of proposals including professional training on the issue for psychiatrists and GPs, linkages to reputable gender clinics abroad and provision for the ongoing collection of epidemiological data. They also emphasised the importance of developing quality standards and procedures for treatment.
- The role of the professional bodies in driving change was highlighted and in particular the Irish College of Psychiatrists given that transsexualism is formally a psychiatric condition.

PERSPECTIVES OF TRANSEXUAL PEOPLE IN IRELAND

Seventeen transsexual people in all participated in the research. Of these, 15 completed and returned questionnaires and more detailed interviews were conducted with 6 people (four of whom had already completed questionnaires).

Key issues emerging from these contacts can be grouped under a number of broad headings. These include the expressed gender identity of those interviewed or who returned questionnaires, the age at which they started questioning their gender identity, the age they subsequently sought support and their experience of this support. Also covered are the elements of the 'treatment path' people have accessed (from psychological assessment through to genital reassignment surgery), perspectives on the barriers to accessing these and other treatments and the impact on people's lives of having access, or not having access, to the services they deemed appropriate to their needs. The chapter finishes with a section on respondents' views on what comprises an appropriate health service from their perspective.

5.1 Gender Identity and Age Groups

Fifteen of those who participated in the research were male to female transsexual people and two people were female to male. The questionnaire returns showed that people identified variously as male (two people), female (seven people), transsexual men (two people) and transsexual women (three people). One person expressed concern about the use of the term 'transsexual' at all, preferring the more medically defined term 'gender dysphoria' and noting that a person is no longer 'trans' once they have changed gender.

One respondent to the questionnaire was less than 20 years old while more than half were in their thirties, three people were in their forties and four people were in their fifties. The two people interviewed who did not complete questionnaires were in their thirties and early forties respectively.

5.2 Questioning Identity and Seeking Support

All but one of the respondents to the questionnaire had started questioning their gender identity before the age of 15 years with a number of people stating subsequently in interviews that this questioning or sense of something '*not being right*' had started when they were small children. Most people however, only started seeking support when they were in their thirties, with only four people seeking support before the age of 20, one of whom sought support before the age of 15.

When respondents were asked to identify those they initially sought support from and the order in which they contacted them, the most important were their own GP, counsellors, the internet and sources within the transsexual and lesbian and gay communities.

The value of these initial contacts varied. For example, many negative experiences were recounted:

- Two people had found their own GPs to be sympathetic but with very limited knowledge of transsexualism as a condition and with little or no awareness of the accepted treatments and treatment protocols for responding to the condition. Nor were the GPs in this instance aware of where to refer the respondents in order to access specialised support, treatment and care.
- In one case the GP was initially supportive but became less so when the respondent made up her mind about pursuing treatment. In the case of another respondent, the GP was dismissive and described the respondent's concerns as 'being all nonsense'. The respondent in this instance sought another GP who turned out to be more supportive and knowledgeable about the issue.
- Even more negative experiences were noted by an older male-to-female respondent who had first sought support in her early teens but had received a very hostile response. She describes 'being thrown out by the scruff of the neck'. This led to a period of a severe depression resulting in the respondent leaving school early and an attempt at suicide.
- A number of respondents described psychiatrists they first met as having very limited understanding of transsexual issues also and in some cases, as with GPs, having no information about where to refer the client for more specialised care.

More positive experiences were noted by those who had been seen by psychiatrists, psychologists or other health professionals who had specialised knowledge of the issue. As one respondent put it:

'Once my sessions started with the psychologist I felt a lot better. As with later hormone therapy, I felt I was finally getting the right treatment.'

For a number of respondents, contact with other transsexual people through different networks was found to be a very important form of emotional support as well as a source of information on treatments available. Also important was sharing of information about medical or mental health professionals known to have knowledge and understanding of gender identity issues. However, some concern was expressed in this respect about the potential for inaccurate information to be circulated, 'urban myths' as one person put it.

