Health Needs Assessment for the Trans and Gender Diverse population of Lancashire 2025

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Contents

1. Introduction

This is the final report of the Health Needs Assessment (HNA) for the trans and gender diverse (TGD) population of Lancashire. This project has been co-produced by the Cumbria and Lancashire Public Health Collaborative with members of the TGD community and voluntary and community sector partners, with support from Blackburn with Darwen, Blackpool, and Lancashire County Councils. For a full list of partners, please see the acknowledgements.

This project has been to better understand the health needs of people whose gender identity is not the same as the sex they were assigned at birth, referred to in this report as trans and gender diverse (TGD), including trans men, trans women, non-binary people, and those who define their gender in another way.

There is strong international evidence that this population experiences health inequalities, but there is still much that is not known, with research tending to focus on mental health and substance use disorders, and communicable disease, especially HIV (Scheim *et al.*., 2024). Less research has looked at non-communicable disease or the determinants of health for TGD people, things like housing, education and employment.

The first part of this project was a literature review. This provided a background of evidence relating to the health needs of TGD communities in the UK and the health inequalities they experience. This also informed the design of the HNA through reference to previous work and best practice. Guided by the project steering group, local data was collected through an online survey which gathered both quantitative and qualitative data.

The literature review, while also acknowledging the need for more and better research, provides evidence that TGD people experience health inequalities in the UK. Ultimately this results in higher levels of mortality compared to cisgender people, with particular concerns around suicide and self-harm.

There are a number of reasons why TGD populations may experience health inequalities. There is the effect of discrimination and minority stress on health; the effect of gender dysphoria on mental health; reduced access to and worse experience of healthcare and other health-supporting services; the effects of hormone treatments for those who receive them; differences in behavioural risk factors, like patterns of exercise or drug use; differences in socioeconomic status and other determinants of health, which may themselves be related to social exclusion and prejudice; and reduced family and social support (Saunders *et al.*., 2023; Shelemy *et al.*., 2024; Watkinson *et al.*., 2024).

Any or all of these might contribute to the health of our local TGD population in Lancashire, and the inequalities they face. This is why remedying inequalities for the TGD population requires action across the system, with supportive general healthcare, including primary and preventative care, as well as access to specialist gender identity services and action to improve the social determinants of health for the TGD population, including stigma and discrimination.

This report ends with a series of recommendations, produced by the steering group, informed by the scientific literature and our local data, for how the Lancashire health and care system can better support the health of this vulnerable population. These recommendations are divided into four key themes:

1. Building a bigger, safer world for TGD people
2. Celebrating progress and positive stories
3. Designing in inclusion
4. Creating a confident and inclusive workforce, championing diversity

2. Acknowledgements

Partner Organisations

Blackburn with Darwen Council
Blackpool Council
Lancashire County Council
Cumbria and Lancashire Public Health Collaborative
Lancashire LGBT
Spectrum Inclusion
Out in the Bay
Chrysalis
Renaissance
Leeds and York Partnership NHS Trust
Lancashire Teaching Hospitals NHS Trust
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3. Literature review

3.1 Definitions and terminology

Before assessing the needs of a target population, it is necessary to define the population in question. In the case of the trans and gender diverse (TGD) population, even this act of definition poses significant difficulties. There is wide variation in the terminology and definitions preferred by members of the community, many attended by significant controversy, and no one set of concepts and descriptors is universally acceptable.

Many, perhaps most, of the TGD population would, for example, accept the distinction between sex as a biological category and gender as a social one. The Office for National Statistics defines gender as "*a social construction relating to behaviours and attributes based on labels of masculinity and femininity; gender identity is a personal, internal perception of oneself and so the gender category someone identifies with may not match the sex they were assigned at birth*" (Office for National Statistics, 2019). Even this usage, however, cannot be assumed to be universal.

This is complicated by governmental use: obtaining a gender recognition certificate (GRC) enables one to change the sex recorded on a birth certificate (Gov.uk, 2022). Similarly, a UK passport has no box for gender, only sex, and a GRC is not necessarily required to change that marker. Trans status is not a protected characteristic under the Equality Act, although 'gender reassignment' is. Non-binary identities are not recognised in UK law, although recent case law has established that those with non-binary identities are protected under the Equality Act category of gender reassignment (Fairbairn, Barton and Pyper, 2022; Brethertons, 2022).

The Office for National Statistics takes a broad definition of trans: '*The trans population is defined as the population whose gender identity differs from their sex registered at birth… this includes those with non-binary identities'* (Office for National Statistics, 2022). This document uses the wider term 'trans and gender diverse' or TGD to make that inclusivity more evident, but the definition is the same.

Other terminology may be used throughout this document when referencing research that related to specific categories. This may include language and terminology which the authors of this report would not choose.

There is a glossary at the end of this report covering some important terms. This glossary is not exhaustive or proscriptive, and it is best to be guided by members of the TGD community and their own preferences, whether in everyday life or in research and service design/provision. For example, Mitchell and Howarth (2009) found that some individuals no longer considered themselves to be trans once their process of transition was completed. The National LGBT Survey began by referencing trans men, but found that 'trans masculine' was a more acceptable term for the majority (Government Equalities Office, 2018).

Emerging evidence from the census suggests that most trans men and women identified their sex as their acquired gender, but that this was not universal.

Gender and gender identity are not alone in lacking scientifically rigorous and universally accepted categorisation: sexuality and ethnicity are both complex socially determined phenomena. The difficulties in terminology and definition must not impede efforts to identify this population and the attendant health needs. They do suggest two key considerations for this HNA and efforts to reduce the inequalities it has identified. First, that all partners involved have an awareness of sensitivities around language used, even if they themselves are part of the TGD community, appreciating that few uses are universal. Secondly, all work must be guided by the local Lancashire population in the choice of language used and remain open and flexible throughout.

3.2 Limitations

This report will not cover the health needs of individuals with **DSD (differences in sex development)**, except insofar as some of those individuals may define themselves as trans or gender diverse. DSD are a range of congenital conditions that result in atypical biological sex characteristics. Historically, DSD stood for disorders of sex development, but this tends to be considered unnecessarily pathologizing, and differences in or diverse sex development is preferred, or alternatively variations in sex development or characteristics (VSD/VSC). Some individuals with DSD may also use the term intersex, and some may consider themselves to be trans or otherwise gender diverse. In considering whether to include intersex people/people with DSD in this needs assessment, the danger of conflating two very different populations with different needs must be weighed against the danger of one group's needs being ignored entirely. While this needs assessment may not be the correct place to include the needs of intersex people/people with DSD, further work may be necessary to ensure that their distinct needs are being met.

The literature review focusses almost exclusively on UK-specific data, unless otherwise specified. There is a large body of global literature, particularly from the United States, that often demonstrates similar inequalities to those suggested by the limited UK data, but the degree to which the experience of TGD individuals in the US can be extrapolated to the UK is a matter for serious consideration.

There is very little routine data on the health and health needs of TGD individuals in the UK. Few services routinely record gender identity, and TGD people may be reticent to volunteer such information for fear of discrimination or harassment. There is some academic literature, but this is limited, and has been supplemented with 'grey literature'. Much of the data therefore comes from surveys that are not necessarily representative of the entire community. For example, many are online and exclusively in English and may therefore skew younger and exclude some migrants and disadvantaged communities.

There is almost no robust data relating to intersectionality: the way in which TGD identity may intersect with other characteristics, such as ethnicity and disability, to generate

particular issues. Nor is there much data disaggregated by age, although older TGD people are likely to face specific challenges. As noted, respondents to online surveys may be more likely to be younger, and so the voice of older TGD people may not be heard.

With all these limitations, conclusions drawn from the existing literature are likely to be tentative. However, we can say that the indications from the available sources provide cause for concern, in key areas around mental health, deliberate self-harm and suicidality; access to and experience of healthcare and other services; and access to gender identity clinics.

Mitchell and Howarth (2009) carried out an extensive evidence review on equality and discrimination as they relate to trans people for the Equality and Human Rights Commission. They found a mass of literature, but very little in the way of robust primary research.

Seven years later, in 2016, the Government Equalities Office (GEO) commissioned a review of the evidence of inequalities experienced by lesbian, gay, bisexual and transgender populations in the UK. This report, Hudson-Sharp and Metcalf (2016), found an evidence base that was sorely lacking in robust, representative, good-quality data, particularly when disaggregated from the LGBT community as a whole, and particularly around gender identity. They concluded that '*a lack of representative quantitative research data precludes a comprehensive and reliable assessment of the extent of disadvantage for LGB&T people in the UK'* (Hudson-Sharp and Metcalf, 2016).

Since these reports, there have been a few significant developments. Trans issues have attracted ever more attention in the wake of the campaign to reform the Gender Recognition Act (2004), and issues at the Tavistock clinic, although the coverage and debates this has sparked often seem to have generated more heat than light. In 2018, the GEO published the results of the national LGBT survey. While this online survey suffered from some of the same methodological limitations previously identified, it did receive over 100,000 valid responses from members of the LGBT community, including over 14,000 trans respondents (using their definition and including non-binary respondents) (Government Equalities Office, 2018).

In a further significant advance, the 2021 census included a question on gender identity for the first time (for adults over the age of sixteen only). Both Mitchell and Howarth (2009) and Hudson-Sharp and Metcalf (2016) had noted that no large datasets routinely gathered data on gender identity, and the census data promises to be the most robust source of information on the trans population of the UK, although it too has limitations. Some of the early census data is presented below.

This literature review draws heavily from the reports by Mitchell and Howarth (2009) and Hudson-Sharp and Metcalf (2016), as well as the national LGBT survey (Government Equalities Office, 2018). While there has been other material published since, in both the scientific and grey literature, which is included here, the conclusions of the earlier reports around the limitations of the evidence base remain true. Some of this is likely to be due to fundamental difficulties inherent to studying the TGD population, discussed in the methodology section below. However, it is crucial that we try to overcome these difficulties

and continue to seek and generate good-quality evidence to support the needs of the TGD population.

3.3 Size and demography of the TGD population

An indication of the dearth of evidence around healthcare for TGD people is the absence, until very recently, of even a reliable estimate of the TGD population of the UK. This question is again affected by many of the methodological difficulties discussed elsewhere, most obviously by the range of definitions used, but also by the lack of routinely gathered data, and by the underreporting associated with social stigma, prejudice and distrust of those gathering such information.

The result was a very wide range of estimates. In 2009, a review from the Office for National Statistics referenced estimates for the trans community in the UK ranging from 65,000 to 300,000 (Office for National Statistics, 2009). A 2016 Lancet review of population studies found a range of estimates internationally, including a 2012 UK study estimating 0.5% of the adult population may identify other than with the gender assigned at birth (Winter *et al.*., 2016). Another large survey estimated 0.8% of the population belonged to a gender identity minority group (Hill and Condon, 2015).

The Gender Identity Research and Education Society (GIRES) updated their estimates in 2011, noting that the individuals who undergo a process of transition emerge from a larger pool of individuals experiencing some form of gender variance who may remain largely invisible to services. They estimated that this group made up around 1% of the total population, and only around 0.2% of the total population would undergo transition at some point (GIRES, 2011)

The population of the 14 local authorities within Lancashire was estimated at 1,515,487 in mid-2020 (Lancashire County Council, 2021). Prior to the census data, taking an estimate of the TGD population between 0.5% and 1% would suggest around 7,500 – 15,000 people in Lancashire, if Lancashire had a similar proportion of TGD individuals as the UK.

In recent years, there has been an increase in the apparent TGD population. Growing awareness and acceptance of trans identities have perhaps enabled more TGD individuals to live their lives openly, and may have encouraged individuals experiencing feelings of gender incongruence to explore this openly.

The apparent TGD population of the UK is disproportionately young, or, to put it another way, gender diversity appears to be highest in younger age groups. This is a common finding, including in the census data (see below) and analysis of GP patient surveys by Watkinson *et al.*. (2024). A large part of this is likely due to generational differences in the acceptance of trans and gender diverse identities, suggesting that there are greater numbers of ‘hidden’ TGD individuals in older age groups. In this interpretation, the rates of ‘out’ TGD individuals in younger age groups more closely reflects the ‘true’ rate. If this is the case, then previous estimates of the TGD population are likely to be underestimates.

However, the Cass report expresses scepticism that the exponential rise in referrals for children and young people's gender identity services can be totally explained by increasing social acceptance, and suggests that there may be other factors at play (Cass, 2024). The interim review found that referrals had increased from approximately 50 per year in 2009, to 2500 in 2020, an increase of 5000% (Cass, 2022). This may advise caution in extrapolating from the TGD population in younger cohorts to the population as a whole. In other words, it is difficult to distinguish between an increase in visibility following an increase in acceptance, and a real increase in gender diversity, from whatever cause.

The apparent older and younger TGD populations also differ in their demographics – the older population containing a greater proportion of trans women and the younger population a greater proportion of trans men and non-binary people. These populations are likely to have distinct needs, and little research has examined these groups separately. Older trans people may well have specific health needs relating to, for example, long-term hormonal treatment (Asti *et al.*., 2024).

Mitchell and Howarth (2009) found a range of estimates for proportions of trans men and women within the trans population. Historically, estimates have suggested that the UK has a higher proportion of trans people assigned male at birth. However, some studies have suggested an equal balance, and international proportions vary. The Cass review found that referrals for young people over the last decade had shifted from predominantly birth-assigned males to birth-assigned females (Cass, 2024). This is in keeping with the findings of the National LGBT Survey, which found respondents under 35 more likely to identify as trans men than those aged 35 or over, while the opposite was true for trans women, who made up over half of respondents 35 or over. More than half of respondents under 35 identified as non-binary (Government Equalities Office, 2018).

3.4 Census 2021

In January 2023, the first ever census data relating to gender identity was released by the Office for National Statistics (ONS). The analysis of this data is ongoing, and further releases will add detail. The census asked "'*Is the gender you identify with the same as your sex registered at birth?"*. This question was produced after a great deal of work to make it acceptable to the population (Office for National Statistics, 2022).

The census found that 262,000 people answered "no" to this question, approximately 0.5% of the population, in keeping with previous estimates (Office for National Statistics, 2023a). For the sake of brevity, those who answered in this way will be referred to as TGD. The question was only asked of over 16s, so this is only an estimate of the adult TGD population.

However, a further 2.9 million people, a full 6% of the population, declined to answer the question. Given that areas with higher proportions of TGD individuals also had higher proportions declining to answer, it is likely that many of those who declined to answer are

themselves TGD and objected to the relevance, framing or necessity of the question[1]. Thus, this count is likely to be an underestimate. Given the relative size of the TGD population in relation to those who declined to answer, it may be a very significant underestimate.

