Prescribing in the Gender Identity Development Service (GIDS), the treatment pathway and associated controversies

Paul Carruthers – Lead Nurse for GIDS, children's weight management and endocrinology

LGBT+ staff chair for LTHT

GIDS Gender Identity Development Service

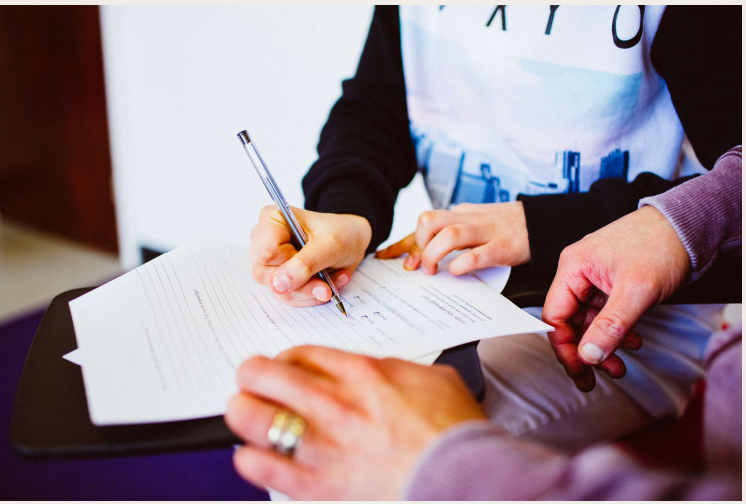
The Tavistock and Portman NHS
NHS Foundation Trust

Aims for today's session

- To give an introduction to the Gender Identity Development Service;
- To think about gender identity in relation to your workplace
- To discuss and share ideas and experiences with one another
- An overview of prescribing in GIDS
- An overview of the treatment pathway

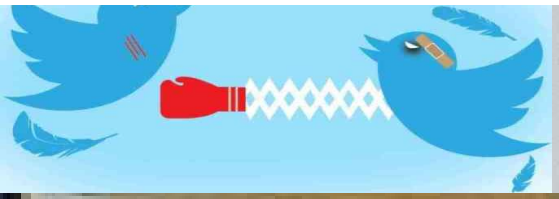
Making the most of today and feeling safe to explore dilemmas

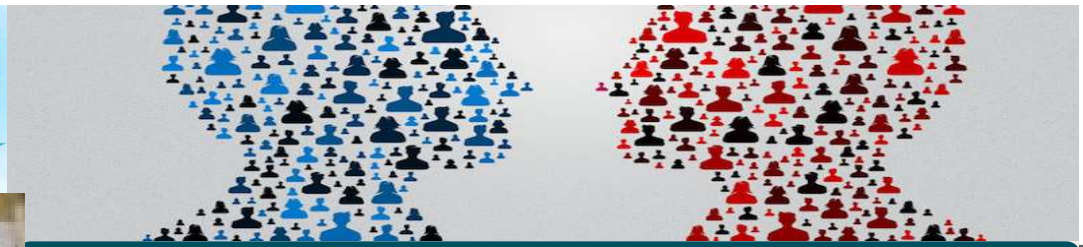
- Please take risks and ask questions
- Assume good intentions
- Allow each other room for curiosity and mistakes
- Do respectfully challenge one another
- Look after yourself and others too – our discussions may affect us all in different ways, gender can be a charged and emotive topic;



I ask that you please do not take photographs, record or tweet about this event.

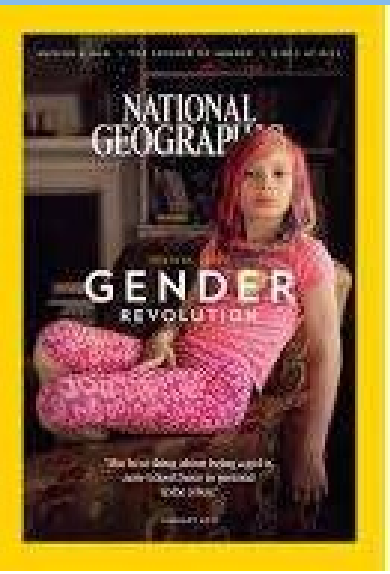
GIDS Gender Identity Development Service