5.3 Treatment Paths

Most respondents and interviewees were currently using or had used a range of services comprising the main elements of what has been described as the 'treatment path' relating to support and transition for transsexual people. These included:

- Counselling/therapy - 10 respondents
- Psychiatric/psychological assessment - 11 respondents
- Hormonal therapy - ongoing for - 12 respondents
- Electrolysis or laser hair removal - 11 respondents
- Speech therapy - 7 respondents
- Surgical interventions (excluding genital reassignment) - 7 respondents
- Cosmetic interventions - 4 respondents
- Genital reassignment surgery - 6 respondents
- "Other" which included 3 people who had undergone laser epilation to remove body hair

For male-to-female respondents, surgical interventions (excluding genital reassignment) included voice surgery and 'cosmetic' procedures such as facial feminisation surgery, whereas in the case of one female-to-male respondent, interventions had included chest surgery and a complete hysterectomy. With one exception all of these surgical procedures, as well as genital reassignment procedures, were undertaken outside of Ireland. The exception in this case related to a hysterectomy.

Some concern was expressed in this instance about the term 'cosmetic' being applied to surgery such as facial feminisation. Such procedures it was noted, are essential in order for a person to pass in the new gender role and were considered as important as genital surgery. 'Passing' in the new gender role it was stressed was critically important if a person was to have any quality of life. Not passing on the other hand can expose people to harassment, discrimination and violence.

With regard to funding, all of those who had undergone genital reassignment surgery had funded this from their own resources. This tended to be true for other surgical procedures also, although in at least three cases either a health board or a private health insurer had provided funding. Services such as electrolysis or laser epilation to remove body hair tended to be funded by people themselves. This is an issue of concern for male-to-female transsexual people given the necessity of hair removal in terms of the feminisation process but also the significant cost involved.

A number of factors were cited as to why people funded services from their own resources. In particular:

- Seven people had been refused funding for treatments, six by health boards and one person had been refused funding by their health insurance company. One respondent who lived a considerable distance from Dublin stated that the specific reason given by the health board for refusing funding (for accessing specialised psychological services in Dublin) was that it was 'not considered urgent or exceptional'.
- In a number of instances these decisions had been challenged through the legal system, one respondent stating that she been reimbursed by the health board following legal challenge. One respondent also stated that a case was currently in process with the Equality Authority regarding the refusal by a health insurer of funding for a particular surgical treatment.
- Other respondents had simply never applied for funding, expecting that the treatments would not be funded or that there would be significant delays in accessing treatments if they were to rely on anything except their own resources.

Limited funding for treatments, or the perception that none would be forthcoming, it has been suggested, is a particularly serious issue for transsexual people. The whole experience leading to gender change and then progressing through it can lead to loss of employment and income for protracted periods of time. One person described a frantic period of seeking treatments and a means of funding them, which led to significant debt and put them at risk of losing their family home.

5.4 Barriers to Access

In addition to funding, respondents and interviewees also highlighted other barriers to accessing health services. The most frequently mentioned issues in this respect were as follows.

Geographic Accessibility

Four respondents, two from the Southern Health Board region, one from the Mid-Western Health Board region and one from the South Eastern region describe having to access psychiatric, psychological and endocrinology services in Dublin, involving considerable disruption and expense. As one person puts it:

'I have to travel to Dublin which is very far. I have to take time off work to organise lifts for the children to school etc. which leads to me missing appointments which then slows the progress of my treatment'

The lack of specialised care at a regional level was consequently considered the most significant access issue for these individuals.

Information

A key issue for almost all respondents was the difficulty in getting any information about their condition, the type of services they might need or where and on what basis these services could be accessed. Two respondents drew particular attention to this:

'There's no one place where you can find out about the services one needs to access. You have to find it yourself or if you are really lucky, you'll know someone who has been there before who can point you to a service. But other than that, you're on your own'.

'Its crucial to TS folks that they know that there are services out there that they can avail of psychiatrists, counsellors, etc.. I didn't know any of this year ago and had to find out the hard way, as it seems has everyone else'.

Another person stated in an interview that there seemed to be an air of *'cloak and dagger'* about services that were provided, as if to acknowledge their existence might cause problems for the service provider. This was seen as presenting an obvious barrier to providing accessible information on the issue and on services available (including funding criteria for accessing treatments).

