NHS Coventry
NHS Warwickshire

Policy Statement	Gender Dysphoria – Policy and referral guidelines
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Policy

NHS Coventry and NHS Warwickshire commission services for people with gender dysphoria.

This document provides the care pathway and approval process in a descriptive format and diagrammatically, which the PCTs within the cluster will follow.

CARE PATHWAY AND APPROVAL PROCESSES

1. At the GP Surgery

1.1 GPs will refer individuals to a local consultant psychiatrist for assessment and diagnosis of Gender Identity Disorder or trans-sexualism (Appendix A). It is important to consider and treat any relevant remediable mental or physical health problems which may affect the reliability of the diagnosis.

1.2 On diagnosis, a referral to the Gender Identity Service, or Specialist Child/Adolescent Gender Identity Unit (hereafter called Gender Identity Services) will be made, following PCT approval. It is recommended that children under the age of 18 years are seen by a Specialist service. Preferred providers are the Charing Cross Clinic, West London Mental Health NHS Trust (surgery at Hammersmith Hospital, Imperial College Healthcare NHS Trust or University Hospitals Leicester), Nottinghamshire Healthcare NHS Trust Gender Clinic, and the Gender Identity Service at Tavistock and Portman NHS Foundation Trust (for children and young people under the age of 18 years).

2. Local PCT Approval

2.1 The GP and local psychiatrist will be expected to advise the PCT whether a referral to Gender Identity Services is advisable, based on their assessment of the patient. The following criteria for referral need to be met:

Inclusions

- Individuals with an initial diagnosis of transsexualism or Gender Identity Disorder.
- The transsexual identity has been present persistently for at least two years.
- Individuals with written support from their GP to ensure future compliance with shared care arrangements.

Exclusions

- Patients who have an active acute psychotic disorder or acute mental illness.
- The disorder is a symptom of another mental disorder.
- Patients with untreated alcoholism and/or other addictions.
- Patients with organic brain disease including dementia.
- Children aged under 16 years who do not have parental consent and are not Gillick competent (according to the Fraser guidelines). Parental consent in all children aged under 18 years is desired.

2.2 If the PCT approve the referral this will be an agreement to commission from the range of approved therapies and surgical procedures detailed in Appendix B. (if appropriate and medically supported by the specialist providers), including (for adults only) any referral that may eventually be made for gender reassignment surgery, although the PCT will need to be notified when referral for surgery is made, with information about how criteria for surgery have been met. This will be detailed in the PCT approval letter.

2.3 Following approval, the PCT will request the local GP and psychiatrist/approved specialist to proceed with the referral to the Gender Identity Services. The approval will be forwarded to the afore-mentioned services.

3. Gender Identity Service Actions

3.1 On receipt of the referral the Gender Identity Services will check they have received formal approval from the PCT to proceed with the assessment.

4. Initial Assessment

4.1 The initial assessment period at the tertiary centre involves diagnostic assessment of the person (including the patient's history of and current experience of gender dysphoria), counselling, general medical examination, psychological and appropriate blood tests.

5. Treatments

5.1 Once the initial assessment has been completed and where it has been resolved that the person wishes to continue with a change of gender they will be considered for treatment. The typical triadic pathway for adults consists of hormonal treatment, real-life experience and genital reassignment surgery. Treatment should be provided in order of their potential to be reversed, as well as according to specific individual needs. Psychological support, Speech and Language therapy and routine pre and post-op care, where appropriate, will be provided by the Gender Identity Service or through routine services commissioned by the PCTs. Please see Appendix B for a list of routinely funded treatments and procedures. For children under 18 years of age, hormone blocking therapy after puberty may be recommended and psychological support should be provided by the Gender Identity Service (any other treatment need to be considered by the PCTs as part of the Individual Funding process).

6. Hormone treatment

6.1 The Gender Identity Service will provide the services of an endocrinologist to advise on hormone treatment for adults. Treatment will then be monitored on an ongoing basis by the

endocrinologist in liason with the GP. Lifestyle advice regarding the greater risk posed by obesity, smoking, illicit drugs or excessive alcohol in combination with hormone treatment will be given. The health risks associated with hormone therapy need to be fully explained to individuals. Initiation and monitoring of hormonal treatment should be conducted as per European guidelines.[1] Hormone blocking therapy may be recommended by the Gender Identity Service following full pubertal development for children and young people under the age of 18 years. Fertility options should be discussed with both adults and children prior to hormone therapy or hormone blocking therapy respectively.