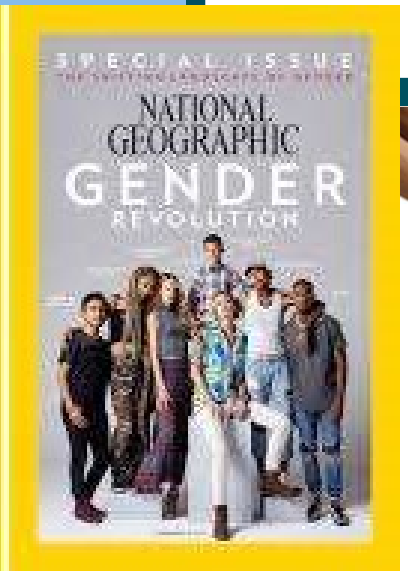




Gender Critical

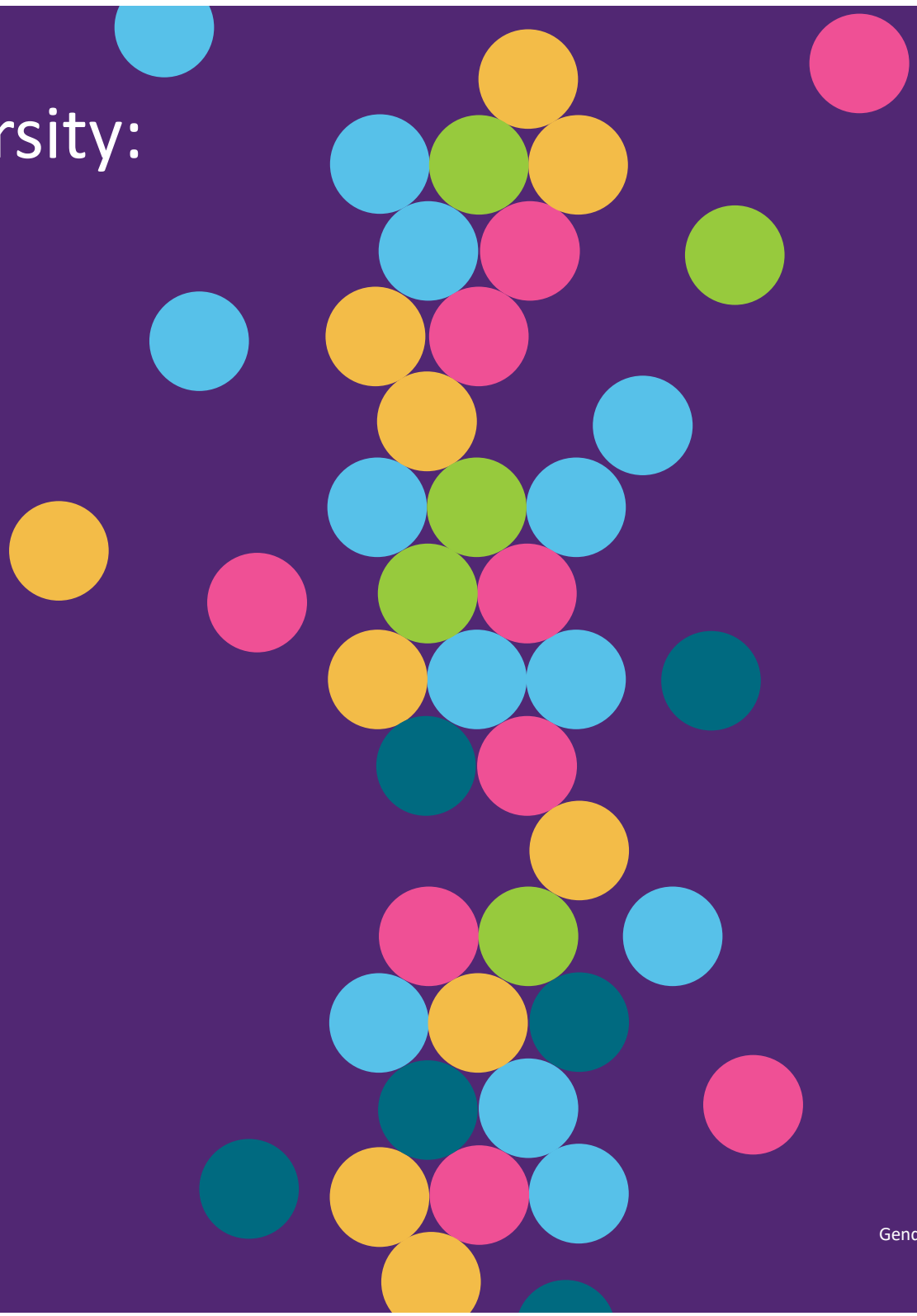
This is a highly contested and very polarised issue where the politics and arguments of adults often gets confused when considering the needs of children.





GIDS Gender Identity Development Service

Gender diversity:
Terminology



GIDS Gender Identity Development Service

Gender expression - Beyond the binary

GIDS Gender Identity Development Service

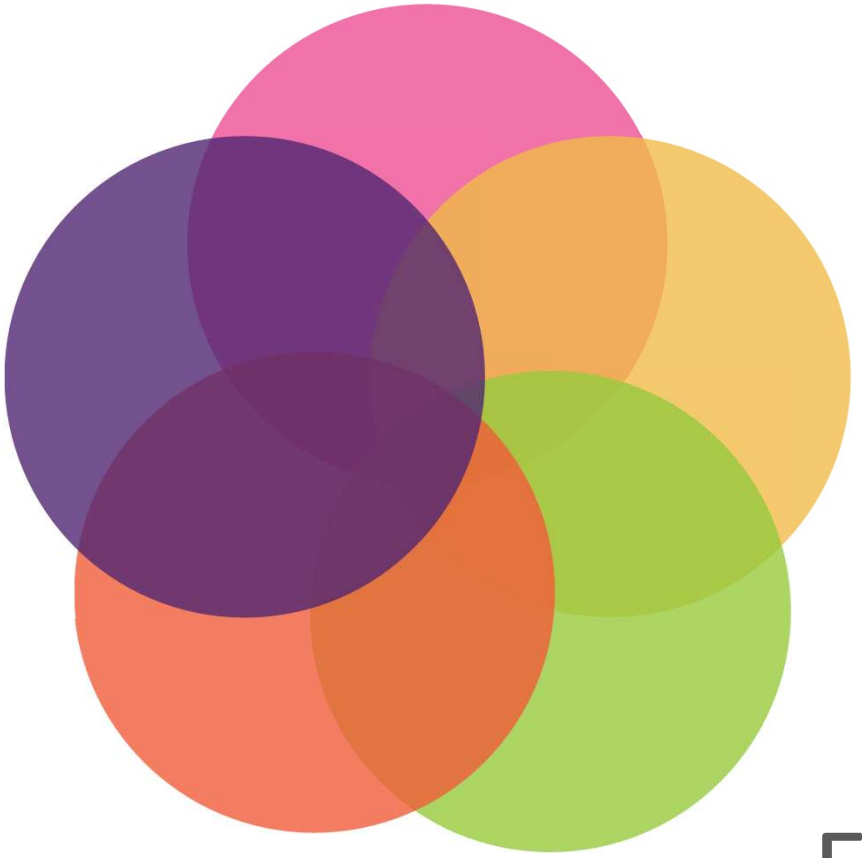
Terminology

- Pronouns – he/she/they/their
- Natal/Assigned at birth
- Trans male/female
- Cisgendered
- Gender Queer
- Gender fluid
- Agender/non - binary

Concepts

Biological Sex

Sexual Identity



Gender Identity

Gender Role

Gender Expression

GIDS Gender Identity Development Service

Normativity

❖ Heteronormativity:

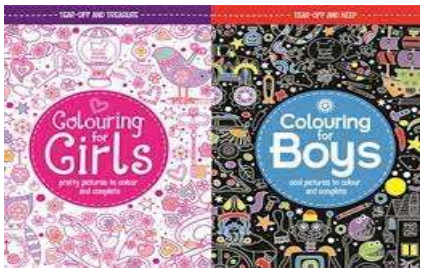
- Culture and assumption that heterosexuality is default, preferred and ‘normal’ mode of sexual orientation
- Social institutions and policies reinforce the presumption that people are heterosexual and that gender and sex are natural binaries
- Fosters a climate where LGBTQ+ individuals are discriminated against

❖ Cisgenderism:

- An ideological system that casts cisgenderism as superior to trans identities
- Belief or assumption that cis people’s gender identities, expressions and embodiments are more natural and legitimate than those of trans people

Gender in context of young people

- Toilets
- PE lessons
- Sports teams
- Schools (e.g. girls schools and boys schools)
- Shops sections