Lack of information it was noted was clearly linked to the apparent lack of policy within the health system or within the professional bodies around meeting the needs of transsexual people. In the absence of such a policy, transsexual people were essentially *'in the dark'* as to what they could expect of health service providers in dealing with their needs. They also had to rely on information coming through a range of transsexual networks, the reliability and veracity of which could not always be guaranteed, although respondents still emphasised the usefulness of these contacts in the context of such limited service provision in Ireland.

Professional Awareness

As mentioned above, many respondents refer to a lack of awareness on the part of health care professionals as being one of the most significant barriers in terms of progressing to specialised provision. Very few providers it was noted, had any knowledge of the condition or the accepted treatments for it. Nor did they appear to have access to information on appropriate referrals. Indeed some respondents talk of having to inform the health professional themselves on these issues.

Limited awareness on the part of service providers also led to increased risk of transsexual people being misinformed about their condition and the treatments available, which one respondent stated:

'...Set me back years and needlessly left me in a state of terrible unhappiness'.

Lack of awareness was also felt to increase the potential for dismissiveness and in some cases, hostility towards the transsexual client. One respondent referred to what he considered to be forms of sexual harassment, where some doctors had engaged in what were felt to be unnecessary physical examinations. This respondent also referred to invasive questions being asked by a service provider about issues such as sexual orientation, which were irrelevant to the service being accessed (medication). Two other respondents also complained of having to take their clothes off so student doctors could have a look *'at the condition'*.

Actual experiences or expectations of being received with hostility, having ones concerns dismissed as trivial or being misinformed about treatment options was a matter of great concern for most respondents. Many emphasised that service providers should be aware of the intense vulnerability of the transsexual person who had actually got to the point of talking to a health professional about the issues arising for them. As one respondent put it:

'Lack of training, understanding and compassion just add to misery'.

Lack of Family Services

Gender identity issues, it was stressed not only affect transsexual people themselves, but also family members, including spouses, partners, parents and children. At least two transsexual people interviewed (one who had undergone gender transition and one who was beginning the process) were married and describe the great support they received from their spouses. However, they were very aware of the difficulties experienced by their spouses and felt that while services for transsexual people were limited, services for their partners were almost non-existent.

Another respondent referred to breakdown of family relationships as being the most difficult issue to deal with during gender reassignment. She suggests that there could be a role for a social worker with a good understanding of transsexual people in working with families to help *'heal the rifts'*.

5.5 Impact of Limited or Inappropriate Service Provision

When asked about the impact of these barriers and of not being able to access the health service they required respondents reported serious negative consequences:

- Many of those who participated in the study referred to experiencing anxiety and depression, in at least one case leading to hospitalisation and in another, with the person confining themselves indoors for a period of ten years.
- Five respondents stated they had considered or thought about suicide.

Such feelings were often exacerbated when a transsexual person received a hostile or uninformed response from a health professional or where people accessed the wrong information, especially information that suggested the barriers to treatments were significant or insurmountable. One person in this respect described a feeling of incredible despondency when they were told that services were not available in Ireland, that funding was not on offer and that accessing services abroad privately was prohibitively expensive. As she put it:

'It was like the end of the road with no hope as I had no money. I knew so much what I needed but everyone was saying no.'

Other impacts of service barriers included cases where people initially accessed hormones on the black market, usually at great expense. Lack of proper medical supervision exposed those who did access hormones in this way to a range of health risks.

Even where transsexual people are on supervised hormone treatment, the opportunity to be open with their primary health care provider such as a GP was mentioned by respondents as being important in terms of safely accessing other health treatments. An example given here is the case of a GP who might seek to treat an illness without knowing that the person is receiving long-term hormonal therapy.

Openness with health providers was also mentioned as being critical for post-operative aftercare. It was suggested that many post-operative transsexual people in Ireland have never engaged with the Irish health system around their condition and are unlikely to be open with health services providers unless they now consider it safe to be so.

