# **Title:** Patient satisfaction with gender identity clinic services in the United Kingdom

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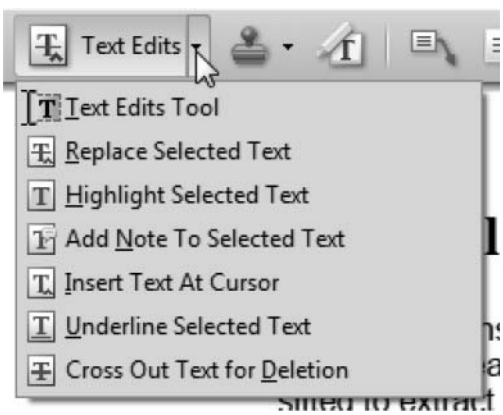


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# Patient satisfaction with gender identity clinic services in the United Kingdom

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Measuring patient satisfaction is important in assessing healthcare outcomes due to the growing emphasis on greater partnership between providers and consumers. National Health Service (NHS) commissioning bodies in the United Kingdom increasingly expect patient satisfaction to be included as a service performance indicator as it is regarded as part of the definition of quality of care. The aim of this survey is to better understand levels of satisfaction with current gender identity clinic services (GICs) provision and to identify areas for improvement. A Patient Satisfaction Questionnaire (PSQ-GD) was developed specifically for use in GICs in the United Kingdom, which was given to all patients during one month. PSQ-GD covers clinical care, administrative and procedural issues as well as patient experience of local service provision from their General Practitioner, local psychiatric services and speech therapy. A total of 330 PSQ-GD were given with a response rate of 85%. Ninety-four percent would recommend the services if a friend or relative had a gender-related problem. Twenty percent were dissatisfied with the level of support for others close to the patient. Thirty-one percent were dissatisfied with local psychiatric services. Twenty-seven percent were dissatisfied with the wait for the first appointment. Administration scored high on satisfaction. A total of 222 positive and 131 negative comments were made. The PSQ-GD offers an opportunity to understand levels of satisfaction with current gender service provision and identifies areas for improvement, most notably the interface between GICs and local psychiatric services. Findings from this study put individual complaints in perspective and show that despite the challenges inherent in providing transgender care good satisfaction can be achieved. We encourage gender care providers to implement quality assurance and improvement procedures to give people with gender dysphoria the opportunity to provide feedback and have a voice in shaping their own health care.

**Keywords:** questionnaire; satisfaction; gender dysphoria; gender identity; gender clinic; National Health Service

## Introduction

Patient satisfaction can be defined as the patient subjective evaluation of healthcare services received. Measuring patient satisfaction is increasingly important in assessing healthcare outcomes due to the growing emphasis on greater partnership between providers (doctor, nurse, therapist, staff) and consumers (patient/client/service user) in healthcare services (Bockting, Robinson, Benner, & Scheltema, 2004). Moreover, National Health Service (NHS) commissioning bodies in the United Kingdom increasingly expect patient

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satisfaction to be included as a service performance indicator as it is regarded as part of the definition of quality of care. Consequently, there has been a growing interest in developing and publishing outcomes of patient satisfaction in all areas of health care with the aim of improving standards of care (Berg, Ekengren, Lee, Acuna, & Burdsal, 2012; Bjertnaes, Sjetne, & Iversen, 2012; Campbell et al., 2009; Lliffe et al., 2008; Raleigh, Frosini, Sizmur, & Graham, 2012).

In care of transgender persons within gender identity clinic services (GICs), achieving good patient satisfaction is particularly challenging given the primary role mental health professionals play as arbiters of who has access to hormone treatment and sex reassignment surgery (SRS) and when such candidates are ready. Dependence on a mental health professional in this "gate-keeping" role is perceived by some members of the transgender community as unnecessarily pathologizing (Bockting et al., 2004; Whittle, Turner, & Al-Alami, 2007). Furthermore, few existing GICs and long waiting times for a first appointment are not conducive to high levels of patient satisfaction (Combs, Turner, & Whittle, 2008; NHS Audit, Information & Analysis Unit, 2008; Bouman and Richards, 2013).

Certainly, the outcome of sex reassignment surgical services has been extensively evaluated, with the subjective satisfaction of transgender patients after surgery as the main indicator of success (Berry, Curtis, & Davies, 2012; Khoosal, Grover, & Terry, 2011; Lawrence, 2003; Nelson, Whallett, & McGregor, 2009; Rehman, Lazer, Benet, Schaefer, & Melman, 1999; Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). However, the focus of these studies was on the satisfaction with the outcome, rather than on the process and specifics of transgender-specific healthcare services received. To our knowledge, only three studies systematically assessed transgender patients' opinions about transgender-specific healthcare delivery.

In the United States, Rachlin (2002) assessed the experience of psychotherapy among a convenience sample of 93 transgender individuals and found a significant correlation between satisfaction and patients' perception of the therapists' expertise in transgender health. Her study is limited by the use of a convenience sample of transgender individuals who varied greatly in whether or not, and if so, what type of approach to transgender health care they received. Two years later, Bockting et al. (2004) developed a Patient Satisfaction Questionnaire (PSQ) specifically for use in transgender health care in the United States. His survey of 180 transgender and 837 other sexual health patients found high rates of satisfaction and few significant differences between transgender and other sexual health patients; nonetheless the results helped target areas in need of improvement (e.g., friendliness and courtesy of staff, handling of phone calls) and stimulated the providers to improve services further. Wylie, Fitter, and Bragg (2009) adapted this PSQ for use in identifying patient satisfaction with specialist clinical services for sexual-, relationship-, and gender-related problems in the United Kingdom. The survey found that 78% of 23 gender clinic patient respondents and 84% of 31 sexual clinic patient respondents expressed being satisfied or very satisfied with the service. Limitations of this survey include small patient numbers and a low response rate (32%). The aim of this study is to better understand the levels of satisfaction with current gender service provision at the two main GICs in the United Kingdom. The study will be also able to identify areas for improvement in these clinics.

## Method

### *The settings*

Charing Cross Gender Identity Clinic (CX GIC) is the largest and oldest gender identity clinic in the world and has been in operation since the 1960s. The clinic is nationally

commissioned and accepts referrals from all over the United Kingdom and deals with a wide variety of people who have issues around their gender. The Nottingham Gender Clinic (NGC) was established in 1997 and is also a nationally NHS commissioned service, which incorporates psychiatric and psychological assessment, endocrine assessment and treatment, and supportive psychotherapy, if required, for people with gender dysphoria.

### *Participants*

The survey population consisted of patients attending the respective GICs at the time of the survey. At CX GIC the survey was conducted during April 2011 and at NGC during May 2011.

