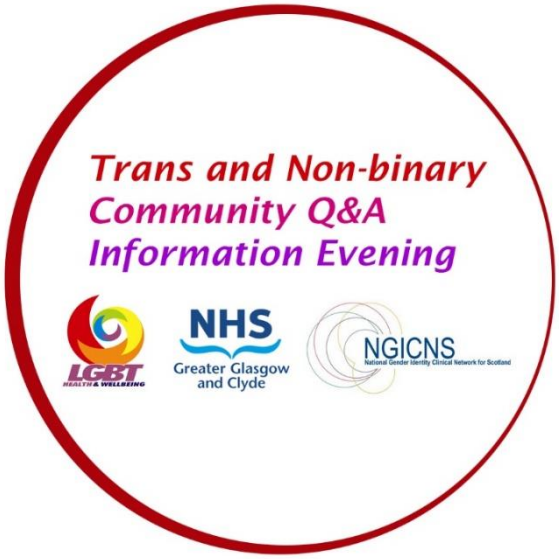

Trans and Non-binary Community Q&A Information Evening

The Albany, Woodlands, 11th May 2017, 6-8pm

Glasgow Trans Support Programme (GTSP), which is part of LGBT Health and Wellbeing, organised this event in partnership with the National Gender Identity Clinical Network Scotland (NGICNS). David Gerber who is Clinical Lead for Gender and Psychosexual Services at Sandyford and Biddy Ramsay who is a Speech and Language Therapist for NHS GG&C based at Stobhill sat on the panel. Aileen Ferguson attended from the NGICNS. Katrina Mitchell, Development Worker at GTSP and Matson Lawrence chaired the meeting; Tommy Nicito, Emma Cuthbertson and Angela-Mariana Aranghelovici attended from GTSP.

Most questions asked had been submitted in advance - these were collated into the broad topic areas. There was a small amount of time left for additional questions at the end. When submitting your question, there was the option to have your question asked anonymously, which many people requested, and those questions were asked by GTSP staff and volunteers. 25 people attended the event.

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Gender clinic general

QUESTION: How do you deal with the sensitive situation of under 18s seeking medical transition under an unsupportive family environment or even hostile family?

David Gerber: The young people's service would try to strengthen that person's resources, so suggest they get support from friends, maybe extended family members and also suggest third sector organisations for support. They'd discuss the hostile environment and how to manage that, if it's dangerous how to extricate themselves from that situation. It's very difficult for anyone if their family is unsupportive. We suggest family members go along to Transparentsees to see if they can learn from other parents' experiences.

Allison Ewing: Transparentsees is a support group for parents of trans people of any age. All parents are very welcome to come along on the first Thursday of month 6 – 7.45pm. Groups also run in Edinburgh, Perth and Elgin.

QUESTION: Why, if there is such an increase in caseload, are there no additional staff in post despite this situation prevailing for at least the last two years?

David Gerber: There are additional staff in post - we've employed 2 new additional psychologists for the adult service and 2 new psychologists in the young people's service, and an occupational therapist providing sessions to both services. There's changes in number of referrals which are always increasing. Another psychiatrist or gender specialist should be joining the team – this post will be advertised in the near future. Chalmers in Edinburgh is looking to expand their service too. Over the next few weeks Sandyford will have some waiting list initiatives on Saturdays so people who've been waiting a long time can get up the waiting list a bit.

QUESTION: There is no wrong way to perform or embody gender and I shouldn't have to justify my womanhood to a cis man in order to receive lifesaving medical care for my dysphoria. Why won't you switch to a patient consent model for access to gender services that doesn't rely on an outdated diagnosis?

David Gerber: I'm afraid the diagnosis is still there, it's still in the DSM5 (Diagnostic and Statistical Manual of Mental Disorders) which is the new classification system in America, and the diagnosis still remains in the ICD-11 (International Classification of Diseases) so it still requires a medical professional to make the diagnosis in accordance with the gender protocol for Scotland. I understand that a lot of people do think it's an outdated diagnosis and shouldn't be a diagnosis at all, unfortunately in the current nomenclature that we have across the world it's still seen as such.

QUESTION: I've heard that some psychiatrists do have issues with DSM in general, with bodies of psychiatrists in the UK possibly looking to use own criteria instead of referring to the DSM. Does the NHS support the use of the DSM as a whole or part of a set of other diagnostic tools used?