And finally, one of the most difficult issues to deal with for many respondents, already mentioned earlier, was relationship difficulties with family members when the person's transsexualism was disclosed. While spouses, partners and children did in many cases support the respondent, the lack of any support services for families or even an official recognition of the condition was considered to have exacerbated the potential for family breakdown.

5.6 Impact of Appropriate and Accessible Service Provision

Where respondents did manage to access the service they felt was appropriate to their needs, the impact was positive in all cases. This included people who had just accessed a psychiatrist with familiarity of the condition right through to those who had undergone complete gender reassignment. For example:

- One person who had just had the condition formally diagnosed felt great relief, knowing that it had not just been in her imagination. The formal diagnosis had also proved very important in terms of informing family and friends.
- Four respondents who had undergone all treatments along the treatment path refer variously to *'now living life'* and to significant improvements in their psychological wellbeing.

Others describe finally accessing specialised services as literally life-saving and expressed concern about those transsexual people now only beginning the process of enquiring about their condition when services are still so underdeveloped.

5.7 Perspectives on Appropriate Services

Addressing the barriers and negative impacts just outlined was a key issue for many respondents when asked what, for them, comprised helpful and appropriate practice in meeting their needs. For example:

- Almost all respondents emphasised the need for transsexualism to be formally recognised as a medical condition by health services. As such it was stressed that it should be treated with the same seriousness as other medical conditions and funded accordingly. Strategic development of health services could then take on board the kind of services and treatments needed and how these could best be organised in an Irish context.
- It was noted that funding criteria for treatments should not just focus on one element of surgery or other services along the 'treatment path' but should recognise how each is inter-linked. This includes services such as electrolysis, which are essential for people to pass in the new gender role.
- Some respondents felt that all treatments, including genital surgery should be provided in Ireland. Others felt that relatively mainstream procedures at least, such as hysterectomy for female-to-male transsexuals should be available in Ireland and that any ethical concerns of surgeons should be addressed through reference to the Harry Benjamin Standards of Care.
- Many respondents stated that a key issue was for medical and mental health practitioners to have an understanding of their needs and service requirements, or at the very least to be in a position to refer the transsexual client to a specialised service. Access to services could also be greatly facilitated, it was suggested, if the health boards and the Department of Health and Children produced a booklet on the condition, outlining services available and criteria for accessing them, including funding.
- The importance of service providers being respectful and polite was emphasised, using correct names and pronouns or enquiring about the appropriate pronoun to use if unsure. Sensitivity to the vulnerability of the transsexual client was also stressed, taking account of the considerable journey the client has already made in getting to a point of seeking service interventions.
- GP's were highlighted as key contact points for accessing services and, according to one respondent, should be able to refer the client to (or participate in) a defined treatment path with appropriate protocols to help the client right through to genital reassignment surgery.

- Respondents considered it important that the needs of family members be considered in future service development. This has implications not just for mental health or primary health care providers but also for a range of services relating to families, including social work.

Other issues mentioned included the need for flexibility in provision, bearing in mind that the needs of individual transsexual people differ and the need for policy and procedures to address the potential for discriminatory practice around issues such as the sex life the client has or hopes to have.

5.8 Summary

During the course of the research contact was made with seventeen people, fifteen male-to-female (MTF) and two female-to-male (FTM) transsexual people. These people were accessed through service providers and by contact through various transsexual networks. In relation to the circumstances, health needs and service requirements of those consulted, the findings from these contacts can be summarised as follows:

- All but one of those contacted began questioning their gender identity before the age of 15 years, with some people stating that they felt they were the wrong gender as small children. However, most only started seeking support when aged 30 or over.
- Initial sources of support sought included GPs and counsellors, although many people report either negative reactions or else a lack of knowledge about the condition and where to refer people onwards for more specialised support.
- Seven people report being refused funding for treatments along the 'treatment path' including genital reassignment surgery, six by health boards and one person by their health insurance company.
- Barriers to accessing support and treatment included: geographic accessibility (given that specialised providers were based in Dublin), lack of information on the condition or information at health board level on treatment options and service availability and location, and lack of family service to support partners, spouses and other family members.
- Respondents also highlight the impact of lack of service provision on their lives. This included depression, suicidal feelings and in some cases people accessing hormones on the 'black market' which were expensive and potentially dangerous without medical supervision.
- On the other hand, where respondents did access services that they felt were appropriate to their needs, the impact was positive in all cases. Some people describe accessing a service 'at last' as being literally life saving.
- Ideas put forward to improve services included official recognition of transsexualism as a condition requiring treatment, accessible information on the condition and how and where to access treatments, support for families and professional training and development on the condition for personnel at different levels of the health service. In providing such training, the need to promote respect and politeness in dealing with transsexual clients was emphasised.

