Gender Reassignment Health Services for Trans People within New Zealand

Good Practice Guide for Health Professionals

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COUNTIES MANUKAU DISTRICT HEALTH BOARD
A Community Partnership

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Preface:

Executive summary

This *Good Practice Guide* is designed to assist practitioners who are not confident or have little experience in working with trans people. By following this guide, simple trans care can be provided adequately and safely in primary care.

This guide uses the word "trans" as an umbrella term to describe gender diversity or gender variance. Simply put, a person with gender variance (sometimes referred to as gender dysphoria) identifies as a gender that is different from their phenotype. This dissonance between phenotypic and identified gender is what motivates people with gender variance to adopt methods, both pharmacological and surgical, to make their body congruent with their desired gender and, in the meantime, results in a great deal of distress and co-morbidity. "Trans" will often not be the term an individual person uses to describe their gender identity, for example, male-to-female (MtF) may identity as whakawahine, transsexual, fa'afafine, fakaleiti, transgender, akava'ine or simply as female. Similarly, female-to-male (FtM) trans people may identity as tangata ira tane, transsexual, transgender, genderqueer or male. Medical terminology also continues to evolve. The medical term transsexualism was introduced in the DSM in 1980, and replaced by Gender Identity Disorder (GID) in 1994. This terminology is being debated during current reviews of the DSM and the World Professional Association of Transgender Health (WPATH) Standards of Care. This includes questioning why gender diversity is viewed as a mental disorder. See Appendix 1: Terminology.

Little is known about the true prevalence of gender variance in New Zealand, but both Māori and Polynesian society in general have a long history of gender variance, especially male to female. Recent research from the United Kingdom suggests a prevalence of 20 per 100,000 population, with a 4:1 ratio of MtF over FtM. Clinic populations suggest the longer the clinic is in operation, the closer the ratio of MtF:FtM is to 1:1.[1]

Although not all practices will see patients with issues of gender variance, general practitioners (GP) are often in a shared care arrangement with other clinicians as they take over care after a multidisciplinary workup and commencement of treatment. Trans patients often present to GPs, or are already with a GP who has suspected the diagnosis.

Trans patients put a lot of stock into having a "trans friendly" GP who treats them with dignity and respect. While this often means having a sensitive and caring approach, and addressing the person by their preferred gender, it also means being sensitive clinically and in terms of management, including the receptionist and records processes.

Trans patients require specialist input, but the GP is often at the centre of ongoing treatment and monitoring, therefore a sensitive approach is needed for such patients.

This executive summary presents a short guide to current best practice in this area but we recommend you read the full guide and appendices.

Evaluation needed for diagnosis

Initial discussions with a trans person should identify what, if any, medical support they are seeking.

The first issue to resolve is that of a correct diagnosis. Although currently there are no New Zealand-specific guidelines, internationally accepted guidelines all stipulate that before hormone prescribing can occur, a

[1] **Reed B, Rhodes S, Schofield P,. & Wylie K.** (2009). *In the UK: Prevalence, incidence, growth and geographic distribution.* London, UK: COI for the Department of Health.

mental health practitioner (MHP) must evaluate the patient and confirm a diagnosis of gender variance.

Most MHPs would utilise diagnostic criteria from the DSM-IV-TR[2], or the ICD 10[3] in making this diagnosis. In addition, MHPs may evaluate the course of "real-life experience" in the chosen gender and pursue individual issues around gender variance for trans patient. This is because following a diagnosis, and before any hormone prescribing begins, persons with gender variance need to have had:

Either:

a. A documented real-life experience of at least three months prior to the administration of hormones; or

b. A period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months). (p 13)[4]

In major centres, local sexual health services may employ MHPs experienced in trans care, or be aware of appropriate practitioners to refer to. However, in smaller centres GPs may not have experienced MHPs close by, and in this case will need to develop a list of appropriate out-of-town MHPs.

Generally, an appropriate MHP will be a vocationally trained psychotherapist or psychologist. In a small number of cases if there is doubt about the diagnosis or a concurrent significant mental health issue exists, then a referral to a psychiatrist or psychologist (doctoral level qualification) with trans experience is necessary.

Following diagnosis there is a well-recognised care pathway that can have a number of different end points. Treatments are usually commenced by specialists, prior to transition back to primary care. Most commonly, the trans patient will end up on cross-hormones. The risks for these often add the known risks of their phenotypic gender to the risks of the medication (eg both thrombotic and prostate cancer risks for trans women on oestrogens, or breast cancer and cardiovascular for trans men).

General practice care consists of the usual for their phenotype, plus that required for their cross-hormone medication and also treatment of ongoing co-morbidities (such as mood disorders). Key interventions are shown in Panel 1.

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[2] **American Psychiatric Association**. (2000). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*. (4th ed, Text Revision ed). Washington, DC: Author.

[3] **WHO**. (2007). *International Classification of Diseases and related health problems, Tenth Revision (ICD 10).* Geneva: World Health Organization (WHO).

[4] **Harry Benjamin International Gender Dysphoria Association Inc.** (2001). *The Standards of Care for Gender Identity Disorders*. (6th ed). Minneapolis, MN: WPATH. Retrieved 14 March,2011, from http://www.wpath.org/publications_standards.cfm.

Key interventions (Panel 1)

- **Diagnosis** seeks help from someone local who is skilled in making the diagnosis.
- **Safety** where necessary deals with co-morbidities such as suicidality, unsafe physical environment, unsafe sex, unsafe drug use and mood disorders.
- **Multidisciplinary team** ensures specialties appropriate to the individual's needs are engaged.
- **Counselling** by someone who knows a lot about gender identity issues and can offer support through the changes of real-life experience; mostly available through NGOs and private services.
- **Hormones** GnRH analogues (blockers) until age 16. Anti-androgens (MtF) or GnRH analogues (blockers) plus cross-hormones after the age of 16.
- **Initial Operations** - for trans men in particular, chest surgery is often a relatively early step. For MtFs breast augmentation or facial surgery may be a medium term goal. These surgeries can be done in regional centres.
- **Lower surgeries -** many trans people do not have all lower genital surgeries. However orchidectomies (for MtFs) and hysterectomies (for FtMs) are more common and may be available through a local or regional DHB. Funding for a very

Subsidised hormone treatments

Within New Zealand there are four types of hormone interventions that are fully subsidised (see below). We recommend these as starting points.

- **GnRH analogues "blockers" (MtF/FtM)**

  These are available as leuprorelin or gasorelin acetate injections, which can be given three-monthly, stopping pubertal development and the emergence of masculinisation or feminisation. This can be given while the diagnosis and real-life experience are being explored because they are "fully reversible" (puberty will restart when the injections are stopped), they are low risk and do not have such a high standard of consent. In post-pubertal patients, they induce a chemical gonadectomy (eunuchoid state).

- **Cross-hormones: oestrogens (MtF)**

  Oestradiol valerate (2–8 mg per day) is a safe feminising hormone which will result in female fat distribution and breast development, as well as bone mineralisation. Its effects are only partially reversible, so a high standard of consent is required.

- **Androgen blockers (MtF)**

  Anti-androgens such as spironolactone or cyproterone acetate are used in the post-pubertal MtF context to block endogenous testosterone. Side effects are rare, but a high level of consent is needed. Cyproterone can occasionally cause depressed mood, so caution should be used in prescribing to trans patients with a history of mood disorder.

- **Cross-hormones: testosterone (FtM)**

  This works better as a depot injection. It stops menstruation (usually), increases bony mineralisation and causes a masculinisation. Its effects are only partially reversible, so a high standard of consent is required.

Monitoring

Ongoing monitoring of the trans patient involves vigilance around undesirable side effects of hormonal medication, and regular blood tests (See Panel 2). Serum hormonal levels are usually monitored by the endocrinologist or relevant specialist, and hormone doses adjusted before handing over to shared care.

Further information

Online resources are shown in Panel 3, including a resource devised by trans youth patients that is also applicable for other ages. Detailed lists of resources and websites are also available in Appendices 7 to 10 of this guide.

Monitoring of trans patients (Panel 2)

MtF trans patients

- Evaluate patient every three months in the first year (weight and blood pressure) and then monitor six-monthly for appropriate signs of feminisation and for development of adverse reactions.
- For individuals on spironolactone, serum electrolytes (particularly potassium) should be monitored every three months in the first year, then six-monthly.
- For individuals on cyproterone, liver function tests should be monitored every three months in the first year, then six-monthly.
- Measure full blood count, glucose and prolactin every three months in the first year, then six-monthly.
- Monitor lipids, fasting blood sugar once a year.
- Sexual health checks as appropriate.
- Cancer screening as appropriate for age.

FtM trans patients

- Evaluate patient every three months in the first year (weight and blood pressure) and then monitor six-monthly for appropriate signs of virilisation and for development of adverse reactions.
- Measure full blood count and liver function tests every three months for the first year and then six-monthly.
- Monitor lipids, fasting blood sugar once a year.
- Sexual health checks as appropriate.
- If cervical tissue is present, PAP smears should follow the normal screening recommendations.
- If mastectomy (chest surgery) is not performed, then consider mammograms as recommended by breast screening guidelines.

Online resources (Panel 3)

- **Department of Health (DH)** exists to improve the health and wellbeing of people within England. They have a range of free medical resources for general practice available. **Website**: *http://www.dh.gov.uk/en/index.htm*
- **Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program.** (2006). *Endocrine therapy for transgender adults in British Columbia: Suggested guideline.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition. Retrieved 14 March, 2011, from *http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-endocrine.pdf*
- **WPATH Standards of Care**: WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA) is a professional organisation devoted to the understanding and treatment of gender identity disorders. As an international multidisciplinary professional association, the mission of WPATH is to promote evidence-based care, education, research, advocacy, public policy and respect in transgender health. **Website:** *http://www.wpath.org/*
- **Trans Care Project:** In partnership with Transcend Transgender Support & Education Society, the Transgender Health Program completed the Trans Care Project in January 2006. The project aimed to create training materials and practice guidelines for clinicians in BC who are already "trans-positive" but lack the clinical knowledge necessary to effectively work with the transgender community. **Website:** *http://transhealth.vch.ca/resources/tcp.html*

How *to use this guide?*

This guide is not comprehensive. More details about specific events and treatments as well as other alternatives can be found in the professional literature for that subject. If the answers to your questions are not found here, the reference section and appendices will either answer your questions or point you in the direction of scientific and scholarly articles.

An attempt has been made to link the needs of the New Zealand trans community, the New Zealand health professional community and the scientific literature. Weaknesses that our process has identified are as follows:

- The trans community is diverse and the views expressed here may not represent your patient.
- The scientific literature is solid in principle but often weak in detail and so the more detail we go into, the more we rely on consensus statements, personal experiences and anecdotes and the less confident we can be in our recommendations. Having said that, there is a great deal of research going on currently and things may change every couple of years. The principles seem unlikely to change.
- The health professional community within New Zealand is not of one voice. Strengths in clinical practice are patchy in terms of geography and professional group. There is not universal agreement as to what should be paid for by the public purse, and different surgical services have different entry criteria and priorities.