Out of the 262,000 members of the TGD community: 118,000 (45%) provided no further details; 48,000 (18%) identified as trans men; 48,000 (18%) identified as trans women; 30,000 (11%) identified as non-binary; and 18,000 (7%) wrote in a different gender identity. This suggests an equal balance of trans men and trans women, as has been suggested by more recent scientific work, but again, the large proportion giving no further detail of their identity makes drawing firm conclusions impossible.

Table 1. Census data relating to gender identity in Lancashire

Local Authority	Gender identity different from sex registered at birth (%)	Gender identity different from sex registered at birth (n)	Gender identity different from sex registered at birth but no specific identity given (n)	Trans woman (n)	Trans man (n)	Non-binary (n)	All other gender identities (n)
England	0.55	251844	113760	45684	46513	28710	17177
North West Region	0.45	29967	13593	5452	5608	3401	1913
Lancashire	**0.50**	**5575**	**2556**	**1011**	**1021**	**624**	**363**
Preston	0.75	891	400	165	154	104	68
Pendle	0.61	455	286	67	78	14	10
Blackpool	0.58	677	316	124	134	59	44
Burnley	0.55	414	227	80	63	32	12
Blackburn with Darwen	0.54	647	368	98	115	36	30
Hyndburn	0.48	313	141	58	73	28	13

[1] However, there are a number of confounders that make it very difficult to draw firm conclusions. Most evidently, TGD populations are concentrated in urban areas, and there may be something about urban populations that makes them more likely to decline to answer, potentially relating to ethnicity, socioeconomic status or minority sexual orientations. In short, when the proportion of the total declining to answer is much greater than the proportion answering “no”, it severely limits what can be said with confidence about the size of the TGD community. The correlation between proportion declining to answer and size of the TGD population is at least suggestive that the population who did not answer may not have the same gender identity proportions as the population who did answer one way or another.

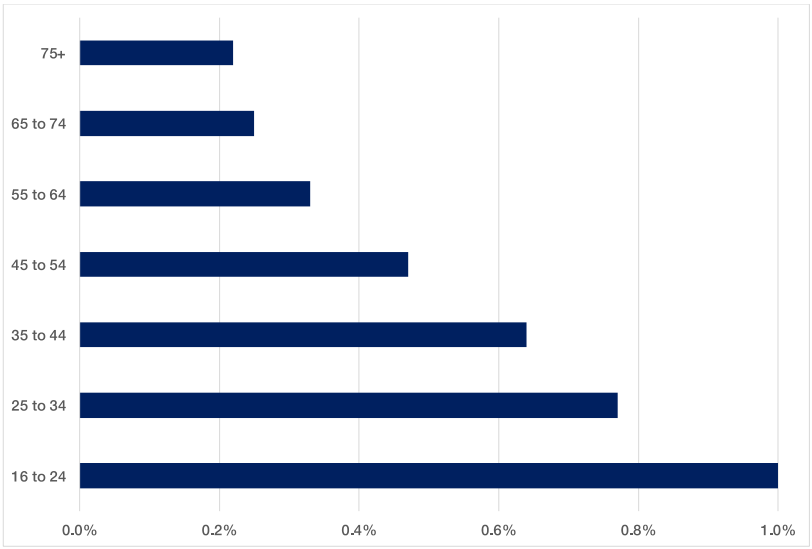
Lancaster	0.46	545	161	92	89	136	67
West Lancashire	0.37	366	136	63	65	66	36
Chorley	0.32	305	128	57	69	26	25
Fylde	0.32	222	90	50	41	30	11
South Ribble	0.27	248	88	54	54	33	19
Wyre	0.27	251	95	59	47	33	17
Rossendale	0.26	148	74	29	19	21	5
Ribble Valley	0.18	93	46	15	20	6	6

Data from Office for National Statistics, Census 2021, released 2023

Table 1 gives some details of the census results for Lancashire. In total, the estimate for TGD adults in Lancashire is 5575. As discussed, this is likely to be something of an underestimate, and does not include under-16s. The census is usually completed on a household, rather than individual basis, which forms part of the logic for not asking the question of under-16s. We might also expect this to contribute to under-counting, if the household reference person answers on behalf of someone who may be TGD-identifying, but is not out.

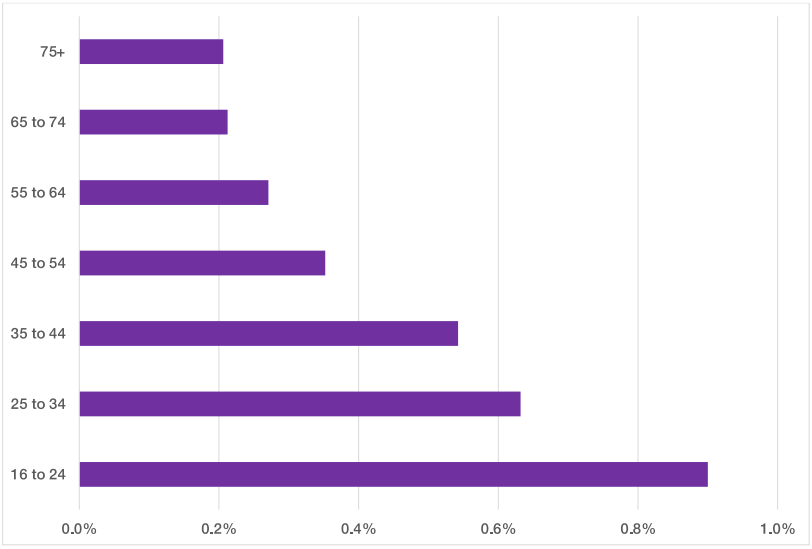
The ONS has also released data relating to the **age distribution** of the TGD population (Office for National Statistics, 2023b). In keeping with the previous evidence, this suggests that the likelihood of identifying as TGD increases with younger age. The highest rates nationally were found in the youngest adult age group, 16 to 24. Nationally, 1% of this age group reported that their gender identity differed from their sex registered at birth. The rates for other age groups are shown below. The pattern is even stronger for non-binary people, 85% of whom are aged between 16 and 34 years.

Figure 1. Percentage of usual residents aged 16 years and over who identified as TGD by age, England and Wales, 2021



The same pattern holds for the Lancashire data.

Figure 2. Percentage of usual residents aged 16 years and over who identified as TGD by age, Lancashire, 2021



As noted above, one explanation for this phenomenon is that it reflects increasing social acceptance of TGD identities, rather than a true increase in gender diversity. This may be the simplest explanation, and reflects similar patterns seen previously with minority sexual orientations, whose apparent prevalence increased as social stigma decreased, before beginning to plateau at what may be closer to the "true" number. If this is the case, it suggests a large proportion of TGD individuals, particularly at older ages, may be present but uncounted.

If, for example, one was to apply the rate for the 16 to 24 age group to the entire population of Lancashire, this would suggest around 13,780 TGD individuals in total, including 2,500

under the age of 16, close to our upper bound calculated before the census data. If this rate is applied only to adults over 16, we reach an estimate of 11,250, nearly double the census count. This is not intended to be an accurate estimate, but indicates the potential scale of the uncounted TGD population.

3.5 Mortality

As gender identity is not recorded on a death certificate, there is not routine mortality data relating to TGD individuals.

One recent cohort study by Jackson *et al.*. (2023) used GP data to assess mortality in the TGD population compare with the cisgender population. This is the first UK study of this kind, included over 3000 TGD individuals, and, unlike most of the available data around TGD health in the UK, was able to control for common confounding factors like socioeconomic status, ethnicity, BMI, smoking and alcohol consumption. However, as the TGD cohort was particularly young, there were not that many deaths in total, and so the conclusions that can be drawn about specific causes of death are necessarily limited.

With those caveats, the study by Jackson *et al.*. (2023) represents the best UK data on TGD mortality. They found that all-cause mortality was higher for TGD individuals than cisgender individuals. Overall, TGD individuals had between a 34% and 75% higher risk of mortality overall. Some causes of death were particularly more common in the TGD population, who had between 3 and 5 times the risk of death from suicide or homicide, and 2 to 5 times the risk of death from accidental poisoning.

3.6 Physical Health

TGD individuals may have specific health needs around medical or surgical **transition**, which may involve specialist psychological support, medical treatment such as hormone therapy, or surgery. These needs are managed by specialist NHS Gender Identity Services (GIS). There is currently no GIS within Lancashire, and so a detailed assessment lies outwith the scope of this review. However, it is worth noting that difficulty accessing appropriate GIS care can have significant impact on the health and wellbeing of TGD individuals.

The nearest GIS to Lancashire is based in Leeds, as part of the Leeds and York Partnership NHS Foundation Trust. In addition to the cost and difficulty of traveling a significant distance for appropriate care, there is also a long waiting list to be seen. As of November 2022, there were 3563 people on the standard waiting list for a first appointment, and appointments were being booked for individuals first referred four years earlier in November 2018. A further waits of approximately six months were expected for follow-up appointments, including surgical opinions and hormonal treatments (Leeds and York Partnership NHS Foundation Trust, 2022).

A recent non-representative survey of trans people found that 98% of their respondents thought that NHS transition-related healthcare was not completely adequate, and 47% that

it was not at all adequate (TransActual, 2021). Qualitative research in Scotland has found long waiting times associated with symptoms of anxiety and depression, including suicidal thoughts and self-harm, as well as evidence of financial loss from funding treatments privately and physical harm from stop-gap measures like chest binding (Leven, 2022). Survey evidence also supports the contention that long waiting lists contribute to worsening mental health and emotional wellbeing (McNeil *et al.*., 2012).

There is evidence of further problems with Gender Identity Services beyond the long waiting times. In one example, it was noted that clinics require from patients two years of experience living as their true gender. Some clinics considered that changing one's name was the starting point of this two-year period, but patients also found that changing their names while on a waiting list would cause them to be dropped from the waiting list due to administrative confusion (Hord and Medcalf, 2020).

Mitchell and Howarth (2009) summarise a body of evidence suggesting that TGD people accessing gender services are subject to medical gatekeeping, including feeling pressure to simplify their experiences and conform to standard scripts of gender dysphoria in order to receive the treatment they feel is appropriate.

There is very little data on the **general physical health needs** of the TGD population, including differences in life expectancy, prevalence of specific conditions or excess mortality. However, there is longstanding evidence of barriers to healthcare including experience of stigma and discrimination from healthcare professionals and others, as well as appropriate screening not being offered, for example prostate screening for trans women or breast cancer screening for trans men (Mitchell and Howarth, 2009). These barriers might be expected to lead to worse health outcomes.

In keeping with this expectation, there is some evidence that TGD individuals are at higher risk of having a **disability or long-term health condition**. Mitchell and Howarth (2009) found limited evidence of higher levels of disability among trans people, noting that gender dysphoria is itself a psychiatric diagnosis and may therefore give an illusory perception of greater mental health disability in the trans population. Hudson-Sharp and Metcalf (2016) found one study suggesting trans people were nearly four times more likely not to be working due to ill health when compared to other survey respondents.

Analysis of data from the 2021 GP patient survey by Saunders *et al.*. (2023) found that, after adjustment for age, ethnicity, and area deprivation, TGD adults experienced higher rates of a number of long-term health conditions. TGD adults were about twice as likely to report a mental health condition as cis patients, and there was also some evidence of elevated rates of other physical health conditions, including diabetes, stroke and kidney or liver disease. TGD adults were in general 20-30% less likely to report having no long-term health conditions (Saunders *et al.*., 2023).

58% of respondents to the Trans Mental Health Study 2012 identified as having a disability or long-term health condition, including high levels of mental ill health, neurodiversity, sensory impairment and physical disability (McNeil *et al.*., 2012). Trans respondents to the National LGBT Survey were more than twice as likely as cisgender respondents to report

that they had a disability: 33% compared to 14% (Government Equalities Office, 2018). A large survey as part of an LGBT health needs assessment in Scotland found that trans and non-binary respondents were more likely to have a long-term health condition significantly impacting their day-to-day life (Leven, 2022). These are all large surveys, but self-selecting, and so cannot be taken to be representative.

A needs assessment in Brighton & Hove also found that trans people locally were more likely to be have a disability or long-term illness and less likely to report that they were in good health than the general population, based on both random sampling and non-random surveys (Hill and Condon, 2015). UCAS application data in 2020 showed 47% of students identifying as transgender declaring a disability (including 22% with a mental health condition), compared to 30% (13% with a MH condition) of LGBT+ students and 12% (2.9% with a MH condition) of non-LGBT+ students (Stonewall/UCAS, 2021). A non-representative survey of 895 non-binary people in the UK found 45% of respondents considered themselves to be disabled or have a long-term health problem, particularly striking given the young age profile of the survey respondents, close to 60% of whom were under 25 and only 1% of whom were over 65 (Valentine, 2016).

There is evidence of an association between trans and gender diverse identities and **neurodiversity.** Saunders *et al..* (2023) found that TGD adults were more than five times as likely as non-TGD adults to report autism or autism spectrum disorder and nearly three times as likely to report a learning disability, Around one third of children and young people referred to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust, the only gender identity service for children and young people in the UK, have autism or another form of neurodiversity (Cass, 2022). A recent survey in Scotland found that 23% of trans masculine and 26% of non-binary people had Attention Deficit Hyperactivity Disorder (ADHD) and that 29% of trans masculine and 26% of non-binary people had Autistic Spectrum Disorder (ASD) (Leven, 2022). A recent systematic review and meta-analysis of published research concluded that there was strong evidence of a link between gender incongruence and autistic traits, but that the nature and strength of that link remains unclear (Kallitsounaki and Williams, 2022).

There is little robust evidence on differences in **sexual health** between trans and cis people in the UK (Hudson-Sharp and Metcalf, 2016). Globally, trans people are at much greater risk of contracting HIV (Stutterheim *et al..*, 2021). There are reasons to suggest that this may apply to the UK, but there is no research to establish this with confidence (Mitchell and Howarth, 2009).

In Scotland, trans masculine and non-binary people invited for cervical **screening** had higher rates of non-attendance than LGB women, one third not attending the appointment (Leven, 2022). Screening can be a particular issue for TGD people, as invitations, particularly if the system is automated, may be based on gender identity markers rather than relevant anatomical features, and TGD people may also avoid tests or procedures that do not accord with their gender. Provision of appropriate screening services must therefore take TGD people explicitly into account, and ensure that invitations are appropriate and procedures are conducted sensitively and in an appropriate (i.e. not gender-specific) setting.

3.7 Mental Health

There is evidence of elevated levels of mental ill health and mental health service need among the trans and gender diverse population. There are a few points to note before outlining this evidence.