### *Instruments*

The original PSQ was used to evaluate service effectiveness and patient satisfaction with psychological services at child guidance clinics (Robinson, 1988, 1989, 1991). Minor modifications between 1994 and 1995 were made by Bockting et al. (2004) and the questionnaire continued to be used by the psychotherapeutic, psychiatric, and sexual medicine services at the University of Minnesota sexual health clinic. With the permission of Bockting et al. (2004), the questionnaire was adapted for use in GICs in the United Kingdom by Wylie et al. (2009). Style of grammar and language was changed accordingly. The authors made some further modifications and developed and used the PSQ-GD (see Appendix 1). The questionnaire includes 19 specific questions to which respondents marked their answer using a 5-point Likert scale reflecting levels of satisfaction. The questionnaire also asked open questions allowing respondents to expand on positive or negative experiences of attending the clinics and any further services they would like to see as part of the service provision and any changes they would like to see at the clinic. Following two meetings between clinicians at CX GIC and NGC some further modifications were made to the PSQ. The PSQ was developed (PSQ-GD) specifically for use in gender identity clinics in the United Kingdom and is reproduced in Appendix 1. The PSQ-GD covers the provision of direct clinical input from the gender identity clinic, administrative issues as well as their experience of local service provision from their general practitioner (GP), local mental health services, and speech therapy.

### *Procedure*

Gaining access to large numbers of trans people who are either markedly dysphoric about their gender or else have a strong identity other than that assigned at birth is extremely difficult. Consequently, most studies on trans people rely on online data collection with a self-report of identity, which may be at odds with the day-to-day reality of that person's life. In this study, due to the nature of people attending gender clinics, a more specific sample was obtained; however, this too brought with it some methodological problems, not least of which was presenting a survey that would not alienate the clients of the clinic in the way in which all too often trans research does (Richards, Barker, Lenihan, & Iantaffi, in press). Consequently, on occasion, methodological rigor was sacrificed in favor of client (patient) experience. Future replication may be well served by considering how this may be made more robust while still retaining the comfort of those people seeking assistance in these settings.

Patients attending their CX GIC clinic appointment were handed the PSQ on their arrival at the reception desk. They were asked by the receptionist to complete the questionnaire before leaving the clinic. Once completed, the questionnaire could be posted into a box within the waiting room. The completed questionnaires were collected at CX GIC at the end of each day. At NGC patients were handed the PSQ after their appointment by their clinician together with an addressed stamped envelope. Once completed, the questionnaire could be given to the receptionist, or alternatively, could be posted via the mail. At both GICs, it was explained that the survey was anonymous. These differences in approach may, of course, have affected the nature of the responses given. However, given the clinics each have different layouts and staffing levels, it was thought best to match the method of return to the clinic rather than have a standardized method of return that may have been taken differently by the participants in each setting. In this way, it was hoped that the data returned would not be overly influenced by the context.

### *Analysis*

Following data collection, the data from both clinics were pooled and the combined data analyzed using descriptive statistics. The responses from the returned PSQs were categorized into two groups. The first group concerned those scoring between 1 and 3, i.e., "very dissatisfied," "dissatisfied" and "neither satisfied or dissatisfied." The other group included, "pleased" and "very pleased" (scoring 4 or 5) in order to discriminate those people who were pleased with the services offered from those who are not. If the question was not relevant to the respondent it was marked as Not Applicable (N/A). The Likert scale is represented on the *x*-axis of the graphs. As the aim was to describe patients' views of Gender Clinic, the study uses descriptive data with values of means and standard deviations. No comparison between GICs was made, as this was not part of the overall objective of the survey.

## Results

### *Patient and treatment characteristics*

A total of 330 patients were invited to participate in the study. Out of the 330 PSQ-GD that were handed out a total of 282 were returned, giving a response rate of 85%. The overall findings from the PSQ-GD are shown in Figures 1–19. The survey includes questions in three broad themes, clinical care, administration, and procedural issues.

### *Clinical care*

With regard to satisfaction with the level of support for others close to the patient ($n = 158$), the mean rating was 3.66. Close to 60% of respondents were pleased or very pleased. In relation to the clinics supervision of the patients time living in their chosen gender role ($n = 179$), the mean rating was 3.91 with 70% expressing they were either pleased or very pleased. For speech and language therapy ($n = 62$) the mean rating was 3.74. Sixty-five were pleased or very pleased.

There were three questions related to hormone therapy. In relation to information given by the clinicians about hormone treatment ($n = 222$), the mean rating was 3.93. Seventy-one percent of respondents were pleased or very pleased. Concerning provision of hormone treatment from their general practitioner (GP) ($n = 178$), the mean was 4.07.

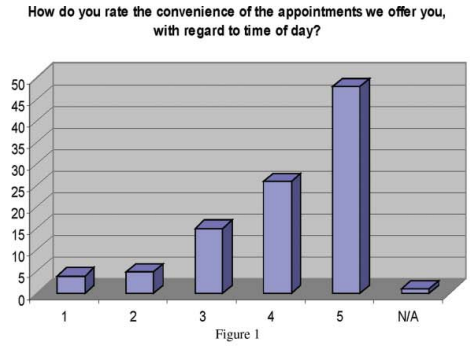
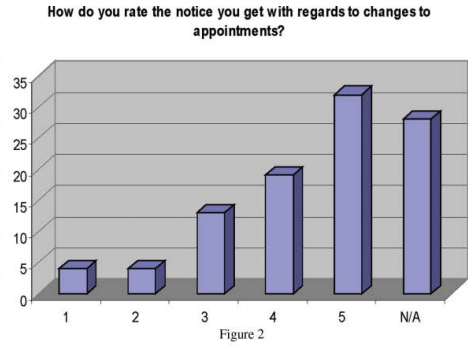



Figure 1

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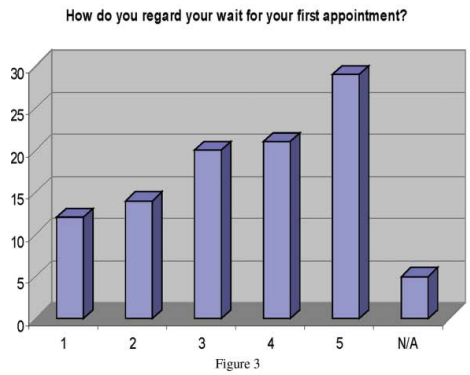