David Gerber: DSM isn't actually used in this country – ICD-11 is used in the UK and Europe, and the DSM is mostly used in the USA, but it does inform some decisions about other diagnoses across the world. Why don't we use an informed consent model? Because we're still reliant on a diagnosis to be made according to the NHS protocol for Scotland. Informed consent just means that you understand the treatment that you're going to be prescribed, so like any other medical condition you still require a diagnosis to be made before a treatment can be recommended. That then leads you onto having informed consent to understand that you're going to take that treatment.

QUESTION: That isn't how GPs work, they give you medication and refer you to counselling etc before diagnosis, or diagnosis is vague eg for anxiety and low mood you would get antidepressants. So it's ridiculous not to give hormones.

David Gerber: I disagree – GPs and all doctors will make a diagnosis before recommending a treatment and check that the person understands the treatment they've been prescribed, or a surgical treatment that they might be offered. That's informed consent.

Katrina Mitchell: Scottish Trans Alliance is the campaigning group for Scotland so if you think it's something that should be campaigned for in terms of changing the way things are done, you could get in touch with them.

QUESTION: Why can't there be a transgender doctor instead of a regular doctor? Why do transgender people get problems from regular doctors, they just don't seem to understand.

David Gerber: There certainly could be a transgender doctor - if they wished to apply for any of the posts advertised they'd be more than welcome to do so. We can't discriminate against cisgender doctors and say that they aren't able to care for trans people, so not a fair question in some respects. We would employ a transgender doctor if there was one but not just because they were trans. And why do trans people get problems from regular docs? Lots of research indicates that trans people do struggle to access medical care in different settings mostly due to a lack of understanding, but things are gradually changing, hopefully improving. Lots needs to be done though, for example informing medical students about trans issues. But with increased media coverage, the population as a whole is becoming less dicriminatory towards trans people.

QUESTION: What are you doing to help there be trans doctors, nurses and practitioners – how are you supporting trans people to enter these sectors? Trans levels of employment are poor so the NHS should be supporting trans people into these professions.

David Gerber: I think it starts before that – the NHS isn't responsible for people who apply to med school – that's reliant on universities, schools and parents and all sorts of things that result in people becoming medical professionals, so I don't think I have a huge role in facilitating that.

QUESTION: Many primary care providers are not aware of trans issues, and, often, it's up to us educate them. I think they should have a mandatory workshop for dealing with trans people, for example learning how bodies change with HRT, how to administer drugs / shots, how to read blood tests, issues connected with binding, and so on.

David Gerber: We've done quite a bit of work through the NGICNS about trying to engage with Primary Care through the Royal College of GPs – tomorrow we're doing a presentation at a GP educational event and we've done similar events over last few years. But as GPs cover so many different aspects of health that for them to be aware of semething that's seen as quite niche in terms of trans healthcare is difficult. Trying to get specialist areas into GP educational programmes is quite difficult but we are making some inroads into doing that.

QUESTION: There are questions we ask the GIC that we could be asking GPs.

David Gerber: There's a training module that GPs can access and it's part of their curriculum now, that they have to have some awareness, and General Medical Council (GMC) issued guidance about treating trans people but still some GPs are unaware of that. So I think unfortunately it's often up to trans people to raise those issues so GPs can become more aware, once you do that they will start to learn a bit more about it.

QUESTION: But why is it not mandatory – a workshop or similar?

David Gerber: It is part of their curriculum. I suppose if it was mandatory then hardly any practices would engage with the workshop meaning limited numbers of practices would be certified 'trans friendly', whereas what we should be aspiring to is for all GPs to be able to provide trans care. If you create some kind of restriction then the GPs probably won't engage in the training, then you'll only have a handful of certified ones, and you'll be travelling all over the

country to find primary care support. There is GMC guidance so if you're having difficulty with a GP you can mention that to them.

Katrina Mitchell: There's also the page on the NGICNS site for professionals which is good for referring GPs to.

QUESTION: Re GP database – is there a field for when first meeting a patient eg preferred pronoun and current gender / birth gender etc so new GPs can see that immediately on the front page so they don't have to read back through notes?

David Gerber: Not sure – think it's M / F / Other, but can check.

QUESTION: Why are patients of the Sandyford not given an agenda prior to each appointment to be properly prepared and best equipped to answer questions posed to them by the staff of the Sandyford relevant to the appointment that is notified to them?

David Gerber: Care is individualised and everybody's different and have different issues to talk about so we can't always predict what's going to happen in an appointment. If we were to do that for every single patient it would mean additional time preparing for that interview and we're already under-capacity and struggling, so we might aspire to that in the future but it would mean a lot of additional work on a hugely overstretched service at the moment.