7. Real Life Experience (RLE)

7.1 The RLE will be 12- 24 months (or longer) of living continuously in the gender role with which the individual identifies. The aim is to assist the patient and the professionals in decisions about how to proceed. There will be circumstances where the RLE may need to be extended. The reasons for this must be discussed with the individual.

7.2 The quality of the RLE is assessed through discussions about the patient's ability to consolidate their gender role in areas such as employment, voluntary work, education or training, or some other stable social and domestic lifestyle; including formal adoption of a gender appropriate first name and demonstration that society is aware that they are living in their new role. There may be occasions when clinicians request verifiable documentation or evidence of the gender change.

8. Genital Reassignment Surgery (GRS)

8.1 Some adults may not wish to progress all the way to complete surgical reassignment and there should be flexibility in the progression from one stage to another.

8.2 Some individuals may prefer lifelong hormone therapy unless contraindicated.

8.3 If gender reassignment surgery is recommended (routinely funded procedures detailed in Appendix B), the Gender Identity Service will ensure that it is recommended by two consultant psychiatrists and inform the PCT that the following criteria are met:

- The patient is aged 18 years or over.
- Surgery is recommended by two psychiatrists.
- The patient must be registered on the list of NHS patients of a GP practice with which either PCT holds a contract.
- The transsexual identity must have persisted for at least two years.

[1] The Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society Clinical Practice Guideline: commentary from a European perspective. European Journal of Endocrinology. 2010; 162(5):831-3.

• The disorder should not be a symptom of any other mental disorder or chromosomal abnormality which would affect the validity of the diagnosis.
• Patients should complete 12-24 months successful continuous full-time real life experience (or possibly longer) in their chosen gender role.
• Patients should have found employment, or been in education or training, in their desired gender role for a minimum period of one year, including employment in the voluntary sector.
• Patients should have continued with an established course of hormone Therapy, usually for at least 12 months
• Patients should have changed their name legally to one appropriate to the transgendered self.
• Patients should have a demonstrable knowledge of the required lengths of hospitalisations, likely complications and post-surgical rehabilitation requirements of the various surgical interventions.

8.4 The Gender Identity Service will refer an individual to a specialist centre for reassignment surgery.

8.5 Following receipt of the referral from the Gender Identity Service the specialist centre for reassignment surgery will check approval status with the PCT to proceed with the surgery.

8.6 Routine pre and post-op care will be provided, as well as appropriate follow up with the Gender Identity Service. The individual will then normally be referred back to the GP and/or local acute and/or mental health services if needed. Reversal operations will not be funded.

9. Other treatments and ongoing care

9.1 The Gender Identity Services will provide psychological support throughout the process for both adults and children, including support and advice on style/image. If psychological support for parents/partners/family members is required, this will be through the usual community routes.

9.2 Speech and Language therapy will be provided for adults by the Gender Identity Services or by services routinely commissioned by the PCTs, at an appropriate time during the course of treatment, if deemed appropriate.