No attempt is made to consider the allocation of resources or to advocate for a particular procedure or treatment to be publicly funded. This guide is for practitioners who wish to use their professional skills to the benefit of trans people whether in the public sector or the private sector.

Overview

We recommend you read the executive summary as it gives the overall plan for healthcare interventions.

Section 1: Principles of Care

This section describes working with trans people and some of the overarching principles that transcend age, gender and clinical presentation.

Section 2: Assessment of the Trans Patient

This will give you more details as to what to do before commencing medical transition.

Section 3: Hormone Treatment

This section is good for “getting started”, but the particular requirements of your patient may require you to deviate from this guide because either the recommendations have not worked well enough or you have enough experience and knowledge to do something different.

Section 4: Surgeries

Some surgeries can be done locally or within New Zealand, particularly initial surgeries such as chest reconstruction or hysterectomy for trans men, or an orchidectomy for a trans woman. For lower genital surgeries generally the best results clinically are by those who are doing the procedures frequently and who are keen to work with trans people

Section 5: Children and Young People

This gives age and development appropriate assessments and interventions. These ages are very dynamic and recent evidence indicates that early intervention gets good results. All the issues of youth development are combined with all the issues of being trans, so it is necessary to combine both.

References and Appendices

These sections contain references, some help with terminology, some specific clinical tools, websites, and publicly available resources for clinicians, trans people and their families. A list of professionals who have identified as resources for their profession is also available.

About this *Good Practice Guide*

Background

The lives of trans people in New Zealand are marked by discrimination, severe barriers to equitable health services and limited legal and public recognition of who they are. One of the recommendations from Human Rights Commission of Inquiry was to:

> *improve trans people's access to public health services and developing treatment pathways and standards of care for gender reassignment services through the Ministry of Health working in co-operation with trans people and health professionals.*[5]

A key finding of the Inquiry was that both health professionals and trans people agreed on the need for the development of treatment pathways and standards of care.[5]

The Ministry of Health contracted Counties Manukau District Health Board to lead a project to help clinicians throughout New Zealand as they work with trans people.

Scope

While taking into account the political and consumer issues, this project is about enhancing clinical practices for trans people. There are several concurrent streams to this project:

- translation and adaptation of international best practice in the New Zealand context for New Zealand practitioners
- fostering a mutually supportive network of transgender health service providers across New Zealand who work with trans people.
- consultation with the Humans Rights Commission
- consultation with consumers as advised and supported by the Human Rights Commission.

Methodology

1. **Establish project team comprising:**
   - Dr Rachel Johnson (Paediatrician, CMDHB)
   - Dr John Newman (Youth Physician, CMDHB)
   - Dr Rick Franklin (Sexual Health Physician, ADHB)
   - Lena Crawford (Information Specialist, CMDHB).
2. **Review international best practices** and reflect the unique qualities of New Zealand that will need to be accommodated.
3. **Develop draft documents for review and consultation.**
4. **Identify and communicate with interested lead clinicians within various District Health Board areas.**
5. **Establish Reference Group** comprising health professionals, trans people, the Humans Rights Commission and other key stakeholders identified through the project as it ensures appropriate clinical and consumer input
6. **Use national meetings of trans people and/or health professionals where available and appropriate.**
7. **Produce regular updates on project progress.**

[5] **Human Rights Commission.** (2008). *To be who I am. Kia noho au ki tooku anoo ao. Report of the inquiry into discrimination experienced by transgender people*. Auckland: NZ Human Rights Commission.

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- **John Delahunt** Senior Lecturer in Endocrinology, University of Otago, Wellington and Consultant Endocrinologist
- **Simon Hatcher** Senior Lecturer in Psychiatry in the Department of Psychological Medicine at the University of Auckland and Liaison Psychiatrist at Waitemata DHB
- **Ruth Barnett** General Practitioner in Dunedin
- **Max Lawson** Secretary/treasurer of Genderbridge, the Auckland-based transgender support group
- **Eleanor Carmichael** Paediatrician
- **Chris McEwan** Clinical Director, Plastic Surgery Specialist, Waikato DHB
- **Mani Mitchell** Counsellor in private practice with 15 years, experience working with gender variant clients., educator and member of WPATH
- **Shannon White** transsexual MtF who works with Kaumatua Kuia/Elderly
- **Jack Byrne** Senior Policy Analyst at the Human Rights Commission
- **Cathy Parker** owner and manager of a magazine publishing company, Adrenalin Publishing, in Auckland and currently a phone counsellor
- **Amie Clisby** Project Manager for Victoria University of Wellington, currently running the University Identity Management programme of work
- **Joey McDonald** is a graduate student. I am writing my MA on pakeha FtM trans experience in New Zealand, looking at themes of embodiment, language and personhood.
- **Paul Bohmer** is a public health physician working in the Planning and Funding Team at Auckland District Health Board. Paul has a keen interest in access to appropriate health services for all groups in the population.

1.1 Roles of general practitioners, counsellors, other clinicians and health professionals

1.1.1 Introduction

There are probably a few thousand trans people in New Zealand. Therefore any individual GP or health professional, unless they are sought out for their experience in this area, is unlikely to have much knowledge about the health needs of trans people. While many trans people have relatively simple health transition issues, many also do not. This is a guide to assessing and managing the health of trans people, including complications and co-morbidities.

Many health professionals are not confident about providing care to trans people. Medical care for trans people involves addressing two categories of concerns:

- general medical conditions
- those related specifically to trans issues.

Primary care providers do not have to be experts in this field to meet the health needs of most trans patients. With appropriate understanding of basic trans issues and a little experience, non-expert primary care providers can offer health maintenance, acute illness and chronic disease management, and referral to specialists.

The overall aim of this resource is to enable health professionals to respond confidently and appropriately to trans people seeking their services.

1.1.2 General principles

Clinical care for trans people should be based on good practice principles[6] around clinical efficacy and safety while also emphasising patient autonomy. In particular, doctors need to make the patient their first concern. Good practice allows for the wide variety of needs among trans people and provides flexible clinical responses. It should also take into account the social and cultural context in which trans people live.

In this guide commonly recommended approaches are explained, while other options that are less usual are referenced.

Like every population, trans communities are diverse and health needs vary greatly from patient to patient. Trans people come from all communities, range in age from young children through to elderly people, and use a wide range of terms to describe their gender identity.

There is a long history of gender diversity within Māori and Pacific communities. As a result, Māori and Pacific people may be aware at an earlier age that transitioning is an option (at least socially, if not physically), and may use indigenous words such as whakawahine or fa'afafine (rather than trans) to describe who they are. Anecdotal evidence also suggests that many whakawahine, fa'afafine, akava'ine and fakaleiti are less likely to seek genital surgeries. This raises a particular challenge to ensure that there is a range of hormonal and surgical options available to trans people, and no set treatment pathway.

Care should be holistic and may involve a trans person getting support from a number of different professionals and peer support networks. Finding this support is often as much of a challenge for health professionals as it is for trans people and their families. Therefore Appendices 7 to 10 provide links to relevant resources and services.

[6] **Medical Council of New Zealand**. (2008). *Good medical practice: a guide for doctors*. Wellington: Medical Council of New Zealand.

1.2 Medical roles in assessment and treatment of trans people

1.2.1 Assessment

Most general practitioners are competent to perform an initial assessment of a trans patient. Then, in line with international best practice, another opinion should be sought from a specialist colleague who is experienced with trans people. International best practice describes this colleague as a mental health professional (MHP).

In some parts of New Zealand, there is less access to publicly funded mental health services. In these cases appropriate "out of town" referrals may be necessary.

Generally, an appropriate MHP will be a vocationally trained psychotherapist or psychologist. In a small number of cases if there is doubt about the diagnosis or a concurrent significant mental health issue exists, then a referral to a psychiatrist with transgender experience is necessary. The role of the MHP is dual: firstly, to assist in diagnostic assessment of the trans person, and secondly, to commence, organise and follow-up on significant mental health issues that have been identified.

The GP should be aware of ongoing co-morbidities, particularly those relating to mental health, sexual health, and drugs and alcohol.

1.2.2 Initiating specific treatments (medical & surgical transition)

Treatment should not be initiated until there has been an adequate assessment and also when serious co-morbidities have been addressed.

Following diagnosis there is a well-recognised care pathway that can have a number of different end points. Treatments are usually commenced by specialists, prior to transition back to primary care.

Blockers and cross-hormones once initiated can be managed by the GP. See Section 3: Hormone Therapy Treatment.

Referrals for surgery can be initiated by the GP but require an assessment by a MHP. A list of resources for health professionals is available in Appendix 11.

1.2.3 Ongoing care

The GP should take as great a role in ongoing care as is appropriate for their degree of training. General practice care consists of the usual for the trans person's phenotype, plus that required for their cross hormone medication and also treatment of ongoing co-morbidities (such as mood disorders).

Trans people and their networks can sometimes identify "transfriendly" GPs. This is helpful in terms of engagement and knowledge but unfortunately there are many parts of the country where there are no such contacts.

1.2.4 Specific GP responsibilities

These include:

- re-prescribing at regular intervals for blockers and cross-hormones
- relevant sexual health, men's health and women's health checks see Section 2: Assessment of the Trans Patient.
- referrals to specialists as clinically indicated
- regular labs for hormone side effects
- regular healthcare unrelated to trans people issues.

1.3 Respect, privacy and appropriate care

Experience with transphobia and discrimination in the healthcare setting, lack of access to trans competent providers, and (for some) discomfort with their body can lead trans people to avoid medical care altogether. Many do not tell their GP that they are a trans person. Gossip, negative stereotyping, moralising or prejudicial comments about trans people should not be tolerated in the health workplace. They may result in complaints of unlawful discrimination and/or breaches of the *Code of Health and Disability Services Consumers' Rights*[7] or your professional code of ethics.

In order to establish a respectful working relationship, it is essential that a trans person feels that their gender identity is being taken seriously by their GP, counsellor or other health professionals. Practitioners should treat trans patients as individuals, respecting their dignity and treating them politely and considerately.[8]

- Refer to the trans person by their preferred name and pronoun, regardless of what name and sex details are on their birth certificate. Discreetly ask what name and pronoun they prefer and change clinic records as requested. This will not alter someone's unique patient identifier (NHI).

- Ensure that front-line staff members understand the importance of checking and using the appropriate details, and reassure trans people about patient confidentiality.

- Care should be taken uf other family members are also practice patients. Families might not be aware of the clinical interventions and are not entitled to information without the consent of the trans patient.

- Some trans people will prefer not to wait in a crowded waiting room and should be offered fixed time appointments.

- Prior to surgery, many trans people are very uncomfortable having physical examinations such as pelvic or testicular examinations and mammograms. It is important to understand this reticence, respect a trans person's wishes about potentially sensitive physical examinations, and find out whether they are really necessary. When such examinations are necessary, discussion and explicit consent are required. It can be respectful to ask what words the trans person would prefer you to use. For example, typically a trans woman will talk about her breasts (and a trans man will use the word chest), from early on in their transition.