GIDS Gender Identity Development Service

Activity: formulating our own gender identities

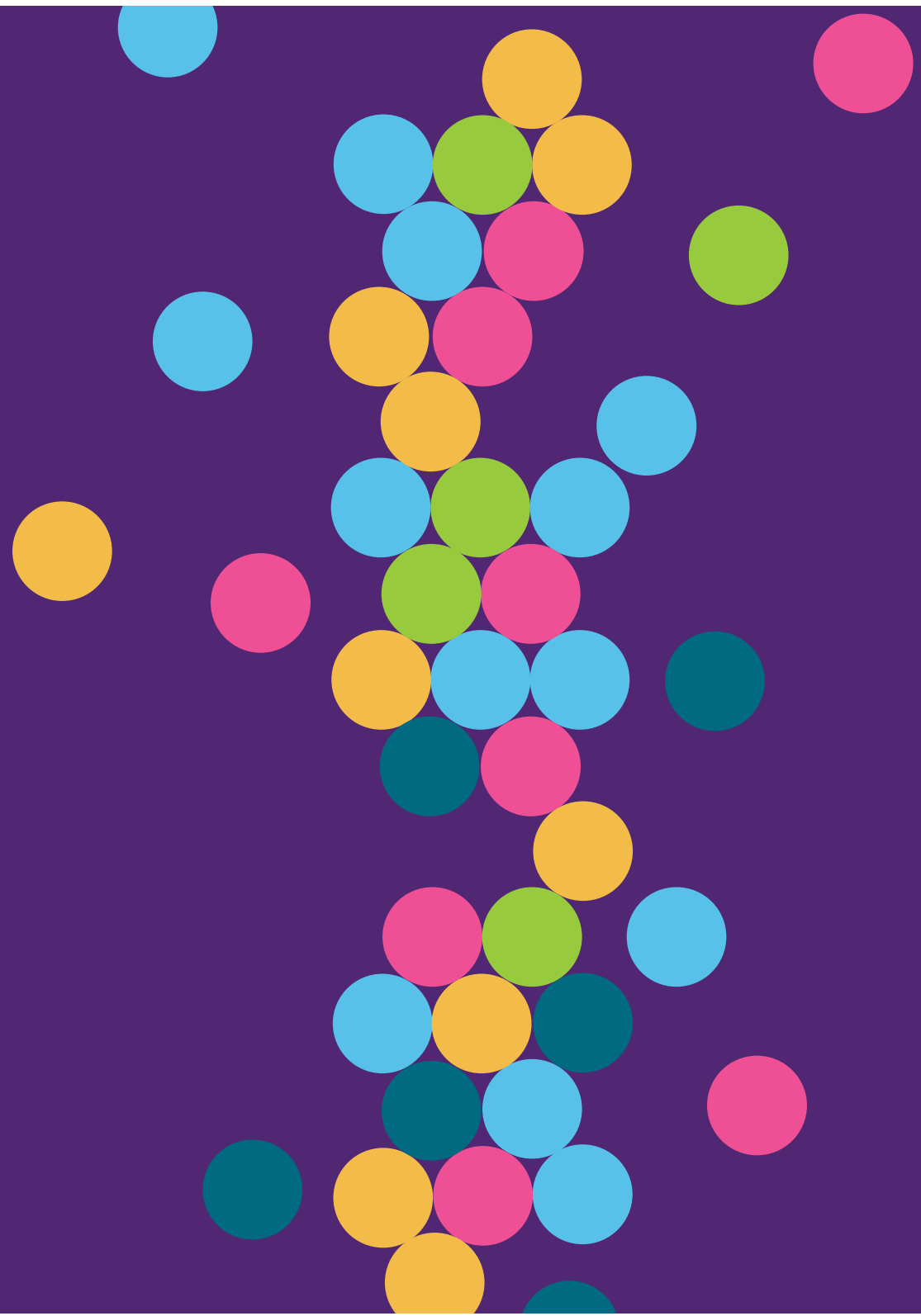
GIDS Gender Identity Development Service

Formulating our own gender identities

(sharing only what you are comfortable with)

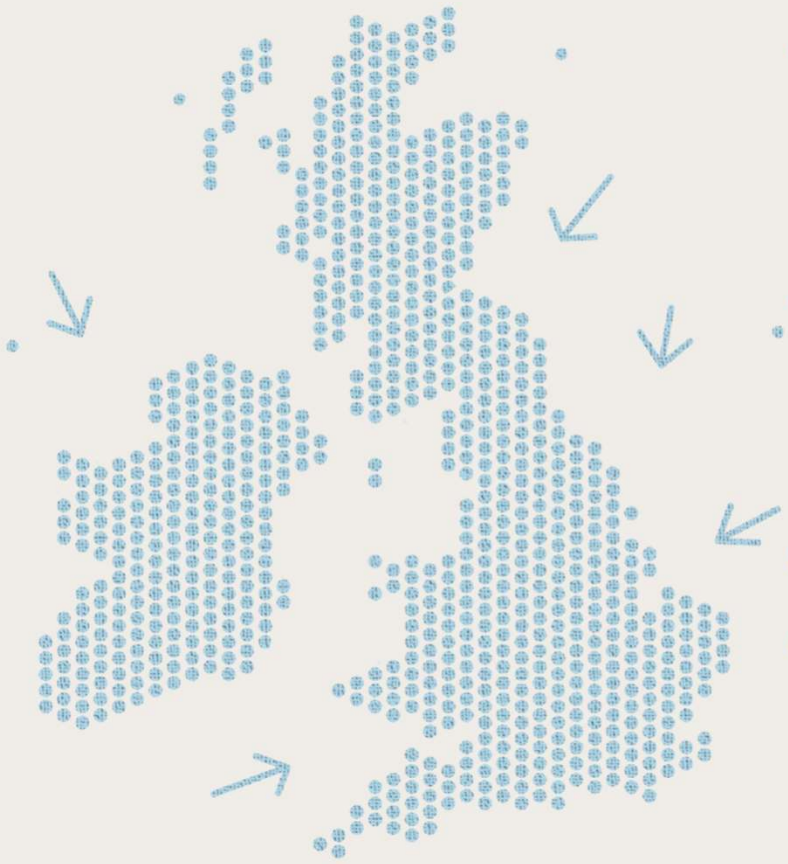
- What is your current gender identity?
- When are you at your most masculine/feminine/agender etc.?
- At what point did you realise you were male, female, gender fluid, gender queer, etc.?
- Do you think it will change? And how do you know?
- How has your gender impacted your behaviour / life choices?
- How has it impacted how you understand others' identities?