CONCLUSIONS AND RECOMMENDATIONS

In this chapter we review the findings of the study and make recommendations aimed at improving policy and practice in relation to access to health services for transsexual people.

6.1 International Developments

The World Health Organisation has defined transsexualism as an overwhelming desire to fulfil one's life as a member of the opposite gender and for this to be facilitated through a range of treatments that can include hormone treatment and surgery. Treatment along these lines has been shown to benefit transsexual people and services relating to gender reassignment are provided or permitted in many countries including the vast majority of the countries of the Council of Europe.

Internationally recognised Standards of Care issued by the Harry Benjamin International Gender Dysphoria Association (HBIGDA) are widely used as a set of guidelines governing provision and access to services. These guidelines give a prominent role to mental health professionals in assessing suitability for treatments, including the supervision of a period of real-life experience of living in the new gender role as a basis for assessing suitability for surgical procedures and other therapies. Various complementary or alternative standards of care have also been produced which have suggested a more central role for transsexual people in determining treatments.

Services for transsexual people have grown worldwide, including many states of the European Union. In the UK for example, transsexualism is now accepted by the Government's Chief Medical Officer as a medical condition that can be properly treated under the National Health Service. Specialised services are provided through a number of gender clinics that encompass specialised psychiatric care and various surgical interventions including genital reassignment. Patients, both male-to-female and female-to-male transsexual people, are treated according to the international protocols set out in the HBIGDA Standards of Care. Access to these services is facilitated by local health authorities, which since 1998 are legally obliged to consider funding applications for treatments on the same basis as other medical conditions.

Policy and programme developments in the UK and other countries identified in the course of this research indicate different models and service options for meeting the needs of transsexual people. These include different philosophical approaches to care: with some services following the HBIGDA Standards and other services adopting more or less stringent criteria governing access to treatments. Less stringent criteria are often followed where the emphasis is on harm reduction (for example, reducing the risks of unsupervised hormone treatment) or where the goal may be to promote service usage by transsexual clients put off by overly restrictive access requirements.

A variety of service options have also been considered in different service environments, for example in high or low population areas. Options in low population areas, where there are likely to be few transsexual people, have often been to refer people outside the area for specialised care but to establish networks of primary health providers and develop their capacity to provide informed initial support and to make appropriate referrals. Other options in these areas are also to identify procedures that could easily be carried out locally such as surgical procedures that are not specific to transsexual care.

6.2 Policy and Practice in Ireland

In Ireland, policy and practice in relation to the treatment and support of transsexual people is underdeveloped at present. One health board contacted in the course of the research stated that the board explicitly recognises transsexualism as an illness that requires treatment, although most of the boards state that they accept applications for gender reassignment under the Treatment Abroad Scheme. Most boards also state that transsexual people can access other services such as mental health and psychiatric services. It is not stated however, whether these services have a capacity to meet the specific needs of transsexual people, whether provision exists for onward referral or what policy framework or standards of care inform such provision in relation to transsexual people.

Policy is also underdeveloped within the professional bodies at present. The Irish College of Psychiatrists for example, does not have a formal policy on the issue, although it was noted that some policy development has taken place in the Royal College of Psychiatrists in the UK, to which the Irish College is affiliated. To date this policy development has related to younger people, with the production of the Council report *Gender Identity Disorders in Children and Adolescents: Guidelines for Management* in 1998. The Royal College has more recently established a working group on gender identity issues, which will have an input from the Irish College.