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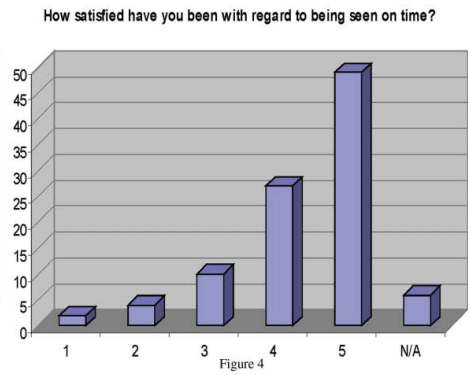


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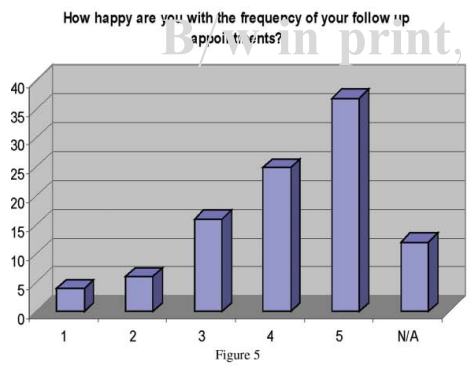


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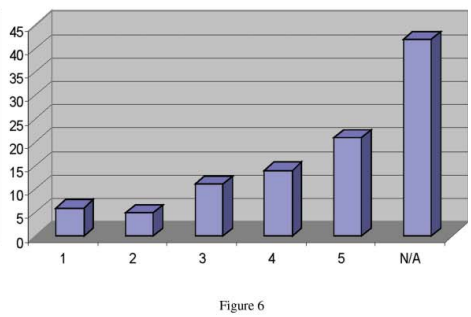


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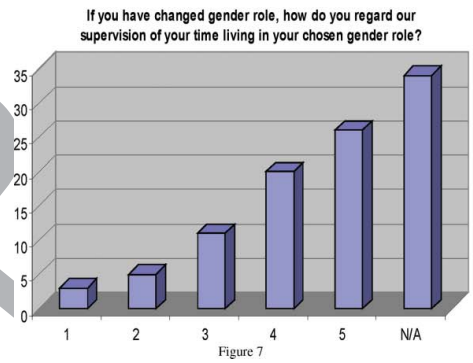


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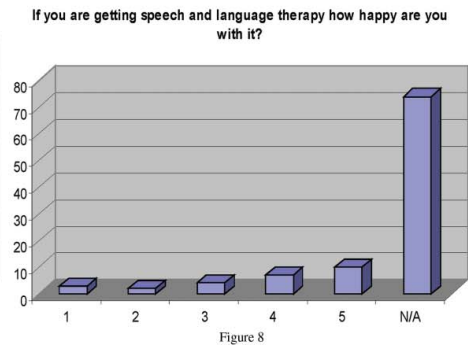
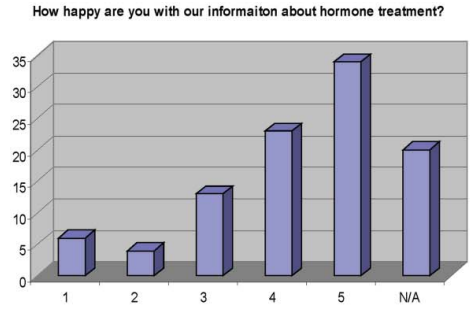



Figure 8

Figures 1–19. Results (in% on *y*-axis) corresponding with questions of PSQ-GD (from left to right). The Likert scale is represented on the *x*-axis from 1 (very dissatisfied) to 5 (very pleased).

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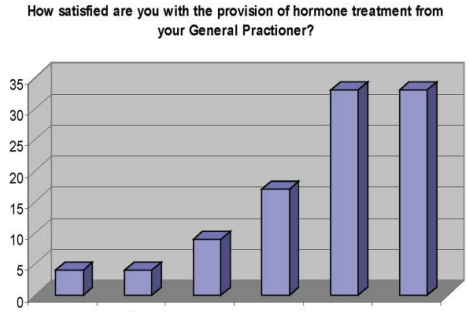


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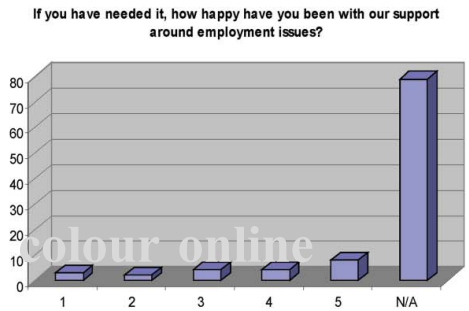


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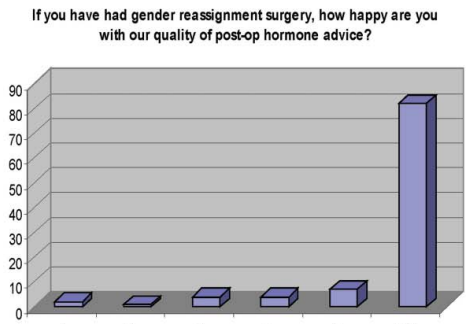



Figure 14

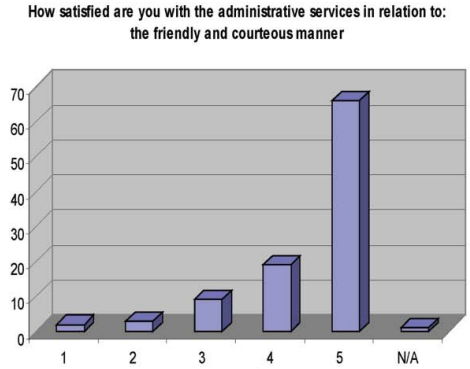
Figures 1–19. (*Continued*)



Seventy-five percent being pleased or very pleased. For individuals who had received postoperative hormone advice ($n = 38$) the mean rating was 3.71. Sixty-one percent expressed they were either pleased or very pleased.

In terms of patients who continued to receive support from local mental health services ($n = 86$), the mean was 3.32. Fifty-four percent were either pleased or very pleased. This meant that 31% were either dissatisfied or very dissatisfied with local mental health services.

