Inside Gender Identity: The Literature Review

A review of the evidence on meeting the health and social care needs of transgender people in the criminal justice system

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1. Introduction

This literature review has been undertaken as part of the specification of work for meeting the health and social care needs of transgender people in the criminal justice system in England.

The NHS is responsible for the provision of healthcare for people in custodial settings within the criminal justice system. The advent of the Social Care Act also places a duty on local authorities to assess the social care needs of those in custodial settings. In discharging these responsibilities the NHS and local authorities need to have due regard to the particular needs of those with protected characteristics, including Gender Reassignment (Equality Act 2010).

It is important to note that the protected characteristic of gender reassignment covers only those who are proposing to undergo, are undergoing or have undergone the process of changing their gender. However, it is best practice to consider all transgender people as though they are equally protected in the provision of appropriate healthcare services.

The terms transgender and trans are used in this report to refer to people whose gender experience, expression and behaviours are diverse and differ from those that are often associated with the sex they were born into. However, a wide variety of terms are used in the literature and where appropriate, the terms associated with the relevant literature are used. A full glossary of terms can be found at Appendix A.

2. Population estimates and demographics

In comparison to other demographic groups, there is a lack of data relating to the health of transgender people. For example, they tend not to be included in population-based studies and statistical datasets, and transgender people are under-represented in peer reviewed journals on which epidemiologists and commissioners of health services base their decision-making. Transgender populations also tend not to be included in:

- international cancer registries or national Department of Health datasets;
- the UK Census;
- the majority of Office for National Statistics surveys; and
- published research into trans health issues outside of gender reassignment pathways of care.

These data issues are further compounded by the variety of people and identities that are encompassed by the term trans. For example, some people identify as non-binary (neither solely male nor female), while others identify as gender fluid. There is a significant diversity of non-binary identities, therefore, it is important that 'non-binary' is understood as both an umbrella term and an identity in its own right (LGBT Foundation, 2017):

"While this might present a new challenge for providers of healthcare, it is an issue that does require consideration. There is a lack of evidence as to the number of people who would identify themselves within these sections and their experiences of healthcare, but healthcare providers should be sensitive to these patients' needs and aware that gendered classification is not always appropriate." (Williams, et al. 2016)

Population estimates for trans people tended to be based on published research in The Netherlands (Van Kesteren, et al. 1996)[1] and Scotland (Wilson, et al. 1999)[2], combined with available data from government agencies that dealt with changes of name and gender e.g. Department for Work and Pensions, Identity and Passport Service, DVLA (DH, 2008).

More recently, using more direct methods for estimating population sizes, in which samples from the general population were questioned about their gender identity, it has been extrapolated that there are around 25 million transgender people worldwide. This gives some idea of the potential worldwide need for transgender healthcare (Winter, et al. 2016).

Survey estimates from the Netherlands suggest that the proportion of trans people in the population may be as high as 3.9% (Kuyper and Wijsen, 2014). This study examined the self-reported prevalence of ambivalent and incongruent gender identities and various aspects of gender dysphoria Data were taken from a sexual health study among the general Dutch population in 2012 and included weighted adjustments to match the socio-demographics of the population, for example with regard to gender, age, education, and urbanicity. The final sample consisted of 8,064 participants and the response rate was 20.9%. Participants who indicated at the beginning of the questionnaire that their sex assigned at birth was male were asked the following questions:

1. Many men experience themselves clearly as a man. For some men, this is not (completely) the case. Could you indicate to which degree you psychologically experience yourself as a man? (1=not at all; 5=completely).

2. Could you indicate to which degree you psychologically experience yourself as a woman (1=not at all; 5= completely).'

Participants who indicated that their sex assigned at birth was female completed the female version of the questions. A measure was developed from the answer to these questions to determine whether participants had an ambivalent or incongruent gender identity. Amongst participants who reported an ambivalent or incongruent gender identity, the following questions were asked:

[1] This research provides the longstanding statistic that gender identity disorder affects 1 in 11,900 of the adult population (rounded in some accounts to 1 in 11,500).
[2] This broadly supports the Dutch figure with a population estimate of 1 in 12,500 of the adult population.

- Do you have a dislike of your male body?'' 1=absolutely; 2=somewhat; 3=not really; 4=not at all)

- Would you like to have hormones or surgery to become (more) feminine?'

As previously noted, participants who indicated that their sex assigned at birth was female completed the female version of the questions. Analysis of the results showed that 4.6% of the natal men and 3.2% of the natal women reported an ambivalent gender identity, while 1.1% of the natal men and 0.8% of the natal women reported an incongruent gender identity. An ambivalent gender identity was determined as having an equal identification with the other sex as the sex assigned at birth. Incongruent gender identity was determined as having a stronger identification with other sex than sex assigned at birth. The authors concluded that:

"The presented prevalence of ambivalent or incongruent gender identities and gender dysphoric feelings in the general population sample confirmed the idea that prevalence rates based on the number of individuals seeking medical help might underestimate the prevalence of gender dysphoria in the general adult population." (*Ibid* Page 383).

While the authors acknowledge the limitations of the study, for example the relatively low response rate and simplicity of the measurements, they did find some diversity in responses amongst those with ambivalent or incongruent gender identities with respect to a desire for hormone treatment or surgery. In particular that there is not a one-to-one relationship between gender incongruent feelings, a dislike of one's natal sex characteristics, and the wish to obtain hormones or surgery to support transition.

A study from Belgium (Van Caenegem, et al. 2015) used the same measurements for gender ambivalence and gender incongruence as in the Netherlands study, but this study used a general population health survey with a higher response rate (40% or 1,832 respondents). The Belgium study found that 2.2% of men identified as gender ambivalent and 1.9% of women. The percentage of males identifying as gender incongruent was 0.7% and amongst women 0.6%. The authors draw a similar conclusion to that of Kuyper and Wijsen regarding population estimates that were based on presentations in clinical settings:

"Consistent with the broader definition of gender nonconformity, our findings confirm that prevalence rates based on the number of individuals seeking medical help underestimate the prevalence of gender nonconformity in the general adult population." (*Ibid* Page11)

In the UK, it has been estimated that there are 300,000 trans people (Reed, 2009). This estimate is based upon numbers accessing Gender Identity Clinics (GIC), however, this figure includes significantly more trans women than trans men.

A report, which worked on the basis that there are likely to be around as many trans men as trans women brings this estimation to approximately 500,000 (GIRES, 2011).

Neither of these studies breaks down data to give details into the numbers of non-binary or gender fluid people. An increasing number of trans people are accessing GICs and it is unclear if this represents an increase in the trans population or an increasing proportion of trans people accessing Gender Identity Services (LGBT Foundation, 2017).

It is also difficult to estimate the demographic characteristics of trans people for the same reasons. Large sample surveys on trans issues give some indication, although these surveys are all self-selecting and therefore cannot be assumed to be fully representative of the trans population as a whole. In spite of this, the research that does exist suggests that around 8%-10% of trans people are non-binary with 10% of GIC attendees being non-binary. These surveys also identified a significant proportion of respondents who had fluid identities, were unsure of their gender and/or sometimes identified as non-binary (McNeil, et al. 2012; NHS England, 2017).

A recent survey in Manchester, which enabled respondents to enter their own gender identity found the most common self-described identities alongside male or female were agender, non-binary, genderqueer and trans, accounting for a third of respondents (Manchester City Council, 2016).

Sexual orientation

Surveys which have reported on the sexual orientation of trans respondents suggest that trans people are more likely to identify as bisexual or queer than gay, lesbian or straight. For example, a study of over 900 trans people found respondents identified as follows:

- 27% bisexual
- 24% queer
- 20% straight
- 15% pansexual
- 13% lesbian
- 10% gay

Many people identified in multiple ways and a large proportion identified in a way other than gay, lesbian, bisexual or straight. For example, a notable proportion identified their sexual orientation using other terms, including asexual, polyamorous, BDSM/kink, unsure and not defining their sexual orientation altogether (McNeil, et al. 2012).

Ethnicity

There is limited research into health needs and ethnic differences amongst trans people. Research from the USA shows that race and ethnicity is a source of stigma for transgender people from BAME groups and the evidence indicates that they experience the most severe discrimination, poverty, and lack of access to basic healthcare and social services (Grant, et al. 2011). An Australian study of transgender people from the indigenous community had similar findings (Kerry, 2014).

In the USA, one study based on a small sample of ethnic minority male to female trans identified youth, highlighted a range of needs, including homelessness, unemployment, substance misuse, unprotected anal intercourse and higher rates of HIV positive status, especially amongst African-American youth (Garofalo, et al. 2006a). In another report of the same study this subgroup of African-American trans youth were less likely to be involved in high-risk sex. The report highlighted the need for further research into the risk behaviours amongst trans Black and minority ethnic youth (Garofalo, et al. 2006b).

A study from the Netherlands found that individuals from non-Western backgrounds reported an ambivalent gender identity twice as often as often as those from Western backgrounds (Kuyper and Wijsen, 2014).

In the UK, the two largest surveys that monitored the ethnicity of trans people from minority ethnic groups reported that only 6% and 2.5% of trans respondents were identified as BAME (Black, Asian and Minority Ethnic) respectively (Whittle, et al. 2007; McNeil, et al. 2012).

While it is possible that BAME people are less likely to be trans, it is far more plausible, given the difficulties of capturing data on trans status, that BAME trans people are being under-represented in research. Neither of the above surveys had a large enough sample of BAME people to provide robust data on the representation of different ethnicities and nationalities (LGBT Foundation, 2017).

Estimating the numbers of **trans asylum seekers** presented even greater challenges as this data is not consistently collected by the Home Office. In 2015, it was reported that 21 trans asylum seekers had been detained in immigration centres but this number was likely to be higher (Action for Trans Health, 2017).

Researchers have calculated the number of trans asylum seekers at around 2% of the total number of Lesbian, Gay, Bisexual and Transgender (LGBT) asylum seekers. This assumption is based on the proportion of UK Lesbian & Gay Immigration Group's (UKLGIG) case load who identify as trans (Bell and Hansen, 2009).

Older transgender people

There is a lack of research on the health needs and visibility of older transgender individuals (McGovern, 2014). Limited Canadian data suggests that older LGBT individuals are more likely to live alone and be socially isolated, and have a strong desire to avoid long-term care facilities (Ottawa Senior Pride Network, et al. 2015).

For older trans people, a key theme in the literature is fear regarding end-of-life care, including chronic disease and disability, as well as fear of discrimination within the medical and legal systems. For example, a large study of 1,963 trans-identified adults that focused on later life and end-of-life preparations found that respondents expressed fear about the potential late-life events and end-of-life needs, including concerns about legal requirements and care needs. The findings indicated that respondents were not prepared for major legal issues and events that take place in the last stages of life and reported fears about the future (Witten, 2014).

A follow-up study using the same database but focusing on transgender-identified lesbians, similarly found that respondents were poorly prepared for end-of-life (Witten, 2015).

Williams and Freeman (2005) and Witten and Whittle (2004) suggest that many transgender elders may be at greater risk for health impairment than those who are younger because of the longer duration of hormone use, which may well exacerbate the effects of aging, such as cardiac or pulmonary problems. Clearly, more research is needed to ensure the appropriate provision of health and social care of older trans people. For example, it is important to ensure that health and social care staff working in care homes and providing home care, as well as in mainstream health care, receive appropriate training and guidance in relation to safeguarding the wellbeing of older trans people.

Younger transgender people

A UK study estimated that 0.6% of people aged over 15 identified as transgender (Reed, et al. 2009).

A relatively small number of studies using nonprobability samples have attempted to assess the incidence of childhood gender-variant identities. One such study found that 1% of parents of boys aged 4–11 reported that their son wished to be of the other sex; for girls, the percentage was 3.5% (Zucker, et al. 1997).

However, there is a lack of research and evidence estimating the number of young transgender people (aged 10–24 years). Although anecdotal evidence does suggest that an increasing number of young people are self-identifying as transgender (Wilson, et al. 2010), some may not develop a full awareness of their gender identity until later in adolescence or young adulthood.

Nevertheless, transgender individuals are coming out to affirm their gender identity at younger and younger ages (Makadon, et al. 2007). Transgender men tend to come out at earlier ages than transgender women (Zucker and Lawrence, 2009).

LGB youth are at increased risk for suicidal ideation and attempts as well as depression. Small studies suggest the same may be true for transgender youth. Almost no research has examined substance use among transgender youth. Some research suggests that young transgender women are also at significant risk of homelessness (Institute of Medicine, 2011).

Grossman and D'Augelli (2006) conducted focus groups with young self-identified transgender males and females aged 15–21 and explored factors related to physical and mental health. In this qualitative study, most of the youth reported experiences of family and peers reacting negatively toward their gender-atypical behaviours. Gender-variant children may have more difficulties with peer relationships and behavioural problems than non-gender-variant children (*Ibid* Page 170).

Another study, of 55 transgender youth aged 15–21, found that 45% seriously thought about taking their lives, and 26% reported a history of life-threatening behaviour. These studies suggest there is an elevated risk for depression and attempted suicide among transgender youth (Grossman and D'Augelli, 2007).

Limited studies suggest that male-to-female transgender youth may face a risk for HIV similar to or even higher than that faced by young men who have sex with men (*Ibid*).

In addition, many young transgender people are particularly vulnerable to transphobia and isolation and, therefore, are less likely to acknowledge their identity to others (World Health Organisation, 2015b). In regards to gender reassignment surgery, in 2015/16, according to data from the Tavistock Clinic 1,398 children applied to have surgery.

The data from the Clinic shows referral numbers have increased in recent years and the number of girls seeking help has also risen. In 2009/10, there were 97 referrals, of which 40 were for girls, 56 referrals for boys and one referral was counselling for the child of a transsexual parent. The number of appointments has continued to increase by 50% in every subsequent year and in 2015/16 the number of referrals increased by 697 from 2014/15. The data also showed that twice as many biological girls than boys were referred to the Clinic. Of the 1,398 referrals in 2015/16, 913 referrals were for girls and 485 referrals were for boys. [3]

The paucity of data on young transgender people, however, is a barrier to providing adequate health and psychosocial services tailored for them, and highlights the need for more research and attention from national governments (World Health Organisation, 2015b).

[3] http://www.telegraph.co.uk/news/2016/04/11/referrals-for-young-transgender-people-double/

3. Experience of prejudice, stigma and discrimination

It is important to understand and acknowledge the particular concerns that trans people have with respect to stigma, discrimination and violence, as it relates to their gender identity. This is, at times, conflated with discrimination and violence on the basis of sexual orientation. However, trans peoples' human rights concerns, grounded in their gender identity, are inherently different and necessitate their own set of approaches (Divan, et al. 2016).

Across much of the world, transgender people experience prejudice, stigma and discrimination on a daily basis, being viewed by others in society as "sexually deviant", "morally corrupt", "unnatural" or "mentally disordered", which can leading to poor health and wellbeing (White, et al. 2016).

Although, it is changing and there are increasing numbers of positive role models of transgender people in the media, the Trans Mental Health Study reported that media portrayals of trans people has impacted negatively on many people, with 51% of the 525 respondents saying that the way trans people were represented in the media negatively affected their emotional wellbeing (McNeil, et al. 2012).

In the UK, trans people have long endured high levels of prejudice (referred to as "transphobia") and misunderstanding. This has manifested in numerous forms and in a wide range of settings, including public services. Discrimination, abuse and violence, including sexual assault and murder are often reported. Prejudice and discrimination can undermine trans people's career opportunities, incomes, living standards, access to social capital, quality of life, and physical and mental health.

The evidence is limited, but the available data indicates:

- 57% of transgender adults have experienced family rejection (Haas, et al. 2014).
- 1 in 4 trans young people experienced physical abuse at school (Whittle, et al. 2007).
- 1 in 5 transgender people reported having experienced homelessness at some time in their lives because of discrimination and family rejection (Haas, et al. 2014).
- 29% of trans people reported having been turned away from a homeless shelter and 55% reported having been harassed by shelter staff or other residents (Grant, et al. 2011).
- 14% of transgender adults reported being unemployed compared to 7% of the general population (Haas, et al. 2014).

- 11% of transgender people reported having engaged in sex work to survive (US Transgender Survey, 2015).

While there are significant gaps in data and knowledge due to the lack of routine monitoring of sexual orientation and gender identity, there is a significant evidence base on the variety of **health inequalities** experienced by trans people from peer-reviewed research, grey literature published by the broader LBGT community and through personal accounts and surveys (Boehmer, 2002; Winter, 2012).

The available evidence on the broader LGBT community points to the **significant impact of discrimination on health and wellbeing outcomes** for LGBT people, such as a heightened risk for HIV, mental health disparities and substance abuse (Beattie, et al. 2012; Poteat, et al. 2013; Williams, et al. 2016), including significantly higher rates of attempted suicide, self-harm and mental ill health across all minority groups compared to the general LGBT population (Guasp, et al. 2012). Domestic violence rates are also higher among trans people than in the general LGB population (Guasp, et al. 2012).

Although the context of the USA is very different to the UK and data cannot simply be extrapolated to the UK, the data does suggest some common patterns of discrimination and inequality. For example, a USA study found that discrimination against transgender and gender-nonconforming individuals in Massachusetts was associated with adverse mental and physical health, as well as delays in accessing health care provision (Reisner, et al. 2015).

This study found that with the exception of an asthma diagnosis, discrimination in healthcare settings led to unique health-related risks, such as psychological symptoms i.e. hypersensitivity and ruminative distress and related affective, cognitive and behavioural responses including avoiding situations in which potential rejection or discrimination may occur.

Anticipatory stress may also be a unique contributor to negative health for transgender people, who based on prior experiences of discrimination may come to expect that others will devalue them based on their transgender and/or gender-nonconforming status. This resulted in postponing medical care when sick or injured, postponing routine preventative care, and postponing care that resulted in having to see emergency or urgent care. Of the 452 transgender people who took part in the study, approximately 1 in 5 respondents (19%) indicated that they postponed or did not try to get medical care when they were sick or injured in the previous 12 months because of disrespect or mistreatment from doctors or other healthcare providers, based on being transgender or gender nonconforming, and because of discrimination, approximately 24% of the sample reported postponing routine medical care (*Ibid*).

In addition, widespread transphobic behaviours and attitudes result in many trans people changing their dress or presentation. 81% of respondents to the Trans Mental Health and Wellbeing Study avoided certain situations due to fear of transphobia (McNeil, et al. 2012). Of these, over 50% avoided public toilets and gyms, 25% avoided clothing shops, other leisure facilities, clubs or social groups. 51% said that a fear of being harassed, being perceived as trans or outed resulted in avoidance of social situations or public places.

This shows that transphobia is not simply "manifested through actual acts" of crime or violence, but also through trans individuals feeling they must avoid social situations in order to prevent potential harassment or discrimination (Ellis, et al. 2014).