It is important to become familiar with commonly used terms and the diversity of identities within trans communities. See Appendix 1: Terminology. This includes recognising that not all trans people identify as transitioning from one sex to another, for example from male to female. Some describe themselves as a third sex or are comfortable moving between female and male aspects of their identity.

There is no set definition of "a trans person" that someone needs to meet in order to transition. While many trans women simply want to live as women (and vice versa), that is not the goal for all trans people. Nor is it always possible for someone to "pass" in their appropriate sex (so that others do not realise they are trans). The idea of "passing" is problematic on many levels and a controversial concept that some trans people do not appreciate. Therefore, the ability to

[7] **New Zealand Health and Disability Commissioner. (nd).** The Code of Health and Disability Services Consumers' Rights 1996. Auckland: NZHDC. Retrieved 14 March 2011, from http://www.hdc.org.nz/the-act--code/the-code-of-rights

[8] **Medical Council of New Zealand**. (2008). *Good medical practice: a guide for doctors*. Wellington: Medical Council of New Zealand

"pass" is not a requirement in order to access hormone treatment.

1.4 Support required for trans people

There is a wide diversity in the type of support a trans person may request from their GP, counsellor and other health professionals.

Increasingly, trans people are obtaining valuable information about medical transition via peer support networks and online resources. Sometimes the first health professional they may contact is a counsellor or psychotherapist, to work through their own and/or others' reactions to the prospect of transitioning. A well-informed counsellor or psychotherapist can play an important role supporting a trans person to come to their own decisions about their gender identity, whether to transition, and the next steps in that journey.

Other individuals who are questioning their gender identity may be unsure how to talk about these issues or may express their concerns as confusion about sexual orientation. Because of the stigma still attached to gender diversity, trans people may be very private or fearful of negative consequences if they disclose their gender identity. Respectful and sensitive listening is essential.

Some trans people will come to their first visit with a GP knowing exactly what support they require. This may include asking for baseline blood tests and a referral to the public health system to see a sexual health physician or endocrinologist or general physician (for hormones), and a psychologist or psychiatrist (to get a diagnosis or assessment) and/or a surgeon (particularly trans men seeking breast (chest reconstruction) surgery.

Children will need access to an appropriate paediatrician or Child and Adolescent Mental Health Service (CAMHS). Others may wish to ask a GP's medical advice about the side effects of hormones and whether they are an option given pre-existing health conditions or medications. Trans people who have transitioned may simply require a GP who can prescribe their hormones on an ongoing basis, monitor blood tests and provide general medical care including screening for any health risk factors.

GPs do not need to be experts on trans health issues to answer these questions. However they are likely to benefit from the resources in this guide, including contact details for experienced counsellors, psychotherapists, specialists and peer support groups. It is valuable for clinicians to circulate this information among their colleagues, especially those who may provide break or locum cover.

Other trans people who approach a GP may be extremely isolated, with no words to describe how they feel. Calmly reassure them that gender diversity is not an illness, and that there are medical options available for people who do decide to physically change their bodies. At the same time, acknowledge that it can be very hard to work through gender identity issues without information and support. Your role may include helping them to identify and find the resources they need.

1.5 Culturally competent care for Māori

The Mauri Ora Associates for the Medical Council of New Zealand have published a resource booklet, *Best health outcomes for Māori: practice implications.* See Appendix 5: Principles of Culturally Competent Care for Māori.[9] The goal of this booklet is help doctors to achieve greater awareness of the cultural diversity and the place of Māori in New Zealand, and to assist in incorporating cultural competence for Māori into continuing education activities, recertification and practice activities such as medical audits. The material

[9] **Mauri Ora Associates for the Medical Council of New Zealand**. (2006). Best *health outcomes for Māori: practice implications.* Wellington: Medical Council of New Zealand.

provides both general guidance on Māori cultural preferences and specific examples around key issues. It is hoped that Māori-specific cultural competencies will be developed in a framework of self-awareness so that doctors will be able to recognise their own values and attitudes, as well as the impact of these on their practices.

Māori have less access to medical care compared to non-Māori. Even though Māori attendance rates to GP appointments are the same rate as non-Māori, they obtain fewer diagnostic tests, and effective treatment plans,[10] and are referred for secondary or tertiary procedures at significantly lower rates than non-Māori patients.[11]

Providers need to be aware of specific cultural preferences of their patients as culture plays an important role in their health care. This includes:

- acknowledging (and incorporating) the role of the broader whānau and other environmental factors in the patient's care
- awareness of Māori belief systems, including views on individual mana, death and dying, reliance upon the family, prayer (karakia), and traditional healing practices and providers (tohunga), practices of tapu/rāhui/noa, and communication styles
- Awareness of Māori lifestyles, including diet, non-work roles, and leisure time activities.
- Learning about existing support mechanisms, such as kaiatawhai, whānau, kaumātua, Māori practitioners and other specialist service providers.

Not all Māori have the same cultural background or experiences and it is misleading to assume that all Māori clients will benefit to the same degree from similar cultural insights. Some will prefer to maintain a deliberate distance between culture and tikanga. Others will feel disadvantaged if assessment and treatment do not include cultural perspective and inputs. An option should at least be made available for Māori clients and their whānau.[12]

[10] **Crengle S, Lay-Lee R, Davis P. & Pearson JA.** (2006). Comparison of Māori and non-Māori patient visits to doctors. *NatMedCa. Report 6.* Wellington: Ministry of Health.

[11] **Gribben B.** (1999). Ethnicity and resource use in general practice in West Auckland. *Experience in practice* Vol.1(1)

[12] **Durie M**. (2001). *Māori Mauri Ora: Dynamics of Māori health*. Auckland: Oxford University Press.

2.1 Introduction

Assessment of trans patients should be multi disciplinary. Some trans people will present for assessment during a crisis. Crises and urgent matters should be addressed first. Crises may be around mental health, life circumstances, personal safety or assault, sexual safety, relationship breakdown or deterioration in life circumstances.

2.1.1 Address safety first

Many trans people, particularly those coming out or starting a gender transition will have safety issues. Safety problems can be at home, work, school or community. Many trans people are or have been exposed to violence. Some trans people have had unsafe sexual practices or drugs and alcohol use. Suicidality is relatively common in trans people.

2.1.2 Assess co-morbidities

In addition to immediate safety issues there is a need to assess mental, sexual and cardiovascular health, as well as alcohol and drugs (including cigarettes) issues.

2.1.3 Assess gender identity

Many clinicians will feel uncomfortable addressing gender identity. It might be easier after establishing engagement through the above process. Then the patient can be addressed along the lines of discussing masculinity and femininity and whether they want any help with that. For instance "Do you want any help with becoming less masculine or more feminine?" The Utrecht Gender Dysphoria Scale Adolescent Version[13] asks a series of specific gender identity questions as a useful way of opening up discussions, particularly as it is a clinical tool which can be applied without an introduction to each question. See Appendix 3: Utrecht Gender Dysphoria Scale Adolescent Version. Be aware that not all trans patients will be ready for this discussion and may not wish to continue an assessment at this stage. If that is the case, then specific medical treatments for gender transition cannot proceed. It is advisable to have this discussion with the help of someone used to working with trans people, such as an experienced MHP.

Generally, an appropriate MHP will be a vocationally trained psychotherapist or psychologist. In a small number of cases where there is doubt about the diagnosis or a concurrent significant mental health issue exists, then a referral to a psychiatrist or psychologist (doctoral level qualification) with trans experience is necessary.

Specific criteria for gender identity disorder (GID) are contained in DSM-IV-TR.[14] See Appendix 2: DSM-IV-TR Criteria for Gender Identity Disorder.
Please note that while a diagnostic assessment should be done, the lack of a clear diagnosis should not deny access to treatment which is required in the view of an experienced practitioner.

2.1.4 Assess regular healthcare issues

Trans people often lack access to preventive health services and timely treatment of routine health problems. To improve access to primary care, we encourage trans sensitive providers to make themselves known to appropriate community organisations.

2.2 Assessment of trans patients

Initial discussions with a trans person should identify what, if any, medical support they are seeking.

[13] **Zucker KJ**. (2005). Gender identity disorder in children and adolescents. *Annual Review of Clinical Psychology*, 1 (April): 467–492.

[14] **American Psychiatric Association**. (2000). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*. (4th ed, Text Revision ed). Washington, DC: Author.

There is no fixed definition or criteria that trans people need to meet in order to transition. Increasingly, trans people are advocating for a wellness model that identifies the support needed for medical issues related to gender diversity. In New Zealand, whakawahine have identified Te Whare Tapa Wha[15] as an appropriate model for their communities.

However there are eligibility and readiness criteria linked to specific medical and surgical procedures. These are set out in the *Harry Benjamin Standards of Care (HBSOC)* and are now known as the World Professional Association of Transgender Health (WPATH) Standards of Care.[16] In the New Zealand context, these "standards of care" are best described as an international best practice consensus document. The WPATH[16] standards are about to be revised. This guide attempts to apply those standards to local circumstances. This includes acknowledging the specific cultural context here, the absence of gender clinics and therefore the pragmatic need to create effective networks.

2.3 Assessment prior to hormone treatment

Initial assessment prior to cross gender hormone therapy requires the assessment of an MHP.

In New Zealand, there is less access to publicly funded mental health services than in countries with gender clinics. In order that this requirement does not deny trans people access to treatment, good networks of appropriate MHPs need to be encouraged and developed.

2.4 Real-life experience is not a real-life test

The WPATH Standards of Care recommends that a person has either lived in their appropriate gender (real-life experience) or undergone psychotherapy for a minimum of three months prior to starting cross-hormones. Either can help a trans person explore the implications of transitioning. However, due to safety or other issues, there may be good reasons why a trans person may wish to commence hormone treatment before changing their gender role, and this is regarded as the typical treatment pathway in the HBSOC. It is useful for the health professional to check whether a trans person feels safe to present in their appropriate gender identity and what, if any, further support they require.

There is a broad range of presentation of men and women with gender dysphoria. The initial assessment should develop a clinical pathway to address the range of social and biological concerns and include flexibility to adjust management according to the physical and emotional responses.

Sometimes medical concerns emerge regarding hormonal treatment (and/or planned surgeries). When possible, efforts should be made to try to control these issues, through behaviour/lifestyle change or medication. Two such examples are smoking and cardiovascular risk factors.

- **Cigarettes –** Because of the increased risk of blood clotting with female hormones, a brief motivational interview should be conducted with all smokers. This should be repeated with each consultation. It may help to emphasise that stopping smoking is likely to improve surgical results and, in the case of trans women, increase breast growth from hormones. Smoking is not an absolute contraindication to hormone treatment.

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[15] **Durie M.** (1998). *Whaiora: Māori Health Development.* (2nd ed) Auckland: Oxford University Press.