For satisfaction regarding support around employment ($n = 45$), the mean was 3.46. Fifty-six percent being pleased or very pleased. For support regarding childcare ($n = 14$),

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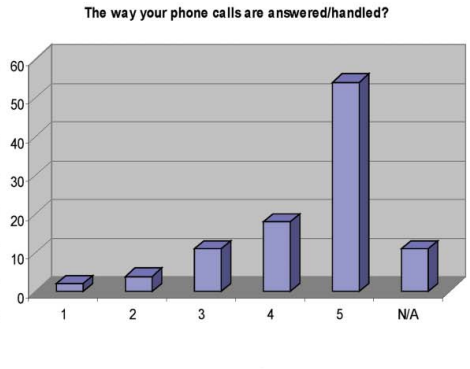


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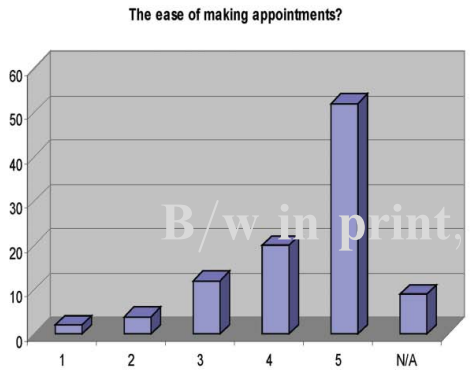


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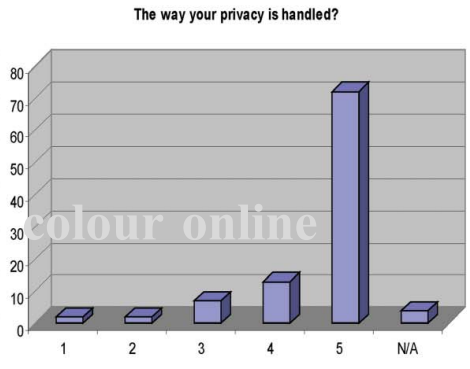


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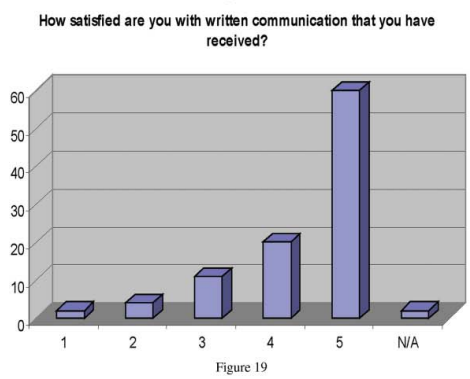


Figure 19



Figures 1–19. (*Continued*)

the mean was 3.64 with 55% being pleased or very pleased. Less than 5% of the 288 overall respondents considered this question applicable to their situation (see Table 1).

### *Administration*

With relation to the friendliness and courteous manner of administrative staff ($n = 273$), the mean rating was 4.50. 86% were either pleased or very pleased in this regard. Regarding the way phone calls were answered/handled ($n = 245$), the mean rating was 4.35, with 80% being either pleased or very pleased. In relation to the satisfaction in the way

Table 1. Results of the PSQ-GD questionnaire, means, standard deviation and percentage of pleased and very pleased patients.

| Questions | *N* | Mean | SD | Percentage of very pleased or pleased |
|---|---|---|---|---|
| How do you rate the convenience of the appointments we offer you, with regard to time of day? | 282 | 4.12 | 1.103 | 75% |
| How do you rate the notice you get with regard to changes to appointments? | 201 | 4.04 | 1.135 | 70% |
| How do you regard your wait for your first appointment? | 272 | 3.40 | 1.379 | 53% |
| How satisfied have you been with regard to being seen on time? | 261 | 4.29 | 0.952 | 82% |
| How happy are you with the frequency of your followup appointments? | 249 | 3.98 | 1.125 | 71% |
| How happy are you with our level of support for others close to you? | 158 | 3.66 | 1.334 | 60% |
| If you have changed gender role, how do you regard our supervision of your time living in your chosen gender role? | 179 | 3.91 | 1.177 | 70% |
| If you are getting speech and language therapy how happy are you with it? | 62 | 3.74 | 1.354 | 65% |
| How happy are you with our information about hormone treatment? | 222 | 3.94 | 1.213 | 71% |
| How satisfied are you with the provision of hormone treatment from your general practitioner? | 178 | 4.08 | 1.186 | 75% |
| If you are also getting help from your local mental health services, how happy are you with the level of their support? | 86 | 3.33 | 1.568 | 54% |
| If you have needed it, how happy have you been with our support around employment issues? | 45 | 3.47 | 1.575 | 57% |
| If you have needed it, how happy have you been with our support around childcare and child access issues? | 14 | 3.64 | 1.598 | 55% |
| If you have had gender reassignment surgery, how happy are you with our quality of post-op hormone advice? | 38 | 3.71 | 1.313 | 61% |
| | How satisfied are you with the administrative services in relation to | | | |
| The friendly and courteous manner | 273 | 4.50 | 0.883 | 86% |
| The way your phone calls are answered/ handled | 245 | 4.34 | 1.011 | 81% |
| The ease of making appointments | 249 | 4.30 | 1.012 | 80% |
| The way your privacy is handled | 262 | 4.63 | 0.810 | 89% |
| How satisfied are you with written communication that you have received? | 271 | 4.37 | 0.983 | 82% |

their privacy was handled ($n = 262$), the mean rating was 4.63, with 89% being either pleased or very pleased. For written communication from the clinic ($n = 271$) the mean rating was 4.37, with 82% either pleased or very pleased (see Table 1).

### *Procedural*

Procedural issues within this survey relate to appointments at the clinic. Satisfaction with the convenience of appointments ($n = 282$) had a mean rating of 4.30 with 75% being either pleased or very pleased. With regards to the wait for the first appointment ($n = 272$) the mean rating was 3.37, with 52% either being pleased or very pleased.

In relation to satisfaction with the punctuality with appointments ($n = 261$) the mean rating was 4.29, with 82% were pleased or very pleased on being seen on time. In terms of satisfaction regarding the frequency of appointments ($n = 249$) the mean rating was 3.98. Seventy-one percent were pleased or very pleased (see Table 1).

### *Written comments on aspects of the service and suggestions for change*

#### *Recommendation of service*

A total of 254 (88%) patients responded to the question "Would you recommend our services if a friend or relative had a gender related problem?" This was a free text response; however, the participants gave answers of an unequivocal valence and so responses have been coded quantitatively here: 239 (94%) responded "Yes" and 7 (2.8%) responded "No." Five (2%) were unsure and 3 (1.2%) marked not applicable.

#### *Positive aspects*

A total of 222 positive comments were made by respondents. Although no formal qualitative analysis was undertaken, dominant themes generally related to positive contact with clinic staff. There were also general comments. For context to the above analysis they are reproduced below.