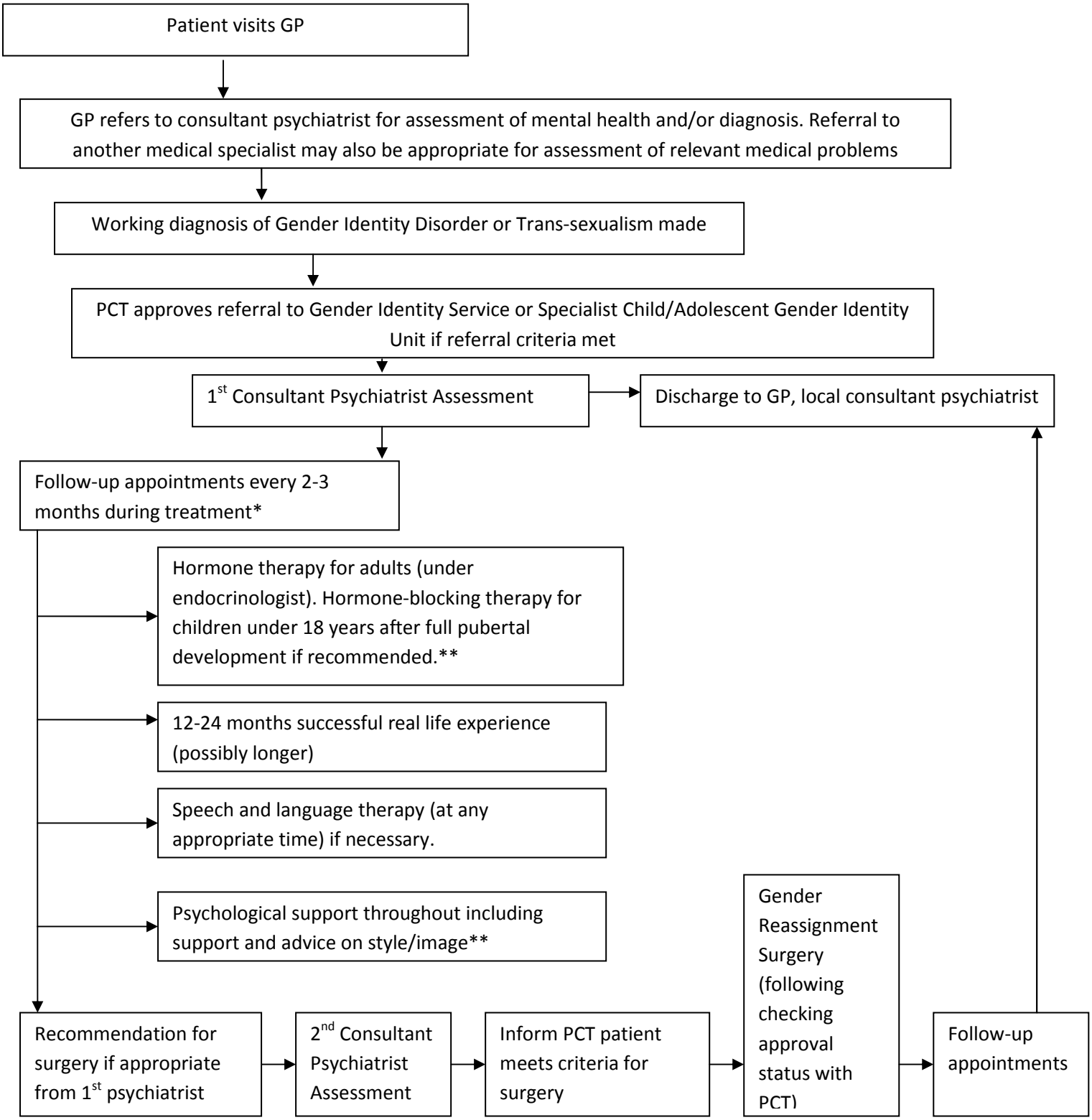
9.3 With regard to ongoing care, physical examinations and screening tests should be offered to patients on the basis of the organs present rather than their perceived gender. See Department of Health guidance Appendix D.10 and D.11 for discussion of appropriate screening.[2] Additional recommendations regarding screening are taken from Canadian Guidance.[3] With regard to breast and cervical cancer screening, female to male patients following chest surgery should

[2] Department of Health. Guidance for GPs, other clinicians and health professionals on the care of gender variant people [Internet]. 2008a [cited 2011 Apr 21]. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084919

[3] Feldman JL, Goldberg J. Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia [Internet]. 2006 [cited 2011 Apr 26]. Available from: http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-primcare.pdf

have annual chest wall and axillary exams, along with education regarding the small but possible risk of breast cancer.[2] Screening mammography is recommended as for natal females in female to male patients who have not undergone chest surgery. If there is prior history of high-grade cervical dysplasia or cervical cancer in female to male individuals, an annual smear of the vaginal cuff until 3 normal tests are documented should be taken, and then continue with screening as recommended for natal females.