Historically, trans identities, like sexualities other than heterosexuality, were often **pathologised** and treated as illnesses in themselves. While it is no longer the case that being trans is considered a mental illness, gender dysphoria remains a medical diagnosis. The diagnosis of gender dysphoria relates to the distress that can be felt by TGD people as a result of the incongruence between their gender and their bodies, and is not felt by all TGD individuals. However, there is some lack of clarity as to what level of distress is diagnostic (Davy and Toze, 2018). Much of the data around TGD mental health is survey data without a great deal of diagnostic specificity, so it may be important to consider how much of the reported ill health is due to diagnoses of gender dysphoria as well as other mental health diagnoses and issues.

It is also important to recognise that being trans or gender diverse is not associated with poorer mental health because being trans is inherently bad for one's mental health. It is likely that **it is being trans or gender diverse in a transphobic society that leads to worse mental health**. Evidence of poorer mental health among minorities, including sexual and ethnic minorities, is common, linked to experiences of discrimination and minority stress (Bignall *et al.*., 2019; Mercer *et al.*., 2016; Lucassen *et al.*., 2017; Mongelli *et al.*., 2019).

There is reason to believe that poorer mental health among TGD people is a result of multiple factors, including minority stress, gender dysphoria, lack of social support, and others (Shelemy *et al.*., 2024; Saunders *et al.*., 2023; Watkinson *et al.*., 2024). Action to improve mental health in the TGD population must therefore include the provision of appropriate and accessible mental health care; action to reduce discrimination and transphobia; and timely access to appropriate gender-affirming care. There is evidence to suggest that interventions for gender dysphoria, particularly hormonal and psychological treatments, may have mental health benefits for TGD people, although there is need for further good quality research (Dolotina and Turban, 2022; Shelemy *et al.*., 2024).

Survey evidence, while non-representative, suggests that undergoing a process of transition, for those that want to, may reduce the demand for mental health services: 45% of respondents used services more before transitioning, and 0% more after, and undergoing a process of transition was associated with better life satisfaction (McNeil *et al.*., 2012). Respondents to the National LGBT Survey associated long waiting times for referrals to Gender Identity Clinics with adverse effects on mental health (Government Equalities Office, 2018).

The final caveat is that being TGD, like being a member of other groups that experience discrimination, does not mean that poor mental health is inevitable. While gender dysphoria can be a source of distress, having a trans identity is not inherently negative. In the Trans Mental Health Survey, the majority of respondents reported that being trans had both positive and negative effects on their life satisfaction (McNeil *et al.*., 2012).

As mentioned above, Saunders *et al..* (2023) found that TGD adults were about twice as likely to report a **long-term mental health condition** as cisgender adults. Analysis of data from the 2021 and 2022 GP patient surveys by Watkinson *et al..* (2024), focussing specifically on mental ill health, found evidence of higher prevalence of mental ill health in TGD adults, concentrated in those younger than 35 years old, and in those with non-binary identities. However, the authors note that this analysis can provide no detail about different types of mental ill health, diagnoses, or level of severity.

There is no routine UK data available of common mental health diagnoses by gender identity or trans status. The Trans Mental Health Survey found **elevated levels of many common mental health problems**: 55% of respondents had either a current or past diagnosis of depression, and 38% of anxiety. In addition, 53% had self-harmed at some point, and 11% were currently self-harming. 25% of respondents felt that they had, or had previously had, a form of eating disorder, although only 5% had received a formal diagnosis. 10% had been an inpatient in a mental health unit at least once (McNeil *et al..*, 2012).

Other evidence supports the conclusion that trans people have higher rates of mental health problems, with some research concluding that as much as 88% of the trans population may have suffered from depression, 80% from stress and 75% from anxiety (Hudson-Sharp and Metcalf, 2016). A recent survey in Scotland also found elevated levels of mental health problems in trans respondents, particularly trans masculine and non-binary respondents (Leven, 2022).

There is evidence from GP patient surveys that TGD patients are more likely to report that they had **unmet mental health needs** in consultations with their GP (Saunders *et al..*, 2023; Watkinson *et al..*, 2024). Watkinson *et al..* (2024) found that much of this disparity between TGD and cisgender patients was mediated by the quality of interaction and communication with primary care providers.

There is strong evidence of elevated **suicidality** – suicide and suicidal ideation – in the TGD population. There is a large body of research in the US context, while in the UK there has been increasing attention over the last decade. Data from the Trans Mental Health Study, a large non-representative survey in the UK, found that 84% of respondents had thought about ending their lives at some point, and 63% had considered suicide in the last year. Out of all respondents, 35% had attempted suicide at least once, and 25% more than once (Bailey, Ellis and McNeil, 2014).

A more recent review of evidence by McNeil, Ellis and Eccles (2017) found a range of estimates for suicidality in the TGD population internationally, supporting the hypothesis that rates of ideation and attempt are significantly higher than the population as a whole, and higher than for other minority groups, such as the LGB population. Comprehensive figures are hard to establish, in part because gender identity is not recorded on death certification. The cohort study by Jackson *et al..* (2023) found evidence for increased mortality in the TGD population attributable to suicide and homicide.

Reduced stigma and discrimination are associated with lower levels of suicidality (McNeil, Ellis and Eccles, 2017). There is also some evidence that undergoing transition for individuals who want it, and timely access to transition-related healthcare services, reduce suicidal ideation (Bailey, Ellis and McNeil, 2014). However, other reviews of the evidence internationally have found a less clear picture of the relationship between transition and suicidality (McNeil, Ellis and Eccles, 2017).

There is some evidence from the US that young people who have successfully undergone social transition have similar rates of anxiety and depression to cisgender peers (Gibson, Glazier and Olson, 2021). This, compared with higher levels of mental ill health found in young people referred to gender identity clinics, may suggest a beneficial effect of transition.

3.8 Access to and experience of services

There is a wealth of evidence that TGD individuals have **greater difficulty accessing a range of services, and have worse experiences in services** (Hudson-Sharp and Metcalf, 2016; Government Equalities Office, 2018; Hord and Medcalf, 2020; London Assembly Health Committee, 2022; Holland *et al.*., 2024).

One survey looking at this issue in particular found that trans people reported **barriers to accessing healthcare**, particularly trans people of colour, neurodiverse trans people, migrants, sex workers and those who had experienced homelessness. Trans people in rural areas found a lack of trans-specific services. Many TGD people found it difficult to navigate the services that were available, facing difficulty with bureaucracy and IT systems recording incorrect data; inappropriate and invasive questioning from professionals; a lack of understanding and education; and difficulty securing information or referrals (Hord and Medcalf, 2020). These issues related to general healthcare as well as transition-specific services.

In analysis of data from the 2021 GP patient survey by Saunders *et al.*. (2023), TGD adults reported **poorer experiences of primary care** than cisgender respondents. The biggest disparities were in interpersonal communication. Differences across domains of access to services, on the other hand, were small. In keeping with other research, TGD patients were more likely to report both very good and very poor experiences. This may in part explain why TGD patients were also much more likely to report a preference for a particular GP. This underscores the importance of continuity of care for this population.

In the National LGBT Survey, 40% of trans respondents who had either accessed or tried to access **public healthcare services** had experienced at least one of a range of negative experiences in the preceding year, including their needs being ignored, receiving inappropriate curiosity, or being dissuaded from care by the anticipation of a negative reaction. 7% had been forced to change their GP. These rates were all significantly higher than cisgender respondents, 87% of whom had faced none of these negative outcomes. Trans men and women were more likely to report these negative experiences than non-

binary respondents. Trans and non-binary respondents were also more likely to have accessed or tried to access healthcare services in the preceding year (Government Equalities Office, 2018).

In a recent survey, 14% of trans people reported that they were refused GP care as a result of being trans on at least one occasion. 45% of trans people and 55% of non-binary people reported that their GP did not have a good understanding of their needs, contributing to the 57% of trans people who reported avoiding going to the doctor when they were unwell (TransActual, 2021). Bachmann and Gooch (2018) found that 7% of trans people reported being refused healthcare because they were LGBT, while 41% said that healthcare staff lacked a proper understanding of trans-specific healthcare needs.

In a survey of non-binary people, only 6% reported experiencing none of a range of negative experiences when accessing services. 80% had at some point felt that they had to pass as either male or female to be accepted, and 70% had been addressed by the wrong name or pronoun (Valentine, 2016).

Mitchell and Howarth (2009) note a body of evidence that trans people are often placed in inappropriate hospital wards, which may deter seeking appropriate medical help in **hospital settings**, and damage the experience of care. In Scotland, 44% of trans people felt uncomfortable being open about their gender identity with NHS staff, which is likely to affect quality of care (Hudson-Sharp and Metcalf, 2016).

36% of trans respondents to the National LGBT Survey had accessed **mental health services**: significantly higher than the 21% of cisgender respondents. Three quarters of trans respondents did not find it easy to access mental health services, and trans respondents were less likely to report their experience as completely positive. Trans respondents were more likely to report that their GP had not known where to refer them, and this was especially the case with non-binary people, 20% of whom reported that their GP had not been supportive (Government Equalities Office, 2018). Evidence from Scotland also suggests that TGD people, particularly trans masculine and non-binary people, make greater use of mental health services (Leven, 2022).

In Scotland, 46% of trans people reported expecting to be discriminated against by mental health services (Hudson-Sharp and Metcalf, 2016). In addition to concerns about discrimination, trans people report that GPs conflate their trans identity with mental ill health, and seek to refer inappropriately to GICs instead of general psychiatric services (Lim and Browne, 2009). This assumption on behalf of referrers that mental healthcare for trans people is always related to gender and requires ‘specialist’ care, resulting in difficulty accessing services, is frequently reported (Hord and Medcalf, 2020; McNeil *et al.*., 2012).

Some TGD people also report avoiding mental health services in order to avoid a diagnosis of mental illness that could be used to delay or prevent their access to transition-related care; or alternatively have felt compelled to access mental health services they do not feel they require in order to access transition-related care (McNeil *et al.*., 2012).

TGD individuals report harassment, misgendering and uncertainty about placement within single sex facilities when accessing **inpatient mental health care** (McNeil *et al.*., 2012).

In the National LGBT Survey, trans respondents were less likely to find accessing **sexual health services** easy than cisgender respondents. The most common reason given was that they had been worried, anxious or embarrassed about going, likely related to anticipated discrimination. Trans respondents were also more likely to have found their GP not to be supportive, or to be unsure where to refer them. When they did attend, 7% rated their experience as wholly or mainly negative, compared with 4% of cisgender respondents (Government Equalities Office, 2018). There is little further evidence about the sexual health of TGD individuals, partly because data on gender identity is not routinely collected.

One survey found that 25% of trans respondents had been discriminated against by **emergency services** in the last year, compared with 3% of cisgender LGB respondents (Bachmann and Gooch, 2017).

3.9 Health Behaviours

There is strong evidence for elevated rates of smoking, excess alcohol intake and illicit drug use in the LGBTQ+ community, although much less data specifically referencing the TGD community (Leven, 2019).

One UK survey found that 19% of adult trans respondents were current **smokers** and half had ever been smokers (McNeil *et al.*., 2012). This is comparable to levels in the general population.

McNeil *et al.*. (2012) found **elevated levels of problematic drinking** among trans adults, with 62% of respondents reporting hazardous levels of alcohol intake. There is more evidence from Scotland, where Leven (2022) found hazardous drinking in 22% of trans women, 16% of trans masculine people and 17% of non-binary people, lower than the rates for gay and bisexual men (31% and 36%) and for bisexual women (265), closer to the rates for gay/lesbian women (18%).

McNeil *et al.*. (2012) found that 24% of trans respondents had used **illicit drugs** in the previous 12 months, lower than cisgender LGB respondents. In Scotland, 42% of trans women and trans masculine people had ever used drugs, and 44% of non-binary people (Leven, 2022). In both cases, the most common drug was cannabis, followed by nitrates (poppers). Commentators have drawn attention to the potential risks of illicit drugs interacting with hormone treatments.

There is evidence that TGD people are dissuaded from taking **exercise** due to fear of harassment or being outed as trans at gyms at leisure facilities. In the Trans Mental Health Survey, 50% of respondents avoided using public toilets or attending gyms, and 25% avoided other leisure facilities, social groups or clubs (McNeil *et al.*., 2012). Gyms were a particular issue for trans men, and for both men and women, those undergoing transition

were more likely to avoid leisure facilities than those who had completed their transition. A survey by Stonewall found that 28% of trans people had experienced discrimination while exercising or doing sport in the preceding year, and 38% avoided gyms and sports clubs (Bachmann and Gooch, 2017).

Similarly, 42% of non-binary people in a separate survey reported avoiding gyms and 33% other leisure facilities (Valentine, 2016). Non-binary people have reported particular issues accessing facilities with gender-segregated changing rooms, or taking part in rigidly gender-segregated sports (Leven, 2019).

There is limited UK evidence on the prevalence of **obesity and overweight** in the TGD population. However, there is good evidence that gender-affirming treatment with hormones is associated with weight gain (Kyinn *et al.*., 2021; Ford, Huggins and Sheean, 2022). This may contribute to higher levels of overweight and obesity in the subset of the TGD population taking hormone therapy.

3.10 Social Determinants of Health

The social determinants of health are the conditions in which we are born, grow, work, live and age, and which influence our health. They include housing, employment, income, education, experience of discrimination and many others, as well as the social, economic and political structures which give rise to these. These are sometimes referred to as the building blocks of health.

There is strong evidence that TGD people experience elevated levels of **discrimination and harassment**. A Stonewall survey found that 41% of trans people had experienced a hate crime or incident in the preceding 12 months, rising to 53% of trans people aged 18 to 24, and 44% of trans people avoided certain streets due to not feeling safe (Bachmann and Gooch, 2017). 79% of those who had experienced a hate crime did not report it to the police. This is in keeping with other evidence that the majority of hate incidents are not reported to the police (Government Equalities Office, 2018).

In the National LGBT Survey, 67% of trans respondents and 76% of non-binary respondents reported that they avoided being open about their gender identity for fear of a negative reaction (Government Equalities Office, 2018).

Increased media visibility in recent years may have worsened the situation. In a recent survey, 99% of trans people reported experiencing transphobia on social media, and 97% in the digital and print media. 93% reported that this had impacted their experiences of transphobia from strangers on the street, and more than 70% felt it had affected their mental health (TransActual, 2021).

It has been reported that transphobic hate crime reports to the police more than tripled in the UK between 2014/15 and 2020/21, from 598 to 2,588 (Hunte, 2021).

49% of respondents to the Trans Mental Health survey had experienced some form of **abuse** during their childhood (McNeil *et al.*., 2012). There is also older evidence that TGD people face more bullying at school (Mitchell and Howarth, 2009). There is also evidence of elevated levels of domestic abuse, with McNeil *et al.*. (2012) finding that 17% of trans people had experienced domestic abuse as a result of their gender identity, and Bachmann and Gooch (2018) finding that 28% of trans people who were in a relationship in the preceding 12 months had experienced domestic abuse from their partner.