- Clinical care

  "The doctors being more in-depth and genuinely caring than private appointments, I paid a million pounds for," "The support given by my clinician in relation to my mental health/moods, which has always been ongoing support and I appreciate how my clinician has always viewed the gender issue as being separate to the mental health issue and has always had faith in my willingness to be who I am and has never felt that any mental health concern has compromised/devotion around gender," "Warm, helpful, respectful, professional, informal staff," "The feeling of being accepted, safe place, no threats."
- Administration

  "Understanding and welcoming admin staff," "Polite, friendly, respectful, positive support."
- General comments:

  "Changed my life from unhappy to happy," "My life has done a 360 turn and I am so happy," "Getting the information and help I needed to change my life," "Being treated as a person, a human, not rejected."

*Negative aspects*

A total of 131 negative comments were made by respondents. Although no formal qualitative analysis was undertaken, dominant themes generally related to waiting times, travel and the location of the clinic, administrative issues, and clinical issues either directly from the clinic or issues arising from their GP and local services.

- Waiting
  "Waiting times too long," "Initial referral wait too long," "Waiting time for treatment," "Wait between appointments," "Waiting time to access service."
- Travel and location
  "It's a long way to travel for appointments," "Distance to travel," Distance from home."
- Administrative issues
  "Leaflets and information should be available," "Not receiving letters."
- Clinical issues
  "Real-life experience should be reduced to one year for those who lived mainly as female," "Hormone therapy and protocol restrictions," "Better communication rewaiting times," "I wish I could be seen more frequently."
- General
  "Obtaining funding from my PCT," "Having to reduce my BMI for surgery."

*Proposed changes*

The following proposed changes were suggested by respondents:

- Seeking group, family or individual therapy (10 respondents)
- Reduce waiting times (9 respondents)
- Travel/location of clinic (11 respondents)
- Wanting a more flexible or reduced real-life experience (14 respondents)
- Refreshments/improve reception area (9 respondents)
- Additional changes asked for by one individual includes the following: give details privately (not in reception); give more support to GPs; a "road map" for the transition process; more information on hormone treatment; friendlier reception staff; parking; appointment booking system; better introduction for first attendance; making GPs more aware of gender services.

*Additional services*

The question: "Are there any types of additional services you would like us to provide?" rendered the following suggestions:

- Hair removal (15 respondents)
- Group, family or individual therapy (32 respondents)
- Speech therapy (9 respondents)
- Personal dress/style advice (8 respondents)
- Refreshments (6 respondents)
- Service to create a network of patients who attend the clinic (5 respondents)
- Facial feminization surgery (2 respondents)

- Other additional services requested by one respondent includes the following: helpline; a mentor; a local GIC; home visits; training GPs; change of name advice; employment advice.

## Discussion

CX GIC and NGC represent the two largest GICs in the United Kingdom. Between them they provide care for the majority of people with gender dysphoria seeking psychological and medical treatment in the NHS. The clinics follow a similar clinical protocol, which incorporates the principle of a social gender role transition period and the ethos of reversible interventions before irreversible physical interventions (Ahmad et al., 2013). The results of the PSQ-GD were pooled and analyzed together representing a sizeable cross section of patient's opinion regarding the quality of care provision in NHS gender services. The response rate of 85% is high and is likely to minimize potential biases in the sampling frame (Baruch, 1999). Moreover, it indicates that patients attending GICs want to be closely involved in, and consulted about, the clinical services available. We may expect this as perceived personal relevance of the subject matter is a strong predictor of response (Goyder, 1982; Hartge, 1999).

### *Clinical care*

Care for people with gender dysphoria involves specialist multidisciplinary input. Some of this is provided direct from the GICs or within a shared care framework within primary care services (Ahmad et al., 2013). In addition, local mental health services may continue to have input when relevant for some patients, while specialist services such as speech and language therapy, hormone treatment and psychotherapy may be accessed from the GICs or obtained from local services. The responses to questions varied the most when related to clinical care. This most likely reflects the fact that respondents to the survey were at different stages of their transition and/or had attended the clinic for different lengths of time. Moreover, the particularities for each patient and the corresponding clinical needs also vary, as well as the therapeutic relationship patients develop with their respective clinician. High levels of satisfaction were apparent for clinical care obtained directly from the GICs. This included issues relating to the overall supervision of their time living in their chosen gender role, information given about hormone treatment from the clinic as well as postoperative hormone advice. Postoperative hormone advice was applicable to relatively few patients as this advice is usually given at the patient's last appointment at the clinic before discharge.

Levels of satisfaction were also good for provision of hormones from GPs. This is at odds with the literature that suggests that almost one in eight transgender people reported that their GP refused to prescribe hormone treatment, even when recommended by GICs (NHS Audit, Information & Analysis Unit, 2008). The reason for this may simply be relief at having a GP prescribe after any previous difficulty in getting them to do so. GP prescribing is further complicated by the fact that some types of hormone therapy are not licensed for gender dysphoria, which is distinctly unhelpful (Royal Pharmaceutical Society, 2013). The level of competence that GPs have in caring for transgender patients is limited due to the relatively small numbers of patients presenting with this diagnosis (Whittle et al., 2007). As a consequence transgender individuals experience a wide variation in treatment in primary care, which is consistent with recent research findings (McNeil et al., 2012). Although the majority of GPs are found to be helpful and

supportive, almost one in six transgender people reported that their GPs were never helpful or supportive (NHS Audit, Information & Analysis Unit, 2008). GICs are tertiary services and serve large areas across the United Kingdom (Combs et al., 2008; Murjan, Shepherd, & Ferguson, 2002). This means primary care is involved in the initiation and management of hormone treatment for the majority of patients. Given the specialist nature of hormone treatment and the fact that some hormonal preparations are unlicensed, the provision of information and support to GPs as well as advocating on behalf of the patient is an important function of the GICs.

Speech and language therapy is a service funded by the majority of primary care trusts in the United Kingdom. While testosterone thickens the vocal chords and deepens the voice of trans men, estrogen therapy has no effect upon the voice (Gooren & Delemarre-van de Waal, 2007). Consequently, it is more often trans women who access speech therapy. There are specialist speech therapists based at the clinics though often therapy is accessed from patients' local services (Antoni, 2007). This survey did not differentiate where the therapy was accessed though does show there to be high levels of satisfaction for this service.

An occupational component is considered an important aspect of social gender role transition period as this facilitates social and professional interaction in the chosen gender role while potentially enabling financial independence. Anxiety can arise for individuals embarking gender role transition within the workplace, and at times people experience overt or covert transphobia within the work place or while seeking employment (Whittle, 2002; Whittle et al., 2007; McNeil, Bailey, Ellis, Morton, & Regan, 2012). However, the findings from this survey show that only a minority found this question to be relevant to them, suggesting that, for the majority of patients, there was no need of support in this regard.