Changes in public attitudes in Britain

The British Social Attitudes survey[4] has been conducted every year since 1983 and was most recently carried out between June and December 2016. It consisted of 2,942 interviews with a random, representative sample of adults in Britain.

The survey found attitudes towards same-sex relationships have become significantly more liberal with 64% of people saying that they are "not wrong at all", up from 59% in 2015, and 47% in 2012.

Attitudes to transgender issues were measured for the first time and the survey reported that low self-reported levels of prejudice to transgender people contrast with when people are asked about specific situations.

The vast majority of people (82%) describe themselves as "not prejudiced at all" to transgender people, but less than half of people say suitably qualified transgender people should definitely be employed as police officers or primary school teachers (43% and 41% respectively).

4. Health and social care issues

Transgender people face multiple health and social care problems that not only impact on their health and wellbeing in the community, but also in the criminal justice system (see section 8 *Criminal Justice issues*). It is, therefore, not a simple matter of having due regard to trans peoples' needs under equality legislation, it is also essential that health and social care commissioners are aware of and able to address the particular health and social needs of trans people outlined in health and social care needs assessments.

Across much of the world, transgender people have difficulty accessing (or affording) good quality healthcare, whether specific to their gender needs or more general in nature.

[4] British Social Attitudes Moral Issues Sex, gender identity and euthanasia, National Centre for Social Research http://www.bsa.natcen.ac.uk/media/39147/bsa34_moral_issues_final.pdf

The view of transgender people as “mentally disordered" has a potentially negative impact on transgender peoples’ health and wellbeing. WHO proposals to abandon the psychopathological model are welcomed by many researchers, clinicians and transgender individuals. These reforms promise empowerment for transgender people, enabling them to exercise greater autonomy in their lives (Winter, et al. 2016).

In the UK (as described above in section 3), LGBT individuals often experience discrimination and marginalisation that impacts on wider factors such as education, housing and perceptions and experiences of crime and violence, meaning that these groups experience specific health inequalities as a result (Williams, et al. 2016). Yet, healthcare that aims to help transgender people live in their affirmed gender is widely regarded as the most effective way in ensuring their health and wellbeing (Winter, et al. 2016).

Some of the particular health and social care issues known to face the trans people includes the following (some of the data is only recorded for LGBT people as a whole).

Physical health

- LGBT people living in neighbourhoods with high levels of prejudice experienced shorter life expectancies of 12 years, compared to peers living in low-prejudice communities (Hatzenbuehler, et al. 2014).

- for transgender adults, hormone therapy has been associated with the potential for worsening cardiovascular disease risk factors (such as blood pressure elevation, insulin resistance, and lipid derangements), although these changes have not been associated with increases in morbidity or mortality in transgender men receiving hormone therapy (Streed, et al. 2017).

- LGBT people are more likely to smoke, drink alcohol and use drugs (see section below on *Substance Misuse*), which increases the risk of cardiovascular disease and so can contribute to premature mortality related to cardiovascular disease.

- trans people may be at more risk of osteoporosis if they do not take either oestrogen or testosterone regularly. Also, older LGB people are more likely to be socially isolated, suggesting that they will experience worse outcomes related to falls (Guasp, 2011).

- Trans people may be at a higher risk of cancer due to certain risk factors, such as higher rates of smoking and alcohol consumption (Ashbee and Goldberg, 2006). There is also some evidence to suggest that long-term exposure to hormones can increase the risk of cancer. For example, the National LGBT Cancer Network has suggested that for those assigned male at birth taking high dosages of oestrogen for a long period of time may result in an increased risk of developing breast cancer.

However, information about cancer screening is not always extended to trans patients due to a lack of awareness in healthcare services. For example, trans women may still need prostate and AAA screening and trans men may still need cervical screening (World Health Organisation, 2015a).

Sexual health

- A lack of standardised data collection across the UK means that prevalence of HIV in the trans community is still unknown. There is very little comprehensive data on HIV prevalence in the UK as studies are small and rarely use actual test results (Bauer, et al. 2013). However, estimates based on USA research indicate that trans people may be up to four times more likely to be HIV positive than those in the general population (Grant, 2010).

- 1 in 2 Black transgender women report living with HIV and 1 in 5 Latino transgender people[5].

- Young trans people appear to be disproportionately affected by HIV, as comparable data from the USA found that 14.3% of trans young people are reported to be HIV positive, the highest rate of any youth group in the USA (Grant, 2010).

- Trans people show lower rates of testing for HIV, with 46% of participants in a Canadian survey never having been tested (Bauer, et al. 2013).

- A survey in the UK, in Birmingham, indicated that 64% of trans respondents had never visited a sexual health clinic, which should be considered especially problematic as international research has suggested that trans women are 49 times more likely to have HIV, compared to a general population (Keeble, 2013).

- The primary contributor to HIV risk is unprotected receptive genital sex. A Canadian study of trans men who have sex with men found that between 44% - 69% reported inconsistent condom use with cisgender[6] men over the past year. Only 46% reported ever being tested for HIV and self-reporting of HIV prevalence was 10 times the baseline prevalence for the region i.e. Ontario, Canada (Bauer, et al. 2013).

[5] https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/transgender

[6] Cisgender (often abbreviated to simply cis) is a term for people whose gender identity matches the sex that they were assigned at birth. Cisgender may also be defined as those who have "a gender identity or perform a gender role society considers appropriate for one's sex" (Crethar, et al. 20017). It is the opposite of the term “transgender” (Schilt, et al. 2009).

- A systematic review and meta-analysis found a pooled HIV prevalence of 19% among transgender women in the 15 countries with available, laboratory-confirmed data. Transgender women had odds of HIV infection 49 times greater than the general population (Baral, et al. 2012). A separate meta-analysis of HIV among transgender women sex workers found that these women had a pooled HIV prevalence of 27%, compared with 15% among transgender women who did not engage in sex work (Operario, et al. 2008).

Despite this, there is a clear difference in the overall risk of HIV when comparing trans men with trans women; whilst just under 70% of trans men are at low/moderate risk, only 30% of trans women are at low/moderate risk (Bauer, et al. 2013). Neglect of the needs of transgender women has contributed to the disproportionate risk of HIV in this group and widespread failure to develop effective interventions to address this global problem (Baral, et al. 2012; AmFAR, 2014).

In addition,

- While the majority of trans men may be at low/moderate risk of HIV, it is important to note that transgender mens' needs for sexual healthcare have been ignored almost entirely (Winter, et al. 2016).

- Medical uncertainty remains over whether and how hormonal contraceptives affect HIV acquisition and transmission among natal women (Geneva: World Health Organization, 2014).

- There is published data that the effect of estrogen on antiretroviral (ARV) efficacy is limited, but the concomitant use of certain antiretroviral (ARV) drugs may decrease estrogen levels. While guidelines of the World Professional Association for Transgender Health (WPATH) discourage the use of ethinyl estradiol for body transition, this is the only formulation of estrogen available to some transgender women. Data is lacking on additional drug interactions between ARVs and 17-ß estradiol, the form most commonly used for hormone replacement therapy (Coleman, et al. 2011).

A better understanding is needed of how hormones used for transition may affect HIV risk among transgender people (World Health Organisation, 2015).

Black transgender individuals have a significantly higher infection rate than other racial or ethnic groups, with male-to-females being at a particularly high risk of infection. In their systematic review, Herbst and colleagues (2008) found that some of the risk factors that may contribute to the high infection rates among trans women include multiple sex partners who are male, casual sex, and sex while under the influence of drugs or alcohol. The authors also note that the studies considered in their meta-analysis included a high percentage of trans women who engage in sex work (Herbst, et al. 2008).

In a qualitative assessment of training needs among providers of HIV-related care to transgender people (n 513), providers admitted discomfort with interviewing such patients, stated a need for more standards and guidelines for their care, and acknowledged a lack of understanding of distinct transgender identities and the nuances of transgender-specific care (Lurie, 2005).

Disability

There is evidence to suggest that trans people have higher rates of disability:

- 58% of trans people were reported to have a disability or chronic health condition, including 8.5% who were deaf and 5% who were visually impaired (McNail, et al. 2012).

- Transgender people may be more likely than the general population to have an autistic spectrum disorder (Pasterski, et al. 2014).

In addition, 18% of trans people have been identified as carers with 7% giving significant levels of care (McNeil, et al. 2012).

Mental health and wellbeing

Mental ill health is thought to be more prevalent among transgender people than in the wider population. Almost all population based surveys of trans people report high levels of depression, which would suggest that self-reported health will be lower (Williams, et al. 2016). In particular:

- The vast majority of trans people experience symptoms of depression at some point in their lives (Mayock, et al. 2009).

- A national Australian study found that 56% of transgender people had been diagnosed with depression at some point in their lives, four times the rate for the general population. 38% had been diagnosed with anxiety, around 50% higher than the background rate (Hyde, et al. 2014).

- A survey which used a clinically validated scale to identify depression amongst respondents and which was not primarily focused on mental health (therefore reducing selection bias), found that 52% of trans men who have sex with men are depressed (Bauer, et al. 2013).

- Trans women on average are more likely than trans men to report paranoid ideation, interpersonal distrust, anxiety, depression, and obsessive-compulsive complaints (Claes, et al. 2015).

- Nearly a third (29%) of transgender people who accessed mental health services felt that their trans status was regarded as a symptom of mental illness. 19% of trans people say they have had an undiagnosed eating disorder, with 5% saying they have had an eating disorder diagnosed (McNeil, et al. 2012).

For transgender people the available studies generally suggest high rates of negative mental health outcomes. Most of these studies, however, are limited by the use of nonprobability samples, and few compare the mental health of transgender people and non-transgender controls (Institute of Medicine, 2011).

Social isolation

The national standards on treatment and care to support trans people states that '*trans people suffer enormous social isolation as one of the most marginalised groups in society*'[7]. This statement is supported by a growing body of evidence, which demonstrates that social isolation of trans individuals is a significant barrier to seeking health and medical support until crises occur and contributes to serious mental ill health and suicidal intent. The evidence strongly suggests that trans individuals will experience significantly higher social isolation than the general population (Williams, et al. 2016). For example:

- In one study, when asked to rate how often they felt isolated due to being trans or having a trans history on a scale of one representing never feeling isolated and 7 representing constant isolation, the average score for trans people was 3.9 (McNeil, et al. 2012).

Also, isolation due to separation from families and loss of employment may result in trans individuals being particularly badly affected by homelessness, and temporary shelters are often single sex (Williams, et al. 2016).

Self-harm and suicide risks

Trans people are known to be susceptible to depression and at risk of suicide (DH, 2008). Many trans people experience a number of discriminatory factors that are likely to increase the risk of self-harm and/or suicide, for example, trans people are more likely than others to experience difficulty in finding work or retaining it if others know their trans identity. They may also be obliged to change jobs because of workplace harassment and abuse. Upon revealing their gender identity trans people are at high risk of being shunned by family and friends and many also experience violent intimidation on the streets or outside their homes. There is a significant body of evidence demonstrating high rates of self-harm and suicide attempts:

- 53% of trans people have self-harmed at some point, with 11% currently self-harming. 84% of trans people had considered suicide and half of trans people had attempted suicide (McNeil, et al. 2012).

[7] Research quoted in 'Social Work Practice with Transgender and Gender Variant Youth' G.P.Mallon. p16. From Israel & Tarver (1997) and Dean et al. (2000)

- Self-harm is more common amongst younger trans people. Three quarters of trans young people have self-harmed and over a quarter (27%) are currently purposely self harming (METRO, 2012).

- A 2007 report highlighted that 34% of respondents in a survey of 872 trans people had considered suicide one or more times before receiving professional assessment and support, which is higher than the risk in many other groups (Whittle, et al. 2007).

- A 2014 study found that in the face of repeated hate and discrimination, trans people in particular were likely to begin considering suicide a 'pragmatic consideration' (Williams and Tregidga, 2014).

- Transgender people can remain at increased risk of death, including death by suicide, even after transition (Dhejne, et al. 2011).

Substance misuse

Local and national research, and needs assessments of LGBT communities have repeatedly demonstrated higher levels of health risk behaviours, such as smoking and drug and alcohol use. LGBT people are less likely to engage with health interventions and screening programmes, and gender-specific screening can present particular challenges for trans and non-gendered individuals. LGBT communities, therefore, have higher levels of need for intervention and targeted support related to these indicators (Williams, et al. 2016). The evidence suggests that:

- 32% of trans people smoke cigarettes regularly compared to LGBT people in general (Rooney, 2012).

- 24% of trans people have used drugs within the last 12 months, the most common being cannabis, poppers and ecstasy (McNeil, et al. 2012).

- 10% of trans people indicated signs of severe drug abuse using the Drug Abuse Screening Test (Rooney, 2012).

- 62% of trans people may be dependent on alcohol or engaging in alcohol abuse (McNeil, et al. 2012).

Chest binding

Chest binding encompasses any activity that involves the compression of breast tissue to create a flatter appearance of the chest and is a common practice amongst trans men, trans masculine and some non-binary people as a means of gender expression (LGBT Foundation, 2017).

An online survey into the chest binding of individuals assigned female sex at birth and intersex individuals (total n=1800) found that 52% of respondents used binding every day for an average of 10 hours per day, for a median duration of two years (Peitzmeier, et al. 2015). 97% reported at least one negative outcome related to binding including back pain (53.8%), shortness of breath (46.6%) and bad posture (40.3%). The study found that binding often was most consistently associated with negative health outcomes and suggested that having days away from binding would provide health benefits. Respondents also reported a significant increase in mood from before to after binding, increasing on average from 2.1 to 3.8 on a 5-point mood scale.

Hormone therapy, self-medication and bridging prescriptions

Both the World Professional Association for Transgender Health (WPATH) and the Endocrine Society (Washington) have created transgender-specific guidelines to help serve as a framework for providers caring for gender minority patients (WPATH, 2011). Guidelines for hormone therapy in transgender men are mostly extrapolations from recommendations that currently exist for the treatment of hypogonadal natal men and oestrogen therapy for transgender women is loosely based on treatments used for postmenopausal women.

Previous guidance stated that the person should have lived in role for at least a period of 12 months before starting hormone therapy. Updated guidelines do not require this step, and instead, WPATH and the Endocrine Society now recommend that patients transition socially and with medical therapy at the same time. The guidance notes that the optimal timing for social transitioning may differ between individuals and that trans people increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment (Hembree, et al. 2017).

WPATH recommends that hormone therapy should be initiated once psychosocial assessment has been completed, the patient has been determined to be an appropriate candidate for therapy, and informed consent reviewing the risks and benefits of starting therapy has been obtained. A referral is required by a qualified mental health professional, unless the prescribing provider is qualified in this type of assessment. The criteria for therapy include:

(I) persistent well-documented gender dysphoria (a condition of feeling one's emotional and psychological identity as male or female to be opposite to one's biological sex) diagnosed by a mental health professional well versed in the field;

(II) capacity to make a fully informed decision and to consent for treatment;

(III) age of majority; and

(IV) good control of significant medical and/or mental comorbid conditions.

(Unger, 2016)

The latter can be a stumbling block for many trans individuals, especially those in the criminal justice system given the evidence of associated mental health and substance problems. The higher incidence and additional complexity of these problems for trans individuals in the criminal justice system may mean that they have commonly been rejected by a GIC for hormone treatment and other transitional related treatments.

Guidance from the Endocrine Society states that the evaluation of transgender youth and adults should include the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy (Hembree, et al. 2017).

Many of the individuals appear to have commonly sourced hormone treatment on the Internet and may have been self-prescribing in this way for some time:

- A published cross-sectional analysis found that one in four trans women self-prescribe cross-sex hormones, most commonly through the Internet (Mepham, et al. 2014).

- In another study looking at 314 trans women in San Francisco, 49% were found to be taking hormones not prescribed by a clinician (de Haan, et al. 2015).

In the UK there is evidence that trans people who are unable to obtain hormone therapy through the NHS may procure them through other means, such as the Internet or the black market. This can have serious implications for their health and wellbeing as the treatment is unregulated and unmonitored (GIRES, 2007). Research into non-binary people's experiences of gender identity services suggests that many non-binary people self-medicate due to a combination of long waiting times for services, a binary-focused treatment pathway, 'real life experience' not being inclusive of non-binary genders, and non-binary people feeling and being excluded from gender identity services due to misunderstandings about their gender identities and a perceived lack of cultural competency from gender identity service clinicians (Bradley, et al. 2015).

The General Medical Council, Royal College of Psychiatrists, GIRES and Action for Trans Health recommend that medical professionals take a harm reduction approach to trans people who are self-medicating and focus on ensuring the safety and efficacy of the medication they are taking, rather than advising the trans person to stop taking the hormones altogether. This can include ensuring the patient has access to clean equipment and providing 'bridging prescriptions' for medication (Royal College of Psychiatrists, 2012; GMC, 2016).

The literature suggests that hormone replacement therapy (HRT) is safe when followed carefully for certain risks (Safer and Weinand, 2015). Research has demonstrated that HRT can improve the quality of life for trans people (Bockting, et al. 2012; Unger, 2016).

However, research into the long-term effects of HRT in trans populations is limited. Research suggests that hyperandrogenism relating to long-term use of testosterone can be associated with increased cardiovascular risk factors (Goodrum, 2014) and that prolonged oestrogen use can result in an elevated risk of thromboembolic complications (Safer and Weinand, 2015).

Finally, long-term hormone use may increase the risk of some health conditions or diseases, which must be considered in monitoring the health of older trans people. For example, older trans people may require a continued hormone therapy in order to maintain mental and physical health but some have reported difficulties with continued provision when entering residential homes (Williams, et al. 2016).

5. Access to health and social care provision

Background

Transgender people may seek healthcare services for reasons related to their gender incongruence (and accompanying dysphoria). They may seek information and counselling support to help explore identity issues or to consider difficult decisions about gender transition and implications for family relationships, employment and broader social stigma.

Children and young people with gender identity issues, as well as their parents and teachers, may require support and information. Young adolescents going through puberty may seek gender-affirming healthcare involving gonadotropin releasing hormone analogues (also called hormonal puberty blocking agents or puberty suppressants). Older adolescents and adults may seek masculinising or feminising ("cross-sex") hormones or surgery, or a range of other services. Such healthcare is sometimes popularly described as sex or gender reassignment, or as gender confirming or gender-affirming healthcare (Winter, et al. 2016).

Transgender people may also seek medical services beyond gender-affirming healthcare. Some will have special sexual and reproductive healthcare needs, for example, those associated with gamete storage or care of a surgically constructed vagina.

Some trans individuals may have more general healthcare needs linked to the use of hormones and silicone injections, and diseases associated with birth anatomy, for example, prostate cancer in a transgender woman (Winter, et al. 2016).