Care Pathway Diagram



* Treatments: hormones, real-life experience, surgery. Order dependent on individual needs of patient. Not all stages are necessary. Psychological support throughout and speech and language therapy at any appropriate time.

** Of all available treatments, only these therapies are routinely funded for children and young people under the age of 18.

Literature and Policy review

Methodology

A scoping search was performed using the Google search engine to identify recently (since 2009) updated PCT/specialised commissioning group policies regarding gender dysphoria, as well as key guidance documents. The outcomes of a recent legal case AC vs. Berkshire West PCT (Mills and Reeve, 2011) were noted and an evidence review undertaken by Bazian regarding Gender Reassignment Surgery was obtained with the permission of the authors. A further scoping search was conducted in NHS Evidence to identify relevant articles and documents pertaining to gender identity disorder treatment and any associated cost effectiveness analyses.

A search for review and systematic review papers regarding therapies and surgical procedures for Gender Identity Disorder was undertaken in the Cochrane Database, NHS Centre for Reviews and Dissemination, NHS Evidence, as well as in Medline (the latter was limited to articles published between 2005 and 2010). A further search was conducted in Medline to identify any controlled studies, or any other relevant studies if no controlled studies or reviews were identified for a particular treatment. Relevant studies published since review search dates were also identified. Finally, a search was conducted in the same database to identify any cost-effectiveness analyses available (to supplement the scoping search mentioned above).

The following search terms were used: gender dysphoria, gender identity disorder, gender variance, transsexual, transgender, gender incongruence. MeSH headings and wildcards were used where appropriate. These terms were used in combination with the terms “treatment”, “cost”, as well as the names of individual therapies (and appropriate synonyms).

Main findings

Epidemiology

The worldwide prevalence of trans-sexualism is 1 in 11,500 population, with a prevalence of 1 in 12500 reported in Scotland (Department of Health, 2008 c). It is thought that there are approximately 5000 trans-sexual individual in the UK currently and approximately 1000 individuals who seek treatment annually (Meads and Pennant, 2009). Eight hundred adults and 50 children are referred each year to one of the ten Gender Identity Clinics in the UK (Department of Health, 2008b). There are a greater proportion of male to female (transfemales) than female to male (transmales) trans-sexuals, with a ratio of between 3:1 and 4:1.

Hormonal therapy

A recent meta-analysis conducted by Murad et al (2010) concluded that: *"very low quality evidence suggests that sex reassignment that includes hormonal interventions in individuals with GID likely improves gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life."* Significant improvements were noted relating to each of these outcomes, although the possibility of confounded effects remains, and the outcomes were self-reported. The authors highlighted the lack of controlled studies in this area. European Guidelines are available regarding hormone therapy in trans-sexual individuals (The Endocrine Society, 2009). No other controlled or other relevant studies were identified.

Real-life experience

The real-life experience relates to the change of gender roles, and an opportunity for individuals to see how comfortable they feel socially in their new role. Individuals will need to have successfully adopted their new role for a period of 12-24 months prior to being considered for genital reassignment surgery (RCPsych, 2006; Department of Health, 2008a). There is a degree of discordance in the guidelines regarding whether hormonal treatment should be initiated prior to undertaking the real-life experience or at some point during the real-life experience (The Harry Benjamin International Gender Dysphoria Association, 2001; Department of Health, 2008a). However, flexibility is recommended and the importance of therapies being initiated in order of reversibility is highlighted, as well as the imperative to focus on the needs of the individual.

Genital Reassignment Surgery

In January 2010, Bazian conducted a systematic evidence review of the literature regarding Genital Reassignment Surgery (GRS) for the purposes of a Court of appeal legal challenge to a funding decision made by NHS Berkshire West (Mills and Reeve, 2011). They concluded that: *"As this is an emerging area of enquiry for gender identity research, few patients have been studied and the non-comparative study designs mean that, at present, this evidence is not adequate, in our view, to be used to inform policy. This field of research should be encouraged and funded on a national level so that in future commissioning decisions can be based on higher level evidence."* (Bazian, 2010). High satisfaction rates with GRS were noted, consistent with previous reviews. Given the limitations of the evidence base, it could not be used to define procedures which should or should not be funded by PCTs, *although "the division of procedures into those that have quality of life data and those that do not broadly aligns with the current division into those procedures that are currently funded by Berkshire West PCT (under agreed preconditions) and those that are not routinely funded."* However, on the specific issue of breast augmentation in trans-females (the focus of the legal challenge), the evidence base was noted to be particularly weak. No cost-effectiveness studies were identified by Bazian.