The study showed that, in general, people were pleased by the level of support for significant others. However, this was somewhat at odds with the data from the individual responses. This may be because it is an extremely salient matter for those who need such support, and feel it lacking, but necessarily an irrelevance for those people for whom it is not relevant, or who are gaining sufficient support. Within both GICs this need for support for specific individuals has been acknowledged for many years and ongoing discussions regarding funding continue to take place between commissioners and clinicians. This issue of childcare may reflect the fact most respondents either do not have children or if they do, they do not feel a need or feel a reason to seek help from a gender clinic. It is also possible in some situations support regarding childcare has already been accessed from local services. There is significant evidence that (nonmandatory) counseling and psychotherapy services for carefully selected individuals improves outcome (Fraser, 2009; King, 2007; Menvielle and Hill, 2010; Menvielle and Rodnan, 2012). The same argument can be postulated regarding the need for facial hair removal for trans females (Paquet, Funal, Piérard-Franchimont, & Piérard, 2002; Schroeter, Groenewegen, Reineke, & Neumann, 2003). Differences in access to NHS treatment have given rise to the notion of a postcode lottery – that where you live defines the quality and availability of NHS Services, including GICs. Central commissioning of GICs by the NHS Commissioning Board in 2014 should ensure equity of access to assessment and treatment for all people with gender dysphoria in England and Wales (DoH, 2012).

The fact that 94% of respondents would recommend the service to others if they had a gender-related problem confirms the high levels of satisfaction related to overall direct clinical care. The levels of satisfaction are broadly similar to earlier reports in the literature (Bockting et al., 2004; Wylie et al., 2009).

***Administration***

Much of the patient experience of attending GICs is the interface they have with administration staff at the clinic. The findings from this survey broadly display high levels of satisfaction in this regard. This includes the friendly and courteous manner displayed by administrative staff, the way phone calls are answered /handled, and how privacy is managed. The ease of making appointments was also highly rated. Indeed both clinics have incorporated appointment systems allowing patients to have involvement in arranging the time and date for their next appointment before they leave the clinic. Given the sensitive and personal nature of patient information, the issue of patient confidentiality is regarded as being of paramount importance. Gender reassignment is characterized as a protective characteristic in law (Great Britain, 2010) and outing someone as transgender is potentially a criminal act (Great Britain, 2004). It is important that patients are able to regard the clinic as a safe place as this provides the base upon which a trusting and honest dialog can be achieved between patient and clinician. The issue of privacy was rated with a high level of satisfaction in this survey. Written communication was also rated with high levels of satisfaction. The communication includes initial information about the clinic prior to the first appointment, clinic appointment times as well as all clinic letters copied to the patient (cf. Department of Health, 2003).

***Procedural (appointments)***

As both GICs are outpatient based and provide care for more than 3000 current patients, the day-to-day running of the appointment system is fundamental to the efficient running of the clinic and consequently the patient experience of attending the clinic. The punctuality of clinicians in terms of patients being seen on time at their appointments was highly rated. In terms of happiness with the frequency of followup appointments satisfaction levels were also high. For both GICs the review of patients runs at approximately every 3–4 months with flexibility when appropriate and agreed upon between patient and clinicians. Furthermore, findings demonstrate good levels of satisfaction with the convenience of appointments with regard to time of day and the notice the patient is given if the clinic changes an appointment time. These issues are particularly important given that GICs are tertiary services and consequently many patients have to travel considerable distances in order to attend their appointment. Some respondents reported this as a negative aspect regarding the care they receive, as it requires time off work, as well as booking travel and sometimes accommodation. The clinics are mindful of these issues and so when appointments are booked effort is made to take into account the distance the patient has to travel.

With regards to the wait for the first clinic appointment, while 52% of respondents indicated they were very pleased or pleased regarding the length of wait, 27% expressed that they were very dissatisfied or dissatisfied. The waiting list for both GICs is dependent upon the number of new referrals made to the clinic and the capacity of the clinic in terms of new patient appointment times available. For several years, both GICs have experienced significant increases in the numbers of patients referred. Both GICs have had to significantly expand their clinical capacity in terms of clinician time available to absorb this increasing demand. In this context, a major problem is that there remains a lack of specialists available to work in gender care. The political environment of gender reassignment implicitly affects the way that the field is viewed by other healthcare professionals. This “image problem” means that it is difficult to find new people to specialize in the field (Combs et al., 2008).

Consequently, with the numbers of new patient referrals continuing to rise, waiting times will remain and pose a considerable challenge. Almost one in three patients with gender dysphoria wait 6 months or longer for a first appointment at a GIC. This figure is based on the time from referral to a GIC (whomever it was made by – GP or specialist) to the first appointment at a GIC (NHS Audit, Information & Analysis Unit, 2008). This figure does not take into account when the first contact with health services was made (i.e., seeing a GP) or any waiting time while being referred to a local mental health service. The latter is often a requirement before a referral to a gender clinic service can take place, so the majority of people with gender dysphoria have to wait a significant time before a first appointment in a GIC. Unless the NHS Commissioning Board (which nationally finances specialist services such as GICs) starts to fund specialist training in gender care and allocates additional funding for new GIC services more local to the patients very little change in access to GICs will occur.

Overall, the PSQ-GD offers an opportunity to better understand the levels of satisfaction with current gender service provision and identifies areas for improvement; most notably the interface between GICs and local mental health services for transgender patients with mental health difficulties. A significant proportion of respondents reported their dissatisfaction with the level of support provided by their local mental health services. There is some evidence to suggest that transgender people are more dissatisfied with local mental health services compared with the general population, although the underlying reasons have not been adequately investigated (Avery, Hellman, & Sudderth, 2001; McNeil et al., 2012). There are significant health disparities according to sexual orientation and gender identity, particularly in mental health (Dhejne et al., 2011; Haas et al., 2011; Mustanski, Garofalo, & Emerson, 2010), possibly due to the fact that there are very few mental health clinicians who specialize in caring for transgender communities (Rutherford, McIntyre, Daley, & Ross, 2012). There consequently continues to be a lack of training opportunities and resources specific to the provision of transgender-sensitive mental health services. Tackling these inequalities would include the introduction of mandatory transgender health content in education curricula that addresses basic terminology, appropriate interview questions to facilitate the disclosure of gender identity, information regarding the health impact of cissexism, transphobia, heterosexism and homophobia, and the specific healthcare needs of trans people.

### *Limitations of survey*

This survey has a number of limitations. First, the main limitation is that this is a questionnaire survey (McLafferty, 2003). It can be hypothesized that only those who have an interest in their care returned the questionnaire. If an alternative method had been used, for example, if independent raters interviewed the sample of patients attending the GICs, responses may have been different. This could be an area of further study.