QUESTION: It would be useful for folk before they go to their first appointment to have an idea of what to expect.

David Gerber: That's available on the website – guide to the protocol. (http://www.ngicns.scot.nhs.uk/wp-content/uploads/2016/04/NGICNS-Explanatory-Notes-for-GRP-v1-0-2.pdf page 4)

QUESTION: Do Sandyford tell patients about T-time, and if not, why not?

David Gerber: Yes we do!

QUESTION: Can you give counselling to my wife and if so how do I go about it - hopefully it will help her understand how I feel and also help her come to terms with things.

David Gerber: Your wife could get counselling at Sandyford, there's a gender counsellor for the adult team and the counselling service is just about to expand, so yes – just call the switchboard and ask, self-referral is fine. Does LGBT Health provide counselling just now?

Katrina Mitchell: I provide one to one support and information, a full counselling service will be starting in the summer. The centre in Edinburgh provides counselling currently.

QUESTION: Why doesn't the NHS provide binders for female to male people? They are quite expensive and, as far as I know, they provide wigs for trans women, so this would be fair. It's more dangerous to use the wrong binder than to use the wrong wig!

David Gerber: I imagine it's because there's a national wig contract, so the wigs for trans people naturally fits into that along with wigs for people with cancer. Binders are probably something that's unique to trans people. I think that's a good suggestion, it probably is fair - we can certainly take that away as an action and see if we can raise that with individual boards.

QUESTION: Binders are designed for cis men who suffer from man-boobs, and the trans community adopted them. They're not really designed for a more curvy figure which can be a problem when binding. To be able to bind safely is

really important, there's a lot of dangerous ways to bind – if you bind for too long it damages tissue which can create issues when you go for surgery. It's a big issue to access binders, we have to send to America or the far east, so to get them supplied by the NHS would be absolutely wonderful.

David Gerber: We can certainly look into that.

QUESTION: Why doesn't the NHS provide something for trans men which is equivalent to facial feminisation surgery for trans women? For example, it would be nice to have options such as male body contouring, provided in the US by Dr Garramone.

David Gerber: I haven't heard about it, must be fairly new, and not spoken widely about in the meetings I go to, but again, we can enquire about it and see if it's a possibility, it would seem equitable.

QUESTION: Can a person go for appointments with a private gender specialist and still stay on the waiting list for Sandyford? When they get their first appointment at Sandyford, can any care be transferred from a private specialist to Sandyford?

David Gerber: Yes.

Facial hair removal

QUESTION: Facial hair removal – why are we only getting a few sessions when it takes up to 400 hours to fully remove a beard? I still have to shave which is very frustrating and distressing. And why is there a postcode lottery for electrolysis – everyone should be treated equally.

David Gerber: It's because of funding – it would cost thousands for each individual person to fully remove facial hair. NGICNS is looking into that. I wanted to ask people about using a cream called Vaniqa which reduces and stops regrowth of hair. It only works on about 60% of people that use it, so people need to try it and see if it works for them. If not, they would have to move on to electrolysis or IPL but at least would give the option of an easier method and would give people some sense of control over facial hair. I'd be interested to hear people's opinions about that.

Woman: I tried it with limited success and it made my skin very tender.

David Gerber: It only works on proportion of people and we won't know who until they try it.

QUESTION: If the numbers in transition are now at the level that I think they are (1500?) then is there not an economic argument to be made for NHS boards to bring the service in house as Glasgow has done with its provision of laser hair removal, but to include electrolysis too - wouldn't that work out cheaper?

David Gerber: It would and the NHS hair removal specialists in post at the moment are able to do electrolysis, but it's more about time - it would take around 400 hours per person, but there's currently only one whole time equivalent hair removal specialist. So the hair removal service itself is overstretched and would need a huge expansion of the number of posts to be able to accommodate everyone. That's the reason there's different levels of funding across different boards – they have different financial pressures, so some can afford to offer 15 sessions or more and others can't or choose not to.

QUESTION: I've been looking into trying to do something that's non-profitable which could help people. Would Sandyford assist if we started up a private electrolysis clinic?

David Gerber: The health board currently uses About Face, but if there were other providers on the market that could undercut them then that would be a competitive tendering process that might be appealing to health boards.

QUESTION: Are you aware of a cross benefit analysis being done to invite the health boards to actively look at it?