However, trans people experience worse health (both physical and mental) than the general population, which is likely to be substantively due to the direct and indirect effects of the inequality, which trans people experience. The House of Commons Women and Equalities Committee (2016) stated:

"We have found that the NHS is letting down trans people, with too much evidence of an approach that can be said to be discriminatory and in breach of the Equality Act."

Access to primary and secondary care

Integrated care, which is centred around the whole person and co-ordinated around their needs as a patient is at the heart of the Health and Social Care Act 2012. This must include addressing the specific needs of patients related to their sexual orientation and gender identity.

However, evidence shows that LGBT people experience barriers to accessing mainstream health and social care services due to a lack of understanding of their specific needs and a lack of targeted service promotion. For example, gender specific screening can present particular challenges for trans individuals where screening risk may be linked to their birth gender rather than the gender they identify with (Williams, et al. 2016).

In order to address some of the difficulties faced by trans people around screening programmes, Public Health England have recently published *Information for trans people NHS Screening Programmes (July, 2017)*[8], which covers breast screening, cervical screening, abdominal aortic aneurysim (AAA) screening and bowel cancer screening. Similar guidance has also been developed by Public Health Wales in collaboration with Transgender Awareness Wales, FTM Wales, Unique Transgender Network and the NHS Centre for Equality and Human Rights (Public Health Wales, 2015).

There is also strong evidence that access to good healthcare for trans people is sporadic in the UK and has contributed to distress. At best, there is widespread ignorance of the healthcare needs of trans people and at worst, there is prejudice. In 2007, research found almost 20% of respondents in a survey of 872 trans people reported that their healthcare was either affected or refused altogether by GPs who knew they were trans. While there are examples of excellent care and good practice, 60% of trans people who thought their GPs and other medical professionals would like to be more helpful and supportive reported that the practitioners felt unable to do so through lack of training and information (Whittle et al, 2007). This survey also reported that:

[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/623309/Transgender_cross_programme_screening_leaflet.pdf

- 21% of respondents' GPs either did not want to help or, in 6% of cases, actually refused to help. This is an improvement of 50% compared with the experience of services over the previous 15 years, but it still presents a considerable barrier.

- In the more general healthcare sector, 17% of respondents had experience with a doctor or nurse who did not approve of gender reassignment and hence refused services.

- 29% of respondents felt that being trans adversely affected the way they were treated by healthcare professionals.

A 2008 report looking into the healthcare experiences of trans people found that 29% of trans people felt that being trans affected the way they could access general healthcare services. Lack of awareness and sensitivity, discrimination in accessing health services, and bad experiences are common, including staff expressing their own negative views of trans people to trans service users and trans patients, or trans people being placed on the wrong-gendered hospital ward.

Many also reported that clinicians focused on their trans status when it is not relevant, including disclosing information inappropriately, and clinicians assuming that being trans or accessing transition-related healthcare is the cause of an unrelated health problem (Whittle, et al. 2008).

More recently, the House of Commons Women and Equalities Committee (2016) found that *"prejudice against trans people among medical staff"* was one of the reasons for poor health outcomes in trans people.

Many healthcare professionals reported that they felt they lacked the skills and knowledge required to meet the needs of trans people. 56% of nurses had provided care directly to a trans person, however, 87% felt that they were unprepared, primarily due to a lack of access to opportunities for training or gaining experience (Lyons, 2016).

Data on patient satisfaction is mixed; with one study finding 46% of trans people rated NHS GP practices as extremely or very good (Scottish Transgender Alliance, 2008) while another found 40% rated their experiences negatively (Bishop, 2013). One study found that out of 83% of respondents who had discussed feelings of gender incongruence with their GP, 80% found this experience to be positive or very positive, but less than 50% found the care given to be appropriate or useful (LGBT Foundation, 2017). The most common difficulty reported with GP practices was in having records updated to reflect individuals' names, correct titles and gender (Morton, 2008).

In terms of **secondary care**, trans people reported lower than average satisfaction with hospitals - 65% compared to 85% non-trans respondents. 89% of trans people who were admitted to hospital were not consulted on which room or ward they would feel most comfortable in, despite hospitals primarily using single-sex wards.

Ward/room allocation is particularly problematic for non-binary people as often no gender neutral facilities are available (LGBT Foundation, 2017). More broadly, non-binary people are least likely amongst all trans people to feel that their needs have been met in healthcare services, with 80% of respondents in a 2016 report stating they had not been met, compared to 67% of men and 60% of women. Misgendering was a key cause of dissatisfaction, alongside inappropriate questioning. 80% of trans people experience anxiety before accessing hospitals due to fears of insensitivity, misgendering and discrimination, with the receiving of intimate care causing the most concern (LGBT Health and Inclusion Project, 2016).

For older trans people, the experience of barriers to accessing services as a trans person can be compounded by age (Williams, et al. 2016). Trans people who have dementia may be particularly at risk as they are typically less able to advocate and make decisions for themselves and may require personal care (Witten, 2014). For some, anxiety and fears about accessing services can result in not accessing services in a timely manner or not accessing services at all, which can have significant negative impacts on health and wellbeing (Jones, et al. 2016).

In order to tackle and address the above issues NHS England created the Transgender and Non-Binary Network in 2013. This network has over 150 members and has held a number of workshops. The group is organised and facilitated by the NHS England Public Participation Team with support and contributions from colleagues in Highly Specialised and Specialised Commissioning, NHS Clinicians, transgender and non-binary people, organisations that represent them and providers.

The overall purpose of the group is to highlight and discuss the needs of trans patients in the hope that the more they are talked about the better they could be addressed. The House of Commons Women and Equalities Committee stated that the creation of the Transgender and Non-Binary Network *"was a commendable step"* (House of Commons Women and Equalities Committee, 2016).

The National LGB&T Partnership was established in early 2010, in order reduce health inequalities and challenge homophobia, biphobia and transphobia within public services. As of January 2017, the Partnership combines the expertise of eleven key LGB&T organisations across England. The Partnership is a Sector Strategic Partner of the Department of Health, Public Health England and NHS England, collaborating with a wide range of organisations as part of the Health and Wellbeing Alliance. It has experience of successfully influencing policy, practice and actions of Government, statutory bodies, and others (https://nationallgbtpartnership.org).

General Practitioners' attitudes towards transgender patients

The House of Commons Women and Equalities Committee (2016) reported that there appeared to be particular problems with the attitude of some GPs. This could create significant difficulties given their role as "gatekeepers" to other NHS services, including Gender Identity Services, as well as their role in providing continuing hormone treatment as part of gender reassignment/confirmation treatment. The Committee highlighted the experiences of trans patients with GPs, including:

- The terms "gender dysphoria" and "transgender" are not fully known throughout the NHS services or the treatment for such issues.

- Many GPs and other local health services have not been trained in trans health issues and do not understand the referral pathways into Gender Identity Services.

- In spite of the fact that gender dysphoria is no longer recognised as a mental health condition, many GPs will not refer to a Gender Identity Clinic (GIC) without assessment from a mental health team.

- Some GPs refuse to even make referrals to a GIC and deny healthcare to trans people based on the fact that they do not agree with the choices that they have made.

- There is a lack of willingness by some GPs to prescribe and monitor hormone therapy.

- There is a fixation that being trans is the important thing about the patient and some GPs write a person's gender identity even when it was completely unrelated to their treatment.

In written evidence to the Committee, NHS England conceded that there appeared to be a particular problem with some GPs who refused:

"..to prescribe [hormone therapy] *to transgender and non-binary people, and to undertake assessments and investigations, even though they have been advised to do so by physicians in the specialist gender identity clinics."*

NHS England responded to this issue by publishing a Specialised Services Circular (SSC1417, March 2014), which is consistent with the General Medical Council's good practice guidance in Prescribing and Managing Medicines and Devices 2013. The circular clarifies that GPs are responsible for the prescription of hormone therapy as recommended by the specialist Gender Identity Clinics; for patient safety monitoring procedures; for provision of basic physical examinations within the usual competences of GPs; and for blood tests as recommended by the specialist Gender Identity Clinics.

The Committee also noted that the Royal College of GPs (RCGP) agreed that GPs were *"overall empathetic but that their knowledge of how to best support transgender patients could be improved"*. In order to address this gap, in July 2015, the RCGP launched an online training module on Gender Variance.

In spite of all this, overall the Committee concluded:

"…. It is clear from our inquiry that trans people encounter significant problems in using general NHS services due to the attitude of some clinicians and other staff when providing care for trans patients. This is attributable to lack of knowledge and understanding—and even in some cases to out-and-out prejudice." (House of Commons Women and Equalities Committee, 2016)

In response, the Government reported that leadership and coordination were provided by NHS England's Task and Finish Group for Gender Identity Services, and the terms of reference for this group would be broadened to encompass the problems that the Committee had highlighted around transgender people's experience of primary care, and in accessing general health services.

In addition, NHS England would continue to seek expert professional advice from relevant Clinical Reference Groups comprised of professionals and lay people with relevant expertise and would continue to publicly hold itself accountable to people who use gender identity services via its regular Transgender Network workshops (Government Equalities Office, 2016).

Access to sexual health services

The evidence indicates that there are specific barriers facing trans people when accessing sexual health services:

- Research from the USA found that health staff were often untrained to provide appropriate services on HIV prevention, care and treatment or information on sexual and reproductive health to trans people (Poteat, et al. 2013).

- HIV voluntary counselling and testing facilities, and antiretroviral therapy (ART) sites can intimidate trans people due to prior negative experiences with medical staff (Sevelius, et al. 2010; Chakrapani, et al. 2011; Beattie, et al. 2012).

- When trans women test HIV positive, they are wrongly reported as men who have sex with men (Health Policy Project UN, 2015).

- Sexual health services can often consist of intimate physical examinations, which can be distressing for trans people. Consequently, testing rates in trans communities are low, which serves to disguise the serious burden of HIV among trans people (Poteat, et al. 2013).

In Scotland, a survey found that there was a dissonance between general perceptions of NHS sexual health services and actual experiences; survey respondents described their experiences favourably and praised the non-judgemental nature of services, whilst also recognising that as sexual health services are delivered as gender binary (i.e. male or female), there is a belief that they will struggle to accommodate trans people within them (Scottish Transgender Alliance, 2008).

Specialist gender identity services

NHS England have acknowledged that there are problems in the quality and capacity of NHS specialist gender identity services, and admitted that the following problems existed (House of Commons Women and Equalities Committee, 2016):

- inequitable access and variability across the GICs;
- poor patient experience, including communication;
- capacity pressures;
- workforce pressures; and
- long waiting times for initial assessment and genital reconstruction surgery (with a shortage of specialist surgeons).

In 2015, the Gender Identity Research and Education Service (GIRES) reported **waiting times** of 2–3 years for access to some of the adult gender identity clinics. Moreover, the waiting time for genital surgery for trans women was 22 months. Without additional services being commissioned, the predicted waiting time was 42 months by 2017 (House of Commons Women and Equalities Committee, 2016).

In regards to capacity, the House of Commons Women and Equalities Committee (2016) also raised concerns:

"….at the apparent lack of any concrete plans to address the lack of specialist clinicians in this field. This will be a serious obstacle to addressing the lack of capacity, which growing demand for the service is sure to exacerbate, and cannot be ignored."

In 2017, NHS England launched a 12 week consultation on specialised gender identity services for adults (those aged 17 and above). NHS England stated that:

"Through consultation we want to hear people's views on two proposed service specifications: one for how Gender Identity Clinics will deliver specialised outpatient services; and another for how surgical units will deliver surgical interventions. The service specifications have been developed taking into account the outcome of engagement with the trans community and clinical experts and describe new proposals for how specialised gender identity services will be delivered in the future." [9]

[9] (https://www.engage.england.nhs.uk/survey/gender-identity-services-for-adults/)

This review of the health and social needs of trans offenders has taken place at the same time as a formal public consultation on proposed service specifications for the specialised services delivered by Gender Identity Clinics, as commissioned by NHS England. Close liaison has taken place between the respective commissioning departments for offender health and specialised services within NHS England, in the expectation that this review report will be considered alongside the responses to the consultation and will inform NHS England's understanding of the issues that are relevant to the successful implementation of the new specification in offender health settings.

International evidence indicates that outcomes for gender-affirming healthcare are generally very good, whether the treatment is evaluated as a whole (Murad, et al. 2010; Dhejne, et al. 2014) or the effects of hormones alone are considered (Gorin-Lazard, et al. 2012; Keo-Meier, et al. 2015). Outcomes are also positive when gender-affirming healthcare is delivered in adolescence (De Vries, et al. 2014).

In England, in 2013, Gender Identity Services became the commissioning responsibility of NHS England. There are currently seven NHS Gender Identity Clinics (GICs) available in England, and one service available for young people under 17. Although, the uneven geographical distribution of GICs mean that many people have to travel long distances in order to access treatment (House of Commons Women and Equalities Committee, 2016).

The evidence shows that the number of trans people presenting to specialist Gender Identity Services with the intention to undergo transition-related treatment through NHS and private providers has consistently increased over the last 10 years (LGBT Foundation, 2017).

The number of people accessing trans-related healthcare annually is not clear, although in 2011 it was estimated that 12,500 people presented for treatment and 7,500 successfully received it (GIRES, 2011). In 2014/15, NHS England reported that around 215 patients per month were referred into a GIC (NHS England, 2015).

NHS England undertook an operational research report of the NHS GICs across England, finding that waiting times varied for first appointments at a GIC from 9 weeks (Northampton) to 69 weeks (Leeds) between October 2014 and January 2015.

The report also stated that the total number of people waiting for their first appointments in January 2015 was 2,377 (NHS England, 2015).

A more recent survey of patients who had a first appointment between May and July 2015 found that the average waiting time for these individuals averaged slightly longer, from between 11 weeks (Northampton) to 89 weeks (Newcastle) (UK Trans Info, 2015). These figures contravene the NHS guidelines that state the expected timeframe from referral to treatment for specialist care should not exceed 18 weeks (NHS England, 2017).

Moreover, when accessing transition-related healthcare, studies and patient engagement suggest that many trans people have poor experiences within the services, largely in relation to experiencing transphobia within the services themselves. For example, 21% of those who have used GICs reported that their complaints were dismissed, with many services being described as 'uninformed', 'out of date' and 'potentially dangerous' (DH, 2007). This can impact on the quality of healthcare that trans people receive as they may choose not to disclose information when it is relevant (Williams, et al. 2016).

This might also be exacerbated by the fact that trans people are often highly reliant on healthcare professionals throughout a transition process i.e. from being referred to a gender identity service by a GP to being diagnosed with gender dysphoria and receiving medical interventions through specialist services (Ellis, et al. 2015). Therefore, many trans people may not feel able to challenge discrimination or transphobic treatment for fear that it will affect their care if they do so.

There is a general lack of literature specifically addressing the experiences trans people have when receiving surgical interventions through the NHS. Some trans people have reported feeling unable to be wholly truthful with their healthcare professionals whilst at a GIC and may withhold information about their identity (particularly non-binary identity), mental health, sexuality and employment issues for fear that the professional will stop treatment from going ahead if they do not 'fit the mould'. In fact, non-binary people often report that clinicians focus on gender identity in order to find an immediate treatment rather than focusing on what the patient actually wants; this is likely to be due to gender identity being the sole criterion for diagnosis (Bradley, et al. 2015).

The Trans Mental Health Study (2012) also reported that a sizeable minority of trans people felt that they were pressured into things they did not want to do by gender identity services in order to 'prove' their identity, such as changing their name or dressing in a highly feminine or masculine way. This suggests a healthcare system which assumes a rigid binary transition for all patients, i.e. exclusively from assigned female to male, or assigned male to female (McNeil, et al. 2012). In light of this, it is not surprising that according to a report published by The Scottish Transgender Alliance, only 25% of the 895 non-binary participants said that they were 'always' comfortable with sharing their non-binary identity when accessing such services and 29% claimed they were 'never' comfortable (Valentine, 2016).

There are additional barriers for non-binary people accessing transition-related healthcare. A study of the experiences of 114 non-binary people who have attempted to access transition related healthcare – both privately and through the NHS – found that a fear of being denied treatment due to their non-binary identity was a common theme (Bradley, et al. 2015).

This can result in individuals presenting themselves in a binary gendered way (either male or female) in order to receive treatment, with almost three-quarters (71.8%) of respondents under private treatment presenting as binary, and almost half (46.4%) of respondents presenting as binary at NHS GICs. Amongst the respondents, many also reported that their clinicians were more concerned with how they identified rather than the treatment they required, demonstrating a lack of person-centred care (LGBT Foundation, 2017).

Access to mental health provision

Despite being at higher risk of poor mental health, trans people face additional barriers to accessing support services and report low levels of satisfaction when they have accessed services (Williams, et al. 2016). Many feel that mental health professionals do not have sufficient knowledge and understanding of trans issues (Morton, 2008).

Some trans people report that mental health professionals have viewed their gender as a symptom of mental ill health rather than accepting their identity (Ellis, et al. 2015).

This includes trans people who have been denied or delayed access to gender identity services due to mental health professionals failing to provide appropriate care and referrals. This impacts on people accessing services as well as creating barriers for those who want to access them. The most common concern trans people have about accessing mental health services is that being trans would be seen as the reason, symptom or cause of their mental health issues (Ellis, et al. 2015).

In term of secondary mental health services, there is little data on the access of services amongst trans people (Williams, et al. 2016).

Access to survivor and crisis support systems

Survivor and crisis support systems can be problematic, particularly for trans women and those who identify as non-binary. Some trans people have been excluded from accessing support because of their gender identity. In addition, crisis centres can be ambiguous, unsupportive and excluding about their support for trans people. As a result, those who are in need may not receive the help they need. However, good practice is emerging from Scotland. The Gender Based Violence strategy pushed forward by the Scottish Government is trans inclusive, and support services across Scotland have engaged in specific training to ensure the needs of trans survivors are met (Stonewall, 2017).

6. Children and young people

Access to primary care

Research on LGBT young people's experiences of accessing health services is limited. However, research by LGBT Youth Scotland, which focused on mental and sexual health, on how supported young people feel and their experiences of coming out to doctors, identified specific problems in terms of the health services they accessed i.e. health professionals assuming they were straight, not catering to their needs, and not understanding the specific issues affecting them. Transgender young people felt less supported by the NHS in regards to their sexual orientation or gender identity than gay and bisexual men. The research found that:

- Less than half (48.1%) of transgender young people felt safe and supported by the NHS in terms of their sexual orientation and/or gender identity.

- Transgender respondents were most likely to be out to their doctors (66.7%), reflecting the fact that they may need to come out to access medical treatment for gender reassignment. They were also likely, however, to state that they would not feel comfortable coming out to their doctor (25.9%).

