YOUNG PERSON'S GENDER SERVICE ASSESSMENT PROTOCOL

Assessment length

The assessment will consist of a minimum of 4-6 appointments over at least 6 months (monthly appointments).[1] It is important for service-users to be aware that this is the minimum length of assessments. Assessments very often take longer than this, depending on the nature of the young person's/family's story and needs. The length of time taken to carry out these appointments will be at the discretion of the clinician. It is not possible to give certainty regarding how long an assessment will take.

Format of appointments

The format of appointments will likely be a combination of remote (telephone or video calls) and face-to-face appointments. Appointments will be tailored to the needs and understanding of the young person and their family. They will involve a number of methods of communication where appropriate: verbal, pictorial, play-based, etc.

Systemic nature of assessment

As per best practice guidelines, assessments of under 18s within gender services should be systemic and involve multiple sources.[2] In other words, assessments should include information gathering from other key systems involved in the young person's life: family, education, healthcare, etc. Parents/caregivers should be included in assessments, given the degree to which adolescents and children tend to be dependent on their parents/caregivers. There should be good clinical or social reasons for parents/caregivers to be excluded from assessments.

Appointments should consist of a mix of joint appointments with young people and their parents/caregivers, appointments with the young person only, and appointments with parents/caregivers only. For older adolescents (16+), while information-gathering sessions with parents remain an important part of the assessment, adolescents should provide consent for any information to be shared with parents. The exception for this is where matters relating to risk or safety arise.

Content of assessment

In line with best practice guidelines, a comprehensive biopsychosocial assessment should be undertaken with all young people considering hormonal interventions for gender dysphoria (ie. puberty blockers or gender affirming hormones).[1,2,3,4]

The assessment should cover the following areas:

- Introduction, confidentiality, explanation of service, explanation of assessment process and what to expect
- Address fears, hopes and expectations from young person (YP)and family re. assessment process

- Current context (level of current functioning, quality of life, etc).
    - Family structure and functioning
    - Social context (friends – both real world and online)
    - School – including educational functioning / early school leaving
    - Engagement with further education / employment
    - Wider community (activities, groups, etc)
    - Hobbies and interests
    - Support system and its ability to support the young person (particularly in relation to medical interventions)

- Gender
    - Current gender identity
    - Current gender expression
    - Development of gender narrative: past identity/identity development, development of gender expression
    - Timeline of gender identity
    - Experience/stage of social transition
    - Experience of/barrier to coming out
    - Impact of puberty/body changes
    - Gender dysphoria: present? Intensity? When did it start? Coping strategies?
    - Family/friend/school views
    - Barriers to (social) transition?
    - Presence of Gender Incongruence (ICD-11)

- Values/goals and hopes for future
    - Values
    - Goals re. future, career, relationships, social functioning, physical health, etc.

- Mental health
    - Emotional and behavioural functioning
    - Experience of Minority Stress
    - Experience of difficult live events
    - Coping styles
    - Risk assessment covering a number of domains (mental health, alcohol / substance misuse / dependence, sexual abuse, sexual exploitation, neglect, physical abuse, risk of harm to self or others, physical health needs met, educational needs met)
    - Sleep/appetite
    - Onset of mental health difficulties, if present
    - Formulation of mental health difficulties – as a result of gender identity difficulties? Other factors at play?

- Body image
    - General body image – body image concerns aside from gender
    - Gender dysphoria re. body
    - Mental health concerns re body image (eating disorders, body dysmorphia)

- Sexuality and relationships
    - Stage of development
    - Experience of romantic relationships
    - Identification re. orientation
    - Barriers to age-appropriate exploration of sexuality/relationships
    - Understanding and consideration of the impact of hormonal treatments on sexuality and sexual functioning

- Developmental history with parents/caregivers (utilise separate Developmental History proforma for additional structure)
    - Physical, cognitive, social and emotional development
    - Developmental milestones
    - Potential neurodevelopmental difficulties
    - Current stage of development

- Physical health
    - Physical health history
    - Any chronic illness?
    - Hx of any significant acute illness?
    - Management of chronic illness: what does this involve? What medical teams are involved? How does YP/family get on with this – any adherence issues?