GIDS
Introduction



GIDS Gender Identity Development Service

An introduction to our service

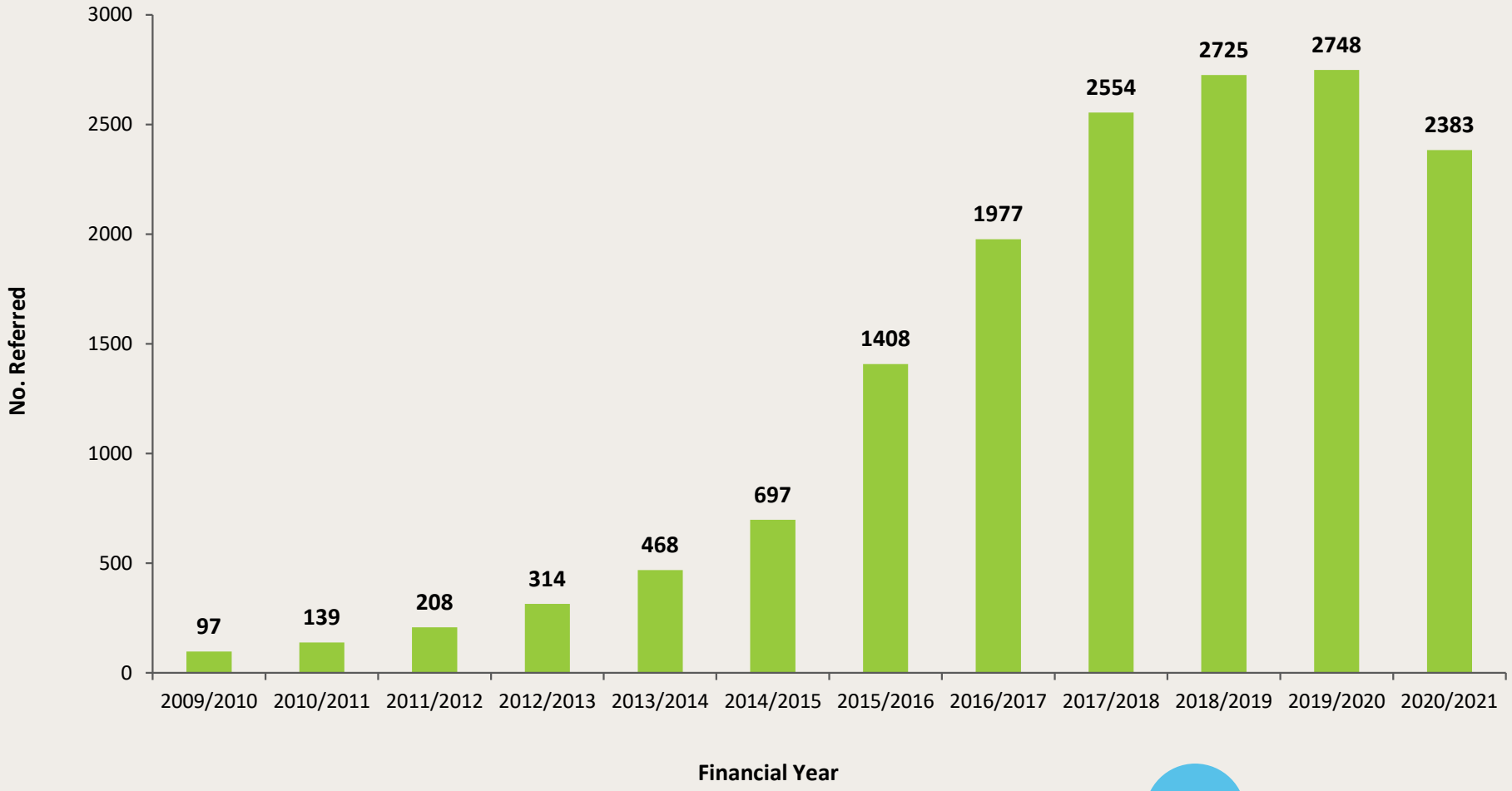


- Established in 1989
- Main bases in London and Leeds, with outreach bases in Birmingham and Bristol
- Children and young people up until the age of 18, experiencing pressing gender identity issues
- Operate a Network Model
- Multi-disciplinary team – psychologists, family therapists, social workers, nurse specialists, psychiatry, child psychotherapists…

GIDS Gender Identity Development Service

Rapid increase in referral rate to GIDS since 2009

Total referrals 1989/90 – 2020/21



GIDS Gender Identity Development Service

How do we work – initial stages

- Work with the whole family
- Families seen by pairs of clinicians
- All contact begins with a therapeutic assessment or work with the network
- Assessments take place over a minimum of 3 to 6 sessions, (most require more), it is tailored to the individuals needs and lasts a number of months (sometimes a year or more)

GIDS Gender Identity Development Service

How do we work - post-assessment

- Some discharged after assessment back to local services
- Some young people referred to other services for support e.g. CAMHS
- Ongoing exploration around identity and gender identity
- Ongoing psychosocial support provided post-assessment in the form of individual work, family work, and consultation to the network
- Some young people referred to endocrinology for physical intervention
- Ongoing discussions for young people accessing medical interventions re: fertility, sexuality, relationships etc.
- Some supported to transition to adult services

Staged model of physical intervention

Assessment

- Holistic psychosocial assessment
- GIDS MDT

Referral to endo process

- **Under 16s** - Multi Disciplinary Clinical Review (MDCR), Multi-professional Review Group.
- **16-17** - GIDS MDT, GIDS Endo MDT (16+GEM)

Blockers

- Hypothalamic blockers possible from Tanner stage 2
- Early intervention (e.g. below age 15)

Gender affirming hormones

- Gender affirming hormones at 16y, if on blocker for at least 12 months
- Partially irreversible, incl. impact upon fertility.

Surgery

- Surgery available only within adult services in NHS
- Early intervention may affect later surgical options

GIDS Gender Identity Development Service

Staged model of medical intervention

- GIDS operates a joint endocrine clinic at UCLH in London and Leeds Children's Hospital.
- All young people have to have started puberty (Tanner Stage 2) and have to complete psycho-social and medical assessment
- First physical intervention considered is hormone blocker, for those young people for whom significant levels of distress is impairing functioning
- Gender affirming hormones considered around 16 and in line with certain criteria – a further assessment is done at that point.

Endocrine Referral

Education session - Nurse Led

- Original model of care was not in the young person or families best interests
- Strong public health agenda
- Informed decision making process
- Options for treatment
- Fertility preservation
- Smoking cessation
- Bone health
- Vitamin D supplementation
- Adult services

GIDS Gender Identity Development Service

Leeds Children's Hospital NHS

First consultant appointment

- GnRH Analogues/hormone blockers – Gonapeptyl initiated
- Prescribing?!
- Reviewed every 6 months

Reversible Treatment

GIDS Gender Identity Development Service

The Tavistock and Portman NHS NHS Foundation Trust
University College London Hospitals NHS NHS Foundation Trust

GIDS Gender Identity Development Service

NHS The Leeds Teaching Hospitals NHS Trust

National Gender Identity Development Service For Children and Adolescents: Hormone therapy schedule

This schedule provides a staged approach towards medical treatment for young people within the GIDS service. Each treatment change should be preceded by individual preparation by the Tavistock clinicians followed by a MDT discussion. Fully informed consent must be taken before treatments are initiated. Generally GnRH analogues (GnRHa) can be initiated once puberty has commenced. Gender affirming hormones are only to be prescribed from around 16 years of age irrespective of the age at starting GnRH analogues.