Hudson-Sharp and Metcalf (2016) found little robust evidence on TGD people and **employment or income**. There was some suggestion that trans people were disproportionately found in higher occupational classes, although other data suggested that trans people were more likely to be employed below the level of their educational attainment. The authors note that these are not necessarily contradictory findings, if trans people tend to be highly qualified individuals. This may reflect greater likelihood of being openly TGD rather than being TGD per se.

In the National LGBT Survey, TGD respondents of working age were much less likely to have been in paid employment in the preceding 12 months (63%) than cisgender respondents (83%) (Government Equalities Office, 2018). Trans men had the lowest rates of employment, at only 56.9%. Respondents reported their gender identity being a potential barrier to getting or holding a job, including concerns that providing any identification would, without a GRC, out them as trans. TGD people were also much more likely not to be open at work about their gender identity, with colleagues, customers or clients, and to experience threats, harassment and violence in the workplace. 20% of trans women and 16% of trans men and non-binary people had experienced verbal harassment at work. Again, most incidents were not reported to seniors or the authorities.

35% of TGD people in one survey reported that they suspected they had been turned down for a job as a result of being trans (McNeil *et al.*., 2012). in Scotland, 40% of TGD respondents to one survey felt that their gender identity had a negative impact on their job prospects (Fearnley, 2021). TGD people may, partially as a result, be particularly likely to be self-employed (Mitchell and Howarth, 2009). Mitchell and Howarth (2009) also note some evidence that TGD people may be particularly likely to work in the public sector, especially post-transition.

In Scotland, there is evidence that TGD people are more likely to face financial worries or experience food insecurity than LGB people (Leven, 2022). Older data also supports the idea that TGD people have greater financial problems (Mitchell and Howarth, 2009). Based on responses to surveys, this may be related both to difficulties securing and maintain employment, but also to the high costs of self-funding transition-related care due to NHS waiting times or other barriers.

There is sparse evidence on TGD people and **housing**. A survey found that 25% of trans people reported being discriminated against when seeking a new home in the preceding 12 months (Bachmann and Gooch, 2017). Older evidence suggest that TGD people may be

more likely to live in the private rented sector, the least secure and lowest quality housing sector (Mitchell and Howarth, 2009).

Bachmann and Gooch (2017) also found that 25% of trans respondents had experienced **homelessness** at some point, while McNeil *et al.*. (2012) found that number to be 19%. This is in keeping with previous research, which has found trans people at a higher risk of exclusion by family and neighbours, putting them at elevated risk of homelessness, with over one quarter of respondents in one survey being forced to move out of their home due to transphobia (Mitchell and Howarth, 2009). This may be in keeping with the suggestion that TGD people are more likely to be in private rented housing.

Mitchell and Howarth (2009) further note that TGD people and housing is "an especially under-researched area". Hudson-Sharp and Metcalf (2016), updating that review, found no new good quality evidence. What evidence there was suggested that TGD people faced difficulty accessing housing services, and TGD status was not taken into account as a potential source of vulnerability by housing services.

Hudson-Sharp and Metcalf (2016) note that very little of what research is available adjusts for major **confounders like socioeconomic status**, thus making it more difficult to identify the root causes of health inequalities for TGD people. They note some evidence from the US where differential outcomes disappeared once these factors were accounted for.

4. Project Outline and methodology

4.1 Methodology

Mitchell and Howarth (2009) provide a very extensive discussion of the methodological difficulties encountered in carrying out research on the TGD population. Most, if not all of these difficulties remain in place today.

These problems include:

- The TGD population can be difficult to define, and is often unspecified or poorly defined in research. Sub-populations, such as TGD individuals who have undergone a medical transition, may have particular needs, but research often fails to make such distinctions.
- Research often subsumes the TGD population within the wider LGBTQ+ population.
- TGD individuals may be reticent to disclose their gender identity to researchers or service providers.
- TGD people may transition at any age. There is evidence that TGD people are beginning to transition at a younger age. This makes estimates of the TGD population at particular ages very difficult.
- Data on gender identity is not routinely collected by most services.
- Above all, the TGD population is a small one, making achieving a statistically representative sample extremely difficult.

The conclusion they reach remains valid today, and is quoted below:

"[*T]he best that can probably be achieved in the current circumstances is to achieve as large a sample as possible with respondents being drawn from as wide a range of sources as possible. This could also be complemented with quota sampling for the range of trans people to help ensure diversity in the sample […] [T]he means by which participants are recruited is less important than the fact that recruitment is monitored to ensure that a sufficiently diverse range of experiences are captured in the sample. A strategy of maximum variation could be employed whereby the aim is to obtain a deliberately heterogenous sample."*

Mitchell and Howarth (2009)

They note four routes through which researchers tend to recruit TGD people: through clinical records; through bars and clubs; through TGD organisations; and through the internet. All of these routes have their drawbacks, tending to skew towards particular sub-groups within the population. Those who have not undergone a medical transition, for example, may not be identifiable through clinical records, while bars, clubs and the internet may all skew younger, and respectively more socially or technologically adept. TGD organisations may be associated with specific parts of the community, and almost by definition, recruiting from social organisations is likely to exclude those who are already most excluded and invisible.

For these reasons, most Health Needs Assessments for the TGD community take a multimodal approach, including elements like online surveys as well as more in-depth qualitative research such as interviews and focus groups. There are significant limitations to what can be achieved by surveys alone, given that samples are unlikely to be statistically representative, and the already existing mass of non-robust survey data.

In Brighton, for example, home to a large TGD population, a multi-stage HNA was conducted in 2015. This HNA included a literature review; a local "data snapshot" exercise; stakeholder interviews with organisations whose work is relevant to the TGD population; and primary research involving both a survey questionnaire and focus groups aimed at specific subpopulations (Hill and Condon, 2015). All of these components contribute to a fuller understanding of the TGD population and their health needs. The "data snapshot" exercise was a secondary analysis of any local government work which had incidentally gathered data on gender identity through equalities monitoring questions and found a range of local data already available but previously unexamined.

A recent national LGBTQ+ HNA in Scotland also combined qualitative and quantitative research, including a very large national online survey, as well as a range of interviews and focus groups, some focussed specifically on Deaf and Deafblind LGBTQ+ people (Leven, 2022).

4.2 The steering group

From a methodological perspective, it was recognised early on that TGD individuals must be involved in the project from the very beginning and in leadership roles, rather than just consultative. It is of particular importance given the very limited data we have that the TGD community is involved in setting the priorities for research, that the process of data-gathering is acceptable to the population, and that the community is seen to have benefitted from the project.

For that reason, the project was guided throughout by a steering group comprising representatives from the TGD community, public health professionals and voluntary and community sector partners. For details of the membership of this group, please see the acknowledgements. The steering group met regularly to set goals, discuss methods and review progress.

4.3 Project outline

Multimodal methods of data collection were initially planned, incorporating both surveys and focus groups. However, the online survey, conducted from May until August 2024 generated rich data, with a large amount of detail on sensitive topics (e.g. on mental health, discrimination and harassment). For this reason, it was decided that the survey results would be analysed first before determining whether to proceed with additional focus groups or stakeholder interviews.

The project changed shape on multiple occasions while underway, guided throughout by the steering group. In particular, there were both local and national elections during the period that this project was running. Guidance was sought on political sensitivities during the pre-election period, and some work had to be delayed or altered to take account of this.

A ‘data snapshot’ exercise was considered, but no services contacted were able to provide good quality, safely anonymised routine datasets on gender identity. As noted above, gender identity data is rarely gathered as a matter of routine, and where it is, it is often recorded inconsistently. Although there are difficulties around the routine collection of such data, and its use in research, the safe and effective collection of such data could offer important insights and help in the design of support services for TGD people (Thomson and Katikireddi, 2019).

The online survey, hosted by the charity Lancashire LGBT, was used to gather both quantitative and qualitative rapidly from as wide as possible a sample of the TGD population. The survey questionnaire was drafted by the project team with oversight from the steering group. The survey covered a range of topics, including demographics; physical, mental and sexual health; access to and experience of services; and social determinants (‘building blocks’) of health.

The design of the survey was and the phrasing of the questions were shaped by a number of considerations. Where possible, standardised questions were used so that results could be compared with other surveys. Standardised questions were taken from the Office for National Statistics when available, and other questions were sourced from the National LGBT Survey or other previous work. For example, the survey used a two-part question on gender identity, as used in the UK census and supported by academic best practice (Scheim *et al.*., 2024).

In other areas, there remains a lack of agreement on best practice in surveying this community. For example, Chapa Montemayor and Connolly (2023) note that alcohol screening tools are not validated for transgender populations, with different definitions of, for example, 'binge drinking' for men and women that do not account for gender/sex differences or non-binary people. In these cases, the team was guided by the community via the steering group to take into account sensitivities within the TGD population.

The survey was advertised to the TGD population in a 'snowball' process making use of the community connections within the steering group. It should be remembered that this is a purposive, not a random sample, and therefore results should be used accordingly. The project's financial and time limitations did not allow for the provision of this survey in languages other than English. This, and the fact that it was hosted online, will limit its applicability to members of the community for speakers of other languages, or to those who do not have access to the internet.

5.0 Survey findings

130 responses were received in total. This constitutes a small proportion of the estimated population of TGD adults in Lancashire (5,575 according to ONS estimates (Office for National Statistics, 2021)). Hence, the sample is unlikely to reflect the larger population. Therefore, comparisons made with other data sources should be interpreted with caution as proportions can be misrepresented.

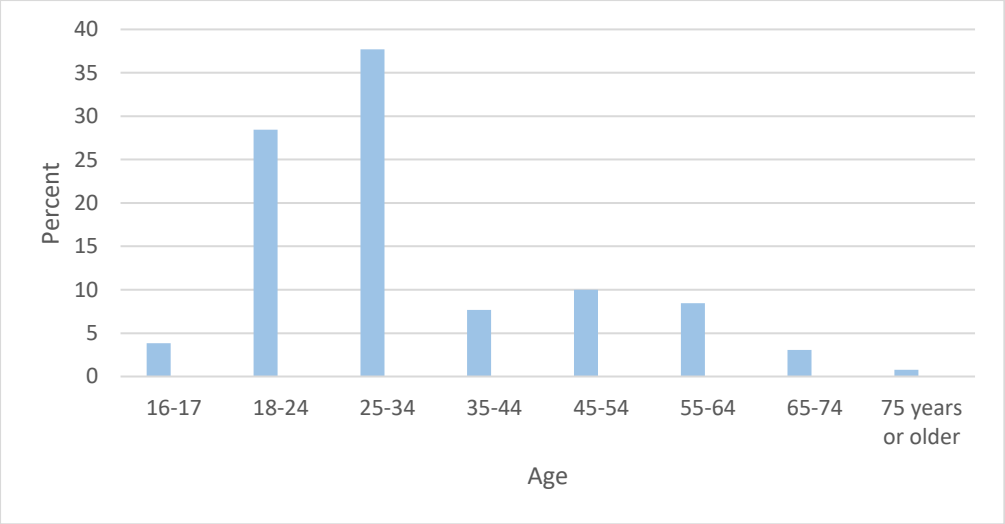
Nevertheless, many responses received included great depth and detail, offering useful insights into health needs across the TGD population in Lancashire.

5.1 Demographic data

Age

While ONS estimates of the proportion of residents identifying as TGD nationally was the largest within the 16-24 age group (Office for National Statistics, 2023b), most survey respondents were aged 25-34 (38%) (*Figure 3*).

Figure 3. Age of respondents, n=130 responses



Geographic region

- **Most participants (62%, 81/130), lived in Lancashire County,** followed by Blackpool (20%, 26/130) and Blackburn with Darwen (12%, 16/130).
- 4% (5/130) lived outside these areas, and 2% (2/130) skipped the question.

Ethnicity

Most survey respondents were white English/Welsh/Scottish/Northern Irish/British. Insights from those outside of this demographic group may therefore not have been captured: this is a limitation of the report.

Table 2. "What is your ethnic group", n=130 responses

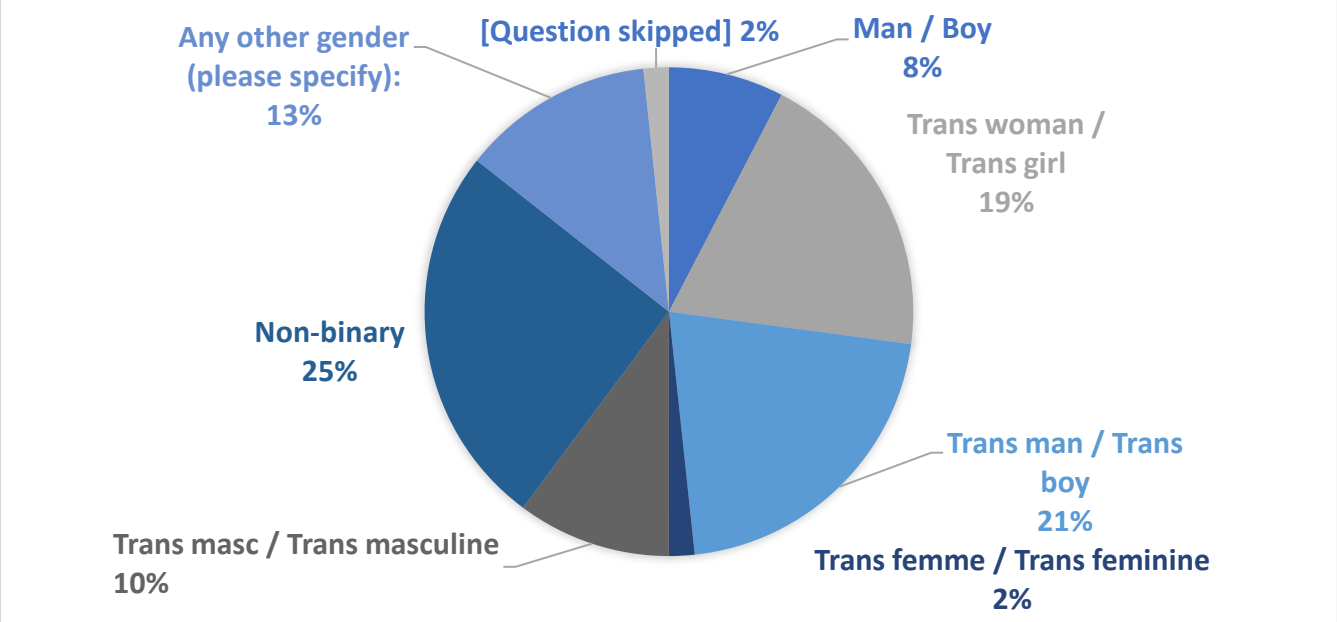
	Response percent	Response total
White		
English/Welsh/Scottish/Northern Irish/British	85%	110
Irish	1%	1
Any other White background	4%	5
Asian/Asian British		
Indian	1%	1
Pakistani	2%	2
Mixed/Multiple ethnic groups		
White and Black African	1%	1
Any other mixed/multiple ethnic background	1%	1
Black/African/Caribbean/Black British		
African	5%	6
Any other ethnic group		
Any other ethnic group (please specify)*	2%	3
[Question skipped]	2%	2

**Those that entered 'any other ethnic group' specified 'British Gibraltarian' or 'British Iranian' in the free text.*

Gender identity

For all participants, gender identity did not match the sex they were assigned at birth. A greater proportion of respondents were registered female at birth (60%) than male (40%).