Second, although the PSQ-GD covers a wide range of issues related to the provision of gender care the instrument is not validated. There are, however, no validated alternative instruments available. It would be helpful to validate this instrument in the future for international usage. This would also allow for more objective comparisons between services, both nationally and internationally.

Third, in order to preserve the tone of anonymity, there was no demographic variable collection. Consequently, analysis between different groups could not be determined in this sample and precluded interpretation of potentially more in-depth and therefore meaningful responses. Despite these limitations, however, the survey findings are important as

the findings identify target areas in need of improvement. Efforts by the providers to improve services will most likely result in significant increases in patient satisfaction. These findings put individual complaints in perspective and show that despite the challenges inherent in providing transgender care good satisfaction rates can be achieved. Consequently, we conclude that the PSQ-GD may be a helpful instrument to measure patient satisfaction, particularly were it to be formally validated.

In conclusion, this study shows that the PSQ-GD offers an opportunity to better understand the levels of satisfaction with current gender service provision and identifies areas for improvement, most notably the interface between GICs and local mental health services for transgender patients with mental health difficulties.

The findings from this study put individual complaints in perspective and show that despite the challenges inherent in providing transgender care good satisfaction can be achieved. We encourage gender care providers to implement quality assurance and improvement procedures to give people with gender dysphoria the opportunity to provide feedback and have a voice in shaping their own health care.

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**References**

Ahmad, S., Barrett, J., Beaini, A., Bouman, W.P., Davies, A., Greener, H.M., … Stradins, L. (2013). Gender dysphoria services: A guide for general practitioners and other healthcare staff. *Sexual and Relationship Therapy, 28*(3), 173–186.

Antoni, C. (2007). The role of the speech and language therapist. In J. Barrett (Ed.), *Transsexual and other disorders of gender identity* (pp. 139–156). Oxford: Radcliffe Publishing.

Avery, A.M., Hellman, R.E., & Sudderth, L.K. (2001). Satisfaction with mental health services among sexual minorities with major mental illness. *American Journal of Public Health, 91*(6), 990–991.

Baruch, Y. (1999). Response rate in academic studies – a comparative analysis. *Human Relations, 52*, 421–438.

Berg, G.M., Ekengren, F., Lee, F.A., Acuna, D., & Burdsal, C. (2012). Patient satisfaction with surgeons in a trauma population: Testing a structural equation model using perceptions of interpersonal and technical care. *Journal of Trauma and Acute Care Surgery, 72*(5), 1316–1322.

Berry, M.G., Curtis, R., & Davies, D. (2012). Female-to-male transgender chest reconstruction: A large consecutive, single-surgeon experience. *Journal of Plastic Reconstructive and Aesthetic Surgery, 65*(6), 711–719.

Bjertnaes, O.A., Sjetne, I.S., & Iversen, H.H. (2012). Overall patient satisfaction with hospitals: Effects of patient-reported experiences and fulfilment of expectations. *BMJ Quality and Safety, 21*(1), 39–46.

Bockting, W., Robinson, B., Benner, A., & Scheltema, K. (2004). Patient satisfaction with transgender health services. *Journal of Sex and Marital Therapy, 30*(4), 277–294.

Bouman, W.P., & Richards, C. (2013). Diagnostic and treatment issues for people with gender dysphoria. *Sexual and Relationship Therapy, 28*(3), 165–171.

Campbell, J., Smith, P., Nissen, S., Bower, P., Elliott, M., & Roland, M. (2009). The GP Patient Survey for use in primary care in the National Health Service in the UK – development and psychometric characteristics. *BMC Family Practice, 10*(57). doi:10.1186/1471-2296-10-57

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., … Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165–232.

Combs, R., Turner., L., & Whittle, S. (2008). *The "Gender Identity Services in England" mapping project report*. London: Department of Health.

Department of Health. (2012). *Equality analysis: Functions of the NHS commissioning board special health authority*. London: Department of Health.

Department of Health. (2003). *NHS policy: Copying letters*. London: Department of Health.

Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A.L.V., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS ONE, 6*(2): e16885. doi:10.1371/journal.pone.0016885

Fraser, L. (2009). Depth psychotherapy with transgender people. *Sexual and Relationship Therapy, 24*(2), 126–142.

Gooren, L.J., & Delemarre-van de Waal, H.A. (2007). Hormone treatment of adult and juvenile transsexual patients. In R. Ettner, S. Monstrey, & E.A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 73–88). New York: The Haworth Press.

Goyder, J. (1982). Further evidence on factors affecting response rates to mailed questionnaires. *American Sociology Review, 47*, 550–553.

Great Britain. (2004). *Gender Recognition Act 2004*. London: Department for Constitutional Affairs.

Great Britain. (2010). *The Equality Act*. London: Department for Constitutional Affairs.

Haas, A.P., Eliason, M., Mays, V.M., Mathy, R.M., Cochran, S.D., D'Augelli, A.R., … Clayton, P.J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality, 58*(1), 10–51.

Hartge, P. (1999). Raising response rates: Getting to yes. *Epidemiology, 10*, 105–107.

Khoosal, D., Grover, P., & Terry, T. (2011). Satisfaction with a gender realignment service. *Sexual and Relationship Therapy, 26*(1), 72–83.

King, M. (2007). A systematic review of research on counselling and psychotherapy for lesbian, gay, bisexual and transgender people. *British Journal of Guidance & Counselling, 35*(4), 474–477.

Lawrence, A.A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299–315.

Lliffe, S., Wilcock, J., Manthorpe, J., Moriarty, J., Cornes, M., Clough, R., Bright, L., & Older People Researching Social Issues (OPRSI). (2008). Can clinicians benefit from patient satisfaction surveys? Evaluating the NSF for older people, 2005–2006. *Journal of the Royal Society of Medicine, 101*(12), 598–604.

McLafferty, S.L. (2003). Conducting questionnaire surveys. In N.J. Clifford, & G. Valentine (Eds.), *Key Methods in Geography* (pp. 87–100). London: Sage Publications.

McNeil, J., Bailey, L., Ellis, S., Morton, J., & Regan, M. (2012). *Trans mental health and emotional wellbeing study*. Edinburgh: Scottish Transgender Alliance.

Menvielle, E.J., & Hill, D.B. (2010). An affirmative intervention for families with gender-variant children: A process evaluation. *Journal of Gay and Lesbian Mental Health, 15*(1), 421–438.

Menvielle, E.J., & Rodnan, L.A. (2012). A therapeutic group for parents of transgender adolescents. *Child and Adolescent Psychiatric Clinics of North America, 20*(4), 733–743.

