

A primary care perspective on gender-focused mental health services in Singapore: Correspondence

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Dear Editor,

This author read with interest the recent letter by Puthran et al. on gender-focused mental health services in Singapore,¹ as well as the subsequent correspondence by Fung et al., which contextualises the integration of such services within general psychiatric care.²

This author welcomes several key directions highlighted across both pieces, particularly the recognition of evolving models of care, and the need for system-wide capability building. This letter response offers a primary care perspective to further contextualise these discussions.

The informed consent model. First, it is encouraging that Puthran et al. acknowledge the current predominance of a mental health assessment model, noting that “most providers seem more comfortable with a prior psychiatric assessment... rather than an informed consent approach.” This distinction is important. While psychiatric involvement remains essential in selected cases—particularly those with complex presentations, significant psychiatric instability, or diagnostic uncertainty—over-reliance on mandatory assessment frameworks risks creating unnecessary barriers to care.³ The American College of Obstetricians and Gynecologists states that “current consensus is that an informed consent process without a separate letter from a mental health care professional is more than adequate for initiating therapy for those patients who wish to medically transition”.⁴ The Endocrine Society’s 2017 guidelines similarly moved away from requiring obligatory psychosocial evaluation, a position affirmed in the World Professional Association for Transgender Health Standards of Care Version 8.⁵

Research demonstrates that the informed consent model is associated with high patient satisfaction, and significantly shorter time to treatment initiation.⁶ For individuals with clear, persistent gender incongruence who are otherwise medically suitable for treatment, an informed consent model allows for more timely care without compromising safety.

Delineating case complexity. Second, this author supports the framing of case complexity, particularly the statement that “more complex cases requiring a second opinion or trained multidisciplinary support” should be referred to specialised services.¹

Implicit within this is the recognition that not all cases are complex. A substantial proportion of individuals presenting with gender-related concerns may be appropriately managed in primary care settings, provided clinicians are adequately trained and supported. Multiple healthcare systems have successfully implemented primary care-led gender-affirming hormone therapy programmes in cities including Toronto, Vancouver, Boston, and Sydney.³ Clear delineation between straightforward and complex presentations is therefore critical to avoid over-centralisation and bottlenecks in specialist services.

Co-occurring conditions as rationale for integration. Third, both letters highlight the high prevalence of co-occurring mental health and neurodevelopmental conditions among gender-diverse individuals.

From a primary care standpoint, this should not be viewed as a barrier to decentralised care, but rather as a rationale for it. Primary care physicians routinely manage mild-to-moderate mood disorders, anxiety conditions, and neurodevelopmental presentations within a biopsychosocial framework.⁵ Integrating gender care into this existing scope aligns with established primary care competencies and supports continuity of care.

Clinical guidelines for co-occurring autism and gender dysphoria emphasise the importance of assessment but do not preclude gender-affirming care. Rather, they recommend an extended diagnostic period with overlap between assessment and treatment.⁶ The presence of co-occurring conditions should trigger appropriate assessment and support, not automatic exclusion from primary care management.

Building system-wide competence. Finally, this author strongly agrees with Fung et al. in that “multiplying subspecialty silos” is unlikely to be

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sustainable in a resource-constrained system, and that “building system-wide competence” should be prioritised.²

In this regard, primary care represents a natural and scalable platform for capability building. The medications used for gender transition are common and can be safely prescribed by primary care physicians with appropriate training. Primary care physicians already have experience managing hormone-based therapies in contexts such as menopause, andropause and contraception. With appropriate training—including understanding the diagnostic criteria for gender dysphoria, prescribing and monitoring hormone therapy, managing common side effects, and recognising when specialist referral is needed—similar principles can be extended to gender-affirming hormone therapy.

Multiple studies emphasise that creating welcoming environments, training all staff in culturally competent care, and integrating gender-affirming services into existing care structures are more sustainable than creating isolated specialty clinics. The AFFIRM framework developed from patient narratives emphasises that care should be flexible, accessible, multidisciplinary, and community-centered.⁹

Singapore’s own mental health landscape demonstrates the value of primary care integration. Studies show that patients often consult multiple providers before reaching psychiatric services, with primary care serving as a key pathway.¹⁰

A pragmatic model for Singapore. Taken together, a pragmatic model for Singapore may involve:

- (1) Primary care-led management of straightforward cases using an informed consent framework.
- (2) Clear referral pathways for complex or uncertain presentations requiring specialist mental health assessment.
- (3) Shared care models linking primary care with multidisciplinary specialist services, where primary care providers maintain ongoing management with access to specialist consultation as needed.
- (4) System-wide training to improve baseline competence across providers, with emphasis on cultural humility, clinical skills, and recognition of when specialist referral is appropriate.

Such an approach would align with the goals of accessibility, equity, and sustainability, while avoiding unnecessary delays in care for patients who could otherwise be managed safely in community settings. The continuum of care framework recommended by

recent guidelines— emphasising creating an affirming environment, establishing diagnosis and goals, selecting appropriate pharmacotherapy, and monitoring both hormone levels and clinical outcomes—can be delivered effectively in primary care settings with appropriate training and specialist backup.¹¹

Ethics statement

Not applicable as no participants were recruited.

Declaration

The authors declare there are no affiliations with or involvement in any organisation or entity with any financial interest in the subject matter or materials discussed in this manuscript.

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