Despite the limited policy context, specialised services for transsexual people were identified in the course of the project, although these services have been developed by the three individual providers concerned and relate to psychological, psychiatric and endocrine services (all based in Dublin). While these health professionals have increasingly co-operated in terms of provision and onward referral (including to recognised gender clinics abroad), they do not as such comprise a formal specialised team and do not operate within a formal policy framework within the Irish health system (although they do adhere closely to international standards of care).

The work of these providers has allowed for a consideration of transsexual needs in an Irish context and of gaps in policy and service provision. They have emphasised the importance of establishing a care team at national level and a system of linkages and referral to services abroad that may not feasibly be provided in an Irish context given population size and estimated prevalence of transsexualism. They also emphasise the importance of establishing certain services at local and regional level, including initial points of contact and support, systems for onward referral and particular services that can be feasibly and cost effectively be delivered at local or regional levels.

Other issues identified, included gender identity issues arising among children and adolescents. While it was recognised that this raised many additional service and ethical issues, it was also stressed that issues of gender identity among children were arising within psychiatric practice and policy and provision for responding was undeveloped. Provision in this respect was clearly relevant to adult transsexual people, given that gender identity problems can arise very early in their lives.

6.3 The Health Concerns of Transsexual People in Ireland

In this study, the first of its kind undertaken in an Irish context, contact was made with 17 transsexual people in all, 15 male-to-female transsexual people and 2 female-to-male transsexual people. The majority of those contacted had begun questioning their gender identity before the age of 15 years old, often much earlier as small children. Yet most did not begin seeking help and support until they were in their thirties.

Barriers to accessing services and treatment highlighted by respondents included lack of accessible information on the condition and lack of knowledge among health professionals, including GPs who were often the first point of contact. In this context it often took respondents a great deal of time and anguish before they were able to access the services of the small number of health professionals in Ireland with some experience of their condition. Information on these services was often accessed through contacts with other transsexual people rather than through primary health care providers. Even then, as these health professionals are based in Dublin, geographic accessibility of their services was a significant issue for many.

Many respondents referred to great psychological distress, particularly when they received a hostile or uninformed response from a health service provider or where they accessed information that suggested the barriers to accessing treatment were substantial or insurmountable. This was particularly the case for respondents with limited resources and who depended on state aid in accessing the treatments they needed. On the other hand, where services were accessed that were considered appropriate to their needs respondents refer to great relief and improvement in their lives.

6.4 Recommendations

Analysis of the data collected for this study shows that transsexual health care is not well provided for in Irish health policy at present and that transsexual people encounter significant difficulties in accessing appropriate health care. It also indicates the importance of appropriate care and related support services for transsexual people and their families. The following recommendations are put forward to begin the process of addressing the gaps in health service provision for transsexual people identified through this research.

- The Department of Health and Children should develop a formal policy on transsexualism and develop broad standards of care and procedures for treatment in partnership with the relevant professional bodies including the Irish College of Psychiatrists, the Irish College of General Practitioners and the Royal College of Physicians in Ireland. Issues this policy should consider include, inter alia, the establishment of a specialist care team, the development of linkages and referral arrangements to services that cannot be provided in an Irish context and funding criteria for same and the provision of other services that could feasibly be delivered at local or regional level.
- The Department should also engage in partnership with transsexual people in identifying needs and barriers to service take-up and in developing policy and standards in this area.
- The relevant professional bodies should develop more detailed policies and standards of care for transsexual people relating to their respective professional areas and in relation to cross cutting issues including the need for health monitoring and referral along the services comprising the treatment path for transsexualism and the need for networking between relevant professionals. The feasibility of establishing a network of GPs equipped to provide initial support, onward referral and possibly ongoing hormonal therapy could usefully be examined in this context.