- Less than half (48%) of transgender respondents felt comfortable speaking with doctors about **sexual health** and a third (33.3%) did not.

- Transgender respondents were the most likely to consider themselves to have **mental health** issues (66.7%).

The research concluded that the majority of transgender young people do not feel safe and supported by the NHS and more needs to be done to support transgender young people in relation to their mental health (LGBT Youth Scotland, 2013).

Access to specialised care

The Gender Identity Development Service (GIDS), also known as the Tavistock Clinic, is a highly specialised clinic for young people presenting with difficulties with their gender identity, including gender dysphoria and other conditions. The GIDS is the only specialist service in the UK providing early-intervention treatment for children and young people. It operates from two main bases in London and Leeds, and regular outreach clinics are held in Exeter, Barnstable, Bath, Bristol and Brighton. GPs can refer patients directly to the GIDS, but referral takes place primarily through Child and Adolescent Mental Health Services (CAMHS). However, as with adult gender identity services, referral pathways appear to be made problematic by a lack of understanding of gender-identity issues in the wider NHS (House of Commons Women and Equalities Committee, 2016).

The demand for the clinic's services is growing rapidly with referrals increasing by 50% a year in recent years. The majority of referrals involve young people aged between 14 and 16, but the service is also seeing an increase in the number of younger (pre-pubertal) children being referred, although the numbers remain small (House of Commons Women and Equalities Committee, 2016).

While the GIDS does not suffer from the long waits associated with the adult service, there still appear to be some problems in this regard. The results of a survey in 2014 of parents of children and adolescents with gender dysphoria found that 27% of all those who responded had waited over 18 weeks for their initial assessment. Parents reported that the wait for the first appointment had a negative impact on the mental health and wellbeing of 31 (77.5%) of the 40 young people and three (7.5%) had attempted suicide whilst on the waiting list to be seen for the first time (House of Commons Women and Equalities Committee, 2016).

The transition to adult gender identity services at the ages of 17 and 18, was a problematic area due to the lack of continuity of care, which can lead to young trans people facing a long hiatus in their care as they sit on a waiting list to enter the adult service. The NHS Gender Identity Services Clinical Reference Group has recommended an easier transition to the adult service from age 17 without the need for a fresh assessment of the patient by the adult service. The GIDS was working with the adult service on this issue (House of Commons Women and Equalities Committee, 2016).

In response to the Committee's report, Public Health England (PHE) and the Royal College of Nursing have developed two toolkits for nurses and health practitioners to support the mental health and wellbeing of LGBT young people. PHE has also supported the publication of health factsheets with the National LGBT Partnership and a range of other projects on LGBT health. These factsheets have been prepared with the interests and wellbeing of all transgender people, including young people under the age of 17 (Government Equalities Office, 2016).

However, parents of children and young people accessing the GIDS continue to express concerns about the content of NHS England's treatment protocols, and their interpretation by clinicians. This dissatisfaction is compounded by the fact that most of those seeking access to the service must travel to London to be assessed. Despite current efforts to increase capacity and reduce waiting times this still means lengthy journeys for many people (Stonewall, 2017).

Access to social care

The House of Commons Women and Equalities Committee (2016) reported that there was a lack of appropriate training for social care staff in trans issues, raising particular issues for gender variant looked-after children or gender variant children in secure accommodation. In response, the Government stated (Government Equalities Office, 2016):

"It is important to understand whether and to what extent training, and knowledge within the profession, is preventing these approaches from driving a sufficiently strong understanding of transgender issues. Government will therefore commission a study to ascertain the adequacy and consistency of knowledge on gender variance in initial social work training and continuous professional development (CPD). It will use the findings to decide whether additional training materials should be made available."

Parental Support

The positive impact of parental support on the mental health of trans young people should not be underestimated. A study with 433 trans young people aged 16-24 in Ontario, Canada showed how important the support of parents is for trans young people. Some of the findings included (Trans Pulse, 2012):

- 100% of trans young people with 'very supportive' parents were in adequate accommodation, versus only 45% of those whose parents were 'somewhat to not at all supportive'.

- 70% of trans young people with 'very supportive' parents reported very good or excellent mental health, versus only 15% of those whose parents were 'somewhat to not at all supportive'.

- 72% of trans young people with 'very supportive' parents reported being satisfied with life, versus only 13% of those whose parents were 'somewhat to not at all supportive'.

7. Families and carers

Background

The existing literature on LGBT people emphasizes the importance of family, friends, and communities for the wellbeing of LGBT individuals. Research also highlights a key role for the *chosen family*[10] for providing social support and caregiving (Stinchombe, et al. 2017). For example, findings from a cross-sectional study of 1,000 USA based LGBT baby boomers, highlighted that respondents were highly involved in the provision of informal care for their families and that non-familial social networks play an important role as a source of social support (MetLife, 2010).

[10] Chosen family refers to friends and community members who provide support, companionship, and love in preference to biological relatives (Brotman, et al. 2007).

Family life

A USA survey of 6,450 trans people focused on questions about family life, and how living, parenting and partnering as a transgender or gender non-conforming person had impacted relationships. The results showed a combination of improved relationships and successful development of families alongside major challenges in retaining friendships, partnerships, and relationships with children. Among some groups of respondents, coming out to family members and friends had a positive impact, while for others, relationships faced considerable challenges (Grant, et al. 2011). On a positive note, the key findings included:

- 45% of respondents reported that their family was currently as strong as it was before coming out.
- 43% maintained the majority of family bonds.
- 38% of the sample were parents with 18% reporting that they had at least one dependent child.
- 70% of respondents reported that their children continued to speak to them and spend time with them after coming out.

However, more negative findings included:

- 57% of respondents experienced family rejection.
- Relationships ended for 45% of those who came out to partners.
- 29% of those with children experienced an ex-partner limiting their contact with their children.
- Courts limited or stopped relationships with children for 13% of respondents, with Black, Asian and Minority Ethnic respondents experiencing higher rates of court interference.
- 19% of respondents reported experiencing domestic violence by a family member because they were transgender or gender non-conforming.

Unsurprisingly, family acceptance was strongly connected with a range of positive outcomes while family rejection was connected with negative outcomes. For example, those who were rejected by family members had considerably elevated negative outcomes, including homelessness (three times the frequency), sex work (double the rate), and suicidality (almost double), compared to those that were accepted by their family members.

Domestic violence at the hands of a family member was also strongly connected to negative outcomes, with domestic violence survivors reporting four times the rate of homelessness, four times the rate of sex work, double the HIV rate, and double the rate of suicide attempts compared to their peers who did not experience family violence.

Transgender parents

There is limited research in this area but a USA report, which reviewed 51 studies on the prevalence and characteristics of transgender people who are parents, the quality of relationships between transgender parents and their children, outcomes for children with a transgender parent, and the reported needs of transgender parents found the following (Stotzer, et al. 2014):

- Substantial numbers of transgender people are parents, though at rates that appear lower than the USA general population. Of the 51 studies included in the review, most found that between one quarter and one half of transgender people report being parents. In the USA general population, 65% of adult males and 74% of adult females are parents.

- There may be substantial differences in the rates of parenting among trans men, trans women, and gender non-conforming individuals. Higher percentages of transgender women than transgender men reported having children.

- People who transition or "come out" as transgender later in life tend to have higher parenting rates than those people who identify as transgender and/or transition at younger ages. This higher rate of parenting could be due to individuals becoming biological parents before they identified as trans gender or transitioned.

- There were more transgender respondents who reported having children than living with children. It may be that many of the respondents had adult children who are no longer living with them. However, there is some evidence that formal and informal attempts to limit the contact of transgender parents with their children may partially explain this discrepancy.

- The vast majority of transgender parents reported that their relationships are good or positive generally, including after "coming out" as transgender or transitioning.

- The outcomes for children with transgender parents have found no evidence that having a transgender parent affects a child's gender identity or sexual orientation development, nor has an impact on other developmental milestones.

- Transgender parents have reported discrimination – either formally through the courts or informally by the children's other parent – in child custody and visitation arrangements. Transgender people who wish to adopt may experience discrimination in adoption.

The review also found that transgender parents reported having **health and social service needs related to child care, networking with other parents, and support for family planning**.

Families in transition

The research on families in transition is limited but a literature review into families in transition of primarily Western European and USA based clinical and social studies found (Dierckx, et al. 2015):

- The coming out as transgender by one partner during marriage can be a shock for the partner and is repeatedly described as resulting in relationship dissolution, although this is not necessarily the case. For example, a USA study described a divorce rate of 12.3% and a marital and registered partnership rate of 19.5% (Rosser, et al. 2007).

- Divorce rates tended to be higher among trans women than among trans men (European Union Agency for Fundamental Rights, 2014).

- Couple assessments showed that partners were likely to experience emotions such as stress, grief, anger, betrayal, loneliness and fear after their partners came out as transgender (Zamboni, 2006). Partners were sometimes found to struggle also with their own sexual orientation and gender identity. They seemed frequently to experience the need to confirm the new gender identity of their partner by reaffirming their own gender identity through expressing gender stereotypical behaviour themselves (Whitley, 2013).

- Various studies revealed that partners of people who make a gender transition experience a lack of psychological and informational support for themselves. Peer support and support of family and friends appears to be an important positive factor for partners (Bischof, et al. 2011; Theron and Collier, 2013).

- Besides a number of different emotional and sometimes negative experiences of non-transitioning partners, some studies mention positive aspects of having a transgender partner, such as developing more effective communication strategies and an increase in the wellbeing of the transgender partner, which increased the level of satisfaction within the relationship (Harvey, 2008).

8. Criminal justice issues

Background

Trans people are most commonly victims of crime rather than offenders. Trans people experience high levels of discrimination, hate incidents and hate crimes in all parts of their lives and can be prevented from fully participating in society because of fear of abuse and humiliation.

Many trans people across the world often live in criminalised contexts i.e. under legislation that punishes so-called unnatural sex, sodomy, buggery, homosexual propaganda, and cross-dressing (Baral, et al. 2011), which can make them subject to extortion, abuse, and violence. Being criminalised, trans people can be discouraged from complaining to the police, or seeking justice when facing violence and abuse, resulting in perpetrators being rarely punished (Divan, et al. 2016).

Hate crimes

The transphobia that surrounds trans people's lives can fuel the violence against them. Transphobia has been defined as:

"A fear of or a dislike directed towards trans people, or a fear of or dislike directed towards their perceived lifestyle, culture or characteristics, whether or not any specific trans person has that lifestyle or characteristic. The dislike does not have to be as severe as hatred. It is enough that people do something or abstain from doing something because they do not like trans people."[11]

Transphobic attitudes and actions can range from the deliberate misgendering of a trans person to theft, serious assaults and sexual abuse. Documentation over the last decade reveals the disproportionate extent to which trans people are attacked, abused and even murdered (Global Commission on HIV and the Law, 2011; TMM IDAHOT, 2015).

Research and literature into transphobia in the UK has focused on hate crime and hate incidents. Hate crime makes up 1% of all reported crime. One percent of reported hate crime is against trans people (Williams, et al. 2016). Compared to a general population, trans people are more likely to suffer from psychological impacts of hate crime, including violent crime. They are also more likely to react physically to such incidents. These problems are thought to be compounded by social isolation and inability to confide in friends and family (Williams and Tregidga, 2014).

Many trans people are worried that the police will not take reports seriously, that reports will be made public and put trans people in further danger, or that there will be negative media coverage resulting from any report (Stonewall, 2017).

[11] Crown Prosecution Service *Guidance on Prosecuting Cases of Homophobic and Transphobic Crime*, http://www.cps.gov.uk/legal/h_to_k/homophobic_and_transphobic_hate_crime/#a20

For example, a survey of 1,275 trans respondents found that half of respondents (47%) said they were most worried about being a victim of a violent crime or harassment. Three-quarters of respondents who were victims of a hate crime had never reported instances to the police, with around half of respondents citing a lack of understanding/sensitivity on behalf of the police as the greatest barrier to them reporting such incidents (The Government Equalities Office, 2011).

It is widely accepted that all hate crime is vastly under reported with the 2014/15 crime survey for England and Wales estimating that there are 222,000 hate crimes committed every year. Only 62,518 hate crimes were recorded by the police in the last hate crime return for 2015/16, which gives an indication of how underreported hate crimes are across the board. Although, this was an increase of 19% with 2014/15 (52,465 offences) (Corcoran, et al. 2016).

In 2015/16, the available data shows that there were 7,194 sexual orientation hate crimes, 3,629 disability hate crimes and 858 transgender identity hate crimes. For 40 police forces, sexual orientation hate crime was the second most commonly recorded hate crime. In the majority of forces transgender identity hate crime was the least commonly recorded hate crime. The transgender hate crimes recorded by the police between 2011/12 to 2015/16 are outlined in the table below (Corcoran, et al. 2016):

	2011/12	2012/13	2013/14	2014/15	2015/16	% change 2014/15 to 2015/15
No. of transgender hate crimes	313	364	559	607	858	**41**

It is likely that recording improvements are a factor in the increase in the number of transgender hate crime offences recorded by the police.

There is anecdotal evidence provided by some forces that there have been drives to improve the reporting and the recording of hate crimes, as well as further training of staff. It is also possible that some of the increase may be due to an increase in actual criminal hate behaviour. These could be genuine increases in hate crimes or increases in the numbers of victims coming forward to report a hate crime (Corcoran, et al. 2016).

However, in 2014/15, in Greater Manchester, a survey of hate crime data listed trans hate crime as the most underreported alongside disability hate crime. The reporting of all hate crimes continues to rise in Greater Manchester, yet barriers to reporting hate crime continue to exist (Greater Manchester Police, 2015).

There is a lack of understanding from police services and a lack of faith from trans people that the police will deal with hate crimes with the necessary respect and understanding (Williams, et al. 2016).

In response, the College of Policing has undertaken action to improve the level of police knowledge and training around hate crime. This includes an ongoing training needs analysis, which seeks to comprehensively assess the level of knowledge and experience of officers and establish new training mechanisms to ensure that they can effectively deal with hate crime for all communities, including transgender people (The Government Equalities Office, 2016).

The Crown Prosecution Service (CPS) Hate Crimes Report (2016), for homophobic and transphobic hate crimes, stated that 2014/15 was the first reporting year following the change to the Criminal Justice Act 2003 to incorporate transgender identity as an aggravating feature. The CPS is now able for the first time to report separately on its performance in relation to prosecutions involving transphobic hostility. Whilst two years (2014/15 and 2015/16) does not provide a sufficiently robust basis on which to draw firm conclusions in respect of trend data, it does provide the following information:

- In 2014/15, the police referred 56 transphobic cases to the CPS for a charging decision. This figure rose to 98 in 2015/16. There were 37 completed prosecutions under the transphobic crime flag on the CPS digital case management system in 2014/15 and 85 the following year.

- The conviction rates for transphobic cases each year were 75.7% (or 28 successful outcomes) and 80.0% (or 68 successful outcomes) respectively. Guilty pleas featured in successful outcomes in 73.0% of prosecutions in 2014/15 and 68.2% in 2015/16.

- No transphobic cases were recorded as unsuccessful due to victim issues in 2014/15 but there were 4 cases (23.5%) impacted in this way in 2015/16.

- In relation to defendants in transphobic cases, in 2014/15, 26 (70.3%) were men and 11 (29.7%) were women: a disclosure rate of 100%. In 2015/16, 66 (77.6%) were men and 19 (22.4%) were women.

- In relation to victims in cases of transphobic hate crime, in 2014/15, 20 (57.1%) were women and 12 (34.3%) were men (with a disclosure rate of 91.4%). In 2015/16, 51 (52.0%) were women and 27 (27.6%) were men (with a disclosure rate of 79.6%).

- The proportion of successfully completed transphobic hate crime prosecutions with an announced and recorded sentence uplift was 21.4% in 2014/15, a figure which increased to 35.3% in 2015/16.

However, a 2017 UK survey on 593 LGBT people reported that direct anti-LGBT hate crimes (measured by direct experiences of victimization) and indirect anti-LGBT hate crimes (measured by personally knowing other victims of hate crime) continue to be highly prolific and frequent experiences for LGBT people. This survey found that:

- Trans people are particularly susceptible to hate crimes, both in terms of prevalence and frequency, and are more likely to experience heightened levels of threat, vulnerability, and anxiety compared with non-trans LGB people.

- Trans respondents were more than twice as likely to have experienced more than three incidents of hate-motivated verbal abuse over the past 3 years, and 9 times as likely to have experienced three or more hate-motivated physical assaults over the past 3 years, compared with non-trans respondents.

- Trans people are more likely to feel unsupported by family, friends, and society for being LGBT, which was correlated with the frequency of direct (verbal) abuse they had previously endured.

- Trans people felt that the police are not effective at policing anti-LGBT hate crime, and they are not respectful toward them as victims; this was especially true where individuals had previous contact with the police.

- Respondents were less confident in the CPS to prosecute anti-LGBT hate crimes, though the level of confidence was slightly higher when respondents had direct experience with the CPS.

(Walters, et al. 2017)

Harassment, sexual harassment and assault, and crime

The first national survey on violence against trans people conducted in the USA, and the largest sample on record, documents the high levels of violence and abuse that trans people face. The study found that 48% of respondents had been victims of assault, including sexual assault and rape, and 78% had experienced verbal harassment (Genderpac, 1997). A more recent national USA study found that:

- 35% of individuals who expressed their gender identity or gender non-conformity at any time between the ages of 5 to 18 years fell victim to physical violence.

- 12% become victims of sexual violence.

- 7% of transgender adults had been physically assaulted at work.

- 6% had been sexually assaulted.

- All these experiences affect the emotional health and wellbeing of transgender people and 41% of the participants in the USA study reported attempting suicide, compared with 1.6% of the general population.

(Grant, et al. 2011)

Other research conducted in the USA found that 43% of the participants had been a victim of violence or crime, with 75% of those attributing a motive of either transphobia or homophobia to it (Xavier, 2000). It has also been suggested that young trans people are particularly vulnerable to victimization and harassment, compared to adults (Ryan and Rivers, 2003). In the UK, respondents in a survey of 872 trans people found that:

- 73% of trans people surveyed experienced some form of harassment in public (ranging from comments and verbal abuse to physical violence).

- 21% stated that they avoided going out because of fear of harassment.

- 46% stated that they had experienced harassment in their neighbourhoods.

- 64% of young trans men and 44% of young trans women experienced harassment or bullying at school, not just from their fellow pupils but also from school staff including teachers.

- 28% stated that they had moved to a different neighbourhood because of their transition. (Whittle, et al. 2007)

There is no official data regarding sexual assaults committed against LGBT people as sexual orientation and gender identity are not routinely monitored in police services or included in the British Crime Survey. However the available data indicates that:

- 19% of trans people have been physically attacked and 38% experienced physical intimidation and threats because of their gender identity (McNeil, et al. 2012).