A further non-systematic review article regarding all forms of therapy for Gender Identity Disorder concluded that*: "although several studies have shown amelioration of gender dysphoria and improvements in social and sexual functioning in transsexuals who have undergone sex reassignment, none have conclusively demonstrated that medical interventions resolve gender dysphoria"* (Gooren, 2011). One further study published subsequently to the Bazian report and not included in the latter review was identified, which demonstrated improved quality of life outcomes in a group of 247 surveyed transgender females who had undergone GRS, facial feminisation surgery, or both, compared to those who had not had surgery. There were, however, no significant differences between these groups (Ainsworth and Spiegel, 2010). This relatively large study contributes to the evidence base regarding the potential effectiveness of genital reassignment surgery, but does not fundamentally alter the conclusions of the Bazian report or subsequent review identified.

Speech and Language Therapy and Phonosurgery

A non-systematic review published by McNeill (2006) suggests: *"speech and language therapy is successful at creating an acceptable fundamental frequency in transgender patients, as well as influencing other communication behaviours. Laryngeal surgery, such as cricothyroid approximation, has an important role in raising the fundamental frequency in those who do not achieve acceptable voice via non-surgical means. There is little information on patient satisfaction and quality of life measures."* These conclusions were reached on the basis of review of a number of case series studies. Further case series published since this review provide evidence of satisfaction with speech therapy results (Carew and Dacakis, 2007) and further evidence of successful voice pitch alteration (Van Borsel and Van Eynde, 2008). This evidence does not change the conclusions of the review presented. It was not possible to access one further identified review of phonosurgery (Spiegel, 2006).

Psychotherapy

There is minimal high quality literature about the effectiveness of psychotherapy for transsexualism, although it is recommended in current UK (RCPsych, 2006; Department of Health, 2008) and international guidance (The Harry Benjamin International Gender Dysphoria Association, 2001), as of importance throughout the therapeutic process.

Aesthetic therapies/procedures

Evidence identified for laryngeal chondroplasty, rhinoplasty, facial feminisation surgery in general and hair removal is limited to case series studies suggesting good anatomical results (Asscheeman and Gooren , 1989; Wolfort and Degerine, 1990; Schroeter and Groenewegen , 2003; Noureai and Randhawa, 2007) or reported patient satisfaction with the result (Becking and Tuinzing, 1996; Hage and Vossen, 1997).

Children and Adolescents

Pre-pubertal children with gender dypshoria are unlikely to become gender dysphoric adults (Wren, 2000; Department of Health, 2008a). However the reverse is true for adolescents. Surgical procedures are not routinely funded for children under the age of 18 years, and although hormonal blocking therapy during puberty is used as a form of treatment, the main child/adolescent Gender Identity Unit in the UK would not consider this therapy until after puberty, due to concerns about suppression of development (Department of Health, 2008b). It is recommended that children and young people under the age of 18 years are seen by a specialist unit (Wren 2000; Department of Health, 2008a; Department of Health, 2008b). The importance of informed consent is highlighted.

Cost

No cost effectiveness analyses were found relating to any of the above-mentioned treatments. However, the East Midlands Specialised Commissioning Group (EMSCG) policy (2009) reports that: "outpatient attendances currently cost £500 for the service…. patients requiring on average 4 appointments a year (depending on the level of support);… the cost of male to female GRS, depending upon the procedures… is approximately £12,000. Female to male GRS costs between £20,000 and £60,000 depending on [specifics of surgery]." Based on an audit carried out in 2007, the EMSCG plan for commissioning referral to Gender Identity Services and subsequent treatment at a rate of 2 per 100,000 per year initially. Crude estimates of costs for NHS Coventry based on these costings and national and international epidemiological evidence are provided in a separate document.