---

1. GnRHa

GNRH analogues			
Preparations	**Dose**	**Method**	**Frequency**
Gonapeptyl	3.75mg	Intramuscular	28 days
Decapeptyl	11.25mg	Intramuscular	10 weekly

Generally start with Gonapeptyl given every 28 days. After 3 injections can change to Decapeptyl at 10 weekly intervals if requested by patient, more convenient for young person or incomplete suppression clinically or biochemically
Monitoring: Clinical review every 6 months, bloods for LH, FSH, testosterone and oestradiol

---

2. Oestrogen (male to female / trans female) (Generally continue GnRHa throughout)

Step number	Oestrogen (increased every 6 months)			
	Preparations	**Dose**	**Method**	**Frequency**
1	Estradiol Valerate	1mg	Oral	Once a day
2	Estradiol Valerate	2mg	Oral	Once a day
3	Estradiol Valerate	3mg	Oral	Once a day
4	Estradiol Valerate	4mg	Oral	Once a day
5	Estradiol Valerate	5mg	Oral	Once a day
6	Estradiol Valerate	6mg	Oral	Once a day

- **Estradiol Valerate**: tablets strength: 1mg and 2mg available: Maximum dose: 6mg/day
- Can titrate by 1-2mg at 6 monthly intervals (depending upon clinical response & oestradiol levels)
- Aim for young adult female levels of 400 - 600pmol/L when on established adult doses

OR

Step number	Evorel patch (17B-oestradiol matrix patch) (increased every 6 months)			
	Patch Preparation	**Dose**	**Method**	**Frequency**
1	Evorel (⅓ of 25mcg patch)	12.5mcg	patch	Changed every 3-4 days
2	Evorel (1 x 25mcg)	25mcg	patch	Changed every 3-4 days
3	Evorel (1 x 50mcg)	50mcg	patch	Changed every 3-4 days
4	Evorel (25 + 50mcg)	75mcg	patch	Changed every 3-4 days
5	Evorel (2 x 50mcg)	100mcg	patch	Changed every 3-4 days

- **Evorel patch**: 25mcg and 50mcg patch available
- Maximum dose: 100mcg
- Aim for young adult levels of 400 - 600pmol/L when on established adult doses
- Combined progestagen patches (e.g. Evorel Combi/Sequi) are not required.
- Aim for young adult female levels of 400 - 600pmol/L when on established doses

3. Testosterone (female to male / trans male)

Step number	Testosterone injection (increased every 6 months)			
	Preparations	Dose	Method	Frequency
1	Sustanon	100mg (0.4mls)	intramuscular	Every 4 weeks
2	Sustanon	200mg (0.8mls)	intramuscular	Every 4 weeks
3	Sustanon	250mg (1ml)	intramuscular	Every 4 weeks
4	Sustanon	250mg (1ml)	intramuscular	Every 3 weeks

- **Sustanon:** Can be given concomitantly with GnRHa.
- Testosterone enantate is an alternative preparation and given in the same dose schedule.
- To stop GnRHa follow as below:
  - 3 weeks after **2nd** dose of 250mg, (immediately pre 3rd dose) measure basal testosterone level.
  - Stop GnRHa when testosterone levels in middle of young adult male range (generally 15-20nmol/L, but check local normal values).
  - If testosterone levels are low, then, Sustanon may be needed **2 weekly**.
- Adult service dose schedules may be initiated from step 3 or 4 if the care is transferred during the titration process.

OR

Step number	Topical Testosterone (Tostran Gel) (increased every 6 months)			
	Preparations	Dose	Method	Frequency
1	Tostran Gel	10mg (1 pump)	topical	Once a day
2	Tostran Gel	20mg (2 pumps)	topical	Once a day
3	Tostran Gel	30mg (3 pumps)	topical	Once a day
4	Tostran Gel	40mg (4 pumps)	topical	Once a day
5	Tostran Gel	50mg (5 pumps)	topical	Once a day
6	Tostran Gel	60mg (6 pumps)	topical	Once a day

- **Tostran Gel 10mg** in 1 pump, applied topically once day
- Titrate: upwards in 10mg increments (although can increase by 10 - 20mg increments every 6 months depending on clinical response)
- Full adult dose is **60mg** (occasionally **80mg** per day may be required)
- Monitor basal testosterone level 3-6 monthly: stop GNRHa when levels in middle of young adult male range (generally 15-20nmol/L, but check local normal values). Recheck subsequently (after 2-3 months) that FSH, LH & E2 are suppressed.

Bloods to Request	1st Appointment	6mth Appointment	12mth Appointment
Haematology			
FBC	✓		✓
Biochemistry			
LFT	✓		✓
U&E	✓		✓
Calcium-Bone Profile	✓		✓
Biochemistry - Lipids			
Cholesterol	✓		✓
Triglycerides	✓		✓
Biochemistry - Haemantics			
Serum Ferritin	✓		
Biochemistry - Adrenal Function Tests			
17 OHP	✓		
Androstenedione	✓		
DHEAS	✓		
Biochemistry - Pituitary Function Tests			
FSH	✓	✓	✓
LH	✓	✓	✓
PRL	✓		
Biochemistry - Thyroid Investigations			
TFT (FT4 & TSH)	✓		
Biochemistry - Hormone Tests			
Testosterone	✓	✓	✓
Oestradiol	✓	✓	✓
Biochemistry - Bone Patient			
Vit D	✓		✓
PTH	✓		

Rationale for the blocker : are all aspects reversible?

- The blocker as a diagnostic intervention
- The blocker as time to explore, understand & consolidate
- The blocker as a reversible treatment
- Impact of puberty on gender identity – ‘persistence’ / ’desistance’ rates
- Timing of the blocker not before Tanner stage 2
- Stage of puberty rather than age

Practicalities of Gonapeptyl

- Side effects
- Do longer acting GnRH Analogues have less side effects?
- Most young people have good tolerability, however ‘put back’ may be considered

It is used:

- **In Men: For the treatment of hormone dependent prostate cancer.**
- **In Women: To suppress the level of ovarian hormones in order to:**
  - **Reduce the size of uterine myomas (commonly known as fibroids)**
  - **Treat endometriosis**
- **In Children: For the treatment of Central Precocious Puberty (before 8 years in girls and 9 years in boys)**

Difficulties in prescribing

- Not licensed in gender dysphoria
- Specialised service
- NHS England shared care agreement

The GMC's *Guidance for Doctors Treating Transgender Patients* (March 2016) states:

"You must co-operate with Gender Identity Clinics and gender specialists in the same way that you would co-operate with other specialists, collaborating with them to provide effective and timely treatment for trans and non-binary people. This includes: prescribing medicines recommended by a gender specialist for the treatment of gender dysphoria; following recommendations for safety and treatment monitoring; making referrals to NHS services that have been recommended by a specialist.

What do we do if GPs will not prescribe?