- 97% of transphobic crime goes unreported (Wilde, 2007).

Research from the USA also indicates that trans women are especially vulnerable to sexual exploitation and abuse (Keeble, 2013):

- Only 22% of trans survivors access statutory or specialist support services following an unwanted sexual experience (Rymer and Cartei, 2014).

- Almost all (91%) trans respondents to one study were worried that their gender identity would affect their experiences of using a sexual violence service. Specifically, 40% did not access services for fear of discrimination by workers or other service users, 20% were not aware of services available to them, 78% were worried they would face repercussions from coming out as transgender while using a service (Rymer and Cartei, 2014).

- 83% of trans individuals would not feel comfortable accessing a sexual violence service that advertises itself as 'for men' or 'for women' (Rymer and Cartei, 2014).

Research has shown that it is not just individuals that experience discrimination and marginalization but also their families and carers. (Cartwright, et al. 2012).

Domestic violence

Trans people have unique experiences of domestic abuse intertwined with both their trans status (Rogers, 2013) and transphobia from others (Viggiani, 2015). Trans people are most at risk of domestic abuse after coming out to a partner and telling them of their intention to transition (Roch, et al. 2010).

The evidence indicates:

- 80% of trans people have experienced emotional, physical or sexual abuse from a current or former partner based on a rejection of their trans identity (Roche, et al. 2010).

- 7% of trans people contacted specialist domestic abuse services and 25% did not tell anyone about. They expected that service providers would not treat them with respect (Roche, et al. 2010).

- 64% of trans people have experienced domestic violence and abuse, compared to 29% of non-trans respondents (Browne and Lim, 2008).

Research suggests that there are few targeted services available for trans women experiencing intimate partner abuse (Maternity Action, 2014). Anecdotal evidence from LGBT service providers suggests there is a similar lack of appropriate services for trans men.

Many domestic abuse services lack cultural competency in working with trans people and have not recognised the need to ensure trans inclusion within resources. Staff in mainstream domestic abuse services do not typically have experience of working with trans people and have had little opportunity to learn about trans identities and experiences (Viggiani, 2015).

Sex work

Anecdotal evidence suggests that sex work is likely to be more prevalent across the trans community, although there is a lack of evidence into the size of the trans population engaging in sex work in the UK. It is thought that barriers to other forms of employment coupled with costs associated with private healthcare could lead to some individuals finding alternative employment through sex work.[12]

This is significant because evidence suggests that trans women sex workers face a prevalence of HIV that is up to 9 times higher than non-trans female sex workers and at least 34 times higher risk than that faced by the general population in the USA (UNAIDS, 2014).

Comparable data from the USA supports this. 11% (n=694) of respondents to the National Transgender Discrimination Survey in the USA reported having participated in sex work, whilst over 2% (n=135) said they had traded sex for accommodation (Fitzgerald et al., 2015). The survey also found that Black respondents had the highest rate of sex work participation overall whilst White respondents had the lowest participation rate.

Canadian research similarly indicated high prevalence of historic and current sex work, with an average of 15% of both trans men and women engaging in sex work, and with an average of 2% reporting current employment as a sex worker or escort (Bauer, 2012).

Major findings of the two known studies that concentrate on transgender sex workers exclusively **without looking at HIV/AIDS** describe how some trans-identified people turn to sex work as a "last resort" due to discrimination experienced in other workplaces (Nadal, et al. 2012; Sausa, et al. 2007).

The choice of trans women to engage in sex work is likely indicative of the fact that 63% of trans women report difficulty in finding employment Garofalo, et al. 2006a).

Trans sex workers can also be vulnerable to brutal police conduct, including rape and being sexually exploited by those who are meant to be protectors of the law (Winter, 2012). In these circumstances, options to file complaints are limited and, when legally available channels do exist, trans complainants are often ignored (Global Commission on HIV and the Law, 2012).

Murders of transgender people

Murders of transgender people may go unreported or are misreported as murders of gay and lesbian people (Winters, et al. 2016). In spite of this, international research documented a total of 2,115 murders of transgender people between January 2008 and April 2016 (Transgender Europe, 2016).

[12] http://actionfortranshealth.org.uk/resources/for-transpeople/sex-work/

9. Transgender people in the criminal justice system

Background

In Britain, people who are living in a gender different to that of their assigned sex at birth should, as a general presumption, be treated by offender management services according to the gender in which they identify. Clear, reasonable criteria should be applied from the outset for all transgender people who receive a binary (i.e. either a male or female) service from the National Offender Management Service (NOMS), where it is required. This process should be free from bias, follow a clear, recorded process and be undertaken by staff who have a sound basic awareness of transgender identity, with access to specialist advice. The transgender person must be fully involved with face-to-face assessment and the giving of reasons both orally and in writing (MoJ, 2016).

Police

There have been reports about transphobic attitudes from some police officers in relation to searching and use of force during arrest (Ryan, 2016). Examples of police mistreatment of transgendered people over the years include:

- “Cupping” a suspect's genitals in order to “determine their real gender” (Fae, 2013).
- Ripping a wig from a trans woman's head, emptying her handbag onto the street, forcing her to the ground and standing on her, shouting at her that she is “not normal” and that she has to “act like a normal human being” (Taylor, 2013).
- Misgendering suspects and refusing to record their acquired gender on the police national computer without sight of a Gender Recognition Certificate (Fae, 2013).
- Telling trans women they need a Gender Recognition Certificate in order to use public toilets (O’Connell, 2008).
- Threatening to arrest trans people demonstrating against transphobia (O’Connell, 2008).

Once a transgendered person is arrested, their immediate detention can be a problem. While many police facilities manage to find a way to detain a transgendered suspect in a way that does not violate their rights such as holding them in a cells on their own or, where this is not possible, in cells with cisgendered people of the same gender identity, there are reports of improper placement of transgender people while they are held; and improper questioning of transgender people.

This includes but is not limited to unnecessarily aggressive and intimidating questioning of transgender victims of crime.

The following recommendations were made in 2007 to improve the police response (Whittle, et al. 2007):

- Police services should make a priority response when a trans person calls for help.
- Police services should not assume the trans person is the cause of any incident.
- Police services need further informing and educating about the nature of trans identities.
- Transphobic crime should be recorded in all police authorities.
- The CPS needs information to enable it to determine whether it is in the public interest to prosecute a trans person who has been a victim of a crime, in the same incident.
- More research is needed to determine the basis of transphobic crime, to develop responsive policies and to ensure appropriate interventions when individuals are vulnerable e.g. providing alternative housing.

Courts

In the USA, the National Transgender Discrimination Survey found that 12% of transgender and gender non-conforming people indicated they had been harassed or disrespected by a judge or court official, with transgender women reporting consistently higher rates of mistreatment by judges, courts, and legal service clinics than transgender men (Grant, et al. 2011). In a survey of transgender and gender non-conforming people who had been in court anytime during the past five years, one quarter (26%) of respondents indicated their gender identity had been raised as an issue in court when it was not appropriate, and 21% had been "outed" against their will in court.

In addition, 33% heard a judge, attorney or other court employee make negative remarks about a person's sexual orientation, gender identity, or gender expression. Black transgender and gender non-conforming people reported even higher rates and 53% of respondents had heard discriminatory comments in the courts (Lambda Legal, 2012).

In Britain, some transgender offenders will have existing vulnerabilities, such as mental health or alcohol misuse, and some will become vulnerable as a consequence of finding themselves in the criminal justice system. Once identified, transgender people's needs and vulnerability may make them suitable for diversion from court and criminal justice altogether (MoJ, 2016).

Within the family courts, during a divorce, many trans people become the one at fault simply by trying to gain recognition of their gender identity. They risk being separated from their children and family members because the family courts fail to intervene and protect them. Furthermore, the family courts have been unable to demonstrate consistency in how they deal with trans young people. There is no guidance in place to help the courts approach family disputes involving a young person's gender identity. This is due to a lack of awareness and understanding of the issues trans people face, whether they are adults or younger people (Stonewall, 2017).

Probation service

A small exploratory survey identified probation practitioners who were in contact with transgendered offenders and explored their views on what would enable them to work more efficiently with this client group. They expressed that they did not have sufficient knowledge or confidence to raise issues of trans status when writing pre-sentence reports. Questions concerning how to appropriately deal with transgender offenders were raised, which included understanding prejudice and discrimination and how to cope with their own feelings about trans people (Poole, et al. 2002).

This study found that officers experienced difficulties in managing other challenging or problematic behaviours that transgender offenders present with. However, they also reported that probation officers considered transgender offenders to be similar to other prisoners in many ways, and that their offending behaviour needed to be addressed regardless of their trans status (Poole, et al. 2002).

Prisons

Research indicates that prison systems across the world operate on the principles that all people should be classified as either male or female and that gender remains constant throughout life and is assigned at birth. Few facilities worldwide have designed housing policies that go beyond placements based on biological sex or genitalia. Clearly, the lack of such policies may create difficulties for inmates identifying themselves as transgender as it places them at greater risk of institutional transphobia, violence and sexual assault (Simopoulos, et al. 2014).

Research has shown that prisoners who exhibit effeminate characteristics are more likely to become targets of sexual abuse (Mariner, 2001).

In the UK, the prison system is currently built to house genders separately, and will distinguish gender based on that which is recognised by law. According to the Gender Recognition Act 2004, proof of gender is determined either by the person's birth certificate, or a Gender Recognition Certificate (GRC). The process for obtaining a GRC is set out in the Act.

It involves satisfying a panel that the individual has or had gender dysphoria, has 'lived in their acquired gender' for a period of at least two years and plans to do so until their death, and has submitted the required documentation and evidence. [13] However, due to the complex process and the cost involved, the symbolism, or because it can have implications for existing marriages, and also pension implications, many transgender people choose not to obtain a certificate. Since the law came into effect in April 2005, the GRC panel has received just over of 4,900 applications (MoJ, 2016d).

Most transgender prisoners are, at least upon first arrival in prison, housed according to the gender they were assigned at birth (Prison & Probation Ombudsman, 2017). However, the most recent Prison Service Instruction (PSI 17/2016) states that decisions on the allocation of transgender people to binary services, especially custody, must include the possibility of a review and rapid remedy if it appears that the initial allocation might have an unforeseen and detrimental impact on the person's mental health or wellbeing, their social integration and access to services, or an impact on safety to themselves or the safety of others. Decisions to transfer serving prisoners between male or female prisons (or vice versa) should be based on clear criteria, with reasons given for the outcome and appeal processes clearly explained. As part of this process, it will be necessary to factor in the impact on, and risks to, those in current or potential establishments especially, for instance, in the women's estate where many prisoners will have been the victims of domestic violence or sexual abuse and may continue to be exceptionally vulnerable (MoJ, 2016).

There is limited research on the numbers of trans people in the prison system. It has previously been suggested that trans people are overrepresented in the UK prison population – more than twice what would be expected with the available estimates of the size of the trans population in the UK as a whole (Poole, et al. 2002).

Many of the offences trans people were incarcerated for involved gaining money for surgery (e.g. handling stolen goods). Poole's (2002) research called for transgender people to be included in diversity policies in the criminal justice system and for training on transgender issues for probation and prison officers (Whittle, et al. 2007).

Data from the USA suggests that proportionately more transgender people spend time in USA prisons than the general population:

[13] https://www.gov.uk/apply-gender-recognition-certificate/overview

(Center for American Progress and MAP, 2016)

The data from the USA indicates that:

- 16% of transgender and gender non-conforming respondents to the National Transgender Discrimination Survey indicated they had spent time in jail or prison, with higher rates for transgender women (21%) and lower rates for transgender men (10%) (Grant, et al. 2011).

- The National Inmate Survey found that in 2011-2012 there were approximately 5,000 transgender adults currently serving time in adult prisons and jails in the USA (Beck, 2014).

- In a survey of 1,100 LGBTQ prisoners, nearly all the respondents (85%) had been placed in solitary confinement during their time in prison or jail. The survey also found that transgender women are put into solitary confinement against their will at the highest rates (Lydon, et al. 2015).

- In a survey of youth in six juvenile justice jurisdictions across the USA, 15% identified as LGBT or gender non-conforming, and the proportion held fairly steady by race. The rates of detention varied greatly by sex, however; 11% of males identified as LGBT or gender non-conforming compared to 27% of females (Irvine, 2010 & 2011).

- Statistics about transgender people in immigration detention facilities are difficult to obtain. However, an investigation by the Center for American Progress found that between October 2013 and October 2014, 104 immigrants stated that they were afraid of being put in detention because of their sexual orientation and gender identity. Of these, 81 were placed in detention anyway (Grant, et al. 2011).

The reasons for the overrepresentation in the USA are attributed to legislative bias i.e. criminalisation of groups that already have a higher proportion of transgender people such as HIV laws, drug laws and laws relating to sex work.

Policing strategies and behaviours are also cited including profiling, collaboration between police and immigration enforcement, misgendering and inaccurate identifying documents, discrimination and mistreatment and violence when transgender people seek assistance.

In England and Wales, until recently there were no official statistics on the number of transgender prisoners. In November 2016, the Ministry of Justice published the first official statistics on transgender prisoners. A data collection exercise in March/April 2016 found (MoJ, 2016c):

- 33 of the 123 public and private prisons (27%) in England and Wales said that they had 1 or more transgender prisoners.
- There were 70 prisoners living in, or presenting in, a gender different to their sex assigned at birth and who have had a case conference (as defined by PSI 07/2011).
- Of these, 52 reported their gender as male, 14 reported their gender as female and 4 did not state their gender.
- 8 of the 70 prisoners reported their ethnic group as Black, Asian and Minority Ethnic Group; 61 as White and 1 was not stated.
- Based on this exercise, there were 0.8 transgender prisoners reported per 1,000 prisoners in custody.

However, it should be noted that this survey did not include non-binary or gender fluid people. The latest statistical bulletin release from the MoJ, shows a marked increase in the number of transgender prisoners identified as part of the annual equality monitoring report. According to the data collection exercise conducted in March/April 2017:

- 47 of the 124 public and private prisons (38%) in England and Wales said that they had 1 or more transgender prisoners;
- there were 125 prisoners currently living in, or presenting in, a gender different to their sex assigned at birth and who have had a local transgender case board;
- of these, 99 reported their gender18 as male, 23 reported their gender as female and 3 did not state their gender;
- 12 of the 125 prisoners reported their ethnic group as Black, Asian and Minority Ethnic Group and 113 as White;

Based on this exercise, there were 1.5 transgender prisoners reported per 1,000 prisoners in custody (Ministry of Justice, 2017).

Prison systems worldwide have historically required transgender prisoners to observe the dress standards mandated at their respective facilities. In most prisons, transgender inmates have historically been prevented from wearing gender-specific clothing and accessories (e.g., female undergarments, other clothes, or makeup) and may only have access to clothing that serves a functional purpose, including brassieres (Simopoulos, et al. 2014).

Women's prison estate

Very little is known about the conditions of trans people within the women's prison estate in England and Wales and the support they receive. There is a lack of data or awareness of the issues for transgender people in female prisons.

Harassment and assault in prisons

Transgender people in prisons are at increased risk of violence and sexual assault by other incarcerated people. For example, evidence from the USA shows the following:

- 24.1% of transgender people in prisons and jails reported being sexually assaulted by another inmate, compared to 2.0% for all people (Beck, 2011).

- Of the transgender women who reported being incarcerated at some point during their lives, nearly half (47%) reported being harassed or assaulted in prison or jail; Black, Latina, and mixed-race transgender women were more likely to be victimized than White transgender women (Reisner, et al. 2014).

- In a survey of transgender women placed in men's prisons in California, more than half (59%) had been sexually assaulted compared to 4.4% of all male respondents — meaning that transgender people were 13 times more likely to be assaulted than incarcerated men (Jenness, 2009)

- Prison officers were less likely to be aware of the incidents involving transgender people (29% compared to 61% of incidents involving all incarcerated people in the same facilities) (Jenness, 2009). In a follow-up study two years later, researchers found that the same percentage of transgender people reported sexual victimization (59%).

- 20% of substantiated assaults in immigration detention facilities involved transgender detainees (United States Government Accountability Office, 2013).

Research suggests that there is a tendency of prison staff to overlook transphobic abuse and victimisation, and a lack of effective challenging of prisoners with discriminatory attitudes and behaviors, particularly in male prisons (Dunn, 2013).

This has resulted in LGBT prisoners being at significantly higher risk of violence while incarcerated. Research in the USA found that:

- 67% of LGBT prisoners in California report having been assaulted whilst in the prison system.[14]

- Transgender prisoners are 13 times more likely than their nontransgender counterparts to be sexually assaulted in prison (Sexton and Jenness, 2016)

- Transgender people in prison reported high levels of unnecessary searches, including strip searches, which are demeaning and can increase the risk of harassment and violence by other prisoners and staff (Bassichis, 2007).

- As transgender people are frequently placed in facilities that do not reflect their gender identity, they may be subject to cross-gender searches and monitoring, making them particularly vulnerable to sexual assault. A survey found that 16.7% of transgender people in prisons reported being sexually assaulted by facility staff in the previous 12 months compared to 2.4% of all incarcerated adults (Beck, 2011).

- This mirrors findings from a survey of transgender women in men's prisons in California in which 14% reported being sexual assaulted by a correctional staff member (Jenness, 2009).

Investigation of complaints and deaths in prisons

The Prisons & Probation Ombudsman is responsible for investigating the deaths and complaints made by prisoners.

The Prisons & Probation Ombudsman reported that they had carried out a limited number of investigations into complaints made by, and the deaths of, transgender prisoners. Until recently, NOMS did not record if a prisoner was transgender so the Prisons & Probation Ombudsman equality and diversity monitoring was limited by this lack of information, and were only able to identify complaint investigations where the prisoner had disclosed to them their transgender status, which usually only occurred in cases where this status was relevant to their complaint (Prisons & Probation Ombudsman, 2015).

It is important to note that all of the complaints and the deaths in custody investigated were related to transgender female prisoners, nearly all of whom were housed in a male estate.

[14] http://www.nclrights.org/press-room/press-release/meeting-to-highlightissues-faced-by-lgbt-people-in-california-prisons/

This does not mean that the Prisons & Probation Ombudsman did not received complaints from transgender male prisoners, simply that their transgender status was not related to the subject of their complaint (Prisons & Probation Ombudsman, 2017).

Complaints

The Prisons & Probation Ombudsman identified 10 complaints relating to transgender issues from 2012/13 onwards, of which seven were eligible for investigation.[15] These complaints came from four different male to female transgender prisoners and related to five prisons, spread across the prison estate: HMP Frankland, HMP Elmley, HMP Wymott, HMP Manchester and HMP Maidstone. The Prisons & Probation Ombudsman upheld, and made recommendations, in three of the complaints.