Conclusions

The policy described is based on the strength of research evidence related to the effectiveness and cost effectiveness of interventions, alongside national and international guidance (as far as this is supported by the literature and/or clinically appropriate) and a review of PCT and Specialised Commissioning Group policies. The evidence does not support grouping of interventions into those which should be routinely funded on the NHS and those which are not, mainly because the evidence base for most of the treatments presented is not of sufficient quality to firmly guide policy. Therefore, the decisions regarding treatments which should be routinely funded, and those which should not be, is based upon the relative strength of the evidence base for each of the treatments, consistency with other institutional policies (e.g. aesthetic surgery) and other NHS policies, and in the light of the legal rights of trans-sexual individuals to have access to medical treatment and recent legal case law.

References

Ainsworth TA, Spiegel JH. Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. Quality of Life Research. 2010; 19(7):1019-24.

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th edition. 2000 [cited 2011 Apr 21]. Available from: http://www.psychiatryonline.com/DSMPDF/dsm-iv.pdf.

Asscheman H, Gooren LJ, Peereboom-Wynia JD. Reduction in undesired sexual hair growth with anandron in male-to-female transsexuals--experiences with a novel androgen receptor blocker. Clinical & Experimental Dermatology. 1989; 14(5):361-3.

Bazian. Gender reassignment surgery for the treatment of gender dysphoria in adults: an update of the Priorities Support Unit review (66/2009). A report for NHS Berkshire West. 2010 (permission needed from Bazian to access report).

Becking AG, Tuinzing DB, Hage JJ, Gooren LJ. Facial corrections in male to female transsexuals: a preliminary report on 16 patients. Journal of Oral & Maxillofacial Surgery. 1996; 54(4):413-8; discussion 419.

Carew L, Dacakis G, Oates J. The effectiveness of oral resonance therapy on the perception of femininity of voice in male-to-female transsexuals. Journal of Voice. 2007;21(5):591-603

Department of Health. Guidance for GPs, other clinicians and health professionals on the care of gender variant people [Internet]. 2008a [cited 2011 Apr 21]. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084919

Department of Health. Medical care for gender variant children and young people: answering families' questions [Intenet]. 2008b [cited 2011 Apr 21]. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_082954.pdf

Department of Health. Trans: A Practical Guide for the NHS [Internet]. 2008c [cited 2011 Apr 21]. Available from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_089939.pdf

East Midland Specialised Commissioning Group. Policy on the provision of Gender Dysphoria services for adults [Internet]. 2009 [cited 2011 Apr 21]. Available from: http://www.emscg.nhs.uk/Library/EMSCGGenderDysphoriapolicyP030v1.pdf

Feldman JL, Goldberg J. Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia [Internet]. 2006 [cited 2011 Apr 26]. Available from: http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-primcare.pdf

Gooren LJ. Clinical practice. Care of transsexual persons. New England Journal of Medicine. 2011; 364(13):1251-7, 2011 Mar 31.

Hage JJ, Vossen M, Becking AG. Rhinoplasty as part of gender-confirming surgery in male transsexuals: basic considerations and clinical experience. Annals of Plastic Surgery. 1997; 39(3):266-71.

McNeill EJ. Management of the transgender voice. Journal of Laryngology & Otology. 2006; 120(7):521-3

Meads C,Pennan M, McManus J, Bayliss S.A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research [Internet]. 2009 [cited 2011 Apr 21]. Available from: http://www.rep.bham.ac.uk/2009/LGBT_health_03.04.09_final_version.pdf

Mills and Reeve. AC v Berkshire West PCT in the Court of Appeal: the latest word on priorities - March 2011 [Internet]. 2011 [cited 2011 Apr 21]. Available from: http://www.mills-reeve.com/ac-v-berkshire-west-pct-in-the-court-of-appeal-the-latest-word-on-priorities---march-2011-03-22-2011/

Möller B, Schreier H, Li A, Romer G. Gender identity disorder in children and adolescents. Curr Probl Pediatr Adolesc Health Care. 2009;39(5):115-6.

Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A, Erwin PJ et al. Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. Clinical Endocrinology. 2010; 72(2):214-31.

NHS Confederation. Priority Setting: Legal Considerations [Internet]. 2008 [cited 2011 Apr 21]. Available from: http://www.nhsconfed.org/Publications/Documents/Priority%20setting%20legal%20considerations.pdf

NHS Dudley. Interim Commissioning Policy and Referral Guidelines for Gender Dysphoria Services and Gender Reassignment Surgery In Adults [Internet]. 2010 [cited 2011 Apr 21]. Available from: http://www.nhsdudley.nhs.uk/sections/publications/documents%5CFOI30634341839.pdf

NHS North West London. Gender Dysphoria [Internet]. 2011 [cited 2011 Apr 21]. Available from: http://www.westminster.nhs.uk/English/about-us/northwestlondon/about-us/Documents/30%20-%20Gender%20Dysphoria.pdf

Noureai SA, Randhawa P, Andrews PJ, Saleh HA. The role of nasal feminization rhinoplasty in male-to-female gender reassignment. Archives of Facial Plastic Surgery. 2007; 9(5):318-20

Parliamentary Forum on Transsexualism. Guidelines For Health Organisations. Commissioning Treatment Services For Individuals Experiencing Gender Dysphoria And Transsexualism [Internet]. 2005 [cited 2011 Apr 21]. Available from: http://www.sct.nhs.uk/_documentbank/Parlimentary_Forum_Guidelines_for_Health_Organisations_Commissioning.pdf

Royal College of Psychiatrists. Draft Good Practice Guidelines for the Assessment and Treatment of Gender Dysphoria [Internet]. 2006 [cited 2011 Apr 21]. Available from: http://www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf

Schroeter CA, Groenewegen JS, Reineke T. Neumann HA. Ninety percent permanent hair reduction in transsexual patients. Annals of Plastic Surgery. 2003; 51(3):243-8.

South Central Priorities Committee (Berkshire PCTs). Policy Statement 4b: Gender Reassignment Surgery for the Treatment of Gender Dysphoria in Adults [Internet]. 2009 [cited 2011 Apr 21]. Available from: http://www.berkshire.nhs.uk/priorities/_admin/policy-up/_policies/BPC-policy-4b-Gender-Reassignment-Surgery.pdf

Spiegel JH. Phonosurgery for pitch alteration: feminization and masculinization of the voice. Otolaryngologic Clinics of North America. 2006; 39(1):77-86

The Endocrine Society. Endocrine treatment of transsexual persons: an Endocrine Society Clinical Practice Guideline: commentary from a European perspective. European Journal of Endocrinology. 2010; 162(5):831-3.

The Harry Benjamin International Gender Dysphoria Association. Standards Of Care For Gender Identity Disorders, Sixth Version [Internet]. 2001 [cited 2011 Apr 21]. Available from: http://www.wpath.org/Documents2/socv6.pdf

Tugnet N, Goddard JC, Vickery RM, Khoosal D, Terry TR. Current management of male to female gender identity disorder in the UK. Postgrad Med J [Internet]. 2007 [cited 2011 Apr 21]; 83(984): 638–642. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600127/

Van Borsel J, Van Eynde E, De Cuypere G, Bonte K. Feminine after cricothyroid approximation? Journal of Voice. 2008;22(3):379-84.

Wolfort FG, Dejerine ES, Ramos DJ, Parry RG. Chondrolaryngoplasty for appearance. Plastic & Reconstructive Surgery. 1990;86(3):464-9; discussion 470.

World Health Organization. International Statistical Classification of Diseases, version 10 [Internet]. 2007 [cited 2011 Apr 21]. Available from: www.who.int/classifications/apps/icd/icd10online

Wren B. Early Physical Intervention for Young People with Atypical Gender Identity Development. Clinical Child Psychology and Psychiatry. 2000; 5(2): 220-231.