- In relation to transsexual people and their needs, provision should be made by the professional bodies for professional development and training taking into account the agreed standards of care and procedures for service delivery. In line with national policy development the Health Service Executive should develop strategies for meeting the health care needs of transsexual people that encompass professional training and development on the issue, the identification of services that can be provided at health board level, formal referral paths and the provision of accessible information on services and criteria for accessing them.
- The Health Service Executive and health service providers should review and/or design their policies and practices in relation to transsexual people to ensure that there is no discrimination under the Equal Status Acts 2000 to 2004 and to ensure that they effectively promote equality for transsexual people.
- Health service providers should implement effective information strategies on transsexualism and on service paths and how these can be accessed. Such strategies should include provision for the information needs of families and friends of transsexual people.
- Consultation and partnership with transsexual people will be vital to the development of policies and practices by health authorities and professional bodies that will effectively meet the needs of transsexual people. It should be a feature of the implementation of all the above recommendations.



GLOSSARY

Endocrinology: Endocrinology is the diagnosis and treatment of disorders of internal (endocrine) glands and diseases such as diabetes, metabolic and nutritional disorders, or pituitary, menstrual and sexual problems.

Gender: Gender refers to the person's own self-identity as a male, female or something else. The overwhelming majority of the population have a gender that accords with their anatomical sex. Gender is less clearly defined than anatomical sex. Gender consists of two related aspects: *Gender Identity*, which is the person's internal perception and experience of their gender, and *Gender Role*, which is the way that the person lives in society and interacts with others, based on their gender identity.

Gender Dysphoria: Gender dysphoria is an umbrella term covering a feeling of unhappiness and incongruity concerning one's physical sex assigned at birth and/or gender role. This covers a range of feelings, from a general sense of discontentment with the socially expected role, through certain forms of gender-motivated transvestism (dressing as the 'opposite' sex to alleviate this dysphoria), through to full-scale transsexualism (with an overwhelming desire to change one's body and genitals, and to actually become, as far as medically possible, the other sex) (The Looking Glass Society, 1998). The term *gender dysphoria* is most applicable to individuals in the beginning stages of transition. Once an individual has self-identified transition goals or has established a self-defined transgender identity, she or he is no longer considered to be gender dysphoric (Israel and Tarver, 1997).

Gender Identity: Gender identity refers to an individual's innate sense of maleness (masculinity) or femaleness (femininity), or both, as well as how those feelings and needs are internalised and how they are presented to others (Israel & Tarver, 1997). It refers to those characteristics that are linked to an individual's intrinsic sense of self that is based on attributes reflected in the person's psychological, behavioural and/or cognitive state. (Ontario Human Right Commission, 1999).

Intersex: Intersex or Hermaphroditism is a very rare condition in which the persons genitals are neither clearly male nor clearly female.

MTF and FTM: MTF and FTM refer to 'male-to-female' or 'female-to-male' transition. These acronyms identify the direction of transition, or which established identity a person has chosen.

Psychotherapy: A form of therapy in which a trained professional uses methods based on psychological theories to help a person with psychological problems.

Real Life Experience (or Real Life Test): Real life experience or test is the term used to describe the period from the time a transsexual individual begins living in the role of the opposite gender to the time he or she has been doing so long enough to be considered an appropriate candidate for genital reassignment surgery. This experience is required under the Harry Benjamin Internal Gender Dysphoria Association Standards of Care (2001).

Sex: Sex refers to someone's anatomical sex as determined at birth by their genitalia.

Transvestism: Very commonly confused with transsexuals, transvestites lack the overwhelming need to change their physical sex characteristics that characterises transsexuals. Transvestites feel a need to dress as the opposite sex from time to time, but have no wish to change sex.

Transgender: Transgender is an umbrella term which includes people of various gender identities and presentations including Intersex people, those who cross dress without any desire for permanent or significant gender change, 'drag queens' and 'drag kings'. While some transsexual people have self-identified as transgender in this respect, others have emphasised the very distinctive aspect of transsexual identity and the specific goal of living permanently in a new gender role (Ontario Human Right Commission, 1999).

Transsexual: Transsexual people have a desire to live and be accepted as members of the opposite gender, usually accompanied by a sense of discomfort with, or inappropriateness of, their anatomic gender and a wish to have hormonal treatment and surgery to make their body's as congruent as possible with the preferred gender (World Health Organisation, 1992). Put simply, a transsexual is a person whose gender (psychological sex) is opposite to their physiological sex (Looking Glass, 1992).