One consistent theme that did appear to emerge from complaints from transgender prisoners was access to, or restrictions on, make-up or clothing, which would help the prisoner to live in their acquired gender.

The Prisons & Probation Ombudsman recommendations were often specific to the nature of complaint, however, in two of the three cases the prison was required to ensure that their local policy was compliant with the Prison Service Instruction or that staff be reminded of the requirements of both local and national policy regarding transgender prisoners. While it was not unusual to make recommendations that prisons should ensure that their staff are aware of, and feel confident in implementing, Prison Service Instructions, the Prisons & Probation Ombudsman noted that this was all the more pertinent in the context of transgender issues about which many prison staff lacked awareness and training.

Additionally, the Prisons & Probation Ombudsman (2015) stated:

"Given the paucity of official information available, it is difficult even to know whether the small number of complaints to the Ombudsman from transgender prisoners is an issue in itself. It may be that the number is proportionate to the number of transgender prisoners within the prison system or that their gender goes unrecognised because it is not apparently relevant to the complaint or that complaints are being satisfactorily resolved at a local level. Without better data this will remain uncertain."

More recently, the Prisons & Probation Ombudsman has reported that from April 2012 to end of August 2016, they received 33 complaints related to transgender equalities issues (Prisons & Probation Ombudsman, 2017). As with the previous report, nearly all of the complaints received, and deaths investigated were related to transgender female prisoners, nearly all of whom were housed in the male estate.

[15] Usually ineligibility is because the complainant has not first gone though the internal prison complaint process before applying to the Ombudsman as required under their Terms of Reference.

Deaths

The Prisons & Probation Ombudsman were better able to identify the transgender status of prisoners who have died, as their investigators and clinical reviewers had access to their medical records as part of the investigation (Prisons & Probation Ombudsman, 2015).

By 2015, the Prisons & Probation Ombudsman identified four investigations into the deaths of transgender prisoners, three self-inflicted and one from natural causes. The transgender status of the prisoner was not found to be a direct causal factor in any of these deaths, although an examination of these cases highlighted the particular vulnerabilities of these prisoners and the need for the Prison Service to improve compliance with Prison Service Instruction (PSI 07/2011[16]).

These cases were in the following prisons: HMP Frankland (2014), HMP Belmarsh (2013), HMP Full Sutton (2012) and HMP Eastwood Park (2006).

The investigation into the death at HMP Full Sutton found that, while the woman wore women's clothing, had access to make up and the majority of staff referred to her as a female and met the prison's diversity officer weekly, she did not formally meet either of her assigned personal officers to discuss her gender reassignment in line with PSI 07/2011, which required personal officers to meet monthly with prisoners going through gender reassignment. There was no evidence of such a meeting in the woman's records. An officer was appointed as an additional personal officer when she moved wings because of her "special circumstances" (gender reassignment), but the officer never made an entry in her case history notes. Her other personal officer did not make an entry in her case history notes for four months, between the end of November 2011, when she first introduced herself, and March 2012.

The Prisons & Probation Ombudsman concluded that this suggested an ineffective and unsupportive relationship which prevented either personal officer from identifying any specific concerns that the woman had and was not compliant with the PSI. More positively, the Prisons & Probation Ombudsman independent clinical reviewer considered healthcare staff addressed her gender dysphoria appropriately and that she received sufficiently regular support from the prison's healthcare team, in particular by the mental health in-reach and psychology teams (Prisons & Probation Ombudsman, 2015).

The investigation into the death at HMP Belmarsh highlighted the challenge that prisons pose to those on the transition pathway. The prisoner, who had been diagnosed with gender dysphoria and had been taking hormone replacement treatment for gender reassignment, decided to live as a man at HMP Belmarsh because he was concerned he would be vulnerable if he chose to live as a woman rather than because he had changed his mind about his gender identity.

[16] PSI 7/2011 has now been now superseded by PSI 17/2016

In January 2017, the Prisons & Probation Ombudsman reported it had now completed investigations into the deaths in custody of five transgender prisoners. It identified six lessons from past cases that aims to protect transgender prisoners better from bullying and harassment, and to support transgender prisoners better to live in their gender identity while in prison, specifically (Prisons & Probation Ombudsman, 2017):

- Evaluating the location of a transgender prisoner based on an individual assessment of their needs and considering the possibility of them residing in the estate of their acquired gender.

- All relevant people involved in a transgender prisoner's care attending ACCT case reviews (for those deemed at risk of suicide or self-harm).

- Meaningfully investigating all allegations of transphobic bullying and harassment and taking steps taken to challenge and prevent it.

- Personal officers having regular, meaningful contact with transgender prisoners, staff being aware of their vulnerabilities and challenging inappropriate behaviour.

- Local policies to be in line with national guidance and not imposing unfair additional restrictions.

- Reasonable adjustments being made for transgender prisoners to help them to live in their gender role.

Care and management of transgender people in prisons

The 2011 policy guidelines for England and Wales stated that prisoners should normally be located in the prison estate of their gender as recognised by UK law. For transgender prisoners, a Gender Recognition Certificate (GRC) would normally be necessary before a person could be placed in a prison corresponding to their acquired gender. There was some flexibility for trans prisoners who were *"sufficiently advanced in the gender reassignment process"* (Strickland, 2016).

The House of Commons Women and Equalities Committee report (2016) on Transgender Equality made 35 recommendations in relation to a wide range of areas including cross-Government strategy, the Gender Recognition Act 2004, the Equality Act 2010, NHS services and on tackling everyday transphobia. In regards to prisons, the report stated that there was a *"clear risk of harm"* where trans prisoners are not located in a prison *"appropriate to their acquired/affirmed gender"*.

The Government published a report on their policy review in November 2016, which acknowledged that the treatment of transgender people in the criminal justice system had not kept pace with wider social views.

The review concluded that treating offenders in the gender in which they identify with is the most effective starting point for safety and reducing reoffending, where an assessment of all known risks can be considered alongside the offender's views. If someone is living in an establishment different to the gender in which they identify, they will be entitled to live and present in the gender in which they identify and to be provided with the items that enable their gender expression (The Government Equalities Office, 2016).

The review resulted in new policy guidelines from NOMS, Prison Service Instruction 17/2016, which stated: *"all transgender prisoners (irrespective of prison location) must be allowed to express the gender with which they identify"*. In summary:

- Arrangements must be in place to determine the legal gender of all offenders at the first point of contact.

- When making initial prison location decisions, transgender offenders must be asked their view of the part of the prison estate (i.e. male or female) that reflects the gender with which they identify.

- If the prisoner's view accords with their legally recognised gender they must be located accordingly, although there are exemptions for women offenders *"where the risk posed to other offenders and/or staff prevents location on the female estate"*.

- Decisions to locate in part of the estate which is not in accordance with their legal gender can only be made following a local Transgender Case Board.

- Where a transgender offender expresses a view of prison location which is not consistent with their legally recognised gender *"the offender must be asked to provide evidence of living in the gender with which they identify"*. The strength of this evidence will be considered alongside all known risk factors before a decision is made.

The guidance also acknowledges that there may be 'exceptional cases' where it is necessary to refuse to locate a male to female prisoner in the women's estate, for example, due to risk and security concerns.

The abrupt cessation of hormone treatment is known to cause particular problems. Case law from the USA relating to trans people who enter an institution on an appropriate regimen of hormone therapy concluded that it should be continued on the same, or similar, basis and monitored according to the Standards of Care (WPATH, 2011). A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002).

The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Continuity of care on leaving prison

Continuity of care is particularly important for transgender individuals who are taking hormones and receiving other transgender related healthcare. Individuals who have received care while in prison need to be able to access appropriate healthcare upon release, but some find that they are unable to access appropriate provision (Center for American Progress, et al. 2016).

There appears to be high rates of recidivism due to the lack of opportunities for employment, and often the victims of violence, discrimination and harassment, many trans people turn to prostitution and sex work (Simopoulos, et al. 2014). A study of transgender people in San Francisco found that nearly 14% of transgender individuals had been incarcerated at least once, a figure that is double the average incarceration rate in the USA (Minter, et al. 2003).

The lack of support for transgender people and the rigorous requirements placed on people on probation or parole can also contribute to high levels of recidivism among parolees and recently released individuals. For example, in the USA, there have been cases in which a transgender person's dressing in accordance with their gender identity has resulted in a violation of parole terms (Transgender Law Center, 2016).

Transgender youth in the criminal justice system

LGBT youth have always been present in the criminal justice system, although many of them have concealed their sexual orientation and gender identities to escape harassment and mistreatment. However, it is particularly important for the youth justice system to recognise the risks and the need for appropriate policies and approaches. For example, placing transgender girls in male units can potentially jeopardise their health and safety. The youth justice system needs to acknowledge the diversity and complexity of gender and sexuality in order to provide individualised services that promote the health and wellbeing of each young person in their care and custody.

Evidence from the USA shows that risk factors, similar to those in the UK – school exclusion, family rejection, homelessness and failed safety-net programmes – contribute to the disproportionate number of LGBT youth who come in contact with the youth justice system (Wilber, 2015). Lesbian, Gay, Bisexual, Questioning (LGBQ), gender-nonconforming and transgender youth in detention were more likely to have experienced child abuse, foster and group-home placement, and homelessness when compared with their heterosexual, cisgender and gender-conforming peers.

They were also more likely to be detained for truancy, warrants, probation violations, running away and prostitution – low-level and victimless offenses related to economic and social marginalisation (Irving and Canfield, 2015).

Similarly, other USA evidence found that:

- LGBQ, gender-nonconforming and transgender youth are significantly overrepresented in the justice system. In a self-administered survey completed by 1,400 detained youth, approximately 20% of youth self-identified as LGBQ, gender nonconforming or transgender. Of these youth, 85% identified as "youth of colour", so Black and Minority Ethnic groups are overrepresented among these young people in the justice system (Irvine and Canfield, 2015).

- This research also showed that the rates of overrepresentation were particularly high for girls, although the reasons for this discrepancy was unknown. The total percentage of boys who identified as LGBQ, gender nonconforming or transgender was 13.6%. By contrast, the total percentage of girls was 39.9% (Irvine and Canfield, 2015).

- 90% of LGBT youth in juvenile detention have been suspended or expelled from school at least once (Irving and Canfield, 2015).

- LGBT youth represent up to 40% of the homeless youth population nationally (Wilber, 2015).

- Young people who are perceived to be gay or lesbian or to transgress gender norms are at heightened risk of verbal, physical and sexual assault in secure settings (Majd, et al, 2009).

- LGBT young people experience disproportionately high levels of sexual abuse in detention and correctional settings. In 2010, a survey of more than 9,000 young people in 195 juvenile facilities across the USA found that those who identified as lesbian, gay, bisexual or "other" reported significantly higher rates of sexual victimisation by other young people (12.5%) compared with heterosexual young people (1.3%), nearly 10 times higher (Beck, et al, 2010). In 2012, a follow-up survey in 326 juvenile facilities found that while overall rates of sexual victimisation decreased about 3%, the rate of abuse of LGB residents remained nearly seven times higher than that of heterosexual young people (Beck, et al, 2012).

Appendix A: Terminology

A wide range of terminologies is used with respect to gender identity diversity. While the use of terminology is clearly an issue identified by respondents to review and in the literature, it should be noted that the following are not intended to provide a typology, nor is there any assumption of hierarchy. It is also important to be aware of the historical and politico-social context of the language that is used to discuss gender diversity.

The following brief glossary has been compiled from a variety of literature sources and on advice from respondents to the review:

- ***Gender identity*** – refers to the psychological identification of oneself as either a boy/man or girl/woman. This identification is usually thought of in these binary terms but this may not always be the case. Gender identity is independent of the issue of preference for a male or a female sexual partner (sexual orientation).

- ***Gender Incongruence*** – has replaced terms such as gender identity disorder, and transsexualism. It refers to the situation where a person's gender identity is not the one typically associated with the birth-assigned sex.

- ***Gender dysphoria*** - refers to discomfort or distress that is associated with gender incongruence. (This term is likely to become gender incongruence in the revised International Classification of Diseases, ICD 11 in 2018).

- ***Gender role*** – refers to the social role of gender, how we perform gender in society through our interaction with others.

- ***Gender diversity, variance or non-conformity*** – while the dominant assumption is that people conform to the gender role ascribed to them by virtue of their anatomy at birth, this is not always the case. This can result in people expressing their gender identity in ways that are perceived by others as acting against cultural gender norms – hence gender diversity. This is often a preferred term for people who object to the pathological connotations and implications of mental illness that are implied by gender dysphoria and the older term of gender identity disorder.

- ***Intersex*** – refers to atypical sex differentiation that is sometimes evident at birth, but may not be diagnosed until puberty, or adulthood, and in some cases may remain undiagnosed. It was common practice in the past, to undertake surgical procedures on infants with visibly undifferentiated sex characteristics (ambiguous genitalia), that is, an appearance that was neither clearly male nor female, on the assumption that bringing the child up in the gender role that was consistent with the surgically modified genitalia would inevitably lead to a congruent gender identity.

This was frequently not the outcome, and many intersex children treated in this way, did not identify consistently with their contrived genital appearance and gender of up-bringing. Intersex people, who only found out in adulthood that they had been subject to this treatment, have challenged this assumption. Many believe this has caused them significant psychological and physical damage. These surgeries are now unlawful in some jurisdictions.

- ***Non-binary***– refers to people who do not identify as either men or women. Non-binary people often prefer the use of pro-nouns 'they' or 'them' rather than 'he' or 'she'.

- ***Gender fluid*** – refers to people whose gender identity fluctuates.

- ***Gender queer*** – the word 'queer' has largely overcome the association with queer-bashing, a hideous episode of physical attacks on gay men and lesbians. It is now used defiantly, and more flexibly, to include anyone whose gender expression is not cisgender. Sometimes 'queer' on its own, is used to embrace the entire LGBT+ communities.

- ***Cisgender –*** describes the majority of the population, in whom the gender identity is that which is typically associated with the birth-assigned sex.

- ***Sex*** – refers to the phenotype or the biological development of male/female characteristics. Sex is normally attributed at birth by the appearance of the genitalia. However, other phenotypic factors such as chromosomes are also important, though these are rarely tested unless there is a genital anomaly.

- ***Trans*** – most commonly used as an umbrella term to cover the wide range of gender diverse identities including both binary and non-binary/gender fluid experiences of gender.

- ***Transgender*** – commonly used synonymously with 'trans', as an umbrella term embracing all those who experience some form of gender diverse identity. Trans and transgender refer to both those who do, and those who do not, seek medical interventions.

- ***Transition*** - refers to the point at which a person undertakes a public change of gender expression, in all aspects of their life. This involves gender-affirming changes to outward appearance, clothing, mannerisms or to the name someone uses in everyday interactions known as 'social transitions'. Transition may also be facilitated by medical interventions, some of which can be undertaken before social transition, and other 'gender affirming' interventions will continue throughout life. These interventions to masculinise or feminise the appearance enable the individual to align their characteristics with their gender identity.

- ***Trans woman*** – is a person who was assigned male at birth, and who identifies as a woman. The abbreviation MtF is sometimes used, but is considered impolite by some.

- ***Trans man*** – is a person who was assigned female at birth but who identifies as a man. The abbreviation MtF is sometimes used, but is considered impolite by some.

- ***Transphobia*** - prejudice directed at transgender people because of their gender identity or expression.

- ***Transsexual(ism)*** – is the old definition used in the International Statistical Classification of Diseases and Related Health Problems (ICD-10. F64.0). It still appears in some legal and medical literature. However, the World health Organisation, in its new edition, ICD11, will move this definition out of Mental and Behavioural Disorders, and into a non-pathologising section, using the description 'gender incongruence'.

- ***Transvestism*** – refers to individuals who like to cross-dress intermittently for a variety of reasons including erotic factors.

References

Action for Trans Health (2017) Trans People in Immigration Centres. Action for Trans Health. http://actionfortranshealth.org.uk/2015/04/04/trans-people-in-immigration-detention-centres/

Almack, K., Seymour, J. and Bellamy, G. (2010) Exploring the Impact of Sexual Orientation on Experiences and Concerns about End of Life Care and on Bereavement for Lesbian, Gay and Bisexual Older People. Sociology, 44, 908–924.

AmFAR (2014) *Trans populations and HIV: time to end the neglect*. New York: Foundation for AIDS Research. http://www.amfar.org/issue-brief-trans-populations-and-hiv-time-to-end-the-neglect

Ashbee, O. & Goldberg, J.M. (2006) *Trans People and Cancer*. Vancouver: Transgender Health Programme

Baral S, Beyrer C, Poteat T. (2011) *Human rights, the law, and HIV among transgender people*. Working Paper prepared for the Third Meeting of the Technical Advisory Group of the Global Commission on HIV and the Law, New York; 7_9 July 2011.

Baral S, Poteat T, Strömdahl S, Wirtz A, Guadamuz T, Beyrer C. (2012) Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infect Dis*; **13:** 214–22.

Bassichis, D.M. (2007) *It's war in here: A report on the treatment of transgender and intersex people in New York State men's prison* New York: Sylvia Rivera Law Project (SRLP).

Bauer, G.R., Redman, N., Bradley, K. & Scheim, AI. (2013). 'Sexual Health of Trans Men Who Are Gay, Bisexual, or Who Have Sex with Men: Results from Ontario, Canada', *International Journal of Transgenderism*, 14(2)

Beattie TSH, Bhattacharjee P, Suresh M, Isac S, Ramesh BM, Moses S. (2012) Personal, interpersonal and structural challenges to accessing HIV testing, treatment and care services among female sex workers, men who have sex with men and transgenders in Karnataka state, South India. J Epidemiol Community Health. 2012;66(Suppl 2):ii42-8.

Beck, A.J., Harrison, P.M., & Guerino, P. (2010). *Sexual victimization in juvenile facilities reported by youth*. Washington, DC: Bureau of Justice Statistics.

Beck, A.J., Cantor, D., Hartge, J., & Smith, T. (2012). *Sexual victimization in juvenile facilities reported by youth*. Washington, DC: Bureau of Statistics.

Beck, A.J. (2014) *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12 – Supplemental Tables U.S.* Washington: Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. http://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf

Bell, M. & Hansen, C. [2009]. *Over not Out: The Housing and Homelessness Issues Specific to Lesbian, Gay, Bisexual and Transgender Asylum Seekers*, London: Metropolitan http://www.metropolitan.org.uk/images/Over-Not-Out.pdf

Bischof, G.H., Warnaar, B.L., Barajas, M.S. and Dhaliwal, H.K. (2011) Thematic analysis of the experiences of wives who stay with husbands who transition male-to-female. Michigan Family Review, 15, 16–33.