- Will the practice nurse administer?
- Health care at home
- Hospital
- Parents/relatives administering
- Be their advocate

Your Next Visit

- Children's & Adolescent Transgender Health Care (lchtv.com)

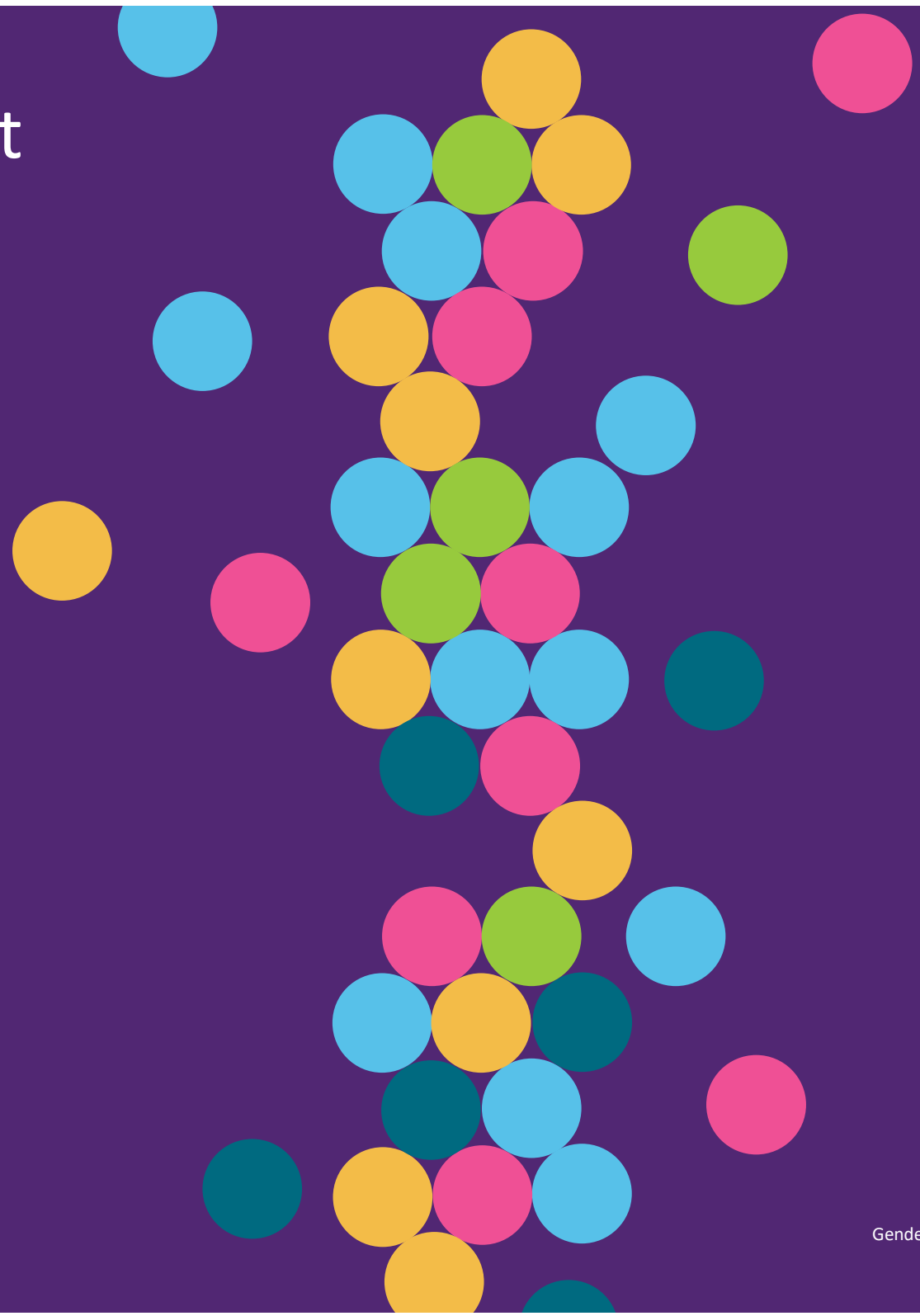
GIDS Gender Identity Development Service

Leeds Children's Hospital NHS

Over 18s – Adult Gender Services

- 7 different GICs in UK
- More emphasis on medical model
- Higher numbers go forward for medical interventions
- Start with partially reversible interventions (e.g. testosterone, oestrogen)
- Surgeries available

Legal context



GIDS Gender Identity Development Service

Legal context

Equality Act 2010

- “Gender reassignment” is a protected characteristic. No requirement to have a medical diagnosis or physical interventions to be covered.
- There is a duty not to discriminate upon this basis.
- How institutions implement this in practice can vary (e.g. unisex accessible toilets, forms, leave for surgeries?)

Judicial Review: Bell vs Tavistock December 2020

- Keira Bell born female, ~ 15 prescribed puberty-blockers to halt process of developing female sexual characteristics.
- Taken testosterone to promote male characteristics, surgery after 18 in adult services.
- Regretted transitioning, now living as female

GIDS Gender Identity Development Service

Judicial Review contd.

- **13 and under:** Highly unlikely that a child would be competent to give consent to puberty blockers.
- **Aged 14 or 15:** Doubtful that a child could understand and weigh the long-term risks and consequences of puberty blockers.
- **16 and over**: statutory presumption that they have the ability to consent to medical treatment. Given the long-term consequences and given that the treatment is as yet innovative and experimental, the court recognised that clinicians may well regard these as cases where the authorisation of the court should be sought before starting treatment with puberty blocking drugs.

- Ruling challenged Gillick competency
- Court involvement in decisions to start PBs

Successful Appeal of the Bell vs Tavistock Judgement – September 2021

- Overturned Judicial Review Ruling
- Policies or practices of either Tavistock or the NHS Trusts (UCH and Leeds) were not unlawful […] claim for judicial review should have been dismissed.
- The Court of Appeal's judgment upholds established legal principles which respect the ability of clinicians to engage actively and thoughtfully with patients in decisions about their care and futures.
- It affirms that it is for doctors, not judges, to decide on the capacity of under-16s to consent to medical treatment.