Yorkshire and Humber Specialised Commissioning Group. Policy on the provision of Gender Dysphoria Services (adults) [Internet]. 2009 [cited 2011 Apr 21]. Available from: http://www.yhscg.nhs.uk/Policy/Final%20Gender%20dysphoria%20policy%20Oct%2009.doc

Appendix A: Terminology and diagnostic classifications

The International Statistical Classification of Diseases (ICD-10), published by the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) offer the following diagnostic criteria:[4]

Gender Identity Disorder (DSM-IV) is a condition in which there is:
"A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
C. The disturbance is not concurrent with a physical intersex condition.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning."

Please see additional DSM criteria for children.

Transsexualism (ICD-10) is experienced when there is:
"a desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex and a wish to have hormonal treatment and surgery to make one's body as congruent as possible with the preferred sex".

The condition may be diagnosed when: *"the transsexual identity has been present persistently for at least two years"*.[5]

The above two classifications describe the same state. The term "gender dysphoria or "gender variance" is used to describe the *"experience of dissonance between the sex appearance, and the personal sense of being male or female*".[6,7]

[4] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th edition. 2000 [cited 2011 Apr 21]. Available from: http://www.psychiatryonline.com/DSMPDF/dsm-iv.pdf.
[5] World Health Organization. International Statistical Classification of Diseases, version 10 [Internet]. 2007 [cited 2011 Apr 21]. Available from: www.who.int/classifications/apps/icd/icd10online
[6] Royal College of Psychiatrists. Draft Good Practice Guidelines for the Assessment and Treatment of Gender Dysphoria [Internet]. 2006 [cited 2011 Apr 21]. Available from: http://www.rcpsych.ac.uk/pdf/Standards%20of%20Care%20Draft%20v8%203b%20final.pdf
[7] Department of Health. Guidance for GPs, other clinicians and health professionals on the care of gender variant people [Internet]. 2008a [cited 2011 Apr 21]. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084919

Appendix B: Routinely funded therapies and surgical procedures

ADULTS

Routinely funded non-surgical treatments

Hormone treatment – managed by the Gender Identity Service and monitored by the service and GP.

Psychological support/therapy including support and advice on style/image – provided by the Gender Identity Service, including regular follow-ups where necessary

Speech and Language therapy – provided through outpatient Speech and Language therapists or through Gender Identity Service

Routine pre- and post-operative medical care.

Routinely funded surgical treatments

For trans-females

Penectomy
Orchidectomy
Vaginoplasty
Clitoroplasty
Labiaplasty
Donor site hair removal on surgeon's recommendation

For trans-males

Mastectomy
Hysterectomy
Vaginectomy
Salpingo-oopherectomy
Metoidoplasty or Phalloplasty
Urethroplasty
Scrotoplasty and placement of testicular prostheses
Penile prosthesis
Donor site hair removal on surgeon's recommendation

NOT routinely funded treatments/procedures

Aesthetic surgery and other procedures including (but not limited to), breast augmentation surgery, larynx reshaping, thyroid cartilage shaving, rhinoplasty, jaw reduction, blepharoplasty, other facial feminisation surgical procedures, hair removal (apart from that defined above – please also refer to the PCTs' Hirsutism policy) , waist liposuction, buttock enhancement, etc. are not routinely funded as part of gender reassignment surgery. Gamete storage is not routinely funded, although fertility issues need to be discussed with individuals as specified in the policy.

Many of the procedures listed above as not routinely funded are covered by other NHS Coventry and NHS Warwickshire commissioning policies, which should be referred to. Clinicians who feel their patients have exceptional circumstances which might make them an exception to this policy or other relevant PCT policies should be considered as part of the Individual Funding Request process.

Reversal operations will not be funded.

CHILDREN AND YOUNG PEOPLE

Treatment services for children and young people (aged under 18 years) with gender dysphoria should be well integrated with adult services. Whilst few pre-pubertal children with gender dysphoria become gender dysphoric adults, young people with gender dysphoria are very likely to need access to adult services,. Cases deemed to require treatments not outlined below should be considered as part of the Individual Funding request process.

Providing children meet the referral criteria, NHS Coventry and NHS Warwickshire will fund:

- GP support and liaison;
- referral to specialist child/adolescent gender identity unit;
- referral to endocrinologist for hormone blocking AFTER full pubertal development, if recommended by Gender Identity unit
- psychological support services.