Bishop, Jenny-Anne (2013) *Trans* Patients' Experiences of their GP Surgery - Annual Survey 2013*. Manchester: Transform.

Blosnich, J.R, Jarrett, T and Horn, K. 'Racial and ethnic differences in current use of cigarettes, cigars, and hookahs among lesbian, gay, and bisexual young adults', *Nicotine Tob Res*, 13:6, 2011, 487-91. doi:10.1093/ntr/ntq261. Epub 2011 Jan 27.

Boehmer, U. (2002). Twenty Years of Public Health Research: Inclusion of Lesbian, Gay, Bisexual, and Transgender Populations. Am J Public Health, 92:7, 2002, 1125-1130.

Bockting, W. Botzer, M. Coleman, E. et al. [2012]. 'Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7' in *International Journal of Transgenderism, Vol 13 (4)*. http://www.tandfonline.com/doi/abs/10.1080/15532739.2011.700873

Bradley, J., Webb, L., and Williams-Schultz, G. (2015). *Falling Through the Cracks: Non-binary people's experiences of transition related healthcare*. UK: Action for Trans Health. http://actionfortranshealth.org.uk/wp-content/uploads/2015/11/Falling-through-the-cracks-final-with-cover.pdf

Brotman, S., Ryan, B., Collins, S., Chamberland, L., Cormier, R., Julien, D., Meyer, E., Peterkin, A. and Richard, B. (2007) Coming out to care: Caregivers of gay and lesbian seniors in Canada. Gerontologist. 47, 490–503.

Brotman, S., Ferrer, I., Sussman, T., Ryan, B. and Richard, B. (2014) Access and equity in the design and delivery of health and social care to LGBTQ older adults: A Canadian perspective. In The Lives of LGBT Older Adults: Understanding Challenges and Resilience; Orel, N., Fruhauf, C., Eds.; American Psychological Association: Washington, DC, USA.

Browne, K., & Lim, J. (2008). Trans people: additional findings report. Count Me In Too: LGBT Lives in Brighton and Hove. Brighton: Spectrum.

Browne, K., McGlynn, N, and Lim, J. (2009) Drugs and alcohol - Additional Findings Report: Count me in to LGBT lives in Brighton and Hove. Brighton: Spectrum.

Brown, G. R. (2010). Auto castration and auto penectomy as surgical self treatment in incarcerated persons with gender identity disorder. International Journal of Transgenderism, 12(1), 31-39. doi:10.1080/15532731003688970

Center for American Progress and Movement Advancement Project (2016). *Unjust: How The Broken Criminal Justice System Fails Transgender People*. Denver: MAP

Chakrapani, V., Newman, P.A., Shunmugam, M. and Dubrow, R. (2011) Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India. AIDS Care; 23(12):1687-94.

Claes, L., Bouman, W.P., Witcomb, G., Thurston, M., Fernandez-Aranda, F. & Arcelus, J. [2015]. 'Non-Suicidal Self-Injury in Trans People: Associations with Psychological Symptoms, Victimization, Interpersonal Functioning, and Perceived Social Support', *The Journal of Sexual Medicine*, Volume 12(1)

Coleman E, Bockting W, Botzer M, Cohen-Kettenis P, DeCuypere G, Feldman J et al. (2011) Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. In J Transgend. 2011;13:165–232).

Corcoran, H. and Smith, K. (2016) *Hate Crime, England and Wales 2015/16 Statistical Bulletin 11/16* London: Home Office https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/559319/hate-crime-1516-hosb1116.pdf

Crethar, H. C. & Vargas, L. A. (2007). *Multicultural intricacies in professional counseling*. In J. Gregoire & C. Jungers (Eds.), The counselor's companion: What every beginning counselor needs to know. Mahwah, NJ: Lawrence Erlbaum. ISBN 0-8058-5684-6. p. 59.

Crown Prosecution Service. *Hate crime and crimes against older people report. 2012*. London: CPS http://www.cps.gov.uk/publications/docs/cps_hate_crime_report_2011.pdf

Crown Prosecution Service. *Hate Crime Report 2014/2015 and 2015/2016* London: CPS https://www.cps.gov.uk/publications/docs/cps_hate_crime_report_2016.pdf

de Haan Gene, Santos Glenn-Milo, Arayasirikul Sean, and Raymond Henry F. (2015) Non-Prescribed Hormone Use and Barriers to Care for Transgender Women in San Francisco LGBT Health. December 2015, 2(4): 313-323.

Department of Health (2007) *Trans Peoples Health* London: DH http://www.edinburghtranswomen.org.uk/Trans_peoples_health.pdf

Department of Health (2008) *Trans: A practical guide for the NHS* London: DH

De Vries A, McGuire J, Steensma T, Wagenaar E, Doreleijers T, Cohen-Kettenis P. (2014) Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics* 2014; published online Sept 8. doi:10.1542/peds.2013-2958.

Dhejne C, Lichtenstein P, Boman M, Johansson AL, Långström N, Landén M. (2011) Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One* 2011; **6:** e16885.

Dhejne C, Oberg K, Arver S, Landen M. (2014) An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: prevalence, incidence, and regrets. *Arch Sex Behav* 2014; **43:** 1535–45.

Dierckx, M., Motmans, J., Mortelmans, D. and T'sjoen, G. (2015) *Families in transition: A literature review* International Review of Psychiatry https://www.researchgate.net/profile/Dimitri_Mortelmans/publication/285200496_Families_in_transition_A_literature_review/links/565d861408aeafc2aac7d8fc.pdf

Divan, V., Cortez. C., Smelyanskaya. M. and Keatley, J. (2016) Transgender social inclusion and equality: a pivotal path to development. Journal of the International AIDS Society 2016, 19(Suppl 2):20803 http://www.jiasociety.org/index.php/jias/article/view/20803

Dunn, P. 2013. Slipping Off the Equalities Agenda? Work with LGBT Prisoners. [Online]. Prison Service Journal. 206. Pp. 3-10. Available From: http://www.crimeandjustice.org.uk/sites/crimeandjustice.org.uk/files/PSJ%20March%202013%20No.%20206.pdf

Ellis, S.J. Bailey, L. & McNeil, J. (2015) 'Trans People's Experiences of Mental Health and Gender Identity Services: A UK Study', *Journal of Gay & Lesbian Mental Health*, Volume 19(1)

European Union Agency for Fundamental Rights (2014) *Being trans in the European Union. Comparative analysis of EU LGBT survey data.* Luxembourg: FRA European Union Agency for Fundamental Rights.

Fae, J. (2013) As the recent incident in Soho shows, police attitudes to trans people must change, The Independent http://www.independent.co.uk/voices/comment/as-the-the-recent-incident-in-soho-shows-policeattitudes-to-trans-people-must-change-8507464.html

Fitzgerald, E; Patterson, S; Biko, C and Tobin, H J (2015) *Meaningful Work: Transgender experiences in the sex trade*. Washington: National Centre for Transgender Equality http://www.transequality.org/sites/default/files/Meaningful%20Work-Full%20Report_FINAL_3.pdf

Garofalo, R., Deleon, J., Osmer, E., Doll, M. & Harper, G.W. (2006a) 'Overlooked, Misunderstood and At-Risk: Exploring the Lives and HIV Risk of Ethnic Minority Maleto-Female Transgender Youth', *Journal of Adolescent Health*, Volume 38 https://www.ncbi.nlm.nih.gov/pubmed/16488820

Garofalo R, Osmer E, Sullivan C, Doll M & Harper G. (2006b) Environmental, psychosocial and individual correlates of HIV risk in ethnic minority male-to-female transgender youth. Journal of HIV/AIDS Prevention in Children & Youth, 7/2 89-104

GIRES & NHS (2007). *A Guide to Hormone Therapy for Trans People*. http://www.gires.org.uk/assets/DOH-Assets/pdf/doh-hormone-therapy.pdf

GIRES (2011) *The Number of Gender Variant People in the UK - Update 2011*. Surrey: GIRES Available From: http://www.gires.org.uk/assets/Research-Assets/Prevalence2011.pdf

Global Commission on HIV and the Law (2011) *Report of the Asia-Pacific Regional Dialogue* [Internet]. http://hivlawcommission.org/index.php/regional-dialogues-main/asia-pacific

Global Commission on HIV and the Law (2012) *HIV and the law: risks, rights and health*. New York, NY: UNDP.

GMC [2016]. Advice for doctors treating trans patients Available from http://www.gmc-uk.org/guidance/28851.asp

Goodrum, B. (2014) 'The Effects of Long-Term Testosterone Use on Lipid-Related Cardiovascular Risk Factors among FtM Patients', *International Journal of Transgenderism*, 12(3) http://www.tandfonline.com/doi/full/10.1080/15532739.2010.514220

Gorin-Lazard A, Baumstarck K, Boyer L, et al. (2012) Is hormonal therapy associated with better quality of life in transsexuals? A cross-sectional study. *J Sex Med* 2012; **9:** 531–41.

Government Equalities Office (2011) *Headline Findings from our Transgender Online Survey*, London: Government Equalities Office https://www.gov.uk/government/publications/headline-findings-from-ourtransgender-online-survey

Government Equalities Office (July 2016) Government Response to the Women and Equalities Committee Report on Transgender Equality Cm9301. HMSO https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535764/Government_Response_to_the_Women_and_Equalities_Committee_Report_on_Transgender_Equality.pdf

Grant, J. (2010) *National Transgender Discrimination Survey Report on Health and Health Care* Washington DC: National Centre for Transgender Equality and National Gay and Lesbian Task Force.http://www.thetaskforce.org/static_html/downloads/resources_and_tools/ntds_report_on_health.pdf

Grant J, Mottet L, Tanis J, Harrison J, Herman J, Keisling M. (2011) *Injustice at every turn: a report of the National Transgender Discrimination Survey*. Washington DC: National Centre for Transgender Equality and National Gay and Lesbian Task Force.

Greater Manchester Police (2015) *Transphobic Hate Crime: A study in the under-reporting of transphobic hate crime, and police interactions with the trans community, 2013-2015* Manchester: Greater Manchester Police: http://www.gmp.police.uk/live/Nhoodv3.nsf/WebAttachments/61FA40D8117BFE9080257F550054D2DC/$File/TRANS-REPORT-INTERACTIVE.pdf

Griebling, T.L. (2016) Sexuality and aging: A focus on lesbian, gay, bisexual, and transgender (LGBT) needs in palliative and end of life care. Curr. Opin. Support. Palliat. Care 10, 95–101.

Grossman, A. H., & D'Augelli, A. R. (2006) Transgender youth: Invisible and vulnerable. Journal of Homosexuality, 51, 111–128.

Grossman, A. H., and D'Augelli, A. R. (2007) Transgender youth and life-threatening behaviors. Suicide & Life-Threatening Behavior 37(5):527–537.

Guasp, A. (2011) *'Lesbian, Gay and Bisexual People in Later Life'* London: Stonewall

Guasp, A. and Taylor, J. *'Ethnicity: Stonewall Health Briefing'*, London, Stonewall, 2012 http://www.healthylives.stonewall.org.uk/lgb-health/briefings/ethnicity.aspx

Haan de G, Santos GM, Arayasirikul S, et al. (2015) Non-Prescribed Hormone Use and Barriers to Care for Transgender Women in San Francisco. LGBT Health 2015;2:313-23).

Haas, A.P., Rodgers, P.L. and Herman, J.L. (2014) *Suicide Attempts among Transgender and Gender Non-Conforming Adults Findings of the National Transgender Discrimination Survey* American Foundation for Suicide Prevention and The Williams Institute https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf

Harvey, K. (2008). *The other side of metamorphosis: An exploratory study of how partners of transsexuals experience transition*. Master's dissertation, Illinois State University. Retrieved from http://ir.library.illinoisstate.edu/mts/4

Hatzenbuehler, M.L., Bellatorre, A., Lee, Y., Finch, B.K., Muennig, P., Fiscella, K. (2014) Structural stigma and all-cause mortality in sexual minority populations. Soc. Sci. Med. 103, 33–41.

Health Policy Project, Asia Pacific Transgender Network, United Nations Development Programme (2015) *Blueprint for the provision of comprehensive care for trans people and trans communities in Asia and the Pacific*. Washington, DC: Futures Group: Health Policy Project.

Hembree, W.C; Cohen-Kettenis,P.T; Gooren, L; Hannema, S. E; Meyer, W.J; Murad, M. H; Rosenthal, S. M; Safer, J. D; Tangpricha, V. and T'Sjoen G.G. (2017) Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline J Clin Endocrinol Metab, November 2017, 102(11):3869–3903

Herbst, J. H., E. D. Jacobs, T. J. Finlayson, V. S. McKleroy, M. S. Neumann, N. Crepaz, and HIV/AIDS Prevention Research Synthesis Team. 2008. Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. AIDS & Behavior 12(1):1–17.

Home Office and The Office for National Statistic and Ministry of Justice (2013) *An Overview of Hate Crimes in England and Wales* https://www.gov.uk/government/statistics/an-overview-of-hate-crime-inengland-and-wales

House of Commons Women and Equalities Committee (January 2016) *Transgender Equality First Report of Session 2015-16 HC 390* London: The Stationery Office Limited https://www.publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf#page=63

Hyde Z, Doherty M, Tilley PJM, McCaul KA, Rooney R, Jancey J. (2014) *The First Australian National Trans Mental Health Study: summary of results*. Perth: School of Public Health, Curtin University, 2014.

IOM (Institute of Medicine). 2011. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academies Press.

Irvine, A. (2010) 'We've Had Three of Them': Addressing the Invisibility of Lesbian, Gay, Bisexual and Gender Non-Conforming Youths in the Juvenile Justice System, *Columbia Journal of Gender and Law* 19, no. 3: 675–701.

Irvine, A. (2011) *LGBT Kids in the Prison Pipeline*, The Public Intellectual http://thepublicintellectual.org/2011/05/02/lgbt-kids-in-the-school-to-prison-pipeline

Irvine, A. & Canfield, A. (2015) *The overrepresentation of lesbian, gay, bisexual, questioning, gender nonconforming and transgender (LGBQ/GNCT) youth in the population that crosses from child welfare to the juvenile justice system*. Working paper. Oakland, CA: Impact Justice.

Jenness, V. (2009) *Transgender Inmates in California's Prisons: An Empirical Study of a Vulnerable Population*. Irvine: University of California http://ucicorrections.seweb.uci.edu/files/2013/06/Transgender-Inmates-in-CAs-Prisons-An-Empirical-Study-of-a-Vulnerable-Population.pdf

Jones, S.M. & Willis, P. (2016) 'Are You Developing Trans Positive Care?' *Quality in Aging and Older Adults*, Volume 17(1).

Keeble, S. 2013. "Transgender Sexual Health in Birmingham: Needs Assessment". [Online]. Birmingham: Birmingham LGBT. https://www.birminghambeheard.org.uk/adults-communities/sexual-health-consultation/supporting_documents/SH%20Needs%20Assessment%20Summary%20v1.7.pdf

Keo-Meier C, Herman L, Reisner S, Pardo S, Sharp C, Babcock J. (2015) Testosterone treatment and MMPI-2 improvement in transgender men: a prospective controlled study. *J Consult Clin Psychol* 2015; **83:** 143–56.

Keogh, P, Henderson, L and Dodds, C. *'Ethnic Minority Gay Men: Redefining community, restoring identity*', Sigma Research & University of Portsmouth, Portsmouth, 2004.

Kerry S. (2014) Sistergirls/brotherboys: the status of indigenous transgender Australians. *Int J Transgend*; **15:** 173–86.

Kruijshaar, M. E. Pimpin, L. Ködmön, C. et al. (2010) TB-HIV co-infection: how does the UK compare to Europe? Thorax 2010; 65:A150 http://thorax.bmj.com/content/65/Suppl_4/A150.1.abstract

Kuyper, L and Wijsen, C (2014) Gender Identities and Gender Dysphoria in the Netherlands. Arch Sex Behav (2014) 43:377–385 DOI 10.1007/s10508-013-0140-y

Lambda Legal (2012) *Protected and Served? Courts*. New York: Lambda http://www.lambdalegal.org/protected-and-served/courts

LGBT Foundation (May 2017) *Transforming Outcomes A review of the needs and assets of the trans community*. Manchester LGBT Foundation

LGBT Health and Inclusion Project (2016) *Trans People's Experiences of Hospital Care*, Brighton: LGBT Health and Inclusion Project.

LGBT Youth Scotland (2013) *Life in Scotland for LGBT Young People: Health Report* https://www.lgbtyouth.org.uk/files/documents/Life_in_Scotland_for_LGBT_Young_People_Health_Report.pdf

Lurie, S. 2005. Identifying training needs of health-care providers related to treatment and care of transgendered patients: A qualitative needs assessment conducted in New England. International Journal of Transgenderism 8(2–3):93–112.

Lydon, J., Carrington, K., Low, H., Miller, R. and Yazdy, M. (2015) *Coming Out of Concrete Closets A Report on Black & Pink's National LGBTQ Prisoner Survey*
http://www.blackandpink.org/wp-content/upLoads/Coming-Out-of-Concrete-Closets.-Black-and-Pink.-October-21-2015..pdf

Lyons, K. (2016) 'UK nurses lacking skills to treat transgender patients, says research', *The Guardian*
http://www.edinburghtranswomen.org.uk/Trans_peoples_health.pdf

Makadon, H. J., K. H. Mayer, J. Potter, and H. Goldhammer, eds. 2007. *The Fenway guide to lesbian, gay, bisexual, and transgender health.* Philadelphia, PA: American College of Physicians Press.

Majd, K., Marksamer, J. & Reyes, C. (2009). *Hidden injustice: Lesbian, gay, bisexual and transgender youth in juvenile courts.* The Equity Project.

Manchester City Council, [2016]. Research Study into the Trans Population of Manchester. Manchester: MBC

Mariner, J. (2001) No Escape: *Male Rape in U.S. Prisons.* New York: Human Rights Watch
http://fl1.findlawcom/news.findlaw.com/cnn/docs/hrw/hrwmalerape0401.pdf.

Maternity Action. 2014. "Women's Voices on Health: Addressing Barriers to Accessing Primary Care". [Online]. London: Maternity Action.
http://www.maternityaction.org.uk/wp-content/uploads/2014/05/Access-to-Primary-Care-report-FINAL.pdf

Mayock, P., Bryan, A., Carr, N. & Kitching, K. [2009]. *Supporting LGBT Lives: A Study of the Mental Health and Well-being of Lesbian, Gay, Bisexual and Transgender People* Dublin: Gay and Lesbian Equality Network
http://www.teni.ie/attachments/ac803e95-78c6-4579-b7ee-885d3f40fb36.PDF

Mays, V.M, Yancey, A.K, Cochran, S.D, et al. 'Heterogeneity of health disparities among African American, Hispanic, and Asian American women: Unrecognized influences of sexual orientation', *American Journal of Public Health*, 92:4, 2002, 632-9.