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Q.7b Could you describe your experience of these initial supports?

Section 2: Use of and access to specific health services

Q.8a Which of the following services *have you used in the past, or are you currently using?*
(✓ all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Counselling/Therapy | <input type="checkbox"/> Psychiatric/Psychological Assessment |
| <input type="checkbox"/> Hormonal Treatments | <input type="checkbox"/> Electrolysis |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Surgical Interventions |
| <input type="checkbox"/> Cosmetic Surgical interventions | <input type="checkbox"/> Genital Reassignment Surgery |

Other (please state)

Q.8b How were you referred to these services (e.g. Self, GP, Psychiatrist, consultant etc.)?

Q.8c Where (city/town) were these services located?

Q.8d How has your access to these services *you have used or are using* been funded?

Q.9 Have you been refused funding at any point for any of the above treatments and services?
Could you outline the service(s) for which you were refused, the reasons for the refusal(s)
and the body/bodies (e.g Health Board, Health insurer) which actually refused.

Q.9b Did you challenge any refusals?

Q.9c If yes, how did you challenge the decision(s) and what has been the outcome?

Q.10 Please describe any barriers you faced in accessing the services you have used or are using.

Q.11 Could you say whether you found the services you have used or are using helpful or unhelpful, and why?

Q.12 Which of the following services are you likely to need in the future? (✓ all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Counselling/Therapy | <input type="checkbox"/> Psychiatric/Psychological Assessment |
| <input type="checkbox"/> Hormonal Treatments | <input type="checkbox"/> Electrolysis |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Surgical Interventions |
| <input type="checkbox"/> Cosmetic Surgical interventions | <input type="checkbox"/> Genital Reassignment Surgery |

Other (please state)

Section 3: Final Comments

Q.13 From your dealings with various services or from the perspective of your own needs and requirements, could you briefly outline what you think is *helpful and appropriate practice* in meeting the health needs of transsexual people?

Q.14 From the same perspective can you describe what you think is *unhelpful or inappropriate practice* in meeting the health needs of transsexual people?

Q.15 What was the impact of you having had access to services which you feel were appropriate to your needs as a transsexual person?

Q.16 What was the impact of you not having had access to services which you felt were appropriate to your needs as a transsexual person?

Q.17 Are there any further comments you would like to make?

Q.18 We would like the opportunity to follow up these questionnaires with a limited number of more in-depth personal interviews. Please indicate below if you would be willing to be interviewed.



ENDNOTES

1. In the UK for example, transsexualism is a widely recognised medical condition that the Government's Chief Medical Officer has confirmed may be properly treated under the National Health Service. There are five specialist centres catering for gender identity disorders in England. GPs and psychiatrist tend to refer patients to these clinics for expert diagnosis and, as appropriate, courses of counselling, hormone treatment and possible surgery (Department of Constitutional Affairs, 2003).
2. A condition whereby people born can be born with the (full or partial) sex organs of both genders or with underdeveloped or ambiguous sex organs. The word 'intersex' replaces the term 'hermaphrodite' (Ontario Human Rights Commission, 1999: 9).
3. Professionals from psychiatry, psychology, general medicine, including endocrine, and surgical specialities update the standards on a regular basis.
4. The ICTLEP guidelines which were developed and adopted over a two year period by the Health Law Project of the International Conference on Transgender Law and Employment Policy.
5. In addition to these centres for adults, specialist psychiatric and endocrinology services for children are provided at the Portman and Tavistock Clinic in London.
6. As noted by Press for Change, this report was clearly not intended for public consumption and its very existence is contentious, since it raises the question why a particular clinical procedure should have to be justified in ways and in terms that others are not. For all that, it is noted, the report is at least a start and, in a climate where too many UK health authorities have to refused to countenance treatment.

The Equality Authority
2 Clonmel Street
Dublin 2

Public Information Centre
Lo Call: 1890 245 545

Tel: (01) 417 3333
Business queries: (01) 417 3336
Text phone: (01) 417 3385
Fax: (01) 417 3331
Email: info@equality.ie
www.equality.ie



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