Managing Transgender Patients Within a Single Gender Psychiatric Intensive Care Unit (PICU)

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Aims and Hypothesis:

There have been three reported suicides of transgender patients within prison services over the past year. There is limited evidence available beyond anecdotes, related to experience of managing transgender patients within services. Are providers of psychiatric services appropriately resourced to manage gender variant patients?

RELEVANT LAW

Equality 2010 Act – Given equal protection of all 7 equality strands: AGE, DISABILITY, GENDER, GENDER IDENTITY, RACE, RELIGION, SEXUAL ORIENTATION
Sex Discrimination Act 1975 (as amended) – Protects against discrimination and harassment in Employment, Vocational Training and Good & Services
Gender Recognition Act 2004 – Protects people whom intend to live in a particular gender for the rest of their lives
Data Protection Act 1998 – 'Sensitive' records such as health records must not be divulged unless consent is sought (unless significant threat to life and to protect vital interests of the person)
Any disclosure of confidential information should be in accordance of Caldicott Principles 1) Justify purpose 2) When absolutely necessary 3) The minimum that is required 4) Access should be on strict 'need to know' basis 5) Staff must understand their responsibilities 6) All staff must understand and comply with the law.

BACKGROUND

Gender variant patients already suffer significant challenge in their transition which is compounded by the lack of specific service provision. A survey of 10 000 people undertaken in 2012 by the Equality and Human Rights Commission found that 1% of the adult population was gender variant. About 1 in every 30,000 people have gender dysphoria pronounced enough for them to seek medical attention. Of these, 73% have experienced public harassment including violence, and 29% have been refused treatment by a doctor or nurse, and 35% have attempted suicide at least once.

METHOD

This will focus on the experience of managing two patients, both biological females living as males, within a male PICU. We will discuss anecdotally the impact on the service with no previous experience of managing a transgender patient. Given that only two patients have been managed, there are clear limitations to this Poster, though we argue that there is value in sharing our experience, nonetheless.

RESULTS

Both patients had significant histories of mental illness with repeated presentations to the GP and then Community Mental Health Team in a state of crisis, with features of parasuicidal behaviour. Both shared histories of repeated inpatient stays for short periods and then rapid destabilisation within community following discharge. Both patients' progress to full gender reassignment was hindered by repeated attempts to self-harm, which was perpetuating the incidents of self-harm. Both had shared histories of traumatic childhood and met criteria for Emotionally Unstable (Borderline) Personality Disorder (ICD-10, F60.31).

Patient 1 was admitted to the PICU subject to s3 MHA, after a suicide attempt with externally directed aggression. There was evidence of pseudo-hallucinations that were distressing. Patient 2 was admitted after assessment in a Police Station after non-compliance with medication in the previous month and cannabis use. He presented with threats to kill and reporting hearing the voice of previous abuser taunting him. He was admitted subject to s2 MHA a year after Patient 1's discharge.

Patient 1's pathway

Staff developed specific care-plans to safely manage a transgender within a male PICU. This included how to address the patient appropriately and sensitively. His discharge was delayed significantly due to placement funding difficulties, possibly exacerbated by his transgender status. He was eventually discharged to a male adult open ward.

Patient 2's pathway

There were fewer incidents of incorrectly and unhelpfully referring to the patient as 'he'. Care plans were developed quickly to manage risk as well as the specific risks based on being biologically female, such as during restraints. The team also organised a formulation meeting led by the Psychologist where any concerns could be managed and discussed openly, with a constructive conclusion drawn. Issues were also discussed at a reflective practice meeting. Patient 2 also benefitted from having a Care Coordinator that was able to help facilitate rapid discharge after medication had been recommenced. Patient 2 was discharged after two weeks into the community.

CONCLUSION

On reflection, the experience of managing Patient 1 within the PICU helped improve the confidence of staff to manage Patient 2 as any other male patient, though with individual needs also identified. Avoiding labels and awkwardness around the use of pronouns was identified early on as a barrier to the development of a therapeutic relationship with Patient 1. Having opportunities for reflection and a formulation meeting also contributed to the improved management of Patient 2.

All UK service providers must uphold requirements of The Equality Act 2010, The Human Rights Act 1998 and The Gender Recognition Act 2004. We conclude that steps to eliminate discrimination (direct or indirect), harassment or victimisation within service provision needs to occur. Services need to re-evaluate their resources to manage this patient group in conjunction with shared learning from other services, and there needs to be further education to reduce the stigma that this group receives, as afforded to them by The European Court of Human Rights.

Reference: THOM B et al. Transgender Guide for NHS Acute Hospital Trust. Royal Free Hampstead NHS Trust