Metlife Mature Market Institute®2 (2010) The Lesbian And Gay Aging Issues Network of The American Society On Aging. Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers 1. J. GLBT Fam. Stud. 6, 40–57.

McGovern, J. (2014) The Forgotten: Dementia and the Aging LGBT Community. J. Gerontol. Soc. Work, 57, 845–857.

McNeil, J; Bailey, L; Ellis, S; Morton J and Regan, M (2012) *Trans Mental Health and Wellbeing Study 2012* Edinburgh: Scottish Transgender Alliance.
http://www.scottishtrans.org/Uploads/Resources/trans_mh_study.pdf

Mepham N, Bouman WP, Arcelus J, et al (2014). People with gender dysphoria who self-prescribe cross-sex hormones: prevalence, sources, and side effects knowledge. J Sex Med 2014;11:2995-3001

METRO, *Youth Chances Survey Baseline Report* (2014) Youth Chances

Minter, S. and Daley, C. (2003) *Trans realities: a legal needs assessment of San Francisco's transgender communities*. San Francisco: The National Center for Lesbian Rights and the Transgender Law Center

Mitchell, M and Howarth, C. *Trans Research Review* (2009) NatCen. Equality and Human Rights Commission Research report 27, 2009, 55.

Ministry of Justice (2016) *Review on the Care and Management of Transgender Offenders*. London: MoJ.

Ministry of Justice (2016b) *The Care and Management of Transgender Offenders*. PSI 17/2016. London : NOMS.

Ministry of Justice (2016c) *Prisoner Transgender Statistics, March/April 2016 England and Wales*. London. MoJ.

Ministry of Justice (2017) *National Offender Management Service Annual Offender Equalities Report 2016/17*. Ministry of Justice Statistics Bulletin London: MoJ.

Ministry of Justice (2016d) *Tribunals and Gender Recognition Statistics Quarterly, Main Tables (January to March 2016)*. London: Ministry of Justice https://www.gov.uk/ government/statistics/tribunals-and-gender-recognition-certificate-statistics-quarterly-january-to-march-2016

Morton, J. [2008]. *Transgender Experiences in Scotland*, Edinburgh: Scottish Transgender Alliance http://www.scottishtrans.org/wp-content/uploads/2013/03/staexperiencessummary03082.pdf

Murad M, Elamin M, Garcia M, et al. (2010) Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clin Endocrinol* 2010; **72:** 214–31.

Nadal, K. L., Vargas, V., Meterko, V., Hamit, S., & Mclean, K. (2012). Transgender female sex workers: Personal perspectives, gender identity development, and psychological processes. In M. A. Paludi (Ed). *Managing diversity in today's workplace* (in press). Santa Barbara, CA: Praeger.

National Center for Lesbian Rights: *Meeting to Highlight Issues Faced by LGBT People in California Prisons*. San Francisco: National Center for Lesbian Rights
http://www.nclrights.org/press-room/press-release/meeting-to-highlightissues-faced-by-lgbt-people-in-california-prisons/

National Offender Management Service (November 2016) *The Care and Management of Transgender Offenders, Prison Service Instruction 17/2016* London: NOMS

NHS England (2015). Operational research report following visits and analysis of Gender Identity Clinics in England. Obtained from NHS England by UK Trans Info, *NB: DRAFT*.

NHS England (2017) *Gender identity services (Adults)* Available at: https://www.engage.england.nhs.uk/survey/gender-identity-services-for-adults/

O'Connell, Z. (2008) *The "Toiletgate" meeting last night, Complicity*. On Line Blog http://www.complicity.co.uk/blog/2008/07/the-toiletgate-meeting-last-night/

Operario D, Soma T, Underhill K. (2008) *Sex work and HIV status among transgender women: systematic review and meta-analysis.* J Acquir Immune Defic Syndr. 2008;48(1):97–103.

Ottawa Senior Pride Network and Ipsos Reid (October 2015) *Housing Survey* Ipsos Reid: Ottawa, ON, Canada.

Pasterski, V., Gilligan, L. & Curtis, R. 2014. "Traits of Autism Spectrum Disorders in Adults with Gender Dysphoria". [Online]. Archives of Sexual Behavior. 43. Pp. 387-393. [Accessed 21/03/16]. Available From: http://link.springer.com.ezproxy.mmu.ac.uk/article/10.1007/s10508-013-0154-5

Peitzmeier, S., Gardner, I., Weinand, J., Corbet, A. & Acevedo, K. [2015]. Health Impact of Chest Binding among Transgender Adults: A community-engaged, cross-sectional study *Culture, Health & Sexuality*, Volume 19(1) http://www.tandfonline.com/doi/full/10.1080/13691058.2016.1191675

Poole, L., Whittle, S. and Stephens, P. (2002) Working with transgendered and transsexual people as offenders in the probation service. *Probation Journal*, 49, 227-232.

Poteat T, German D, Kerrigan D. (2013) Managing uncertainty: a grounded theory of stigma in transgender health care encounters. Soc Sci Med; 84:22-9.

Poteat, T. and Reisner S. (2013) HIV epidemics among transgender women. Curr Opin HIV AIDS; 9(2):168-73.

Prisons & Probation Ombudsman Independent Investigations (2015) Letter to Mrs Maria Miller MP, Chair of the Women and Equalities Committee, Houses of Parliament, London, SW1A 0AA; 1 October 2015 http://www.ppo.gov.uk/wp-content/uploads/2015/12/PPO-Submission-to-the-Women-and-Eq-Committee-Sept-2015.pdf

Prisons & Probation Ombudsman Independent Investigations (2017) Learning lessons bulletin PPO Investigation Issue 3 Transgender Prisons January 2017 http://www.ppo.gov.uk/wp-content/uploads/2017/01/PPO-Learning-Lessons-Bulletin_Transgender-prisoners_Final_WEB_Jan-17.pdf

Public Health England (2017) *Information for trans people NHS Screening Programmes*. London: PHE

Public Health Wales (2015) Breast, cervical, aaa, bowel screening information for transgender service users. Cardiff: Public Health Wales

Reed, B; Rhodes, S; Schofiled, P, Dr and Wylie, K, Professor (2009). *Gender variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution*. London: GIRES. http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf

Reisner, S.L., Bailey, Z. and Sevelius, J. (2014) Racial/ethnic Disparities in History of Incarceration, Experiences of Victimization, and Associated Health Indicators among Transgender Women in the U.S. *Women & Health* 54, no. 8 (2014): 750–67, doi:10.1080/03630242.2014.932891.

Reisner, S.L., White Hughto, J.M., Dunham, E.E., Heflin, K.J., Begenyi, J.B.G., Coffey-Esquivel, J. and Cahill, S. (2015) Legal Protections in Public Accommodations Settings: A Critical Public Health Issue for Transgender and Gender-Nonconforming People. The Milbank Quarterly, Vol. 93, No. 3 (September 2015), pp. 484-515

Roche, A., Morton, J., & Ritchie, G. (2010). *Out of Sight, Out of Mind?* Edinburgh: Scottish Transgender Alliance.

Rogers, M. (2013) TransForming Practice: understanding trans people's experience of domestic abuse and social care agencies, Sheffield: University of Sheffield.

Rooney, Eoin. (2012) *All Partied Out? Substance Use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community* Belfast: The Rainbow Project

Rosser, B.R.S., Oakes, J.M., Bockting, W.O. and Miner, M. (2007) Capturing the social demographics of hidden sexual minorities: An internet study of the transgender population in the United States. Sexuality Research and Social Policy, 4,50–64.

Royal College of Psychiatrists, (2012). *Good practice guidelines for the assessment and treatment of adults with gender dysphoria*. https://www.gires.org.uk/assets/Medpro-Assets/CR181_Nov15.pdf

Ryan, J. (2016) Transgender issues in the criminal justice system. Published in Legal Action, November 2016 http://www.lag.org.uk/media/275551/november_2016_jane_ryan_column.pdf

Rymer, S., & Cartei, V. (2015). Supporting transgender survivors of sexual violence: Learning from users' experiences. Critical and Radical Social Work, 3 (1)

Safer, J. D. and Weinand, J. D. (2015) Hormone therapy in transgender adults is safe with provider supervision; A review of hormone therapy sequelae for transgender individuals *Journal of Clinical & Translational Endocrinology,* Vol 2 (2) http://www.sciencedirect.com/science/journal/22146237/2/2

Salerno, J.M., Murphy, M.C., & Bottoms, B.L. (2014). Give the kid a break – but only if he's straight: Retributive motives drive bias against gay youth in ambiguous punishment contexts. *Psychology, Public Policy, and Law, 20*(4), 398-410.

Sausa, L. A, Keatley, J., & Operario, D. (2007). Perceived risks and benefits of sex work among transgender women of color in San Francisco. *Archives of Sexual Behavior, 36*, 768–777.

Schilt, Kristen; Westbrook, Laurel (August 2009) *"Doing Gender, Doing Heteronormativity: 'Gender Normals,' Transgender People, and the Social Maintenance of Heterosexuality"*. *Gender & Society*. ***23*** *(4): 440-464 [461].* *doi*:*10.1177/0891243209340034*.

Scottish Transgender Alliance (2008) Transgender Experience in Scotland research summary: Key research findings of the Scottish Transgender Alliance Survey of transgender people living in Scotland http://www.scottishtrans.org/wp-content/uploads/2013/03/staexperiencessummary03082.pdf

Sevelius, J.M., Carrico, A. and Johnson, M.O. (2010) Antiretroviral therapy adherence among transgender women living with HIV. J Assoc Nurses AIDS Care. 21(3):256-64.

Sexton Lori and Jenness, Valerie (2016) ''We're like community'': Collective identity and collective efficacy among transgender women in prisons for men Punishment & Society 2016, Vol. 18(5) 544–577

Simopoulos, E.F. and Khin, E. K. (2014) Fundamental Principals Inherent in the Comprehensive Care of Transgender Inmates The Journal of the American Academy of Psychiatry and the Law: 42:26-36, 2014

Streed CG, Harfouch O, Marvel F, Blumenthal RS, Martin SS, Mukherjee M. Cardiovascular Disease Among Transgender Adults Receiving Hormone Therapy: A Narrative Review. Ann Intern Med. 2017;167:256–267. doi: 10.7326/M17-0577

Stinchcombe, A., Smallbone, J., Wilson, K. and Kortes-Miller, K. (2017) Healthcare and End-of-Live Needs of Lesbian, Gay, Bisexual, and Transgender (LGBT) Older Adults: A Scoping Review. Geriatrics 2017, 2, 13; doi:10.3390/geriatrics2010013
www.mdpi.com/journal/geriatrics

Stonewall (2017) *A Vision for Change Acceptance without exception for trans people 2017-2022* London: Stonewall
https://www.stonewall.org.uk/sites/default/files/stw-vision-for-change-2017.pdf

Strickland, P. (2016) *Transgender Prisoners Briefing Paper* Number 07420, 28 November 2016 House of Commons Library

Stotzer, R.L., Herman, J.L. and Hasenbush, A. (2014) Transgender Parenting: A Review of Existing Research The Williams Institute
https://williamsinstitute.law.ucla.edu/wp-content/uploads/transgender-parenting-oct-2014.pdf

Taylor, J. (2013) *Police accused of mocking transgender woman during arrest* The Independent.
http://www.independent.co.uk/news/uk/crime/police-accused-of-mocking-transgender-woman-during-arrest-8505650.html

Theron, L. and Collier, K.L. (2013) Experiences of female partners of masculine-identifying trans persons. Culture, Health & Sexuality, 15(supp1l), 62–75.

Trans Murder Monitoring (TMM) IDAHOT Update 2015 [Internet]. Berlin: TGEU. https://tgeu.org/tmm-idahot-update-2015/

Transgender Europe. IDAHOT 2016: *Trans Murder Monitoring update. Update 2016.* [Internet] http://transrespect.org/en/idahot-2016-tmm-update

Transgender Law Center (2016) *Policy Recommendations Regarding LGBT People in California Prisons.* Transgender Law centre

Trans Pulse (2012) *Impacts of Strong Parental Support for Trans Youth A report prepared for Children's Aid* Society of Toronto and Delisle Youth Services
http://transpulseproject.ca/wp-content/uploads/2012/10/Impacts-of-Strong-Parental-Support-for-Trans-Youth-vFINAL.pdf

UK Trans Info [2015] Current Waiting Times & Patient Population for Gender Identity Clinics in the UK
http://uktrans.info/attachments/article/341/patientpopulation-july15.pdf

UNAIDS (2014) The Gap Report
http://files.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf

United States Government Accountability Office (2013*) Immigration Detention: Additional Actions Could Strengthen DHS Efforts to Address Sexual Abuse* USA: GAO-14-38

Unger, Cécile A. (2016) Hormone therapy for transgender patients. Translational Andrology and Urology 2016;5(6):877-884.

US Transgender Survey (2015) Report
http://www.transequality.org/sites/default/files/docs/usts/Executive%20Summary%20-%20FINAL%201.6.17.pdf

Valentine, V. (2016) *Non-binary people's experiences in the UK* Edinburgh: Scottish Transgender Alliance
https://www.scottishtrans.org/wp-content/uploads/2016/11/Non-binary-report.pdf

Van Kesteren PJ, Gooren LJ, Megans JA, An epidemiological and demographic study of transsexuals in The Netherlands Arc Sex Behav. 1996 Dec; 25(6): 589–600.

Viggiani, G. Editor (2015) Domestic and Dating Violence Against LBT Women in the EU*, Bleeding Love: Raising Awareness on Domestic and Dating Violence Against Lesbians and Transwomen in the European Union.*

Walters, Mark A, Paterson, Jennifer L, Brown, Rupert and McDonnell, Liz (2017) Hate crimes against trans people: assessing emotions, behaviors and attitudes towards criminal justice agencies. Journal of Interpersonal Violence. ISSN 0886-2605http://sro.sussex.ac.uk/67633/4/Hate%20Crimes%20Against%20Trans%20People%20-%20final%20version%20for%20open%20access.pdf

Whitley, C.T. (2013) Trans-kin undoing and redoing gender: Negotiating relational identity among friends and family of transgender persons. Sociological Perspectives, 56,597–621.

Whittle, S. Turner, L. and Al-Alami, M. (2007). *Engendered Penalties: Transgender and transsexual people's experiences of inequality and discrimination*. A Research Project and Report Commissioned by the Equalities Review undertaken by Press for Change and MMU.

Whittle, S. Turner, L. Combs, R. & Rhodes, S. 2008. *Transgender Eurostudy: Legal Survey and Focus on the Transgender Experience of Healthcare*. London: Press for Chance.

Williams, H; Varney, J, Dr; Taylor, J; Fish, J Dr; Durr, P and Cane-Elan, C. 2016. *The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document*. 2016 update prepared by Daniel Edmondson, Rachael Hodges and Heather Williams, LGBT Foundation. London: PHE.

Wilber, Shannon (2015) *Lesbian, Gay, Bisexual and Transgender Youth in the Juvenile Justice System: A guide to juvenile detention reform*. Baltimore: The Annie E. Casey Foundation

Wilde, Berkeley. *'A Lifestyle Choice? Myths and Facts about Lesbian, Gay, Bisexual and Trans People'* London, Camden LGBT Forum, 2007. http://camdenlgbtforum.org.uk/wp-content/uploads/2010/01/ALifestyle-Choice-Myths-Facts-about-LGBT-People-A5-screen.pdf

Williams, M.L. & Tregidga, J. 2014. "Hate Crime Victimization in Wales: Psychological and Physical Impacts Across Seven Hate Crime Victim Types". [Online]. British Journal of Criminology. 56(2). Pp. 1-22. [Accessed 21/03/16]. Available From: http://bjc.oxfordjournals.org/content/early/2014/06/27/bjc.azu043.full.pdf

Williams, M. E., and P. A. Freeman. 2005. Transgender health: Implications for aging and caregiving. Journal of Gay & Lesbian Social Services 18(3/4):93–108.

Wilson, E.C., Garofalo, R., Harris, R. and Belzer, M. (2010) The Transgender Advisory Committee, and the Adolescent Medicine Trials Network for HIV/AIDS Interventions. Sexual Risk Taking Among Transgender Male-to-Female Youths With Different Partner Types. American Journal of Public Health. August 2010; 100(8):1500,1505

Wilson, P., Sharp, C. and Carr, S. (1999) The prevalence of gender dysphoria in Scotland: a primary care study Br J Gen Pract. 1999 Dec; 49(449): 991–2.

Winter S. (2012) *Lost in transition: transgender people, rights and HIV vulnerability in the Asia-Pacifi c region*. Bangkok: United Nations Development Programme.

Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S. and Wylie, K. (2016) Transgender people: health at the margins of society. *Lancet* 2016; 388: 390–400 Published Online June 17, 2016 http://dx.doi.org/10.1016/S0140-6736(16)00683-8

Witten, T. M., and S. Whittle. 2004. Transpanthers: The graying of transgender and the law. Deakin Law Review 9(2):503–522.

Witten, T.M. (2014) *'End of Life,* Chronic Illness, and Trans-Identities', Journal of Social Work in End-of-Life & Palliative Care, Volume 10(1)

Witten, T.M. (2015) Elder Transgender Lesbians: Exploring the Intersection of Age, Lesbian Sexual Identity, and Transgender Identity. J. Lesbian Stud. 19, 73–89.

World Health Organisation (2014) *Hormonal contraceptive methods for women at high risk of HIV and living with HIV. 2014 guidance statement*. Geneva: World Health Organization

World Health Organisation (2015a) *Transgender People and HIV*. Geneva: Word Health Organization http://apps.who.int/iris/bitstream/10665/179517/1/WHO_HIV_2015.17_eng.pdf?ua=1

World Health Organisation (2015b) *HIV and Young Transgender People A Technical Briefing*. Geneva: Word Health Organization http://www.unaids.org/sites/default/files/media_asset/2015_young_transgender_en.pdf

World Professional Association for Transgender Health (WPATH). (2011) *Standards of care for the health of transsexual, transgender, and gender nonconforming people. 7th ed*; 2011. Accessed July 2017: http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351

Zamboni, B.D. (2006) Therapeutic considerations in working with the family, friends, and partners of transgendered individuals. Family Journal, 14, 174–179.

Zucker, K. J., S. J. Bradley, and M. Sanikhani. 1997. Sex differences in referral rates of children with gender identity disorder: Some hypotheses. Journal of Abnormal Child Psychology 25(3):217.

Zucker, K. J., and A. A. Lawrence. 2009. Epidemiology of gender identity disorder: Recommendations for the standards of care of the world professional association for transgender health. International Journal of Transgenderism 11(1):8–18.

Case law

Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002.

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