Pausing for thought

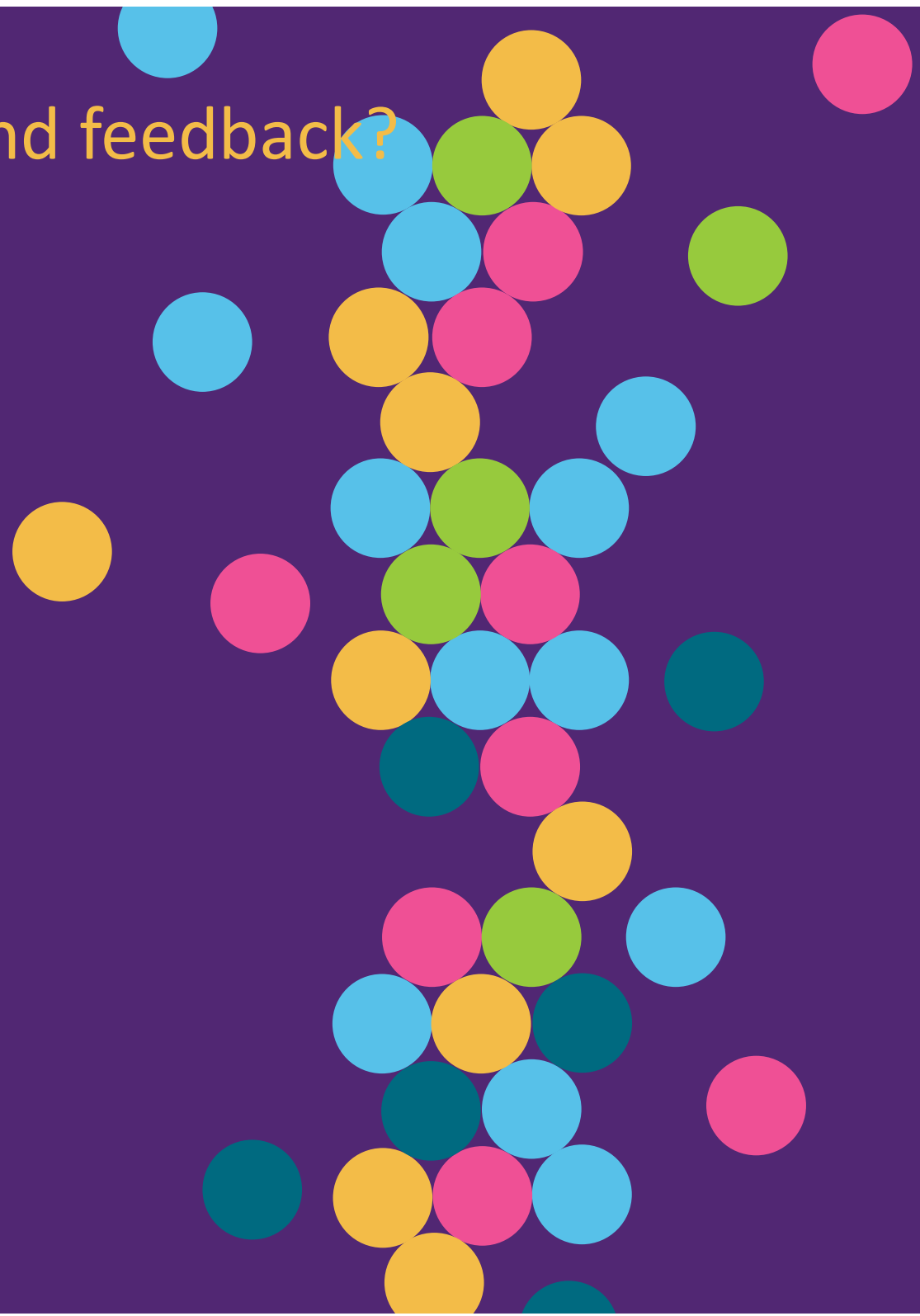
For the next 5 minutes…

Talk in small groups:

In the context of being a healthcare provider, what are your thoughts and reflections about the topics covered so far?

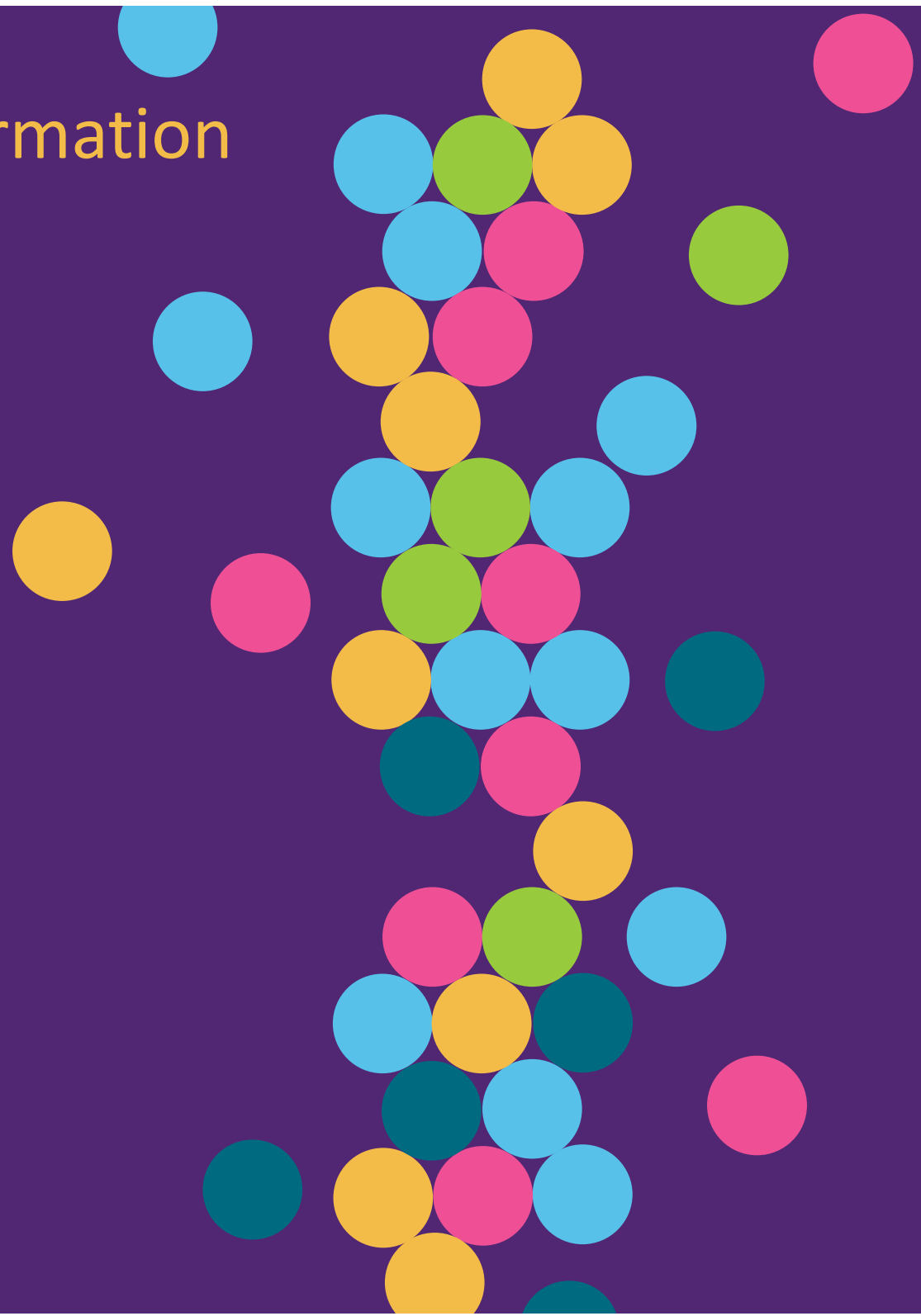
GIDS Gender Identity Development Service

Questions and feedback?