Figure 4. "Which of the following best describes your present gender identity?", n = 130 responses



Responses suggested gender identity is more diverse than the options which were available in the survey (*Figure 4*). 15 respondents identified as 'any other gender', with one

participant commenting they did not know how best to describe their gender identity. The rest described their gender identity as the following:

- Agender (n=5)
- Pangender (n= 1)
- Gender-fluid (n=1)
- Genderqueer (n=1)
- Trans guy non-binary (n= 1)
- Trans-androgynous transsexual and gender flexible (n=1)
- Bigender (n=1)
- Femdrogynous (n=1)
- Trans masculine non-binary (n=1)
- Agender/gender queer/gender fluid (n=1)

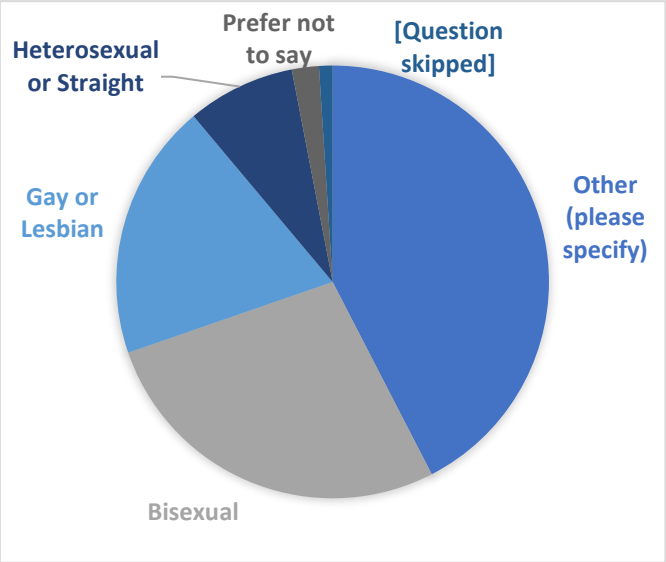
Intersex/differences or variations in sexual development (DSD/VSD)

10 respondents either identified as intersex/DSD/VSD or had been diagnosed with an intersex/DSD/VSD condition by a medical practitioner.

Sexual orientation/sexuality

When asked to select an option which best described their sexual orientation (*Figure 5*), the most frequent answer choices were 'other' (42%), bisexual (27%) and gay or lesbian (18%).

Figure 5. "Which of the following best describes you", n=130 responses



The responses suggested a greater diversity of sexual orientations or sexualities than the options available in the survey (*Figure 5),* with those that selected 'other' describing themselves as:

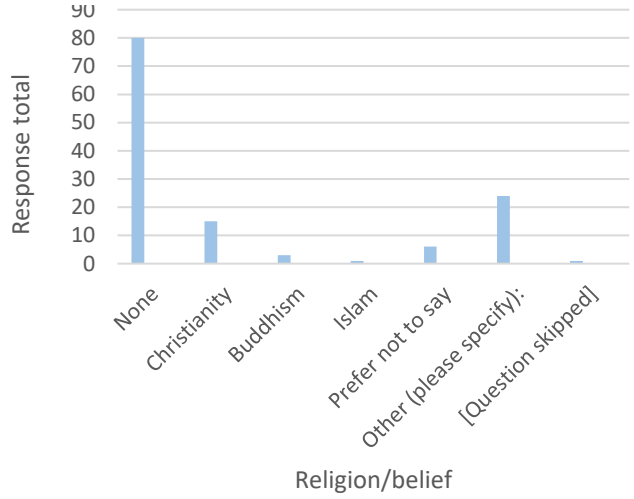
- Pansexual (n=14)
- Queer (n=11)
- Asexual (n=8)
- Unlabelled (n=2)
- Asexual lesbian (n=1)
- Asexual panromantic (n=1)
- Asexual/queer (n=1)
- Biromantic homosexual (n=1)
- Bisexual or queer (n=1)
- Demi-romantic ace (n=1)
- Demiromantic, Pansexual (n=1)
- Depends on gender (n=1)
- Graysexual (n=1)
- Greysexual, sapphic (n=1)
- Homo-romantic asexual (n=1)
- Likely asexual spectrum (n=1)
- Mostly lesbian (n=1)
- Not really interested in sex at all (n=1)
- Omnisexual (n=1)

- Pansexual & demisexual (n=1)
- Pansexual with an erotic interest in men (n=1)
- Questioning (n=1)
- Transbian (n=1)
- Transgender (n=1)

Religion and belief

Most participants (62%) did not have a religion/belief (*Figure 6)*.

Figure 6. "What is your religion/belief", n=130 responses



Legal marital or registered civil partnership status

Most respondents were never married and never legally registered in a civil partnership (76%, 99/130). 9% (12/130) were divorced and 6% (8/130) were married.

Immigration status

Almost all participants were citizens of the United Kingdom (93%, 121/130), some were asylum seekers (2%, 2/130) or overseas students (1%, 1/130).

5.2 Risk factors/general health

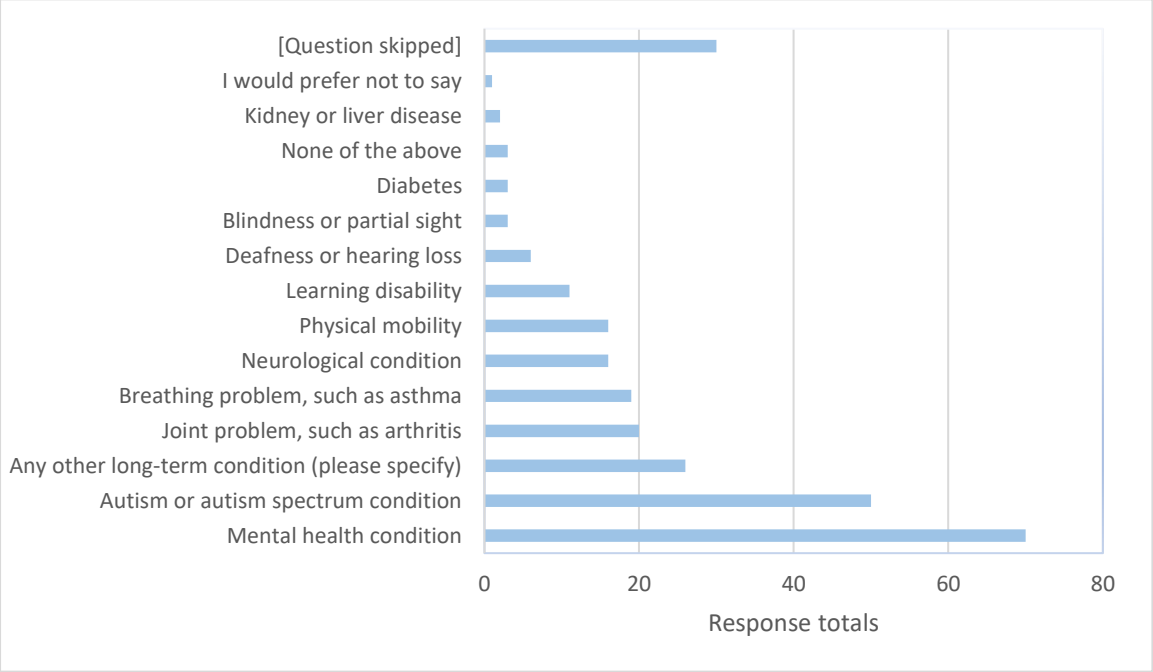
Physical and mental health

20% of respondents (26/130) had a long-term health condition (*physical or mental health condition, disability or illness that had lasted or was expected to last 12 months or more*). Responses to related questions indicate this might be an underestimate:

- 30% (39/130) of respondents felt their condition or illness reduced their ability to carry out day-to-day activities 'a lot'
- 40% (52/130) felt their condition or illness reduced this ability by 'a little'.
- **Most respondents (60%, 78/130) felt their ability to carry out day-to-day activities had been reduced for more than twelve months**.

These findings are in keeping with existing evidence which suggests TGD people are at a greater risk of experiencing a disability or long-term health condition (Hudson-Sharp and Metcalf, 2016; McNeil *et al.*., 2012; Government Equalities Office, 2018; Leven, 2022). For example, trans respondents to the National LGBT Survey were more than twice as likely as cisgender respondents to report having a disability: 33% compared to 14% (Government Equalities Office, 2018).

Figure 7. Response totals to the question: "Do you have any of the following physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last 12 months or more? Tick all that apply"



As Figure 7 demonstrates, **the most common long-term conditions were mental health** conditions (70/130 respondents) and **autism or autism spectrum** condition (50/130 respondents). For those that selected 'any other long-term condition' (26/130 respondents), the following were mentioned in the free text:

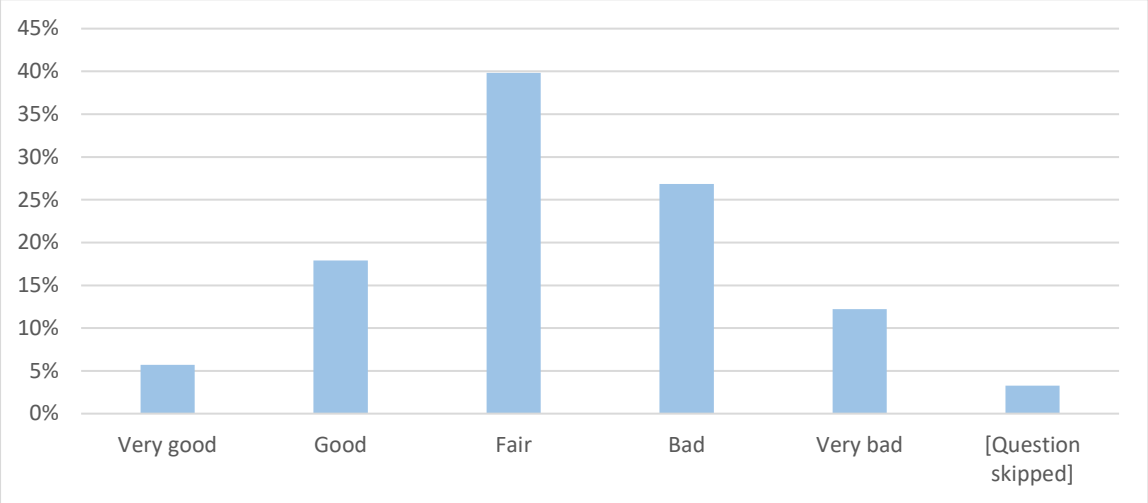
- ADHD (n=6), possible ADHD (n=1)
- Inflammatory bowel disease (n=2)
- Postural orthostatic tachycardia syndrome (n=2)
- Dyspraxia (n=1)
- Chronic pain (n=1)
- Insomnia (n=1)
- Ehlers-Danlos Syndrome (n=1)
- PTSD (n=1)
- Histamine related disorder (n=1)
- History of myocardial infarction (n=1)
- Migraines (n=1)
- Tinnitus (n=1)
- Fibromyalgia (n=1)
- Coeliac disease (n=1)
- Multiple sclerosis (n=1)
- Rheumatoid arthritis (n=1)
- Haematological condition (unspecified) (n=1)
- History of head injury (n=1)
- Hypermobility (n=1)

Mental health

84% of respondents (109/130) felt their mental health negatively affected their day-to-day life. This relates to findings from the Trans Mental Health Survey which found elevated levels of common mental health problems (McNeil *et al.*., 2012).

As demonstrated by Figure 8, a minority of participants (24%) described their general mental health as 'good' or 'very good'.

Figure 8. "How is your mental health in general?"



Deliberate self-harm and suicide

Rates of deliberate self-harm and suicide are much higher than those reported in the general population in the Adult Psychiatric Morbidity Survey (APMS) in 2014 as demonstrated below:

- **65%** (85/130) **of respondents had deliberately harmed or hurt themselves**
  - (versus 7.3% nationally (APMS, 2014))
- **73% of respondents** (95/130) **had ever had suicidal thoughts**
  - (versus 21% nationally (APMS, 2014))
- **43%** (56/130) **reported having attempted suicide in the past**
  - (versus 6.7% nationally (APMS, 2014))

Again, due to the small number of study participants, comparisons with national statistics are limited – particularly as the APMS was carried out many years ago. However, more recent evidence also suggests that the TGD population are at a higher risk of suicide and suicidal ideation (McNeil, Ellis and Eccles 2017; Jackson *et al.*., 2023).

Personal well-being

When compared with national wellbeing scores (Office for National Statistics, 2022), respondents appeared to face more difficulties with personal wellbeing than the general population across the UK.

Average well-being scores

- 5.7 out of 10 for life satisfaction (7.54 nationally)
- 5.7 out of 10 for feeling things done in life are worthwhile (7.77 nationally)
- 5.2 out of 10 for happiness yesterday (7.45 nationally)
- 5.8 out of 10 for anxiety yesterday (3.31 nationally)

In terms of sleep quality, **most participants (79%, 103/130) had trouble sleeping over the past month**. On average, respondents had difficulties sleeping 4 days per week.