Murjan, S., Shepherd, M., & Ferguson, B.G. (2002). What services are available for the treatment of transsexuals in Great Britain? *Psychiatric Bulletin, 26*, 210–212.

Mustanski, B.S., Garofalo, R., & Emerson, E.M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual and transgender youths. *American Journal of Public Health, 100*(12), 2426–2432.

Nelson, L., Whallett, E.J., McGregor, J.C. (2009). Transgender patient satisfaction following reduction mammaplasty. *Journal of Plastic, Reconstructive and Aesthetic Surgery, 62*(3), 331–334.

NHS Audit, Information and Analysis Unit. (2008). *Survey of patient satisfaction with transgender services*. London: Department of Health.

Paquet, P., Funal, I., Piérard-Franchimont, C., & Piérard, G.E. (2002). Long-pulsed ruby laser-assisted hair removal in male-to-female transsexuals. *Journal of Cosmetic Dermatology, 1*(1), 8–12.

Rachlin, K. (2002). Transgender individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6*(1). Retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no01_03.htm

Raleigh, V.S., Frosini, F., Sizmur, S., & Graham, C. (2012). Do some trusts deliver a consistently better experience for patients? An analysis of patient experience across acute care surveys in English NHS trusts. *BMJ Quality and Safety, 21*(5), 381–390.

Rehman, J., Lazer, S., Benet, A.E., Schaefer, L.C., & Melman, A. (1999). The reported sex and surgery of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior, 28*(1), 71–89.

Richards, C., Barker, M., Lenihan, P., & Iantaffi, A. (in press). Who watches the watchmen?: A critique on the theorization of trans people and clinicians. *Feminism and Psychology*.

Robinson, B.E. (1988). *Child guidance clinics annual program evaluation reports*. St. Paul, MN: Wilder Research Center. Amherst H. Wilder Foundation.

Robinson, B.E. (1989). *Child guidance clinics annual program evaluation reports*. St. Paul, MN: Wilder Research Center. Amherst H. Wilder Foundation.

Robinson, B.E. (1991). *Child guidance clinics annual program evaluation reports*. St Paul, MN: Wilder Research Center. Amherst H. Wilder Foundation.

Royal Pharmaceutical Society. (2013). *British national formulary*. London: BMJ Publishing Group Ltd and RPS Publishing.

Rozenblum, R., Lisby, M., Hockey, P.M., Levtizion-Korach, O., Salzberg, C.A., Lipsitz, S., & Bates, D.W. (2011). Uncovering the blind spot of patient satisfaction: An international survey. *BMJ Quality and Safety, 20*(11), 959–965.

Rutherford, K., McIntyre, J., Daley, A., & Ross, L.E. (2012). Development of expertise in mental health service provision for lesbian, gay, bisexual and transgender communities. *Medical Education, 46*(9), 903–913.

Smith, Y.L.S., Van Goozen, S.H.M., Kuiper, A.J., & Cohen-Kettenis, P.T. (2005). Sex reassignment: outcomes and predictors of treatment for adolescents and adult transsexuals. *Psychological Medicine, 35*, 89–99.

Schroeter, C.A., Groenewegen, J.S., Reineke, T., & Neumann, H.A. (2003). Ninety percent permanent hair reduction in transsexual patients. *Annals of Plastic Surgery, 51*(3), 243–248.

Weston, R.L., Hopwood, B., Harding, J., Sizmur, S., & Ross, J.D. (2010). Development of a validated patient satisfaction survey for sexual health clinic attendees. *International Journal of STD and AIDS, 21*(8), 584–590.

Whittle, S. (2002). *Respect and equality: Transsexual and transgender rights*. London: Cavendish Publishing Limited.

Whittle, S., Turner, L., & Al-Alami, M. (2007). *Engendered penalties: Transgender and transsexual people's experiences of inequality and discrimination*. Wetherby: Communities and Local Government publications.

Wylie, K.R., Fitter, J., & Bragg, A. (2009). The experience of service users with regard to satisfaction with clinical services. *Sexual and Relationship Therapy, 24*(2), 163–174.

## Appendix 1. Patient Satisfaction Questionnaire for Individuals with Gender Dysphoria (PSQ-GD)

We strive continually to improve the service we offer. We would be grateful for your views on the experience of attending this clinic in order to further improve our service. Many thanks for helping with this feedback survey.

Please grade the quality of our service with regard to the following. Please use a 'marks out of five' system by circling the appropriate number, where 1 is very dissatisfied, and 5 very pleased. If the question is not relevant to your situation please circle Not Applicable (N/A).

How do you rate the convenience of the appointments we offer you, with regard to time of day?
1 2 3 4 5 N/A

How do you rate the notice you get with regard to changes to appointments?
1 2 3 4 5 N/A

How do you regard your wait for your first appointment?
1 2 3 4 5 N/A

How satisfied have you been with regard to being seen on time?
1 2 3 4 5 N/A

How happy are you with the frequency of your followup appointments?
1 2 3 4 5 N/A

How happy are you with our level of support for others close to you?
1 2 3 4 5 N/A

If you have changed gender role, how do you regard our supervision of your time living in your chosen gender role?
1 2 3 4 5 N/A

If you are getting Speech and Language Therapy how happy are you with it?
1 2 3 4 5 N/A

How happy are you with our information about hormone treatment?
1 2 3 4 5 N/A

How satisfied are you with the provision of hormone treatment from your General Practitioner?
1 2 3 4 5 N/A

If you are also getting help from your local mental health services, how happy are you with the level of their support?
1 2 3 4 5 N/A

If you have needed it, how happy have you been with our support around employment issues?
1 2 3 4 5 N/A

If you have needed it, how happy have you been with our support around childcare and child access issues?
1 2 3 4 5 N/A

If you have had gender reassignment surgery, how happy are you with our quality of post-op hormone advice?
1 2 3 4 5 N/A

**How satisfied are you with the Administrative services in relation to:**

The friendly and courteous manner
1 2 3 4 5 N/A

The way your phone calls are answered/handled
1 2 3 4 5 N/A

The ease of making appointments
1 2 3 4 5 N/A

The way your privacy is handled
1 2 3 4 5 N/A

**How satisfied are you with written communication that you have received?**
1 2 3 4 5 N/A

**Would you recommend our services if a friend or relative had a gender-related problem?**

**What are some of the positive aspects of your experiences at the GIC?**

**What are some of the negative aspects of your experiences at the GIC?**

**If you could change anything, what would you change?**

**Are there any types of additional services you would like us to provide?**

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE**