the grave concerns and potential dangers concerning the clinical practice of euthanasia, we strongly believe in scientific evidence as important in informing the juridical, philosophical, political, societal and ethical arguments in this debate. This provides a sound basis both to legitimately question euthanasia and provide sufficient built-in safeguards to protect against potential abuses.

1 Dierickx S, Deliens L, Cohen J, Chambaere K. Euthanasia for people with psychiatric disorders or dementia in Belgium: analysis of officially reported cases. *BMC Psychiatry* 2017; **17**: 203.

2 Verhofstadt M, Thienpont L, Peters G-JY. When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *Br J Psychiatry* 2017; **211**: 238–45.

3 Dees M, Vernooij-Dassen M, Dekkers W, van Weel C. Unbearable suffering of patients with a request for euthanasia or physician-assisted suicide: an integrative review. *Psychooncology* 2010; **19**: 339–52.

4 Ministry of Justice. Law on euthanasia of May 28, 2002 [in Dutch and French], *Belgian Official Gazette*, 2002; 22 June (http://www.npzl.be/files/107a_B3_wet_euthanasie.pdf).

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The *Pool* judgment has not changed the law of expert evidence

We are concerned that the editorial by Series & Herring[1] is likely falsely to give readers the impression that the *Pool* judgment represents a change in the law of expert evidence. The judgment has not changed the law in any way. And we would advise doctors who work, or wish to work, as experts should read the detailed analysis of the current law concerning the definition, in law, of expertise recently published in *BJPsych Advances*.[2] This includes a review of the seminal cases, and also some other recent relevant judgments, none of which is referred to in the editorial. Psychiatrists undertaking expert witness practice should also refer to the Royal College of Psychiatrists' College Report CR193,[3] soon to be amended after discussions with professional and regulatory authorities so as to make the law as clear as possible to experts.

1 Series H, Herring J. Doctor in court: what do lawyers really need from doctors, and what can doctors learn from lawyers? *Br J Psychiatry* 2017; **211**: 135–6.

2 Rix K, Haycroft A, Eastman N. Danger in deep water or just ripples in the pool: has the *Pool* judgment changed the law on expert evidence? *BJPsych Adv* 2017; **23**: 347–57.

3 Rix K, Eastman N, Adshead G. *Responsibilities of Psychiatrists Who Provide Expert Opinion to Courts and Tribunals (College Report CR193)*. Royal College of Psychiatrists, 2015.

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Authors' reply: We are grateful to Dr Rix and colleagues for pointing out to those who might misread our editorial[1] that the *Pool* case has not changed the law of expert evidence, although we find it difficult to see how our brief reference to the case of *Pool* could be seen as misleading. They refer to their own very helpful analysis of recent case law on expert evidence in the September issue of *BJPsych Advances*,[2] which, unfortunately, had not been published at the time our editorial went to press.

Readers who would like a full and scholarly account of the law on expert evidence are referred to Hodgkinson & James,[3] although even the most recent edition (2015) was not able to include discussion of *Squire* and *Pool*. We look forward with much interest not only to the publication of Rix *et al*'s further article in *Advances*, but also to the revision of CR193, the College's guidance on the responsibilities of experts. All of us who give expert evidence are of course also required to take note of the relevant GMC guidance.[4]

1 Series H, Herring J. Doctor in court: what do lawyers really need from doctors, and what can doctors learn from lawyers? *Br J Psychiatry* 2017; **211**: 135–6.

2 Rix K, Haycroft A, Eastman N. Danger in deep water or just ripples in the pool: has the *Pool* judgment changed the law on expert evidence? *BJPsych Advances* 2017; **23**: 347–57.

3 Hodgkinson T, James M. *Expert Evidence: Law and Practice (4th edn)*. Sweet and Maxwell, 2015.

4 General Medical Council. *Giving Evidence as an Expert Witness*. GMC, 2017 (http://www.gmc-uk.org/guidance/ethical_guidance/21193.asp).

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Conflating sexual orientation and gender identity

It is ironic that an editorial which highlights the lack of knowledge of lesbian, gay, bisexual and transgender (LGBT) issues among healthcare professionals should open with a sentence that conflates sexual orientation with gender identity.[1] Using 'heterosexual' as a contrast to LGBT is inaccurate, as any number of trans heterosexual individuals could attest to. In their discussion of Miranda-Mendizábal *et al*'s paper,[2] Meader & Chan make it clear that the paper only covers LGB youth, and that differing sexual orientations within this group may lead to differing experiences; however, in the rest of their editorial 'LGBT youth' is treated as a monolithic entity. For example, Public Health England has two toolkits on suicide prevention in sexual minority groups, one for LGB individuals and one for transgender individuals, in recognition of the different needs of these groups (www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people), rather than a single LGBT toolkit as suggested in the editorial.

It is also perhaps disappointing that the first suggestion of why transgender young people have a greater risk of suicidality is 'higher rates of stigma'. Although this is undoubtedly important, there is increasing evidence that supporting transgender young people to live and present as their gender identity improves mental health outcomes. For example, Olson *et al* found that transgender children who were supported in their gender identities had rates of depression the same as their cisgender peers, rather than the much higher rates of depression previously reported for transgender children living as their birth-assigned gender.[3] In this context, the waiting times for gender identity clinics (GICs) should be highlighted. For many in the UK, this is more than a year: for example, the Tavistock GIC currently gives a waiting time of 14 months from referral to first appointment (https://gic.nhs.uk/appointments/waiting-times). In fact, many

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people transition socially without contact with a GIC, and others self-medicate with hormone therapy bought online.