Loneliness and social capital

Loneliness

Most respondents reported:

- Feeling they **lacked companionship** either some of the time (48%) or often (38%)
- **Feeling left out** some of the time (37%) or often (48%)
- Feeling **isolated from others** some of the time (34%) or often (56%)
- **Feeling lonely** some of the time (35%) or often or always (35%)

Social capital

- **General trust** in most people was low with a mean score of 4.4 out of 10
- Only **18% of respondents felt they belonged to their neighbourhood**. 54% felt they could rely on the people they have in their life if they had a serious problem
- **75% felt they did not have any say in what the government does**

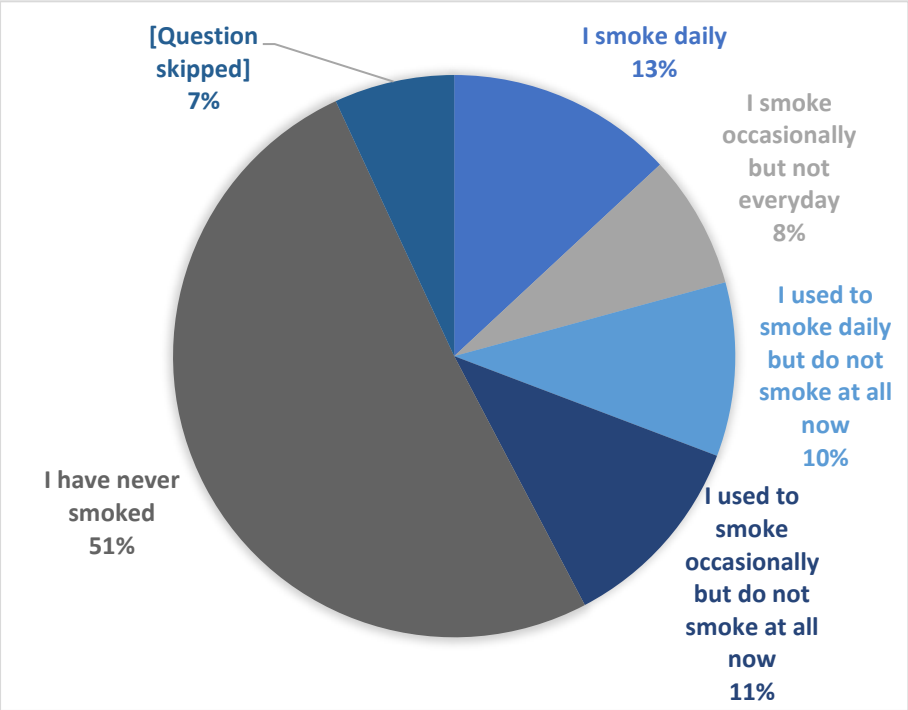
Although there were difficulties with loneliness and reduced social capital, **a majority of participants 55% (71/130) had given unpaid help to clubs, groups, charities or organisations over the last 12 months.** This exceeds national figures (34%) (Office for National Statistics, 2023c).

Health behaviours

Smoking

42% of respondents either currently smoked or had smoked in the past (*Figure 9*). This is comparable with findings from a UK survey which found half of adult trans respondents had ever been smokers (McNeil *et al.*., 2012).

Figure 9. Smoking, n=130 respondents

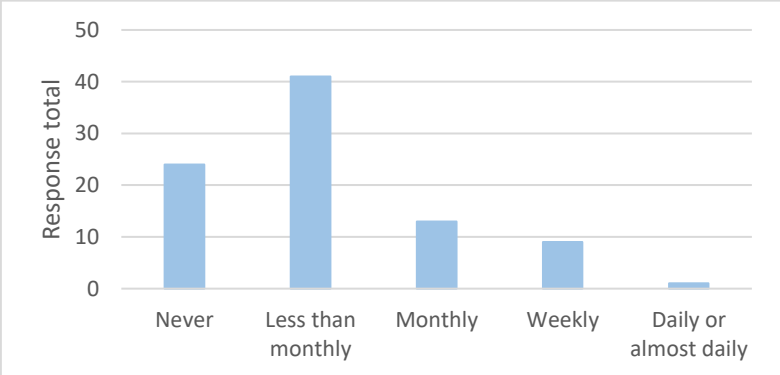


- *Most participants smoked cigarettes (19 respondents), followed by vapes or E cigarettes (18 respondents).*
- *A few participants performed waterpipe smoking (2 respondents) or smoked cigars/pipes (2 respondents).*

Alcohol

- 68% of survey respondents (88/130) drank alcohol, 25% (33/130) were teetotal and 7% (9/130) skipped this question.
- **Most participants who drank alcohol had consumed six or more units on a single occasion over the past year** (Figure 10).
    - This relates to research by McNeil *et al.*. (2012) which found elevated levels of problematic drinking among trans adults, with 62% of respondents reporting hazardous levels of alcohol intake.

Figure 10. "How often have you had six or more units on a single occasion in the last year?" (n=88 responses)



Drug use

- Most participants never used drugs (72%, 93/130) whilst 22% (28/130) had.
- Again, this corresponds with findings from McNeil *et al.*. (2012) which found 24% of trans respondents had used illicit drugs in the previous 12 months: these rates were lower than cisgender LGB respondents.

Gambling

Some participants also had difficulties with problem gambling:

- 8% (11/130) answered 'yes' when asked "when gambling, have you ever felt the need to bet more and more money?"
- 7% (9/130) answered yes when asked: "have you ever had to lie to people important to you about how much you gambled?"

Weight, diet and exercise

Most respondents (54%, 70/130) **felt they needed to lose weight,** 31% (40/130) felt they were a healthy weight and 6% (8/130) felt they needed to gain weight.

Some respondents described **struggling with eating disorders** either currently or in the past, which had implications on their weight. This relates to findings from the Trans Mental Health Survey which found a quarter of participants felt that they had, or had previously had, a form of eating disorder (McNeil *et al.*., 2012).

> "I previously suffered from anorexia, it is in recent years that I've managed to find myself much more healthy in terms of my weight. I know dysphoria caused my anorexia and coming to terms with my identity helped me understand why losing weight didn't change how I felt with my body, but I still have bad habits for not eating properly or skipping meals from exhaustion."

Some participants described **using weight loss or weight gain to assist with their transition**, such as gaining weight to grow breast tissue or to make breast tissue appear less obvious.

> "I once tried to "transition" by losing too much weight, which I achieved but hated because it made me feel ill and made my dysphoria worse."

> "I intentionally gained weight prior to top surgery because I felt it made my boobs stand out less/ made my shape less feminine."

> "Deliberately gained weight to grow breasts"

Poor **mental health** was also described as a barrier to maintaining a healthy diet as well as performing regular exercise. **Difficulties in accessing weight services** were also described.

5.3 Access to services

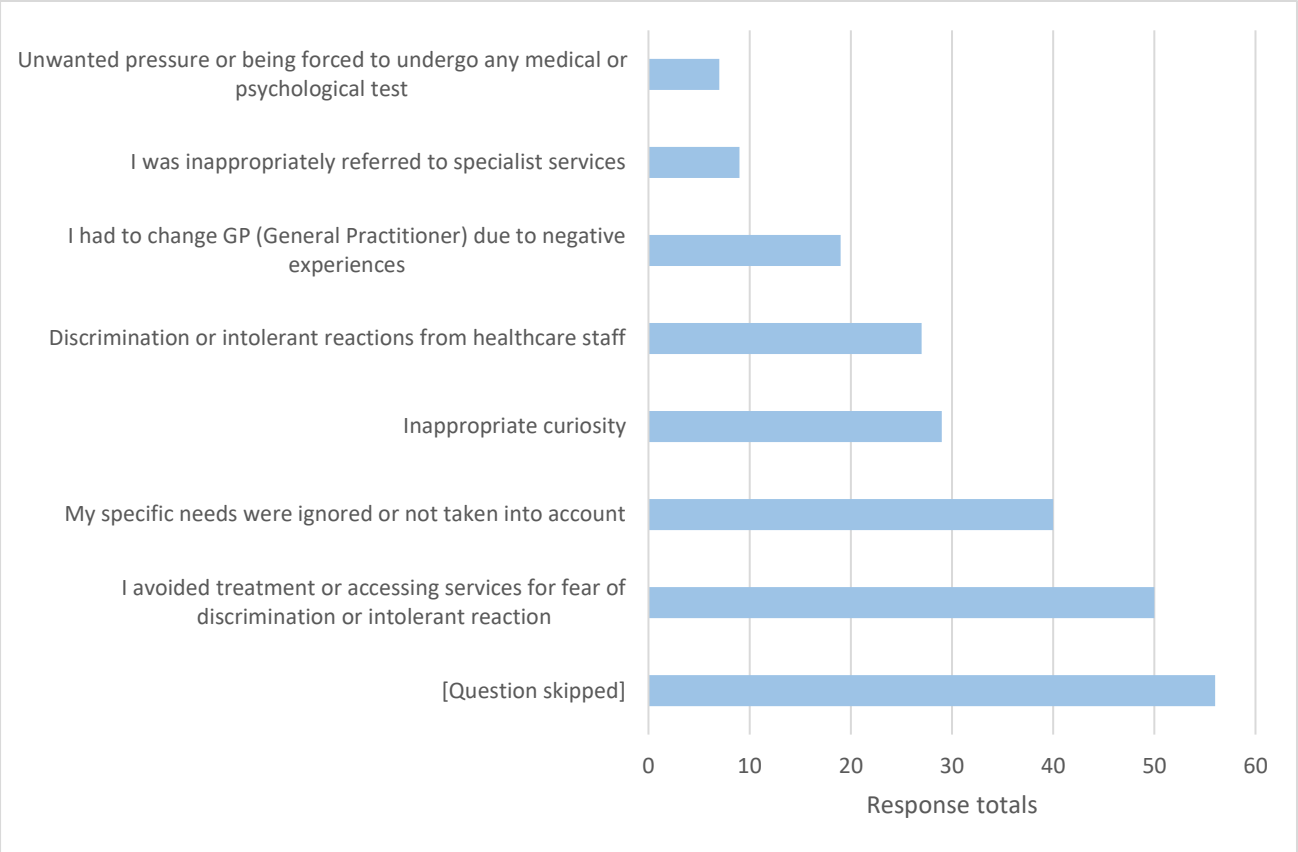
Access to healthcare services

Participants were asked about issues mentioned when trying to access healthcare services (*Figure 11*) over the past year. The most common experiences included:

- **Avoiding** treatment or accessing services due **to fear of discrimination or intolerant reactions** (38%, 50/130)
- Having **specific needs ignored** or not taken into account (31%, 40/130)
- **Inappropriate curiosity** (22%, 29/130)

This relates to current evidence from the National LGBT Survey which found higher rates of the following issues amongst TGD people than cisgender respondents: inappropriate curiosity; needs being ignored and being deterred from accessing care due to fear of a negative reaction (Government Equalities Office, 2018).

Figure 11. "In the past 12 months, did you experience any of the following when using or trying to access healthcare services because of your transgender status or gender identity? Tick all that apply. Leave blank if none."



Mental health services

- Participants were asked if they had accessed or tried to access mental health services over the past 12 months:
  - **43% (56/130) had accessed mental health services**
  - **13% (17/130) tried but were not successful**

    - **10% (13/130) did not try because they thought they would be unsuccessful**
    - 26% (34/130) had not accessed these services.

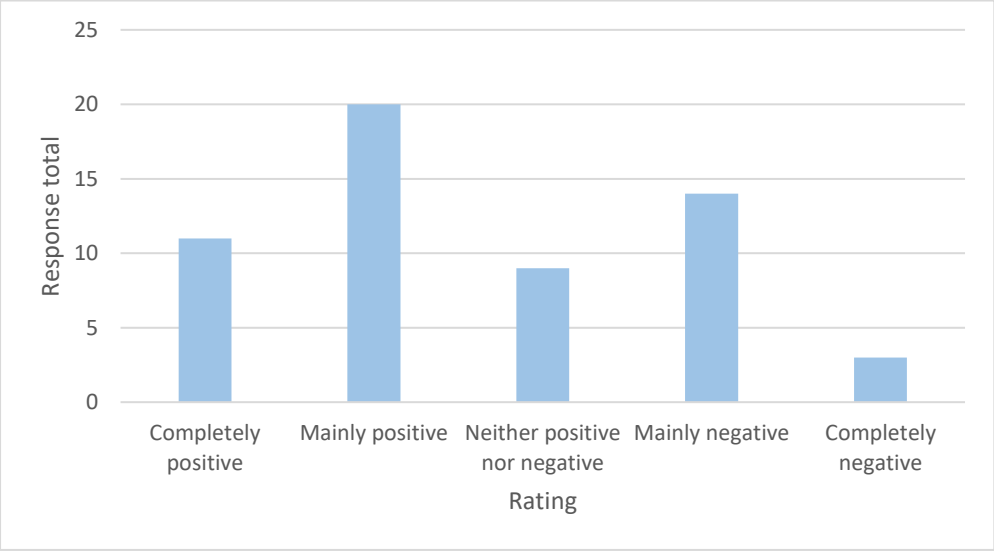
- These figures indicate that 23% of respondents were not able to or did not access mental health services when needed and that most respondents had required mental health services.
    - The National LGBT Survey found rates of access to mental health services were higher amongst trans respondents (36%) than cisgender respondents (21%) (Government Equalities Office, 2018).

- On average, study participants rated ease of access to mental health services over the past 12 months as 3.2 out of 5 with 1 being "very hard" and 5 being "very easy".

- When asked why accessing mental health services was difficult over the past 12 months, the most frequent answer choices were:
    - having to **wait too long to access the services** (21 responses)
    - **feeling worried, anxious or embarrassed** about going (13 responses).

- Overall experiences of mental health services over the past 12 months were varied (Figure 12).

Figure 12. "Overall, how would you rate the mental health services you used in the past 12 months?" (n=57)



Participants were asked if there was anything else they wanted to mention about their experiences with mental health services. 46 respondents answered.

Some **positive experiences** were described, including in relation to accessing mental health services through the NHS, private providers and Horizon LGBTQ+.

> “At first I was scared of taking mental health so people don't think [I’m] mad but later took the service which has helped me a lot and would encourage people to get the service”

Despite this, many negative experiences were described. A key issue that emerged was **difficulties accessing mental health services** due to **long waiting lists**, leaving those suffering from mental health problems without support.

- This is consistent with findings from the National LGBT Survey which found three quarters of trans respondents did not find it easy to access mental health services (Government Equalities Office, 2018).

> “In 2022 I'm being told to jump through 5000 hoops that will take about 5 years before being allowed CBT. […] I gave up, I now just struggle every day and have stopped going outside/living […]”

Participants also commented that psychotherapies available were often limited to cognitive behavioural therapy (CBT), with **little provision of trauma-informed talking therapies**.

> “I have had CBT multiple times, which does not work for me and is unhelpful. I need longer-term therapy to work through trauma, which I cannot get.”

Instances of **misgendering and/or discrimination** were also described when accessing mental health services.

- This is also reflected in existing literature: McNeil *et al.*. (2012) found that when accessing inpatient mental health care, TGD individuals report harassment, misgendering and uncertainty about placement within single sex facilities. Similarly, findings from a study performed in Scotland found 46% of trans people reported expecting to be discriminated against by mental health services (Hudson-Sharp and Metcalf, 2016).

> “I have had several private therapists and the one I disclosed my gender identity and pronouns to didn't do a good job of getting them right.”