David Gerber: There's currently a needs assessment of services for the trans community as a whole, being carried out by Public Health. It's looking at all the services and whether they're meeting needs because of the rise in referrals, looking at costs which will include all aspects of treatment – hormones, hair removal, speech and language therapy etc. So more information about that will hopefully come out of that piece of work.

QUESTION: What impact does current NHS policy have on the workload of the Sandyford Centre's staff? Does dealing with this matter consume a higher proportion of the Sandyford team's staff time than might be expected? As this is one of the first big steps that someone undergoing transition may take, do the Sandyford's staff spend significant time on letters and exceptional case funding applications in support of their patients' requests for funding for more than the 15 hours indicated in the NGICNS Guidance to Scottish Health Boards?

David Gerber: I do spend some time doing that, not a huge amount of time, but yes, obviously I could not be doing that.

QUESTION: Why was the limit for facial hair removal set at 15 hours? If the level was higher you wouldn't have to spend time on that admin.

David Gerber: I'm not sure of the exact reasons.

QUESTION: You mentioned research that's currently being carried out, does that mean that current treatment - ie the 15 hours - is set on the basis of no research, ie arbitrary figures?

David Gerber: I don't think it's plucked out of the air, it probably arose from a discussion with hair removal specialists who felt that 15 sessions of IPL which is what is offered would be sufficient to remove facial hair completely. Obviously that's not a permanent solution and IPL doesn't work on pale, ginger or grey hair, so that's the issue. But I think health boards have interpreted the electrolysis provision as being the same as the IPL standard, which isn't the same as electrolysis takes a lot longer.

QUESTION: Well we all know that, but why are the professionals choosing to hide behind a guideline? They're unshiftable on this.

David Gerber: Just before this meeting we had the NGICNS steering group meeting where this was raised and we will be writing out to health boards on this issue again, to separate IPL from electrolysis. But it's still open to boards to interpret that guidance however they choose – the NGICNS can only suggest things to boards, they don't necessarily have to accept our advice.

QUESTION: The current funding policy appears to underestimate the psychological impact of limited access to funding for hair removal. Speaking for myself this is not solely a cosmetic issue but a critical part of my transition and revealing my true self. I think part of the issue is that it's seen as cosmetic, ie not essential.

David Gerber: No it's not seen as just cosmetic.

QUESTION: So it's just a financial issue?

David Gerber: I think it probably is, yes.

QUESTION: Have you ever thought of asking Nicola Sturgeon about this? The government could put more money in towards this.

David Gerber: That's something that we can do through the network, there are routes to government, so yes we certainly can take that forward.

QUESTION: Got a letter from NHS A&A recently – the health board seems to be confused – is it communication, or funding?

David Gerber: I imagine that in health boards, the goalposts change as they review things and things get changed. In all the years I've been doing this, all boards change their policies regularly, so it's difficult to keep track, but that's just the nature of it when you're communicating with so many different people.

QUESTION: I've finished my allocation of hair removal, but still have some facial hair – can I access any more?

David Gerber: Talk to the person you're seeing at Sandyford so they can make a case for funding for further treatment – it's always worth asking.

Surgeries

QUESTION: Travelling to Manchester to see the surgeons for chest surgery is stressful, costly and time consuming for those who need this surgery. It involves in total at least four visits, including the operation itself and the post op visit. Are there any plans to hold some of these consultations at Sandyford, as is done for lower surgery consultations for trans masculine people?

David Gerber: Yes. We've met with the surgeon based at Manchester quite a few times now and there's just an issues about funding her visits to Sandyford as their board in England has some processes they need to go through before that can happen, but the plan is that she'll come up to Sandyford once a month to see people for pre-op and post-op assessments. This should hopefully start within the next year.

QUESTION: I've read that it's possible to go elsewhere for genital surgery outside of the UK. Why are there no options or information to better inform the GRS patients so that they can avail themselves of this option?
David Gerber: For NHS patients living in Scotland it isn't possible to go outwith the UK because NHS Scotland has got a national contract with the service in Brighton [and London].

QUESTION: Would the NHS not consider compiling a list of recommended private surgeons? It's a bit pot luck if you're travelling across the globe to find a reputable surgeon.

David Gerber: I think the NHS would be very reluctant to do that because they'd have to be assured that surgeons' governance mechanisms were in accord with UK standards. It would be too risky.

Allison Ewing (Transparentsees): I'm surprised to hear that an under 18 received sex reassignment surgery in Thailand privately as all the surgeons I know of there would not operate on a person under 18.

QUESTION: How come some people are offered FFS (facial feminisation surgery) and breast enlargement and others are not?