[16] **Harry Benjamin International Gender Dysphoria Association Inc.** (2001). The Standards of Care for Gender Identity Disorders. (6th ed). Minneapolis, MN: WPATH. Retrieved 14 March 2011, from *http://www.wpath.org/publications_standards.cfm.*

- **Cardiovascular –** Assessment of cardiovascular risk factors or actual disease may influence when hormone treatment starts and actual hormone doses, particularly oestrogens for trans women. Specific assessments of weight, blood pressure, lipids and cholesterol are required. When medically recommended, support should be provided to help trans people lose weight prior to or during hormone treatment**.**

2.5 Laboratory tests

Both during the assessment process and ongoing maintenance there is a requirement for lab testing. If lifestyle indicates, a full sexual health screen may be indicated. If there has been poor hygiene, unsafe sex practices, intravenous drug use or sex-working, hepatitis A, B, C, D and E, syphilis, chlamydia, gonorrhoea and HIV should be tested. If there is a possibility of intersex, a karyotype will be helpful. Baseline tests for liver function and lipid profile should be obtained.

2.6 Mental health and wellbeing

It is useful to encourage trans people to identify possible forms of support, and provide referrals to counsellors, psychotherapists and peer support networks when appropriate.

It should be established who the supportive family members and friends are and who are not. The home should be both emotionally and physically safe. It is helpful if the trans person brings a partner, support person or significant supportive family member to part of their assessment. If the trans person's transition has a significant impact on others' lives, they should be encouraged to seek separate support to work through those issues.

A trans person may choose to change their school or job as part of their transition. It is unlawful for an employer to require a trans person to leave their job or change their duties, except in extremely limited circumstances. A medical certificate with appropriate advocacy may help a trans person in their relationships with their school or employer. Transitioning in a supportive school or work environment can be very affirming and empowering for a trans person.

When appropriate, a trans patient should be assessed for depression and anxiety symptoms, for post-traumatic stress disorder (if exposed to trauma) and suicidality.

2.7 Drugs and alcohol

Some trans people have high drug and alcohol use, sometimes as a form of self-medicating. Significant use or abuse should be addressed before and during treatment, using harm minimisation and motivational approaches. During a holistic treatment programme many trans people will reduce their drug use as distressing symptoms decrease and ease of lifestyle improves.

2.8 Assessment for surgeries

Currently a diagnosis of gender identity disorder (GID) is required for someone to access genital surgery in New Zealand or overseas. This diagnosis is set out in the *Diagnostic and Statistical Manual of Mental Disorders*[17]. Alternatively there are the medical diagnoses of transsexualism described in the *International Classification of Diseases..*[18] Letters of support are generally required from two MHPs for genital surgery (lower surgeries) but this is usually reduced to one opinion for non-genital (lower) surgery, such as facial surgery and breast (chest reconstruction) surgery.

[17] **American Psychiatric Association**. (2000). *Diagnostic and Statistical Manual Of Mental Disorders (DSM-IV-TR)*. (4th Ed, Text Revision ed). Washington, DC: Author.

[18] **WHO.** (2007). International *Classification of Diseases and Related Health Problems*, Tenth Revision (ICD-10). Geneva: World Health Organization (WHO).

2.9 Assessment of adolescents

Puberty is acutely stressful for trans adolescents. For trans girls, there is the distress associated with increasing muscle bulk, coarsening of bone structure, voice dropping, and body hair and beard growth. For trans boys, the growth of breasts and start of the menstrual cycle are often traumatic.

For adolescents, it is also necessary to assess who is best to consent for the transition process. Assessment of the competence of young people to give consent is the same as other consents and requires that they have comprehension of the issues and treatments. All adolescents should have a risk and resiliency assessment of HEEADSSS[19]. Appropriate adults to include in the assessment and who can support the young person will be identified through this process. Similarly, an assessment must be made as to which (if any) adults are safe and competent to consent on behalf of the young person. Specific identity issues include which personal pronoun (he/she) is preferred and which name is preferred.

In order to reduce the acute distress of puberty and to stop further unwanted feminisation or masculinisation, the patient should be assessed for pubertal development. In particular they should be asked about which parts of pubertal development are distressing. Height, weight and Tanner staging should be done, usually through self-identification with pictures in the Tanner Charts. Assessment of GID can take place over years, but puberty can be (reversibly) stopped by the use of GnRH analogues (blockers) as part of the assessment process.

[19] **Goldenring JM., & Rosen DS.** (2004) Getting into adolescent heads. an essential update. *Contemporary Pediatrics,* 21(1): 64-90.

2.10 Assessment of children

All children are different and we can't expect children to always be who we want them to be.

Many children claim to be in the wrong body or to wish that they were the "other gender". They may want clothes of the other gender or to be called by a different name reflecting the other gender. They may wish to be treated as the other gender or some in between gender.

Trans issues (parents not being sure of which gender is right for a child or a child being born into the wrong gender) are not that uncommon, but we don't know how often they occur.

Most of these children (about three quarters) will not be trans adults, but many will retain some sexual preference or gender issues. Those that are most gender dysphoric as children seem to be most likely to persist as a trans person in adult life.

Being different is very distressing and often results in teasing, mocking or bullying. On the other hand, trying to act out the role of your body (rather than your personality) is often more distressing. Distress often shows as bad behaviour or anger. The distress often gets greater around puberty and may result in mental health issues and behaviour issues such as anger, self harm or self-medicating (taking drugs). Most doctors don't know a lot about this and the research is improving very rapidly. Identifying and dealing with the gender issue rather than just focusing on the behaviour can reduce distress and improve the child's function.

During puberty, there are medical interventions called GnRH analogues (blockers) that can stop pubertal development and reduce the distress (and developing into the "wrong" adult gender). They can be started at what doctors call stage two or three puberty.

In the meantime all children need love and support for who they are. Parents who love their children for who they are will find they have a happier and better adjusted child, even if they are disappointed in whom the child is becoming. In some ways it is similar to the grief many other parents experience when their children turn out different from how they wanted or expected.

Therapy such as Cognitive Behavioural Therapy (CBT) can help manage anger or depression, and can be obtained from your local mental health service.

So these interventions are needed:

- Show love and respect.
- Let the child grow up and support that growth.
- Seek mental health support for serious mood or behaviour problems.
- Discuss and address gender issues rather than focusing on behaviours.
- At early puberty consider stopping the puberty if the cross-gender identity is getting stronger or if the problems are getting bigger. This probably needs referral to a local youth specialist or endocrinologist.

Section 3: *Hormone Therapy Treatment*

3.1 Introduction

Hormone therapy will be a desired option for many trans people. This should be initiated following the recommended assessment and diagnostic process as detailed in Section 2: Assessment of the Trans Patient.

Hormone therapy is beneficial in alleviating some of the psychological distress associated with gender variance and can be an important aid in successful transition if choosing to live as the identified gender.

3.2 Consent

Before hormone therapy begins it is crucial that individuals fully understand both the potential benefits and risks. Both verbal and written information must be given as well as allowing an adequate time period for individual to consider the implications discussed.

Further guidelines to hormone therapy for trans people are included in *A guide to hormone therapy for trans people*[20] *as well as booklets such as* Hormones: a guide for FtMs and Hormones*: a guide for MtFs.*[21]

Written consent is recommended for cross-hormone treatment, especially as it has potentially serious irreversible side effects, such as infertility. Fertility options need to be discussed with patients. Storage of sperm should be discussed with MtF patients.

Consent forms for feminising hormones/androgen blockers or masculinisation hormones and GnRH blockers are available. See Appendix 4: Samples of consent forms.

[20] **Gender Identity Research and Education Society (GIRES).** (2007). A *guide to hormone therapy for trans people*. London, UK: COI for the Department of Health.

[21] **Trans Care Project**. (2006). *Hormones: a guide for FtMs.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition.

3.3 Subsidised hormone treatments

There are four general types of subsidised hormone treatments fully funded and available in New Zealand.

3.3.1 Gonadotrophin releasing hormone (GnRH) Analogues – "Blockers" (MtF/FtM)

GnRH analogues act on the pituitary gland, inhibiting production of gonadal hormones. This does not affect testosterone production by the adrenal gland.

GnRH analogues can be considered a safe and fully reversible treatment and can be used in both adolescence and post-pubertal trans people. If initiated in adolescence they can be used from Tanner pubertal stage two to halt pubertal progression and the progression of unwanted masculinisation or feminisation. Because they are generally considered fully reversible, puberty will restart once the blockers are stopped. There is however a very low risk that fertility may not return so the consent process must acknowledge this. See Section 5. Children and Young People for more information on the use of blockers with young people.

GnRH analogues can be used in post-pubertal trans people to help block sex hormone production. This is particularly important for MtFs as androgens can reduce the feminising effects of oestrogen treatment, so either a concomitant androgen blocker or GnRH analogue is usually prescribed with oestrogen.

Leuprorelin is fully subsidised for precocious puberty, prostate cancer and endometriosis. This guide recommends the use of Leuprorelin (or GnRH analogues) regardless of funding status.

For FtMs, once testosterone therapy is established oestrogen effects are suppressed. Ongoing GnRH analogue use is not usually needed once oestradiol levels are sufficiently low (pre-pubertal levels or nearly so);

however, it may be considered initially to halt menstruation.

Long-term use of GnRH analogues without cross-hormones (oestrogen/testosterone) would not usually be recommended because of the increased risk of osteoporosis, cardiovascular and other health risks.

Table 1. New Zealand subsidised GnRH analogues (blockers)

1. Leuprorelin (Lucrin Depot three-month) 11.25 mg IM three monthly **– most commonly used in New Zealand**
2. Leuprorelin acetate (Lucrin Depot one-month) 3.75 mg SC depot one-monthly
3. Goserelin acetate (Zoladex 3.6 mg) 3.6 mg SC depot implant one-monthly

Side effects

Side effects generally include potential infertility, reduced bone density, vaginal dryness, loss of libido, inability to ejaculate/orgasm and hot flushes.

For further information on prescribing and full side effects information see *Guidance for GPs, other clinicians and health professionals on the care of gender variant people* (pp.59 & 66)[22] *and endocrine therapy for transgender adults in British Columbia.*[23]

For further information on GnRH analogues see *A guide to hormone therapy for trans people (pg. 20)*[20]

Consent

Samples of consent forms for GnRH analogues are in Appendix 4: Samples of Consent.

Monitoring on GnRH analogues

Ongoing monitoring while on GnRH analogues is most important if aiming to suppress puberty. FHS/LH levels and testosterone should be tested three-monthly until LH/FSH and testosterone levels are suppressed to pre-pubertal levels. The aim is for testosterone to be in the normal female range for post-pubertal MTF and LH/FSH suppression to pre-pubertal levels in females.

If there is inadequate suppression while on three-monthly injections than reduce time between injections, to every 10 weeks.

Because of cost and limited experience in New Zealand at present, GnRH analogue therapy would ordinarily be undertaken with specialist supervision or advice, as the initial injection is stimulatory, with subsequent suppression. It is important to have continuous therapy; GnRH test, stimulating LH and FSH levels with pre-injection steroid measurements, may be used to confirm suppression just before the first and later injections. Single LH and FSH samples, measuring the secreted gonadal steroid in addition, should be sufficient as a routine serial evaluation. In adolescents who may still be growing a baseline and roughly annual bone age estimations can be matched to changes in height and weight.

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[22] **Gender Identity Research and Education Society (GIRES)**. (2008). Guidance *for GPs, other clinicians and health professionals on the care of gender variant people***.** London, UK: COI for the Department of Health.

[23] **Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program.** (2006). *Endocrine therapy for transgender adults in British Columbia: Suggested guideline.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition.

3.3.2 Cross-hormones: Oestrogens (MtF)

Feminising hormones are associated with potential positive effects which include female fat distribution, breast development (irreversible), reduced muscle bulk, slowing or cessation of male pattern baldness and slight reduction in genital size.

Table 2. New Zealand subsided treatment oestradiol

1. Oestradiol Valerate/Progynova 2–8 mg per day – usually in divided doses.
    1.1. Post gonadectomy 1–2 mg once daily.
2. Oestradiol patches 100–200 mcg applied twice weekly.
    2.1. Post gonadectomy, 50–100 mcg patch applied twice weekly

Oestradiol is recommended as it has the best safety profile. Ethinylestradiol (including its use in the combined oral contraceptive, such as Estelle) and conjugated oestrogens, (such as Premarin) are **not** recommended as they are associated with increased risk of side effects. Oestradiol patches are lower risk than oral oestradiol and should be considered in patients who are over 40, smoker or have circulatory problems. Smoking (either cigarettes or marijuana) reduces plasma oestrogen levels and reduces the effect of oestrogen while marijuana may have additional oestrogen antagonism.

A detailed medical and family history should be taken to assess the risks of starting oestrogen, similar to be process before starting oral contraceptives.

Side Effects

Serious side effects include: thrombosis (deep venous thrombosis, pulmonary embolism, cardiovascular accident), altered liver function, eventual infertility (irreversible), oestrogen-related cancers, prolactinoma (veryrare). Less serious side effects include breast tenderness and reduced libido.

Remind patients that smoking reduces the feminising effect of oestrogen and increases cardiovascular risks. Consider counselling and treatment for other cardiovascular risk factors, obesity ang hypertension.

It is important to stress there is little scientific research on the use of feminising hormones and the aim of treatment is to minimise overall health risks.

For full information on oestrogen prescribing regimes and side effect is see *Endocrine therapy for transgender adults in British Columbia*[24].

Website:
http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-endocrine.pdf

Monitoring on Oestrogen

Regular ongoing monitoring of baseline BMI, blood pressure and blood tests are recommended after starting treatment.

Please note that in the case of hormone levels it is important to check your regional laboratory to find your normal reference ranges (female for MtF and male for FtM).

[24] **Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program.** (2006). *Endocrine therapy for transgender adults in British Columbia: Suggested guideline.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition.

3.3.3 Cross Hormones: Progesterone (FtM)

Progesterones are rarely used as part of the feminising treatment plan for MtFs since they have androgenic effects, encouraging hair growth, and provide no obvious added benefits. They increase the risk of breast cancer and cardiovascular accident and may cause additional side effects. In non-trans women they are combined with oestrogen to protect the uterus from cancer.

3.3.4 Androgen antagonists – "Blockers" (MtF)

Androgen antagonists are used in post-pubertal trans MtFs to block androgen receptors and therefore testosterone effect. Side effects are rare but a high level of consent is needed. Androgen blockers can be stopped at the time or soon after surgical gonadectomy.

Table 3. New Zealand subsidised androgen antagonists

Cyproterone acetate 50–100 mg po daily
Spironolactone 100–200 mg po daily

Side effects

Cyproterone acetate is the most appropriate oral androgen blocker. Initially it needs to be prescribed by a specialist, but can then be continued by a GP. Side effects are very rare apart from possible weight gain and decreased libido. Rare complications include abnormal liver function or hepatitis, jaundice, fatigue and depression. It is best avoided in heavy alcohol users, and patients with liver impairment, malignancy or diabetes.

Spironolactone is a second choice oral androgen blocker as it is less effective and predisposes to salt depletion with muscle cramping in hot and/or humid climates. Further side effects include liver impairment, kidney impairment, and headaches and reduced clotting time.

For full information on androgen blocker regimes and side effects see *Endocrine therapy for transgender adults in British Columbia*[25]

Website:
http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-endocrine.pdf

3.3.5 Cross-Hormones: Testosterone (FtM)

Positive testosterone effects include beard and body hair growth, redistribution of body fat, muscle bulk increase and deepening of the voice. Menstruation usually ceases, together with an increased libido and irreversible infertility. The degree of clitoral enlargement is variable, with studies reporting a range of 3.5-6 cm maximal length when stretched. Long-term testosterone use causes vaginal and cervical atrophy, with decreased vaginal secretions and difficult penetration reported by some patients.

[25] **Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program.** (2006). *Endocrine therapy for transgender adults in British Columbia: Suggested guideline.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition.

Table 4. New Zealand subsidised androgen antagonists replacements

1. Testosterone Esters (Sustanon) 250 mg/ml – Usual dose 250 mg three-weekly but this can be built up to over 2–3 injections. Care must be taken if patient has a peanut allergy.
2. Testosterone Cypionate 100 mg/ml. –usual dose 200–300 mg IM three-weekly but this can be built up to over 2–3 injections.
3. Testosterone patches 2.5 mg. (Androderm) 2–3 patches applied every 24 hours.

Side effects

Unwanted side effects are minimal but include polycythaemia, an increase of oily skin and or acne, abdominal pain, headache, weight gain, abnormal lipids and depression. Androgens are contraindicated in carcinoma of the breast or known or suspected carcinoma of the prostate, nephrotic syndrome and hypercalcaemia.

For full information on testosterone regimes and side effects see *Endocrine therapy for transgender adults in British Columbia.*[26]

Website:
http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-endocrine.pdf

[26] **Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program.** (2006). *Endocrine therapy for transgender adults in British Columbia: Suggested guideline.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition.

3.3.6 Monitoring on oral blockers and cross-hormones

MtF trans patients

- Evaluate patient every three months in the first year (weight and blood pressure). Then every six-months to monitor for appropriate signs of feminisation and for development of adverse reactions.
- For individuals on spironolactone, serum electrolytes (particularly potassium) should be monitored every three months in the first year and then six-monthly.
- For individuals on cyproterone, liver function should be monitored every three months in the first year and then six-monthly.
- Measure full blood count, glucose and prolactin every three months in the first year and then six-monthly.
- Monitor lipids and fasting blood sugar once a year.
- Sexual health checks as appropriate.
- Cancer screening as appropriate for age.

FtM trans patients

- Evaluate patient every three months in the first year (weight and blood pressure). Then six-monthly to monitor for appropriate signs of virilisation and for development of adverse reactions.
- Measure full blood count and liver function tests every three months for the first year and then six-monthly.
- Monitor lipids and fasting blood sugar once a year.
- Sexual health checks as appropriate.
- If cervical tissue is present, PAP smears should follow the normal screening recommendations.
- If mastectomy is not performed, then consider mammograms as recommended by breast screening guidelines.

Plasma oestradiol and/or testosterone (free and serum) can also be measured in plasma as a occasional check on the appropriateness of therapy to avoid overdose or to assess reasons for an inadequate response. However,

there can be wide variation in levels in individuals, and some tests are very inaccurate.

Fertility

It should be assumed that both masculinising and feminising hormone treatment will usually cause irreversible infertility. It is unclear as to the length of time before irreversible infertility develops so it is important to counsel about this prior to initiating hormone treatment both in terms of sexual health precautions and fertility options.

Options for alternative fertility methods should be discussed as you would with any other patient undergoing treatment that will affect their fertility. The options include sperm storage for trans women and egg collection and storage for trans men.

Section 4: *Surgery*

4.1 Introduction

Many trans patients (but not all) will go on to have surgery. Surgery should not be seen as a prerequisite for a successful gender reassignment process. Patients should not feel they need to declare an aim for eventual surgery to obtain initial therapy and may be comfortable living with suppressed rather than excised genitalia if this is their preference.

Surgery is best performed by those who are interested in trans people, specifically trained in the surgical techniques and performing these surgeries regularly.

4.2 Breast (chest reconstruction) surgery ("top surgery")

Often the first surgery for FtM will be breast (chest reconstruction) surgery. This can be done in the private or public sector. Public sector breast (chest reconstruction) surgery will go through DHB prioritisation processes and may attract a low weighting and hence a long wait. This will vary from region to region but trans patients might expect the same access to surgery as those with other similar conditions. The access to surgery will depend on the symptoms of the patient and the severity of the disfigurement. For an FtM the degree of distress, the size of the breasts and/or the use of binding will be relevant. In both public and private sectors a mental health professional assessment needs to occur before surgery is undertaken.

For an MtF, breast augmentation can be done in the usual way by private or public plastic surgeons.

4.3 Facial surgery

Currently three public plastic surgical centres have the skills to do facial surgery for transgender clients. Again DHB prioritisation process may lead to long waits for these surgeries in many areas.

4.4 Laryngeal surgery

The only surgery on the larynx that is considered safe and efficacious is a laryngeal "shave" to reduce the bulge of the laryngeal bulge. Typically this will not result in permanent voice change.

4.5 Sex/gender reassignment surgeries

Many trans women and a small proportion of trans men have sex/gender reassignment surgery (SRS/GRS) so their genitalia align with their lived gender. The techniques for MtF surgery are well proven and have developed significantly since the 1950s. However, significant complications still exist with SRS/GRS for FtMs.

Surgery is irreversible and involves removal of some features as well as reconstruction, so it will not normally be done before 18 years of age. Most surgeons will require two psychiatrist or psychologist reports before commencing surgery. Generally the patient will need to have been living full time in their new gender for at least 12 months and some surgeons require two years. Public funding is available through the Special High Cost Treatment Pool (SHCTP) for up to three MtFs and one FtM to have SRS in each two year period. **Access to the SHCTP is made through a referral by a DHB Specialist. This should be someone knowledgeable about trans health such as a sexual health physician, psychiatrist, adolescent physician, endocrinologist or plastic surgeon.** The SHCTP application form is available from the Ministry of Health to referring DHB specialists or managers on request. The following link provides information about applying to the SHCTP:
http://www.moh.govt.nz/moh.nsf/indexmh/special-high-cost-treatment-pool#apply

4.5.1 MtF surgery

All SRS/GRS for MtFs involve gonadectomy and may be obtained through the public health system. There are two main techniques available. The first and by far the most common is termed penile inversion, where penile and scrotal skin is used to form the vaginal lining and labia and nerves from the glans create a sensate clitoris. The second technique utilises a section of the colon to create the vagina. This allows greater length and is self-lubricating but is more invasive surgery and has higher risks.

Both techniques result in realistic and functional genitalia with a high success rate. However, there are a number of potential complications that patients should be aware of. Generally the surgeon will discuss these with patients as part of the informed consent process.

The SHCTP funds 3 MtF GRS's every 2 years. SRS/GRS for trans women is currently provided in New Zealand. The Special High Cost Treatment Pool (SHCT Pool) does not fund surgery overseas if the surgery can be successfully carried out in New Zealand. Supported applications must be made by a DHB specialist on behalf of the patient.