Psychiatry and psychiatrists often have a poor reputation among sexual minority groups, for very understandable historical reasons. To overcome this, we need to provide genuinely inclusive care – which starts with knowledge and understanding.

1 Meader N, Chan MKY. Sexual orientation and suicidal behaviour in young people. *Br J Psychiatry* 2017; **211**: 63–4.

2 Miranda-Mendizábal A, Castellví P, Parés-Badell O, Almenara J, Alonso I, Blasco MJ, et al. Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis. *Br J Psychiatry* 2017; **211**: 77–87,

3 Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. *Pediatrics* 2016; **137**: e20153223.

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Authors' reply: We thank Margaret White for responding to our editorial[1] and would like to take this opportunity to respond to some of the points she makes. First, she argues that we conflated gender identity and sexual orientation and treated LGBT youth as a 'monolithic entity'. We agree that LGBT young people are not a 'monolithic entity'. We stated clearly that we think it is important to understand the experiences of LGBT young people and to identify where risks for engaging in suicidal behaviour differ between groups. We also gave brief illustrative examples of why risk factors may vary between groups.

On the basis of the findings of the Miranda-Mendizábal review[2] we stated there was insufficient data to draw firm conclusions on differences in risk of suicidal behaviour among LGB young people. In addition, the Miranda-Mendizábal review did not assess risk factors in transgender young people and therefore we could not draw conclusions from that study on differences in risk factors experienced by transgender young people and other populations. However, it is important to clarify that this does not imply that we think LGBT young people constitute a monolithic entity or that we are conflating sexual orientation with gender identity.

Second, White provides two examples that she considers reflects a conflation of gender identity and sexual orientation. We are sorry for any misunderstanding and acknowledge that wording could have been more precise.

Reading the first paragraph of the background section in context, we thought it was clear that we were not suggesting transgender young people cannot be heterosexual. Reading the two sentences that immediately follow the first sentence cited by White makes clear that the comparative data we refer to are between LGB and heterosexual young people. The data on suicidality in LGBT groups that we cited is non-comparative data.

White is correct there are two toolkits developed by Public Health England and the Royal College of Nursing that are presented together on the same web page as guidance on 'Preventing suicide: lesbian, gay, bisexual and trans young people' (www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people). We're sorry for any misunderstanding caused by the article inadvertently using the singular 'a toolkit'.

Third, as regards risk factors for transgender youth, we agree that there are a number of potential factors that may have an impact on risk of suicidality in transgender young people. When read in context as a suggestion for further research on risk factors for suicidal behaviour in transgender populations, we thought it was clear that we were citing higher rates of stigma as an illustrative example and not intending to provide a comprehensive list of risk or protective factors, as that would be pre-empting what emerges from future research.

1 Meader N, Chan MKY. Sexual orientation and suicidal behaviour in young people. *Br J Psychiatry* 2017; **211**: 63–4.

2 Miranda-Mendizábal A, Castellví P, Parés-Badell O, Almenara J, Alonso I, Blasco MJ, et al. Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis. *Br J Psychiatry* 2017; **211**: 77–87.

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Authors' reply: We thank Meader & Chan[1] for their appreciation that our review updated and refined the evidence on risk of suicidal behaviour in LGB youth. We concur with these authors that there is a lack of research about suicidal behaviour among the LGBT population. Moreover, we firmly believe that there is a need for identifying specific risk and protective factors of suicidal behaviour in this population, especially among transgender people, for better prevention. Although some factors may be common for the whole LGBT population, it is likely that different mechanisms may be operating. Longitudinal assessment of mediators such as victimisation, stigmatisation and discrimination might help to identify causal pathways for suicidal behaviours, specifically regarding sexual orientation and gender identity.[2]

We agree with White that it is important to distinguish between gender identity and sexual orientation. Considering LGBT as a monolithic identity may not be adequate since sexual orientation is a multidimensional concept referring to an enduring pattern of emotional, romantic and/or sexual attraction to males, females or both genders,[3] whereas gender identity is one's own sense or conviction of maleness or femaleness.[4] Therefore, homosexuality or heterosexuality must be understood only as forms of sexual expression, whereas transgenderism corresponds to gender identification. Sexual orientation and gender identity ought to be measured in a homogeneous way, preferably using the same definition by expert consensus, to allow comparisons between studies.[2]

Owing to the relatively small number of observations, many research studies assessing health problems among minorities are forced to consider different population groups as a single category. The LGBT population is a clear example of this is. As a previous study showed, individuals see the importance of giving health providers information about their gender identity rather than just their sexual orientation.[5] Given the underrepresentation of transgender patients in healthcare and the general population, it is crucial to include LGBT education for healthcare providers, and to provide a safe environment for LGBT individuals. These results can be a starting point for a more specific assessment of the health disparities among the LGBT population, considering that factors may affect these individuals in diverse ways.

1 Meader N, Chan MKY. Sexual orientation and suicidal behaviour in young people. *Br J Psychiatry* 2017; **211**: 63–4.

2 Miranda-Mendizábal A, Castellví P, Parés-Badell O, Almenara J, Alonso I, Blasco MJ, et al. Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis. *Br J Psychiatry* 2017; **211**: 77–87.