- Capacity to consent to medical procedures (in family and YP and for those requesting this or for whom the clinician feels may benefit from this)
    - Motivation re medical intervention
    - Knowledge and understanding of medical interventions
    - Understanding of pros and cons of procedures, including potential negative side effects/long term impacts (potential impact on physical health/fertility, possibility of detransition/change of mind, etc)
    - Expectation of what intervention entails
    - Expectation of outcome (realistic?)
    - Awareness of alternative options (including non-medical options) and pros and cons of these
    - Gillick competence
    - Any worries?
    - Feel they have been given enough information?

- Ability to think about 'future self'. Future orientated?

- Fertility preservation options

- Emotional, cognitive and social maturity
    - Ascertained via above assessment as a whole and ability to reflect on the nature of life-long, irreversible treatments etc

Standardised Measures

As is standard practice in psychological and mental health assessments with young people, the assessment should incorporate relevant standardised psychometric measures that have been standardised and validated on adolescent and child samples.[2]

Other Considerations

Risk management

If during the assessment risk is identified, then this will be assessed and a short-term plan put in place whilst liaison with local services takes place. The clinician can make use of supervision, NHSGG&C Child Protection Unit, GP, CAMHS local to the young person and Social Work Services local to the YP to assist in the management of the risk.

Psychological or other interventions

As part of the assessment the clinician may find that brief psychological intervention such as the management of anxiety or distress is indicated and this will be carried out. If the young person requires more substantial intervention then discussion will take place about the potential for a referral to their local mental health service (CAMHS or other services as appropriate) with the plan for a joined up approach between the YP Gender Service and that service in order to best support the young person.

Assessments by other services

In some cases, other assessments may be helpful where unmet needs have been identified (eg. neurodevelopmental assessment, assessment of cognitive functioning, etc). Service users should be referred to the relevant services for the completion of these assessments.

Working with young people with social communication difficulties

There is a high rate of autistic spectrum disorder (ASD) in the young people referred to the Young People's Gender Service. ASD is associated with difficulties with social communication. Guidelines on working with individuals with ASD and gender dysphoria indicate that assessments will likely need more time as a result.[5]

In particular, ASD can involve difficulties with expressive communication. Individuals with difficulties with expressive communication will likely struggle with communicating information during an assessment. In these cases, it may be necessary to work with other professionals in order to help the young person to express their experiences and needs. Speech and language therapists trained in 'Talking Mats' may be especially helpful in these instances.

Information giving

A key part of the assessment involves giving a young person and a family information about relevant topics (eg. about puberty, sex hormones, the effects and

risks of hormonal treatments, fertility and fertility preservation, etc) and subsequently assessing a young person and parent/caregivers understanding of this information.[2,3]

Assessment with young people with Learning Disabilities (LD) or Cognitive Impairment (CI)

Determining Gillick competence in young people with LD and CI is a complex process. There are a number of complex issues to consider in relation to hormonal treatments (for example, their long term impacts on sexual function and fertility). Consideration needs to be given with regards to how best to assess young people with LD or CI, and the role of parental/caregiver consent in instances where Gillick Competence cannot be determined.

This document has been drafted by senior clinicians in the Young Person's Gender Service. It was made with reference to w-PATH guidelines, Standards of Care Version 8, the current best practice guidelines for transgender health. In addition, colleagues from the Dutch, Australian and English models of service delivery were consulted as part of the drafting process to ensure the assessment preform is in line with current international best practice in Young Peoples Gender Services.

REFERENCES

1. Young adult psychological outcome after puberty suppression and gender reassignment. De Vries, McGuire, Steensma et al, Paediatrics 134 (2014) ('The Dutch Model')
2. World Professional Association for Transgender Healthcare (WPATH), Draft Standards of Care, Version 8 (Child and Adolescent Chapters)
3. Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse People, Child & Adolescent Version
4. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guidelines. Hembree, Sjoen et al, J Clin Endo Metab (2017)
5. Initial clinical guidelines for co-occurring autism spectrum disordering gender dysphoria or incongruence in adolescents. Strang, Meagher, Kenworthy et al, JCPP (2018)