Because of the number of surgeons and level of expertise, Thailand has been a destination favoured by many New Zealand MtFs in recent times, but Australia has also become a common destination. Local trans groups can put people in touch with others that have used a variety of surgeons who specialise in SRS/GRS.

4.5.2 FtM surgery

Full genital surgery for FtM typically involves two phases. In the first, the female internal organs are removed (oophorohysterectomy). This can be done by local gynaecologists but if further surgery is anticipated it may be best to contact the (overseas) surgeon first. The second phase creates a micropenis (metatoidoplasty) or a full phallus (phalloplasty), redirecting the urethra to the tip of the new genitals and creating testicles.

Both procedures involve a series of separate staged operations and complications are very common. Neither procedure is available in New Zealand. The SHCT Pool funding pays for one FtM to travel overseas every two years for SRS/GRS. Supported applications must be made by a DHB specialist on behalf of the patient

FtM peer support groups can also provide contact details of some renowned surgeons and clinics.

5.1 Children

Gender variance may be expressed in children from an early age and can present in a variety of ways, including preference to dress or engage in play more typical of the opposite sex. In some instances children may show they are uncomfortable with their physical sex or insist they are the opposite sex. Gender variance may be expressed in children from an early age and can combine alternative gender expression and/or gender identity. Gender expression is more external and may include preference to dress in ways that are more typical of the 'opposite' sex. This is common amongst many non-trans children too. In some instances children may show they are uncomfortable with their physical sex or insist they are the 'opposite' sex. Some children who express gender variance go on to identify as trans adults, while a significant proportion of trans adults expressed gender variance as a child. Creating an environment where such diversity can be expressed creates a positive foundation for a child, whatever their decision later in life. However very few children who express gender variance go on to identify as trans adults particularly those who are most gender variant

For further information for families refer to *Medical care for gender variant children and young people.*[27]

5.2 Young people

For children whose gender variance persists into adulthood, feelings of discomfort or distress at their physical gender usually become more pronounced during puberty. Puberty may also be the time when gender variance is first recognised in some young people. There is often a huge amount of psychological distress associated with these feelings, which can manifest as mental health issues, including depression and suicide, poor sexual health and other risk-taking activities.

It is important that young people and families have access to appropriate medical and emotional support. This usually requires referral to local paediatrician, youth health specialist or adolescent mental health team to begin the assessment process or *HEEADSSS*[28] assessment and facilitate access to hormone treatment if appropriate. However, the General practitioner may be the first port-of-call for information for either the young person or the family. Assessing the general safety of the young person within the family and community context should be a priority. This will identify other problems that must be addressed as well as transgender issues (co-morbidities) and which may require more urgent intervention than the trans person issues.

5.3 Assessment and diagnosis

A rigorous assessment and diagnosis process is required and based on that as detailed for adults. The Utrecht Gender Dysphoria Scale Adolescent Version is a useful tool that can aid assessment and encourage discussion around trans people feelings. *See Transgender Adolescents in BC: Suggested Guidelines* (Appendix C-16).[29]

In addition, a risk and resiliency assessment (such as a *HEEADSSS*[28] assessment) is very important, and the young person must be seen in the context of the family or whānau. In some cases, a young person may be adamant they do not want their family involved, which may be on the basis of safety reasons or that they are

[27] **Gender Identity Research and Education Society (GIRES)**. (2008). *Medical care for gender variant children and young people: answering families' questions.* London, UK: COI for the Department of Health.

[28] **Goldenring JM. & Rosen D. (2004).** Getting into adolescent heads: an essential update. *Contemporary Pediatrics.* 21:64.

[29] **Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program**. (2006) *TransgenderaAdolescents in BC: Suggested guidelines.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition: British Columbia.

not yet ready for this. It is important that this is respected and should not be a reason to exclude them from the appropriate health care support.

5.4 Consent and confidentiality

It is important to explain consent, confidentiality and its limitations with the young person and family. As previously discussed, a high level of consent is required for starting both GnRH analogues and sex hormones.

If the young person is under 16, and usually until the age of 18 (though not legally required), gaining consent from both the young person and parents/caregivers as family support is strongly recommended during the transition process. However, in exceptional circumstances if the young person is under 16 and deemed Gillick competent they alone may be allowed to consent. We would recommend this is discussed with other health professionals experienced with working with youth prior to starting treatment.

For further information on consent see Gillick competency *Medical care for gender variant children and young people (p 27).*[30]

5.5 Psychosocial assessment

Psychosocial assessment identifies both the risks and resiliencies, especially with regards to safety issues (attention must be paid to sexual health, mental health and drug and alcohol assessment). The HEEADSSS Risk and Resiliency Assessment Tool is commonly used in New Zealand. It structures questions to maximise communication and minimize stress. The acronym expands to **H**ome, **E**ducation/employment, **E**ating, **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression and **S**afety.[31]

If significant risk is identified then appropriate referral to necessary supporting health services should be made. See Section 2. Assessment of the Trans Patient.

5.6 Family

Adolescence can be a very distressing time for some families coming to terms with the young person's gender variance. Family members will often require individual time for discussion and further counselling. Useful resources for families are listed in Appendix 10.

5.7 School

For some young people transitioning while at school is a daunting and potentially unsafe situation and they may chose to defer until leaving school.

For those young people that do choose to transition or are already living as their desired gender while still in school, a high level of support is required. There are some common issues that need to be addressed and it is most helpful to identify a key person in the school who is sympathetic and able to support the young person and family as they work with the school to prepare a management plan to best support the young person.

It is often most useful for the clinician, with the permission of the young person and family, to liaise directly with the school to provide both information and practical advice.

Management will differ between different schools and should be guided by the individual needs of the young person. It should be supportive and without discrimination.

[30] **Gender Identity Research and Education Society (GIRES)**. (2008). *Medical care for gender variant children and young people: answering families' questions.* London, UK: COI for the Department of Health.

[31] **Goldenring JM. & Rosen D.** (2004). Getting into adolescent heads: an essential update. *Contemporary Pediatrics*. 21:64.

Panel 4. School: Common general areas for consideration

1. Identify the people/staff in school who do and do not need to be aware about the young person's gender variance. .
2. Uniforms –It would be generally recommended that the young person is allowed to wear the uniform appropriate to their expressed gender. However, this may not be appropriate if they are continuing to attend a single sex school and identify as the opposite gender identity. Those instances would need to be negotiated on an individual basis. It might be useful to consider the uniform flexibility available to other students because of their religious beliefs or a relevant disability.
3. Toilets/changing room – safety and privacy are the key issues for gender variant young people, as they are for all students. Ideally students should be able to use a toilet that matches their gender identity. Other options might include toilets in a sick bay/health centre, unisex disability toilets or staff toilets.
4. Sports- this should not be an issue except when a trans young person has reached puberty and is playing in competitive sex-segregated sport competitions. Mixed or non-competitive sports are other good options for trans young people, enabling them to play in their appropriate sex.
5. Gender variant children and young people can be the target of bullying and violence at school. A positive school environment is one that celebrates diversity and fosters respect for others, including trans youth. The school has a responsibility to provide a safe environment and should have clear anti-bullying policies. A safe place the young person can go to during the school day if needed is may be helpful, e.g. library pass, school health centre etc. A useful resource recommended for schools is "Transphobic bullying" which is listed in Appendix 10.
6. Psychological wellbeing – the school guidance counsellor or school nurse may be a good contact for a trans young person in school.

For further information for teachers, see Appendix 10

5.8 Health records and names

Most trans patients want their health records to be altered to reflect the name and gender of their choice. The health practitioner should raise this subject because the patient may be too embarrassed to ask or may fear that it is not possible. The health record should record the new name and gender. The unique patient identifier (NHI) should also be altered to reflect these changes. Some patients may change their mind either about gender or name and this should also be accommodated. It is easy to check by asking "how should I address you?"

5.9 Medical treatment

5.9.1 Gonadotrophin releasing hormone (GnRH) analogists – "blockers"

Following the careful assessment process (as previously detailed), for some young people hormone blockers (GnRH analogues) will be the desired treatment. It is well recognised that young people presenting during puberty with extreme distress by the physical changes of puberty are most likely to have persisting gender variance.

Blockers are recommended not usually before Tanner stage two and are often started later in puberty. They can relieve a significant amount of the young person's acute distress by putting physical changes on hold, thus allowing more time for the young person to make decisions about their future gender. If started early enough it also prevents the development of permanent physical changes, such as beard growth, breast growth, facial changes that are very difficult to remove once established. Trans adults often have to spend a huge amount of time, money and surgery trying to correct these unwanted changes.

Therefore, it is very important, while considering the medical risks of giving blockers to an adolescent, to also consider the risks and implications of not giving or delaying giving the blocker. If the young person changes

their mind, the blocker may be stopped at any time and normal puberty will resume. Although GnRH analogues are classed as a reversible treatment and return of fertility is highly likely it cannot be guaranteed. A high standard of consent is still recommended. *See Appendix 4: Samples of Consent Forms.*

For further information for clinicians read *The Guidance for GPs, other clinicians and health professionals on the care of gender variant people (p59)*[32] as well as the article, *Clinical management of gender identity disorder in adolescents.*[33]

Prolonged use of hormone blockers without cross-hormones may lead to increased adult height and reduced bone density during a normal period of significant bone mineralisation. For this reason, growth should be carefully monitored and a bone density scan may be necessary.

5.9.2 Sex steroids

Treatment with sex steroids (oestrogen or testosterone) may be considered from about the age of 16. These are recognised as only partially reversible treatments and therefore a high level of consent is needed. Although parental consent is not required once the young person is Gillick competent, it is strongly encouraged in all young people as family support is very important during the transition period. For further detail see Section 3: Hormone Therapy Treatment.

A second opinion should be sought before commencing any treatment. In some areas this may need to be done within the private sector. However, the clinical network provides a list of clinicians with an interest or expertise in this area who are often happy to provide email or phone consultation advice. Refer also to Section 1: Principles of Care.

[32] **Gender Identity Research and Education Society (GIRES)**. (2008). Guidance *for GPs, other clinicians and health professionals on the care of gender variant people*. London, UK: COI for the Department of Health.

[33] **Delemarre-Van de Waal, HA. & Cohen-Kettenis, PT.** (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155 (Suppl 1): S131-S137.

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Appendix 1

Terminology

Appendix 1: *Terminology*

Gender identity and its expression vary greatly and not all trans people fit neatly into one of the definitions below or their broad descriptions. These definitions are a guide only. Counties Manukau District Health Board have selected terms (below) from Human Rights Commission (2008): *To be who I am. Kia noho au ki tooku anoo ao. Report of the inquiry into discrimination experienced by transgender people*. This diversity is acknowledged and cannot be overstated. Some common terms used in Aotearoa / New Zealand include those shown here. . Having a clear understanding about the differences between the following terms can also be useful when a GP, nurse, counsellor or other health professional is discussing gender identity issues with a trans person.

Cross-dresser	A person who wears the clothing and/or accessories that are considered by society to correspond to the opposite gender
Disorders of Sex Development (DSD)	Is a recent medical term to describe intersex medical conditions. Some intersex people and health professionals disagree with the reference to ”disorders” and have proposed the alternative term Variations of Sex Development (VSD).
Fa’afafine (Samoa), Fakaleiti (Tonga), Akava’ine (Cook Islands), Mahu (Hawaii), Vaka sa lewa lewa (Fiji), Fafafine/fiafifine (Niue), Rae rae (Tahiti)	Pasifika terms used to recognise people born biologically male who embody the spirit of a woman, have female gender expressions and perform female as well as male gender roles.
Gender	The social and cultural construction of what it means to be a man or a woman, including roles, expectations and behaviour.
Gender expression	How someone expresses their sense of masculinity and/or femininity externally.
Gender identity	A person’s internal, deeply felt sense of being male or female (or something other or in between). A person’s gender identity may or may not correspond with their sex.
Genderqueer	People who do not conform to traditional gender norms and express a non-standard gender identity. Some may not change their physical sex or cross-dress, but identify as genderqueer, gender neutral or androgynous.
Gender reassignment services	The full range of medical services that trans people may require in order to medically transition, including counselling, psychotherapy, hormone treatment, electrolysis, initial surgeries such as mastectomy, hysterectomy, orchidectomy, and a range of genital reconstruction surgeries.
FtM/trans man (female-to-male)	Someone born with a female body who has a male gender identity.
Intersex	A general term used for a variety of conditions in which a person is born with reproductive or sexual anatomy that does not seem to fit the typical biological definitions of female or male. Some people now call themselves ”intersex” while many prefer to simply be known as male or female.
MtF/trans woman (Male-to-female)	Someone born with a male body who has a female gender identity.

Queen	Another term for someone born with a male body who has a female gender identity.
Sex	A person's biological make-up (their body and chromosomes), defined usually as either "male" or "female" and including indeterminate sex.
Sexual orientation	Whether someone is attracted to someone of the same sex (homosexual, for example gay, lesbian or queer), "opposite" sex (heterosexual), or both/all sexes (bi/pansexual). Some people always identify with one sexual orientation, whereas others may change their primary orientation and the meaning they give it at different times through their life. When a trans person transitions, often their sexual attraction remains the same, but it is not uncommon for it to change. If a trans woman who was previously married is still attracted to women, she is likely to identify as a lesbian. Conversely, a trans man who has a long-term female partner may now be considered heterosexual by others. Given these complexities, the umbrella term 'queer' is increasingly used by trans youth to describe both their sexual orientation and sex/gender diversity.
Takatāpui	An intimate companion of the same sex. Today used to describe Māori gay, lesbian, bisexual and trans people. It refers to cultural and sexual/gender identity. Also spelt Takataapui.
Tangata ira tane	A Māori term describing someone born with a female body who has a male gender identity.
Trans person/people	An umbrella term to describe someone whose gender identity is different from their physical sex at birth. Increasingly this is a preferred, more neutral, term.
Transgender	In New Zealand it is often used as a catch-all umbrella for a variety of people who feel that the sex they were born with is a false or incomplete description of themselves.
Transsexual	A person who has changed, or is in the process of changing, their physical sex to conform to their gender identity. The terms "pre-operative" and "post-operative" are used by some transsexuals to describe whether or not they have had all gender reassignment surgeries. However, many trans people do not wish to disclose their surgical status, except in the very limited circumstances when that information is necessary.
Transitioning	The social and/or medical steps taken by trans people to live in their gender identity. Usually trans people consider they have transitioned once they live in the appropriate sex, well before they completing any medical steps they have chosen to take. Transitioning often, but not always, involves hormone therapy and may involve a range of surgeries. These include chest reconstruction and hysterectomies for trans men, breast augmentation and facial surgery for trans women, as well as genital surgeries. The latter are often referred to as sex/gender reassignment surgeries (SRS/GRS), or as sex/gender *realignment* surgeries by some trans people.
Whakawaahine, Hinehi, Hinehua	Some Māori terms describing someone born with a male body who has a female gender identity.

Appendix 2

DSM-IV-TR Diagnostic Criteria for Gender Identity Disorder

Reference: Excerpt from **American Psychiatric Association**. (2000). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*. (4th Ed, Text Revision ed). Washington, DC: Author.

Appendix 2: *DSM-IV-TR Diagnostic Criteria for Gender Identity Disorder*

A. A strong persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In children, the disturbance is manifested by four (or more) of the following:

1. repeatedly stated desire to be, or insistence that he or she is, the other sex.
2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.
3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
4. intense desire to participate in the stereotypical games and pastimes of the other sex.
5. strong preference for playmates of the other sex.

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: *in boys*, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; *in girls*, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:

- **302.6 Gender Identity Disorder in Children**
- **302.85 Gender Identity Disorder in Adolescents or Adults**

Specify if (for sexually mature individuals):

- **Sexually Attracted to Males**
- **Sexually Attracted to Females**
- **Sexually Attracted to Both**
- **Sexually Attracted to Neither**

Please note the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) is planned for release in May 2013. For updates, see DSM 5 website: http://www.dsm5.org/Pages/Default.aspx

Reference: Excerpt from **American Psychiatric Association**. (2000). *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*. (4th Ed, Text Revision ed). Washington, DC: Author.

Appendix 3

Utrecht Gender Dysphoria Scale Adolescent Version

Reference: Cohen L, de Ruiter C, Ringelberg H. & Cohen-Kettenis PT. (1997). Psychological functioning of adolescent transsexuals: Personality and psychopathology. *Journal of Clinical Psychology*, 53: 187–196

Appendix 3: *Utrecht Gender Dysphoria Scale* 42

Adolescent Version

Female-to-Male Version

Response categories are: agree completely, agree somewhat, neutral, disagree somewhat, disagree completely. Items 1, 2, 4-6 and 10-12 are scored from 5-1; items 3 and 7-9 are scored from 1-5.

1. I prefer to behave like a boy.
2. Every time someone treats me like a girl I feel hurt.
3. I love to live as a girl.
4. I continuously want to be treated like a boy.
5. A boy's life is more attractive for me than a girl's life.
6. I feel unhappy because I have to behave like a girl.
7. Living as a girl is something positive for me.
8. I enjoy seeing my naked body in the mirror.
9. I like to behave sexually as a girl.
10. I hate menstruating because it makes me feel like a girl.
11. I hate having breasts.
12. I wish I had been born as a boy.

Male to Female Version

Response categories are: agree completely, agree somewhat, neutral, disagree somewhat, disagree completely. Items are all scored from 5-1.

1. My life would be meaningless if I would have to live as a boy.
2. Every time someone treats me like a boy I feel hurt.
3. I feel unhappy if someone calls me a boy.
4. I feel unhappy because I have a male body.
5. The idea that I will always be a boy gives me a sinking feeling.
6. I hate myself because I'm a boy.
7. I feel uncomfortable behaving like a boy, always and everywhere.
8. Only as a girl my life would be worth living.
9. I dislike urinating in a standing position.
10. I am dissatisfied with my beard growth because it makes me look like a boy.
11. I dislike having erections.
12. It would be better not to live than to live as a boy.

Scoring and Evaluation

As can be expected most non-transsexuals score close to the minimum score, which is 12.

Most transsexuals score close to the maximum score, which is 60.

Problematic applicants in terms of eligibility for sex reassignment and in terms of treatment course tend to score in the middle range of the scale.

Reference: Cohen L, de Ruiter C, Ringelberg H. & Cohen-Kettenis PT. (1997). Psychological functioning of adolescent transsexuals: Personality and psychopathology. *Journal of Clinical Psychology,* 53: 187–196

Appendix 4

Samples of Consent Forms

Counties Manukau District Health Board andGIRES

Appendix 5

Principles of Culturally Competent Care for Māori

Reference: Excerpt from Mauri Ora Associates for the Medical Council of New Zealand. (2006). Best *health outcomes for Māori: practice implications.* Wellington: Medical Council of New Zealand. *Retrieved 14 March 2010 at* *http://www.mcnz.org.nz/Default.aspx?tabid=269*

Appendix 6

Medical Therapy and Health Maintenance for Transgender Men

Reference: Gorton R, Buth J and Spade D. (2005). *Medical therapy and health maintenance for transgender men: A Guide for health care providers.* Lyon-Martin Women's Health Services. San Francisco, CA. *Retrieved 14 March 2010 at* *http://www.nickgorton.org/Medical%20Therapy%20and%20HM%20for%20Transgender%20Men_2005.pdf*

Appendix 7

Resources for Clinicians

Useful Resources

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual Of Mental Disorders (DSM-IV-TR)* (4th ed, text revision). Washington, DC: Author. **DSM 5 Website:** http://www.dsm5.org/Pages/Default.aspx

Delemarre-Van de Waal HA & Cohen-Kettenis PT. (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology*, 155(Suppl 1): S131-S137.

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Gorton R, Buth J & Spade D. (2005). *Medical therapy and health maintenance for transgender men: A Guide for health care providers.* San Francisco, CA: Lyon-Martin Women's Health Services. http://www.nickgorton.org/Medical%20Therapy%20and%20HM%20for%20Transgender%20Men_2005.pdf

Human Rights Commission's Transgender Inquiry focus is on implementing the Inquiry's recommendations and other suggested actions. This requires work by the Human Rights Commission, government agencies, trans people and the wider community. **Website:** http://www.hrc.co.nz/human-rights-environment/action-on-the-transgender-inquiry/resources/health/

Lev, Arlene Istar. (2004). *Transgender Emergence: therapeutic guidelines for working with gender-variant people and their families.* Binghamton, NY: Haworth Press.