GIDS Gender Identity Development Service

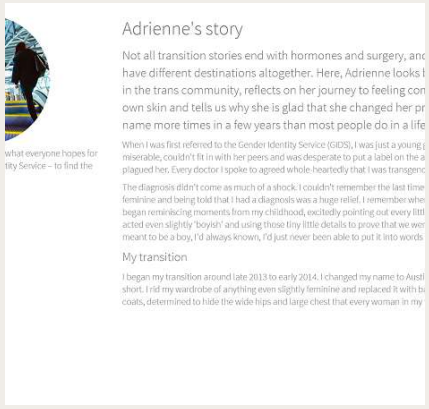
Further information

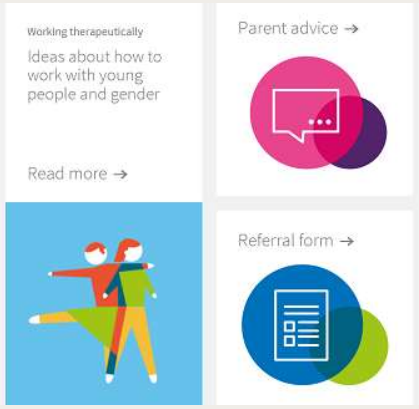


GIDS Gender Identity Development Service

Our website

www.gids.nhs.uk





- Information for young people, parents, and professionals – including a review of the evidence base
- Coming soon: secure online referrals via the GIDS website
- Paper referrals will be phased out

GIDS Gender Identity Development Service

Youth organisations

Some examples of organisations supporting young transgender or non-binary people in the UK:

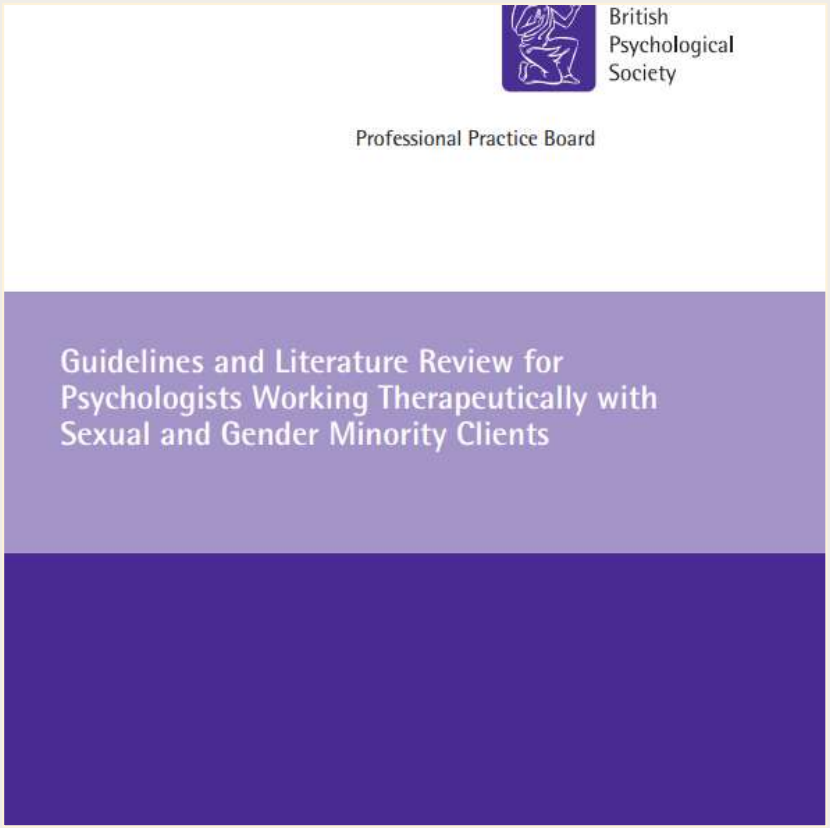
Gendered Intelligence (London+)	www.genderedintelligence.co.uk
Allsorts (Brighton)	www.allsortsyouth.org.uk
Intercom Trust (SW England)	www.intercomtrust.org.uk

BPS guidelines (2012)

The British Psychological Society has produced guidelines for working therapeutically with sexual and gender minority clients.

The full document is available for free on the BPS website:

www.bps.org.uk



GIDS Gender Identity Development Service

Good practice guidelines for working with schools

Cornwall Schools Transgender Guidance
www.intercomtrust.org.uk/resources/cornwall_schools_transgender_guidance.pdf

Brighton & Hove Trans* Inclusion Schools Toolkit
www.lgbtyouthnorthwest.org.uk/wp-content/uploads/2014/07/Trans-Inclusion-Schools-Toolkit.pdf

Challenging gender stereotypes in the early years – resources
http://www.fawcettsociety.org.uk/policy-research/challenging-gender-stereotypes-in-early-years/

GIDS Gender Identity Development Service

Selected further reading

Di Ceglie, D., & Freedman, D. (1998). *A stranger in my own body: Atypical gender identity development and mental health*. Karnac Books.

Di Ceglie, D. (2008). Working at the edge: engaging in therapeutic work with young people with atypical gender identity development. *Neuropsychiatrie de l'enfance et de l'adolescence*, *56*(6), 403-406. doi:10.1016/j.neurenf.2008.06.005

Eracleous, E., & Davidson, S. (2009). The gender identity development service: examples of multi-agency working. *Clinical Psychology Forum, 1*, 46–50.

Kaltiala-Heino, R., Sumia, M., Työläjärvi, M., & Lindberg, N. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and adolescent psychiatry and mental health*, *9*(1), 9.

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical child psychology and psychiatry*, *16*(4), 499-516.

Skagerberg, E., Davidson, S., & Carmichael, P. (2013). Internalizing and externalizing behaviors in a group of young people with gender dysphoria. *International Journal of Transgenderism*, *14*(3), 105-112.

Ristori, J., & Steensma, T. D. (2016). Gender dysphoria in childhood. *International Review of Psychiatry*, *28*(1), 13-20.

Wiseman, M., & Davidson, S. (2012). Problems with binary gender discourse: using context to promote flexibility and connection in gender identity. *Clinical Child Psychology and Psychiatry, 17*(4), 529–538. doi:10.1177/1359104511424991

Wren, B. (2014) Thinking post-modern and practising in the enlightenment: managing uncertainty in the treatment of transgendered adolescents. *Feminism and Psychology, 24*(2),271-291. doi:10.1177/0959353514526223