David Gerber: All surgeries and treatments are led by what the person in front of us wants. It's not incumbent on us to suggest things to people because that would perhaps be leading people to treatments that they don't necessarily need or want. So if you want to access those, there has to be some discussion with the person you're seeing for that to happen. Or this question could be referring to someone being denied surgery after seeing the surgeon which would be a different question?

QUESTION: It seems there is more red tape for trans women to get breast augmentation – is it seen as valid for a trans woman to need this or does the NHS think trans women are just trying to get a free boob job on the NHS?

David Gerber: This has changed very recently actually – it's one of the things that the NGICNS has been campaigning on for a while – to remove breast augmentation and other surgeries like FFS from the AEARP (adult exceptional aesthetic referral protocol pathway). It's been removed in the last month or so. It's not seen as cosmetic.

QUESTION: The recent promulgation of WPATH (revised) version 8 implies (eg) NHS funds will 'have to be found for FFS for those on the regular transition racetrack. Is there even a miniscule chance this 'nirvana' will become the norm / a reality within the UK?

David Gerber: I was interested in that question because I was not aware of WPATH8 or discussions about it so I googled it but couldn't find anything about WPATH8. However in Scotland we're quite lucky as we are able to access FFS whereas in most health authorities in England that's not available to people. So Scotland is kind of like a nirvana in that respect!

QUESTION: If you've transitioned a few years ago, can you re-enter the system to access FFS or breast augmentation, if so how?

David Gerber: Yes you can, just contact the Sandyford. You wouldn't be on the main Sandyford waiting list, although you'd still have to wait quite a while for the surgery.

QUESTION: How many people go through FFS in a year in Scotland?

David Gerber: Not sure, probably less than a hundred.

QUESTION: Why is the wait for FFS so long?

David Gerber: It's variable – a lot of that waiting list was created by the closure of two operating theatres at the QEUH, but I think that might have changed now. FFS has come out of the AEARP now so things will change.

QUESTION: I was assigned female at birth. I feel really bad because of my female body and don't want people to see me as a woman, but I don't identify as a man either. Would I get access to mastectomy and chest reconstruction? And is it possible to have this surgery without taking testosterone?

David Gerber: Yes. People can go through the normal clinical route.

QUESTION: How does that work when the surgeons insist on people being on testosterone before chest surgery?

David Gerber: I've spoken to the Manchester team about it, and they're seeing increasing numbers of referrals of non-binary people. The surgical team is happy to proceed with surgery without the person taking testosterone if that person has a positive recommendation for surgery from the gender clinic.

Voice

QUESTION: In speech services should there be any follow up of people who have accessed speech and language therapy in voice aftercare? You get so many sessions and after that you're just left, there's no follow-up really.

Biddy Ramsay: At the moment we're able to offer a total of about 12 sessions at NHS Greater Glasgow & Clyde (NHS GG&C). The format is often 4x4x4 individual sessions (4 sessions followed by a break, then the next 4 and a break before the final 4 sessions); or 6 individual sessions and then 6 in a group. But it depends on how the person is responding to treatment – sometimes people feel halfway through that it's not the best time for them, or they're not able to enter into all the practice needed, so they break away from it. They can be re-referred back later if they want. Typically, patients who have finished a course of speech and language therapy (SALT) have a wealth of exercises to go away and practice. Then take some time to use it and try and generalise the use of it outwith the clinic. If you're still struggling or needing further help, then ask for it, come back for a refresher. That's how it's managed in NHS GG&C.

QUESTION: I know, it can be quite intensive and the onus is on the patient to do all the work.

Biddy Ramsay: We work together but yes, there comes a point where you have to take that away from the clinic and use it yourself. And that's the hardest bit.

QUESTION: I know some people fly to Seoul to get their vocal chords altered, but I don't think the NHS would pay for that?

Biddy Ramsay: There was a spell when pitch surgery was quite popular but it has become less so now. I understand that there are some centres in England which may still provide it but it's non-core and not offered on the NHS in Scotland.

QUESTION: (from a woman) After an infection, my voice has deepened more than ever and I keep getting called Sir. I've had SRS but can I still access NHS voice therapy, if so how?