21 Ways to be an Ally to your Trans Client. This is an American resource developed by Aidan Dunn, Brooklynne Thomas and Simon Knaphus for the Youth Gender Project. ©2004 Youth TIES.Youth TIES (previously the Youth Gender Project). **Website:** http://www.youthgenderproject.org

Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program. (2006). *Transgender adolescents in BC: Suggested guidelines.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition. **Website:** http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-adolescent.pdf

Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program. (2006). *Transgender primary medical care: Suggested guidelines for clinicians in British Columbia.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition. **Website:** http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-primcare.pdf

Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program. (2006). *Endocrine therapy for transgender adults in British Columbia: Suggested guideline.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society, and the Canadian Rainbow Health Coalition. **Website:** http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-endocrine.pdf

Useful Websites

Human Rights Commission's Transgender Inquiry webpage includes links to more community organisations. **Website**: http://www.hrc.co.nz/human-rights-environment/action-on-the-transgender-inquiry/

Trans Care Project: In partnership with Transcend Transgender Support & Education Society, the Transgender Health Program completed the Trans Care Project in January 2006. The project aimed to create training materials and practice guidelines for clinicians in BC who are already "trans positive" but lack the clinical knowledge necessary to effectively work with the transgender community. **Website:** http://transhealth.vch.ca/resources/tcp.html Includes:

- Surgery: A guide for FTMs
- Surgery: A guide for MTFs
- Hormones: A guide for FTMs
- Hormones: A guide for MTFs

WPATH Standards of Care: WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA) is a professional organisation devoted to the understanding and treatment of gender identity disorders. As an international multidisciplinary professional association the mission of WPATH is to promote evidence-based care, education, research, advocacy, public policy and respect in transgender health. **Website:** http://www.wpath.org/

Appendix 8

Resources for Trans People

Useful Resources

Gender Identity Research and Education Society (GIRES). (2007). A *guide to hormone therapy for trans people.* London, UK: Department of Health.
This booklet was produced by a team of doctors and trans people. This publication gives trans men (female to male individuals) and trans women (male to female individuals) straightforward information about the benefits of hormone therapy and the risks and side effects. Simple information on cross-sex hormones and common side effects (does not include re blockers).
Website: Department of Health (DH)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081580

Goodrum AJ. (2005). *Gender Identity 101: a transgender primer*. Arizona: Southern Arizona Gender Alliance.
This information will provide the reader with a basic understanding of the transgender community and the issues faced by those within it, as well as an opportunity to learn more about this vibrant and diverse community. It is not intended to be the final word in this multi-faceted and ever expanding story – there are many voices within the transgender community that reflect our rich diversity and some of them contradict and even conflict with each other.
Website: Southern Arizona Gender Alliance - SAGA
http://sagatucson.org/saga/index.php?option=com_content&task=view&id=42&Itemid=94

Useful Websites

Agender New Zealand: We are an organisation that provides support and lobbying services for the transgendered community in NZ. **Website:** *http://www.agender.org.nz/*

Department of Internal Affairs has collated information for transgender applicants together on one page on their website. This covers changing sex details on a birth certificate, passport, citizenship or evidentiary certificate. **Website:** *http://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Services-Births-Deaths-and-Marriages-Information-for-Transgender-Applicants?OpenDocument*

FtM Aotearoa is Wellington-based one-on-one peer support and mentoring for FtMs, friends and whānau. **Website**: *http://ftmaotearoa.tripod.com/*

Genderbridge is based in Auckland and meets the second Tuesday of every month in Ponsonby and operates a toll free support line, 0800 TG HELP (0800 844 357). **Website:** *http://www.genderbridge.org/*

Gender Identity Research and Education Society (GIRES) is a British-based website created to inform people about the issues surrounding gender identity and transsexualism. **Website**: *http://www.gires.org.uk/*

New Zealand Human Rights Commission's Transgender Inquiry webpage includes links to more community organisations. **Website**: *http://www.hrc.co.nz/human-rights-environment/action-on-the-transgender-inquiry/links/*

Trans Care Project: In partnership with Transcend Transgender Support & Education Society, the Transgender Health Program completed the Trans Care Project in January 2006. The project aimed to create training materials and practice guidelines for clinicians in BC who are already "trans positive" but lack the clinical knowledge necessary to effectively work with the transgender community. **Website:** *http://transhealth.vch.ca/resources/tcp.html* Includes:

- Surgery: A guide for FTMs
- Surgery: A guide for MTFs
- Hormones: A guide for FTMs
- Hormones: A guide for MTFs

Transgender.co.nz has been set up to help bring the transgender community closer together and to offer mutual support and help. **Website:** *http://www.transgender.co.nz*

Appendix 9

Resources for Young People

Factsheet: *Resources for Young People*

Useful Resources

Simpson A J & Goldberg JM. (2006). *Trans Care Youth: Let's talk Trans.* Vancouver: Vancouver Coastal Health, Transcend Transgender Support & Education Society and Canadian Rainbow Health Coalition.
This booklet was produced as part of the Trans Care Project, a joint effort of Transcend Transgender Support & Education Society and Vancouver Coastal Health's Transgender Health Program. **Website:** *http://vch.eduhealth.ca/pdfs/GA/GA.100.L569.pdf*

21 Ways to be an Ally to your Trans Client. This is an American resource developed by Aidan Dunn, Brooklynne Thomas and Simon Knaphus for the Youth Gender Project. ©2004 Youth TIES.Youth TIES (previously the Youth Gender Project). **Website:** http://www.youthgenderproject.org

Trans Youth Group for Sci:Identity, Gendered Intelligence & GALYIC. (2007). A *guide for young trans people in the UK.* United Kingdom: Department of Health.
This booklet by a group of young trans people aged between 15 and 22, in conjunction with Gendered Intelligence, aims to offer information to young people who know they are trans or are confused about or questioning their gender in any way, so as to help clarify some of their questions and offer them language to express themselves. **Website:** http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074258

Useful Websites

Curious: A national queer youth development initiative between New Zealand AIDS Foundation and Rainbow Youth. Curious is a resource for young people to share feelings and experiences about sexuality and gender identity with the aim of enhancing connectedness and supporting them to promote diversity in their communities. **Website:** http://www.rainbowyouth.org.nz/queer-youth/txt-support

Forge A network for trans and gender diverse youth in Christchurch and Dunedin, which meets in Christchurch. **Email:** forge.south@gmail.com

G-IQ (Gender Identity Quest) is an Auckland social support group for youth questioning or unsure about their gender identity. G-IQ is part of Rainbow Youth and is a supportive environment that affirms youth regardless of how they identify. **Website:** http://www.rainbowyouth.org.nz/groups/rainbow-youth-groups/gender-quest

Rainbow Youth is an Auckland-based organisation support for trans and queer young people and their families. Can provide contact details for trans-inclusive youth groups in other parts of the country. Also has a drop-in centre. **Website:** http://www.rainbowyouth.org.nz/

Same Difference is a Dunedin queer social support group for people aged 20 and under that is very trans-inclusive. You can contact Same Difference on **email:** youthlinecommunity@youthline.co.nz

SPINZ: We are a national information service, run by the *Mental Health Foundation*, and our main role is to provide high quality information to promote safe and effective suicide prevention activities. **Website:** http://www.spinz.org.nz/page/5-Home

Transgender Youth Clinic LA *Transgender Harm Reduction Project*. **Website:** http://www.transyouthla.com/index.html

TRANZform is a Wellington group for young people who identify as transgender, genderqueer, non-gendered, questioning and their allies. **Website:** http://www.brooklynnemichelle.com/tranzform/

Appendix 10

Resources for Families and Schools

Useful Resources & Websites for Families

Gender Identity Research and Education Society (GIRES). (2008). *Medical care for gender variant children and young people: answering families' questions.* London, UK: COI for the Department of Health. This publication provides answers to the questions typically asked by parents of gender variant children and young people (up to the age of 17). It helps families to understand about gender variance and gives some suggestions about how to respond. **Website:** http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082976

Gender Identity Research and Education Society (GIRES). (2009). *Transgender experiences: information and support*. London, UK: Department of Health. This leaflet has been produced to help trans people and their families understand about the experiences of trans people, their rights and their choices. It also helps healthcare staff to understand about their role when caring for trans people. **Website:** http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097169

Human Rights Commission Transgender Inquiry webpage includes links to more community organisations. **Website:** http://www.hrc.co.nz/human-rights-environment/action-on-the-transgender-inquiry/resources/children-young-people-and-their-famlies/

Pride & Prejudice/Central Toronto Youth Services (CTYS). (2006). *Families In TRANSition: A Resource Guide for Parents of Trans Youth*. Toronto: CTYS. This booklet addresses the needs of parents and families supporting their Trans children. It summarises the experiences, strategies, and successes of a working group of community consultants, researchers, counsellors, parents advocates and as well as trans youth themselves. It provides stories of parents and youth along with practical and sensitive parent-to-parent and professional therapeutic advice. **Website:** http://www.ctys.org/programs/prideprejudiceparents.htm

TransKids Purple Rainbow. (2008). *10 Most commonly asked questions.* Florida: TransKids Purple Rainbow Foundation. This resource answers commonly asked questions by families with a child expressing gender variance. **Website:** http://www.transkidspurplerainbow.com/pdf/10questions.pdf

True Colours represents young people who experience transsexualism and a network of their parents, families and supporters throughout Australia. **Website:** http://www.truecolours.org.au/index.html

Useful Resources & Websites for Schools

Gender Identity Research and Education Society (GIRES). (2008). *Transphobic bullying in schools: could you deal with it in your school*. London, UK: Home Office. This guides schools on effective ways to support and protect transgender pupils and staff. It addresses the needs of parents and families supporting their trans children. A useful guide for schools with explanations and potential safety issues that may arise and advice on management. **Website:** http://www.gires.org.uk/transbullying.php

Family Planning NZ. (2007). *The Family Planning Affirming Diversity* resource is a training resource to help schools be more accepting of diversity. **Website:** http://www.familyplanning.org.nz/resource_shop/order_online/teaching_resources

Qtopia provides a social support group for queer youth that affirms and appreciates the diverse qualities of participants. By providing a safe and interesting space for queer youth to meet others, q-topia aims to provide an environment where those who attend the group can safely explore issues and be supported in having pride in who they are. **Website:** http://www.qtopia.rainbow.net.nz

Rainbows Youth's drop-in centre in central Auckland is open every weekday. Come along, hang out, meet new people, surf the web, check out our library of books and DVDs, and talk to our friendly staff. There is also a range of classroom resources and list of school support groups. They provide support for trans and queer young people and their families. Can provide contact details for trans-inclusive youth groups in other parts of the country. **Website:** http://www.rainbowyouth.org.nz/

Safety in Schools: NZ AIDS Foundation, Rainbow Youth, Outthere. 2005. An action kit for Aotearoa New Zealand schools to address sexual orientation prejudice. This is available via **SPINZ Website:** http://www.spinz.org.nz/resourcefinder/index.php?c=listings&m=results&topic=113

Transtastic: Trans resource for schools (draft) produced by Rainbow Youth (supported by HRC). They aim to have it completed by June 2011. **Website**: http://www.rainbowyouth.org.nz/transtastic

Appendix 11

List of Professionals

Name	Contact Details
John Newman (Youth Physician)	24A Williamson Ave, Grey Lynn Mobile: 021 629 067 Email: johnnewman.nz@gmail.com
Rachel Johnson (Paediatrician)	Kidz First Hospital & Community Health Centre for Youth Health Counties Manukau DHB Private Bag 93311, Otahuhu 1640 Website: http://www.healthpoint.co.nz/default,23135.sm Phone: (09) 261 2262
John Delahunt (Endocrinology Specialist)	Capital & Coast DHB Endocrine Service Wellington Hospital - Nga Puna Waiora Wellington Hospital Private Bag 7902, Wellington South Phone: (04) 806 2140 or Phone: (04) 358 5999
Antony Felin (National Executive Officer)	NZ Association of Counsellors Website: http://www.nzac.org.nz/ Phone: (07) 834 0220 Email: execofficer@nzac.org.nz
E Peter Walker (Plastic Surgeon)	E Peter Walker Plastuc & Reconstructive Surgery Block 1 St Georges Medical Centre 249 Papanui Road, Christchurch Phone: (04) 03 3559 089 Email: e.peter.walker@xtra.co.nz