Biddy Ramsay: Absolutely. It's common for someone's voice quality to change during an infection, especially if there's lots of coughing which means that you will have been using your vocal cords more strenuously than usual and therefore your voice quality might change temporarily. If that persisted, visit your GP and they might refer you to ENT. During that time people can feel a loss of control of their voice and confidence in their voice, so we do see people whose voices have changed. They come for an assessment where we can discuss it and give them strategies and ways to manage their voice, so they don't develop bad habits when they have an infection. We can review their voice production technique and feminisation of their voice. So yes, refer either via Sandyford or your GP. If you've left SALT sessions but still want to make changes, call your SALT to request another review.

QUESTION: Could you tell us a bit about group voice therapy?

Biddy Ramsay: Group voice therapy (GVT) for trans women is available in different parts of the UK and typically is part of their voice therapy programme. Usually people have 6 to 8 individual sessions and then it might be considered appropriate for them to participate in group voice therapy. Like all groups it's not appropriate for everyone. GVT is considered a bridge – from changing your voice in a one to one situation and familiar situations, to using your modified voice in a group of strangers, and doing slightly more complex tasks. It's a voice practice group. The group can be quite social when it's finished but the actual hour that we spend together is voice skills work. We're currently running a pilot group which is the first one in Glasgow for trans women – it's at Stobhill with 6 people attending with two speech and language therapists once a month. It's been exciting. The aim is to build voice skills and confidence using a voice that matches your identity. We do vocal warm ups that cover resonance and pitch and intonation tasks. And we work in a group and with conversational partners and look at things like telephone voice, voice projection and assertive voice – how to be assertive and still maintain your modified voice, and vocal stamina. When people first start vocal

exercises, they can do it for about ten minutes or an hour, or maybe 3 hours before losing it. Depending on the success of the pilot group it may be that more will be offered in the city. We have to measure outcomes and prove that it's beneficial.

QUESTION: Is it possible for people living in other health board areas to access group voice therapy in Glasgow?

Biddy Ramsay: We haven't got that far yet – we need to wait and see whether this group is viable. Maybe discuss with your local SALT whether you both feel that GVT would be really helpful for you and if it's not available where you are, suggest it and see if they can set it up – definitely worth asking them.

QUESTION: Should trans men get voice therapy – what would it help me with?

Biddy Ramsay: From our experience in NHS GG&C SALT we have very very few referrals for trans men – part of the reason is because with hormone therapy, the vocal cords thicken and therefore the pitch drops and becomes more appropriate to the person's identity. If people are concerned, they can refer in – we can look at the male voice and communication styles and provide an assessment with a voice specialist who will give advice and feedback on voice quality. Anyone concerned about their voice can be referred for SALT.

QUESTION: For a lot of trans men and transmasculine non-binary folk, it's a long wait to get hormones, so guys are self-conscious about their voices. Also there's people who won't access hormones. If we were aware that this was something available to address this, word would get about the community. Maybe as people don't know it exists, no-one's thought of asking for it. Maybe you'll get a rush of trans men now – if you do, is there something prepared to help with their voices?

Biddy Ramsay: We can certainly assess your voice and take measurements to see what range your voice is in and offer suggestions based on those, yes.

QUESTION: That'd just be for those in NHS GG&C health board area though?

Biddy Ramsay: I'm sure it's available in other health boards too. SALTs are qualified to assess and treat any voice problem – in the case of trans men it would be about developing a voice that matches who you feel you are.

QUESTION: Can you clarify whether voice therapy is NHS funded for non-binary people whether they're trans-masculine, trans feminine, androgynous or trans men? It's never been presented as an option to me. I asked my GP and community mental health team if I could get SALT for other reasons and they said it doesn't exist for adults.

Biddy Ramsay: It's a discussion to have with your GP or Sandyford. If it's something you want, then you should be at least given a one off appointment with a SALT to see if that's something that would be helpful.

QUESTION: Can you self-refer to SALT?

Biddy Ramsay: Yes although our preference is that people have a diagnosis from a consultant or a referral from a GP, but we do have an open referral system. Phone up.

QUESTION: I just had one appointment with a voice therapist - she said my voice is fine, but I feel a bit uncomfortable because I have to use the phone at work, and I feel I still have a masculine voice whereas I was hoping I could make it sound a bit more feminine.

Biddy Ramsay: Call her and ask to have a session to work on particular issues like your telephone voice. I think you've got a nice voice. Remember voices come in all shapes and sizes, we don't all have the same voice. There's a wide range of feminine voices, and it's not always about the pitch – people describe folks' voices as being soft or light.

Hormones

QUESTION: Is there going to be stream-lining of issues with GPs issuing hormones and other treatments and ending confusion and delays? For example, repeat prescriptions are a problem for me, and a friend has had issues with their GP using their old name.

David Gerber: As discussed earlier, we've tried quite a bit of engagement with primary care, but it's difficult to get in. On the NGICNS website there's guidelines for primary care staff in relation to prescribing. The issues you describe are maybe in relation to people changing their CHI numbers, which is something that you do need to do so that you're identified correctly by your GP practice.

QUESTION: It happens all the time! I feel messed about.

David Gerber: It's about awareness raising amongst GPs. It shouldn't be down to you, but try and remind them. I don't know how I can make that any clearer in my communication with GPs. We do occasionally have problems with GPs refusing to prescribe, but we can deal with that. But the vast majority of GPs are really supportive of prescribing and monitoring hormonal treatments.

QUESTION: The Scottish guidelines state that bridging prescriptions and monitoring tests should be made available through GPs to people who're self-medicating, as part of a harm reduction model. Testimony from trans people across Scotland indicates that the availability of this is precarious at best. What is being done to fix that?

David Gerber: Again, it goes back to education, and also General Medical Council (GMC) guidance is clear about bridging prescriptions, although many GPs don't seem to be aware of that. They should be. If you or someone you know is having difficulties then I suggest they make their GP aware of that guidance. It's quite clear from every aspect of GP education and from medical management in this country that that should be happening, so it's just resistance on the part of individual practitioners.
(http://www.gmc-uk.org/guidance/28851.asp)

QUESTION: Once I start treatment do I have follow-ups for life? Are the appointments weekly or fortnightly?

David Gerber: Don't worry, it's definitely not as often as that. Once people have started on hormones, their follow up is usually after a few months. Then once you're on a stable dose where your blood levels are adequate, you usually stay on that dose and you just need a yearly check-up which is often done by your GP.

QUESTION: Would having Fragile X Syndrome affect the amount of hormones you can take?

David Gerber: No it shouldn't have any effect on the amount of hormones that you take. But everyone is different because everybody's metabolism is different and that's why people are on different doses of hormones.

QUESTION: In hormone treatment aftercare for postoperatively Male to Female transsexuals - should we receive in endocrine aftercare the hormone testosterone?

David Gerber: No, not unless you had issues with really low testosterone levels and lower sexual desire as a result, as testosterone is sometimes recommended in a low dose for people that have hypoactive sexual desire.

QUESTION: I've had to ask for testosterone, as after surgery testosterone drops too low causing a number of issues including dry skin, dry hair and lack of energy because the level of testosterone drops below usual female levels.

David Gerber: That's quite an unusual situation, but yes, in that situation testosterone might be indicated.

QUESTION: I feel they're too busy monitoring oestrogen levels and don't check other hormones in the body?

David Gerber: No, everyone should be having testosterone levels checked too, as part of their annual monitoring.

QUESTION: Last year we were promised that hormone blockers for trans kids would become available through local endocrinologists. Has this happened and how many patients have been able to access this?

David Gerber: I don't think it's happened across the country. I've written to all health boards across Scotland to ask them to identify a local endocrinology lead, but haven't had a complete response from all health boards. Some have said they aren't able to do that. A lot of endocrinological treatments for younger people has to be through central units in Edinburgh or Glasgow. I don't know what the numbers are.

QUESTION: A lot of parents who come to Transparentsees have noticed that the log-jam has been broken with children being seen sooner because of increased clinical staff at Sandyford Young Person's Gender Service. But they're reporting that there's possibly increased waits to see endocrinologists. Are there plans to expand the Glasgow paediatric endocrine service for the under 18s? (Q from Allison from Transparentsees)

David Gerber: I don't know if there have been any more endocrinologists appointed, I don't think so. There's two in post currently.

QUESTION: There is a lot of people being refused hormones because of weight / BMI. Why? My GIC doctor told me that there is no medical evidence to say that heavier people are more at risk because of their weight. In fact, being refused hormones for this reason puts the person more at risk of suicidal ideation, suicide and self-harming. What is the official stance on hormones and weight? Also, I am a heavier person, am nearly two years on hormones, and have had no problems whatsoever!

David Gerber: The main issue with weight is related to surgery because the surgeons have a very clear cut-off for when they're prepared to operate. This can particularly be a problem for trans men. So if a trans man had a really high BMI you can potentially be stuck in a difficult situation like having chest hair growth while still having to bind. If you have a very high BMI then breasts are larger and more difficult to hide, and it becomes a difficult position for the person to be in. We don't say absolutely no to hormones for a person with a high BMI but I think there has to be a degree of understanding which is about informed consent, about the person knowing that they're going to be stuck in this limbo position where they won't be able to access surgery until they've lost some weight. So not an absolute no-no, but we'd ideally like to see people make some effort to lose some weight so they're closer to that goal weight before they start on hormones. There's an element of motivation to achieve some weight loss.

QUESTION: There's a lot of confusion about BMI and what a higher BMI will affect in terms of hormone treatment and surgery. What you're saying should be up to the individual, or at least a discussion between them and the clinician. Lots of trans women are getting refused, and there seems to be a lack of continuity between clinicians. Hormones is such a big thing for everybody, so it would be nice if the goalposts were the same for everyone, instead of one person gets it, then another person who's lighter doesn't get it. Why?

David Gerber: You can be lighter than someone but your BMI can still be higher because it's a ratio – it doesn't necessarily relate to your weight specifically. So it's about BMI rather than weight. But yes, there should always be a discussion between the patient and the doctor about the risks involved.

QUESTION: Is there medical evidence to say that people with a higher BMI are more at risk from taking hormones?
David Gerber: Yes – for male to female transitions, for someone with a high BMI going onto oestrogen there's a higher risk of deep vein thrombosis and clotting problems. For people transitioning female to male, going on testosterone, there isn't really evidence to show that there's health risks associated with having a high BMI, apart from the risks of having a high BMI.

QUESTION: Most of us know what BMI is and know that it's not really a useful measure to look at individuals. I don't think you've given a clear answer about what range or number of BMI for feminising surgery is required.

David Gerber: The surgeon who performs male to female surgery also asks for a BMI of less than 30.

QUESTION: What number is it for hormones?

David Gerber: It's a discussion between the patient and the doctor so there's informed consent and they understand that they might not be able to access surgery until they've reached a BMI that'll enable them to do so, and knowing what the implications are of them living in that limbo position for a long period of time potentially.

QUESTION: My surgeon said that my BMI was high and I needed to lose some weight, but I have a heavy bone and muscle structure. Do I still need to get down to that lower level?

David Gerber: If that's what the surgeon's asking you to do, then yes, because if not, they won't do the procedure.

Additional questions

QUESTION: Given how many trans people are autistic, when are the gender team going to stop treating autistic and other neurodivergent people inappropriately and discriminatorily and get basic training in working with autistic people?

David Gerber: I don't know what the discriminatory practice is that the question's referring to.

QUESTION: Autistic and other neurodivergent people are getting inappropriate responses if they act in a way that's not neurotypical. Sandyford clinicians have an obsession with their autisticness and try and blame their transness on the autism which there is a narrative about which is nonsense, but it seems that clinicians have taken on this narrative. So when are clinicians going to get basic autistic training? Because it's needed.

David Gerber: Certainly all the clinicians at the Sandyford have had some basic training about autism.

Matson Lawrence: There's some research being done at the moment by academics in terms of looking at any links between autistic spectrum disorders and gender – there's certainly lots more conversations to be had around that.

QUESTION: In terms of moving from a private gender identity clinic to the Sandyford – how would a person do that? If they've got to the top of the Sandyford waiting list, what should they bring along to their first appointment?

David Gerber: If they've got their information from the private doctor they've been seeing, in terms of a report, or the treatment they've been given, that can be really helpful – just bring it along to the appointment.

QUESTION: In terms of the Sandyford Gender Clinic drop-in – if people are waiting for a first appointment, can they access the drop-in?

David Gerber: No, it's only for people who've already engaged with the service. You should really be using the drop-in once you've been started on hormones and had your mental health assessment, as mostly the psychologists are doing the first assessments now so once that's happened and you've seen the doctor who's prescribing then you can start using the drop-in.

QUESTION: Is there any scope to bring extra help to the admin side at Sandyford GIC?

David Gerber: Yes there's interviews on Monday actually!

Many thanks to David Gerber, Biddy Ramsay, Aileen Ferguson, Matson Lawrence, Tommy Nicito, Emma Cuthbertson, Angela-Mariana Aranghelovici, and all the attendees. Summary written up by Katrina Mitchell.

Feedback

It was really informative! Really good range of topics covered.

Good night, really useful

Found it helpful, all my questions answered. Good discussion

Very good, well structured & organised

Good, informative, welcoming

Lots of interesting questions. Felt okay although I have social anxiety. Thank you for this event.

Brilliant and helpful. Was good to get a chance to ask the questions of professionals, that we ask amongst ourselves.