Experiences around transition

During the past 12 months, **54% (70/130) of respondents had been open to all their friends about their gender identity**, 50% (65/130) had been open to all their partners and 36% (47/130) were open to all family members. Only 21% (27/130) had been open to all their colleagues, 13% (17/130) to all their neighbours and 8% (11/130) to all fellow students.

- This relates to findings from the National LGBT Survey which found 67% of trans respondents and 76% of non-binary respondents reported they avoided being open about their gender identity due to concern about receiving a negative reaction (Government Equalities Office, 2018).

Respondents were asked what information they had on how to access support with their transition in Lancashire. 32 of the 79 responses received for this question included examples of where to find such information: most mentioned **Lancashire LGBT**. Other sources of support listed are as follows:

- Gender Identity Clinics (both NHS and private services such as GenderGP)
- Gender outreach workers and gender outreach services (e.g. Blackpool gender outreach)
- General practitioners
- Local support groups (such as Trans-Masc provided by Lancashire LGBT)
- Health and wellbeing services (Horizon LGBTQ+)
- Community projects or collectives (Queer by Gum, Queer boots).
- Online sources of support: TransActual; UK Transgender Association; Stonewall and Brook
- Speaking to friends and family

The remaining responses did not identify any sources of support, with many stating they had limited information on this.

> *"*I'm not currently seeking transition, but have little to no idea what services are out there if it was something I wanted to look into.*"*

Respondents were also asked what sources of information/resources would be helpful. Many participants valued **in-person support groups**. Some participants also preferred online spaces such as **virtual support groups or online chat groups** or **message boards**. The following resources were also felt to be useful: **websites; helplines** (including crisis lines); **email support; live chats; videos**.

Peer support was also valued, including a **buddy system** and conversations with or written information from those with **lived experiences of transition**.

Amongst some of the content that was felt to be useful, participants felt information on the following would be helpful: how to **liaise with GPs**; how to obtain **referrals for medical support**; **location specific resources** and **harm reduction information** on buying hormones from the internet.

Gender identity services

34% (44/130) of respondents were on a waiting list for specialist GIS in the UK, and 6% (8/130) had tried to access these services but were unsuccessful. 31% (40/130) of

respondents had accessed UK GIS, 28% (36/130) had not tried and 2% (2/130) skipped the question.

The services that were most frequently accessed or attempted to be accessed were **public (83%, 76/92) or private (49%, 45/92).**

Participants were asked to suggest services which would have been useful while trying to access GIS or while on a waiting list. The responses are summarised below:

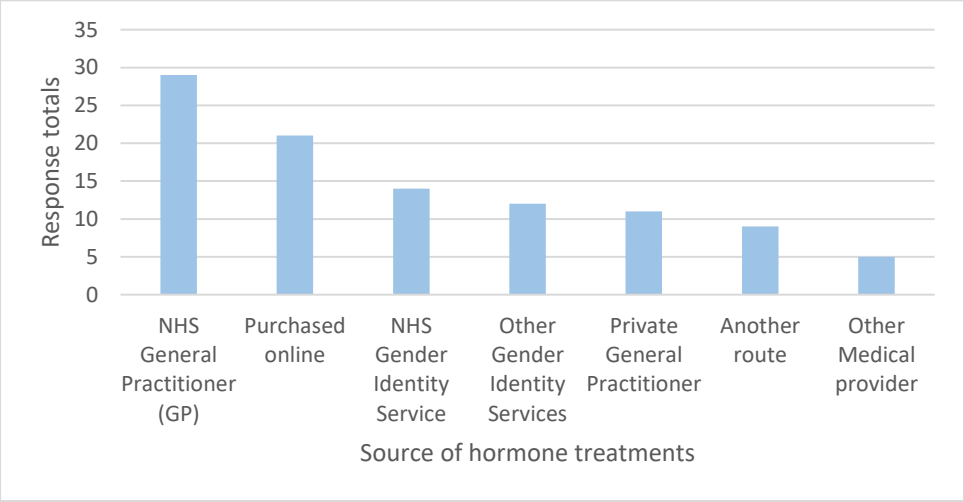
- **Information on clinics available** including how to access these and waiting times
- **Updates on waiting times**
- Information and help on **social transition** (e.g. voice workshops, clothing swaps)
- **Mental health support**
- Information on **how to access private care**
- **Gender outreach workers**
- **Support groups** including peer support
- **Local trans groups or organisations** (e.g. Lancashire LGBT, Horizon Blackpool, Chrysalis Transsexual Support Groups, Queer By Gum)
- **Online forums** or communities

The request for mental health support relates to qualitative research which suggests long waiting times may be associated with symptoms of anxiety and depression (Leven, 2022).

Medical interventions

45% (59/130) of respondents were taking hormone treatments at the time of the survey. Hormone treatments were most frequently obtained via **NHS GPs** (22%, 29/130) or **purchased online** (16%, 21/130), as demonstrated in Figure 13.

Figure 13. Response totals to the question: "Where did you get your hormone treatments from? Tick all that apply."



Participants were asked about any local sources of support they received or any other support which might have been useful around accessing hormones, safe injecting practices or other issues relating to hormone treatment. The responses are summarised as follows.

Support received

- **Support groups**
- Groups and societies at **Lancaster University**
- **Needle exchange** programmes
- **NHS Gender Identity Service**
- **NHS blood monitoring**
- Support from **GPs and health providers**
- Online **video** on self-injection
- **Charities**: Brook; Lancashire LGBT; The LGBT Foundation; Trans Lancashire
- NHS Lancashire and South Cumbria Integrated Care Board
- Advice from **friends**
- Information from a clinic based in the **United States**

Support wished for

- **Peer support**
- **Safe injection practices**
- Harm reduction **information around unregulated online hormone** treatments
- Information on **target hormone levels and dose adjustments**
- Improved **funding** in public healthcare
- Further **support from trans-informed healthcare providers**
- **Trans-specific groups** focusing on hormone treatments
- **UK-specific online resources**
- Written information for **patients and GPs on trans healthcare** including NHS guidelines and dosing of hormone treatments
- Support on **hormone patches** (including placement and issues with them falling off)

Gender affirming surgery

30% (38/130) of respondents had at least one gender affirming procedures, whilst 44% (57/130) had not, but wished for this in the future.

33 responses were received when asked about local aftercare received after gender affirming surgery and other sources of support which might have been useful.

- 6 participants described travelling abroad for their surgery
- **12 respondents described not receiving any aftercare at all**, 3 of which mentioned this was due to undergoing surgery abroad
- Comments on aftercare received and wished for are summarised below:

Aftercare received

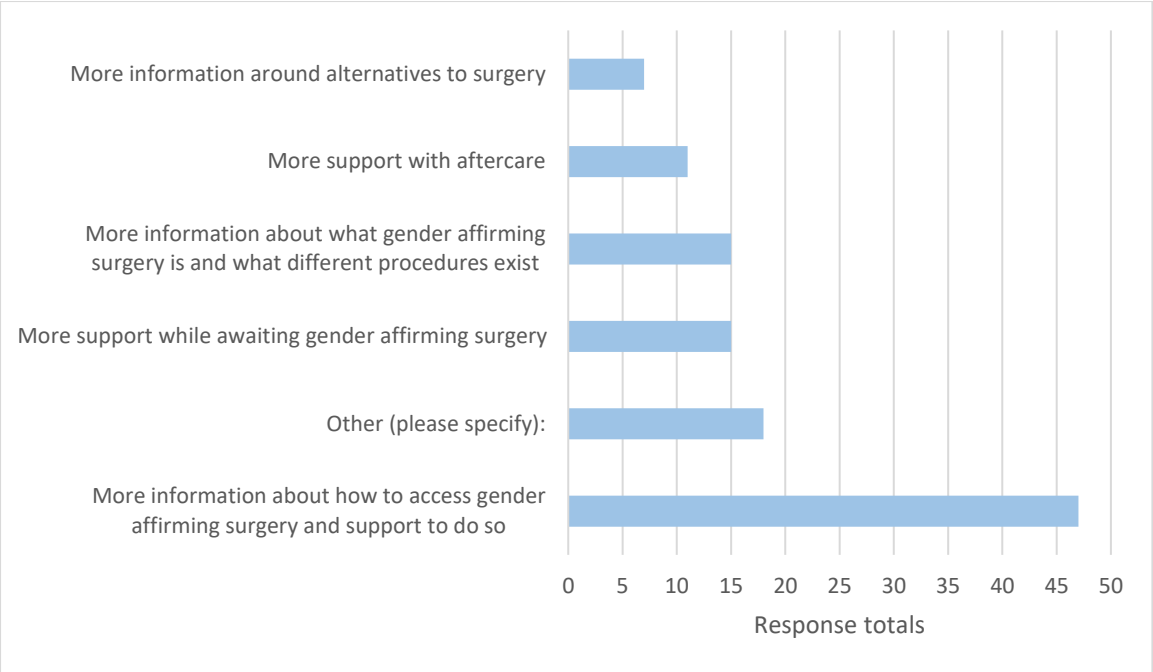
- Support from **district nurses**
- **Wound care**
- Local **community nursing services** to change dressing
- **Analgesia from GP**
- **Support from surgeon** – private care

Aftercare support wished for

- **Peer support groups**
- Local **post-operative checkups**
- **Trans-informed physical therapist** for wound care and rehabilitation
- Regular **mental health check-ins**
- **Online resources and forums**
- **Practical support for those living alone** (e.g. peer support for post-operative checks and to reduce loneliness during recovery)

Respondents were asked where they would like more support around accessing gender affirming surgery. Most participants felt more support was needed – in particular, provision of **more information and support on how to access surgery** (*Figure 14*).

Figure 14. 'Where might you have liked more support around accessing gender affirming surgery?'



Most of those that selected 'other' felt that support across all these areas (n=7) or multiple (n=4) is required.

Other than specialist GIS, participants were asked if they used any other services to explore their gender identity or support their transition. 74 responses were received. 29 respondents stated **no other services had been used**. Services mentioned in the remaining 45 responses are detailed below:

Other services used to explore gender identity or support with transition

- **Talking therapies**
  - Psychosexual therapy (accessed through *SHARE* or *Brook*)
  - Counselling (*Understanding Autism North West counselling services; Horizon LGBTQ+ counselling;* private counselling)
  - Eye Movement Desensitisation and Reprocessing
  - CBT
  - One-to-one therapy (accessed through the *LGBT Foundation*)
- **Community mental health teams** (e.g. *Strand Road's mental health services*)
- **Local community groups**/organisations/charities e.g. *Lancashire LGBT*
- **Holistic wellness services**: meditation; reiki and somatic healing
- **Primary care** - GPs
- **Sexual health support services**
- **Online support**
  - Online services/forums/support groups
  - Informational resources e.g. *Nonbinary Wiki*, *YouTube* videos
- ***Trust House Lancashire***
- **Support groups**
- **Support from friends and the trans community**

When asked about desired additional services, 52 free-text responses were received, which are summarised below.

Other services wished for

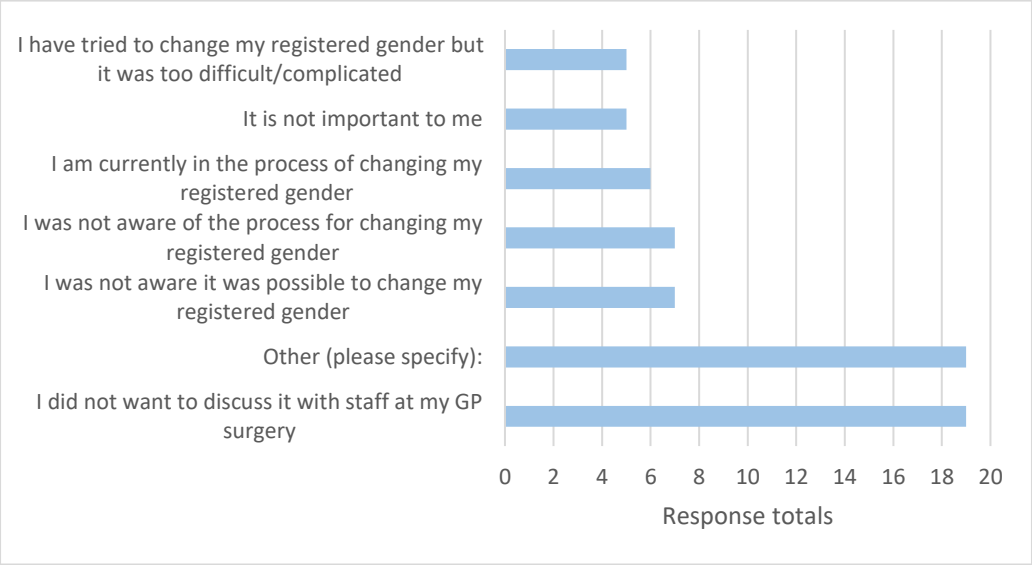
- **Talking therapies**
  - Counselling, including trans-informed and with a focus on relationships/family dynamics
  - Psychosexual therapy
- **Local support groups**, including opportunities to meet other TGD people
- **Peer support**
- **Practical advice** such as how to navigate the NHS or advice post transition (e.g. how to get a new driving licence and how to change name)
- Support with **social transition:** voice training, support with make-up and hairstyles
- **Physical health support** including trans-friendly fitness classes
- Discussion with a **healthcare professional**
- **Online support** including forums and communities
- **Legal services**
- **Financial advice**
- Advice on **sharing gender identity** with others
- A **care co-ordinator service**
- **Wellbeing services** e.g. mindfulness or art therapy
- **Holistic therapies** e.g. acupuncture or massage
- **Sexual health services** (trans-informed)
- **Nutrition counselling**

General practice

- Most participants were registered with an NHS GP (91%), 4% were registered with a private GP and 5% either did not know if they were registered with a GP or skipped the question.
- **42% (55/130) of participants were not registered with their GP with the same gender as their gender identity**. Participants were asked why this might be the case (*Figure 15*):
    - Most felt they **did not want to discuss this with staff at their GP surgery** or selected 'other' for this question
    - Amongst those that selected 'other', reasons for having a registered gender identity with their GP being different to their gender identity included:

        - **No options for their gender identity were available** (e.g. not being able to register as non-binary)
        - Gender identity **not being amended as requested**
        - **Fear of receiving worse care** as a result of their gender identity
        - Being **denied permission** to change registered gender (including requiring a deed poll)
        - Concerns **NHS number will change or current healthcare referrals** or processes will be affected
        - Being **unaware** that changing registered gender is permitted or of how to do this

Figure 15. "Why might the gender with which you are registered with your GP (General Practitioner) not be the same as your gender identity?", n = 68 responses



Over the past 12 months, 82% of participants had accessed or tried to access the GP practice. On average, study participants rated ease of access to their GP practice over the past 12 months **3.3 out of 5** with 1 being "very hard" and 5 being "very easy".

When asked why accessing primary care services were difficult over the past 12 months come at the most commonly selected answer choices were:

- having to **wait too long to access the services** (33 responses)
- **not being able to go at a convenient time** (26 responses)
- **feeling worried anxious or embarrassed** about going (22 responses)

Almost half the study population rated the GP practise they used in the past 12 months as completely positive or mainly positive (48%, 63/130). Although comparisons with external data sources are limited, these rates appear to be lower than national averages: the 2023 GP Patient Survey found 71.3% of patients rated their overall experience with their GP practice as good (36.8% rated their experience as 'very good' and 34.5% rated this as 'fairly good') (NHS England, 2023).

Participants were asked if there was anything else they would like to mention about encounters with their GP. 54 responses were received. 23 participants **described positive experiences, particularly with care received from their GP**, as demonstrated by the following quotations:

"When I went to my GP about my gender they were very open and listen to everything I had to say and all questions where respectful. They referred me to a GIC that appointment and explained to me waiting times and why I was referred where I was"
"My GP has always been respectful and helpful in relation to my transition"
"The GP practice I am with (a practice in Preston) is very helpful regarding gender. They are willing to provide shared gender care with the private gender care I get and are happy to perform regular blood tests to monitor my hormone treatment. The reception staff always sort this out and give me the blood forms without the need to speak to a GP"
"Nothing but excellent experience"
"The staff have been fantastic at my GP"
"My GP has been outstanding"
"GP has always been very understanding and supportive"

However, some difficulties with staff in general practice were also described, as demonstrated by the following quotes:

> “The clinical staff are usually fine and understanding and supportive, the reception staff are sometimes rude and question my identity”

> “The only issue I have had was with the misgendering by a nurse following a cervical screening”

> “One of the doctors still keeps misgendering me”

> “My GP have been very accommodating with my transitioning offering shared care and looking after me. If anything it would be nice if they knew more about transitioning and could offer me advice or help, but they rely on myself or my private Gender doctor to know things already to help”

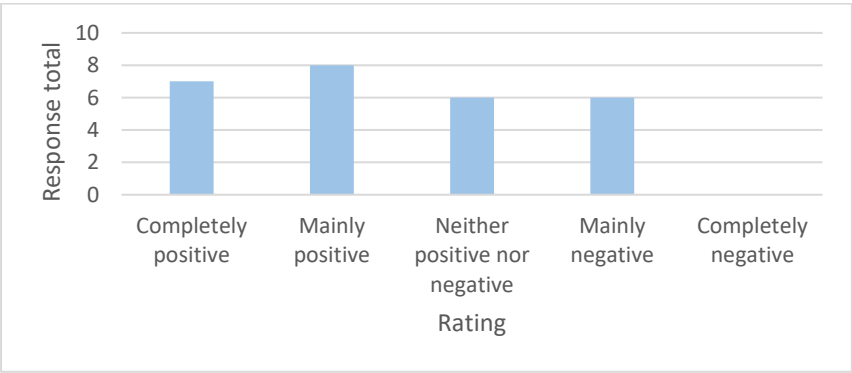
Participants also described issues in primary care at a higher level, including: **limited availability of appointments**; difficulties **finding practices which offer shared care agreements with private providers** and **limited GP continuity**.

> “The staff have been fantastic at my GP. The problems have been entirely caused by practice policies and NHS policies. For the most part they have been personally supportive but had their hands totally tied in what they are willing to offer”

Hospital inpatient services

Overall experiences of hospital inpatient services over the past 12 months were mixed (*Figure 16*).

Figure 16. “Overall, how would you rate the hospital inpatient services you used in the past 12 months?” (total responses received = 27)



- Participants were asked if they had accessed or tried to access hospital inpatient services over the past 12 months.
    - 21% (27/130) had, 8% (11/130) did not try because they thought they would be unsuccessful and 3% (4/130) tried but were not successful.

- On average, ease of access to hospital inpatient services over the past 12 months was rated **3.2 out of 5** with 1 being "very hard" and 5 being "very easy".

- When asked why accessing hospital inpatient services was difficult over the past 12 months the most commonly selected answer choices were: having to **wait too long to access the services** (7 responses) and **feeling worried anxious or embarrassed** about going (7 responses).

Participants were asked if there was anything else they wanted to mention about their experiences with hospital inpatient services – 23 responses were received. Some positive experiences were described, including being proactive in checking pronouns, inclusivity and friendliness as demonstrated by the following quote:

> "Only been an impatient once for gall bladder surgery and it was a very positive experience, the nurse distracted me from my gender concerns by making me talk about my tattoos. Very nice man."

15 negative experiences were described – this included**: long waiting times; inappropriate curiosity; discrimination; assuming pronouns; lack of cultural competence and sensitivity from staff; poor management of mental health** and being **assigned gender-based wards which did not align with their gender identity**.

- This latter concern is reflected in existing evidence which suggests trans people are often placed in inappropriate wards: this may deter seeking help in secondary care settings (Mitchel and Howarth, 2009).

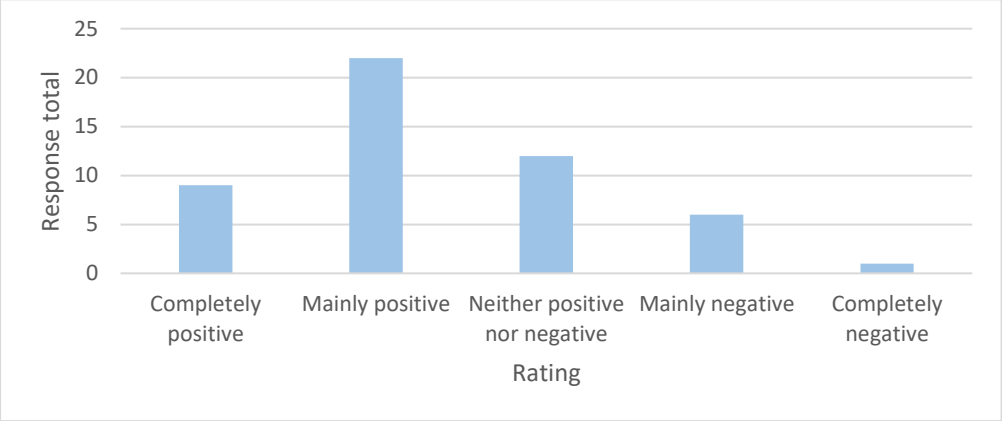
An example of discrimination experienced as an inpatient is demonstrated by the following quotation:

> "Had very negative experience due to gender following stroke […], nurses made it very clear they didn't think I belonged on the men's ward, spoke loudly about breasts and genitals, presumably in attempt to out me"

Hospital outpatient services

Overall experiences of hospital outpatient services over the past 12 months were mostly positive (Figure 17).

Figure 17. "Overall, how would you rate the hospital outpatient services you used in the past 12 months?" (total responses received = 50)



- Participants were asked if they had accessed or tried to access hospital outpatient services over the past 12 months.
    - 38% (50/130) had, 5% (6/130) did not try because they thought they would be unsuccessful and 3% (4/130) tried but were not successful. 46% (60/130) had not accessed these services.

- On average, ease of access to hospital outpatient services over the past 12 months was rated **3.1 out of 5** with 1 being "very hard" and 5 being "very easy".

- When asked why accessing hospital outpatient services was difficult over the past 12 months, the most frequent answer choices were:
    - Having to **wait too long to access the services** (16 responses)
    - **Feeling worried, anxious or embarrassed** about going (12 responses)
    - Their GP not being supportive (7 responses)
    - Not being able to go at a convenient time (7 responses)

Participants were asked if there was anything else they wanted to mention about their experiences with hospital outpatient services. Both positive and negative experiences were described. Positive experiences included good communication and support.

> "[…] my experience was really wonderful and felt very supported by staff"

> "[Gynaecology] asked my about my gender and ways to make me more comfortable […]"

Negative experiences included **long waiting times; being misgendered** and **limited cultural competence** around gender diversity.

Sexual health services

- Participants were asked if they had accessed or tried to access sexual health services over the past 12 months

    - 25% (33/130) had, 4% (5/130) tried but were not successful and 4% (5/130) did not try because they thought they would be unsuccessful.
    - *59% (77/130) had not accessed these services.*

- Sexual health services appeared to be relatively accessible to the study population:
    - **Ease of access was rated as 4.15 over the past 12 months**, with 1 being "very hard" and 5 being "very easy"
    - **Most experiences of sexual health services over the past 12 months were either completely positive (12%, 15/130) or mainly positive (11%, 14/130).**
        - The remaining respondents either rated their experiences as neither positive or negative (2%, 2/130) or mainly negative (1%, 1/130) or skipped the question (75%, 98/130))
        - Comparisons with external datasets are limited – in particular due to the low response rates for this survey question. However, this contrasts with findings from the National LGBT Survey which reported 7% of trans respondents rated their experience of sexual health services as wholly or mainly negative, compared with 4% of cisgender respondents (Government Equalities Office, 2018).

- **A majority of respondents (55%, 71/130) had never had a HIV test** whilst 38% (50/130) had.
    - However, **85% (111/130) stated they had not had any difficulties getting a HIV test**.
    - One participant did have difficulties with this, commenting in the free text that there were no testing facilities available to them which they could trust.

- 16% (21/130) of respondents had ever been diagnosed with a sexually transmitted infection.

Participants were asked if there was anything else they would like to mention about their experiences with sexual health services. Many positive experiences were described, including around **support and inclusivity**.

> “I had a very good experience accessing sexual health services - they were very inclusive”

> “Every time I've gone it's been great. […]”

> “My local GUM clinic are really nice and understanding, nothing but praise for them”

> “The sexual health clinic is very respectful of my gender identity. Of all the healthcare services I have accessed in Lancaster, it is the one where I feel most safe as a transgender person”

> “Very respectful of language as I'm transgender. Do their best to be supportive and assist in every way they can”

Difficult experiences were also described, such as:

- **Issues accessing sexual health services**, including:
  - inconvenient operating hours
  - lack of information on trans-friendly sexual health services
  - difficulties accessing the HPV vaccine due to their assigned sex
- Receiving advice which was **not relevant to their gender identity and or sexuality**
- Limited support around **family planning**
- Experiencing **discrimination from healthcare staff**

Screening

Cervical screening

- **10% of respondents (13/130) did not feel they had received the appropriate invitation to cervical cancer screening,** 31% of respondents (40/130) believed they had
- 29 participants took up their invitation to cervical cancer screening whilst 12 participants did not
  - A recent study suggested trans masculine and non-binary people invited for cervical screening may have higher rates of non-attendance than LGB women (Leven, 2022)

Participants were asked a free-text question on whether there was anything else they wanted to comment on regarding cervical cancer screening. 36 responses were received. Positive experiences were described by some participants as demonstrated by the following quotations:

> “The appointments themselves went very well with very respectful and decent clinicians“

> “ […] my last one was a good experience […]“

Negative experiences described included: **experiencing gender dysphoria**; being **misgendered**; being **assumed to be in a heterosexual relationship**; being **deadnamed** during correspondence; experiencing **discrimination and gendered language** used.

Barriers to attending cervical screening described included: **not receiving an invitation** to screening; **mental health difficulties; gender dysphoria; history of sexual assault**; prior **adverse experiences** with healthcare and feeling that staff at General Practice are **not understanding or inclusive.**

Suggestions for improvement in cervical screening services included:

- Resources for cervical screening **tailored to TGD people** and those with **history of sexual trauma**
- Offering **smaller sized speculums**
- **Home testing kits**
- More **support and empathy around the pain and discomfort** experienced

Breast cancer screening

- **11% of respondents (14/130) believed they had not received the appropriate invitation to breast cancer screening**, 12% of respondents (15/130) believed they had

- 10 respondents took up their invitation to breast cancer screening whilst 5 did not

When asked whether there was anything else they wanted to comment on regarding this screening programme, a positive experience was described by one respondent:

> "I felt treated with respect and compassion"

However, some participants commented they **had not received an invite to breast cancer screening despite being eligible**.

Suggestions for improvement in breast screening services included:

- Open access breast screening
- Provision of support groups

Abdominal aortic aneurysm screening

- 5% of respondents (6/130) believed they had received the appropriate invitation to Abdominal Aortic Aneurysm (AAA) screening whilst a higher **proportion (11%, 14/130) believed they had not**.
    - This finding should be considered in the context of the age distribution of study participants: a minority were eligible for AAA screening based on age alone (5/130 were 65 years and older, and 11/130 were aged 55-64)
- When asked whether there was anything else they wanted to comment on regarding this screening programme, some participants stated they were **not aware of AAA screening or did not know whether it applies to trans females.**

General experiences of NHS screening programmes

Although some positive experiences were described, participants commented that the binary nature of recording gender in NHS systems is limited and can exclude trans and gender diverse individuals from screening programmes, as demonstrated by the following quotation.

> "I need breast and prostate screening, because I'm a trans woman. […] But I understand the NHS system can only record binary sex, so either way there is at least one screening I will need and probably not get invited to. I wish I could mark my sex as 'trans' or 'both' because it is a spectrum and I have multiple needs."

This is reflected in research performed by Mitchell and Howarth (2009) which suggests TGD people may be less likely to be offered the appropriate screening (e.g. prostate screening for trans women or breast cancer screening for trans men).

Participants recommended areas for improvement in NHS screening services – these are summarised below.

Suggestions for improvement in NHS screening services included:

- **Raising awareness** of screening programmes to increase rates of participation
- **Improving accessibility and inclusivity** of screening services
- **'Body part based' rather than 'birth sex based' screening**
- Improved **documentation of sex affirming surgeries on primary care systems**
- **Psychological and emotional support** with screening: including for gender dysphoria or anxiety
- **Opportunities for at-home cervical cancer screening** tests

Addiction services

- Over the past 12 months, 3% of participants (4/130) had accessed addiction services, 3% (4/130) tried to access them but were unsuccessful and 1% (1/130) didn't try because they thought they would be unsuccessful.
- Experiences of addiction services over the past 12 months were rated either mainly positive (3/130) or completely positive (1/130). (126 participants skipped this question).

Accessing any other public services at any time

Participants were invited to share any additional comments about their experiences accessing other public services at any time. 16 participants responded, highlighting the following issues:

- **Limited cultural competence** for TGD people

- **Insufficient options for recording gender identity** (including lack of gender-neutral title options)
- Difficulty **accessing disability benefits** or council housing
- Difficulty **receiving support from the police**

One participant highlighted the need for a collaborative approach to addressing issues in public services experienced by TGD people.

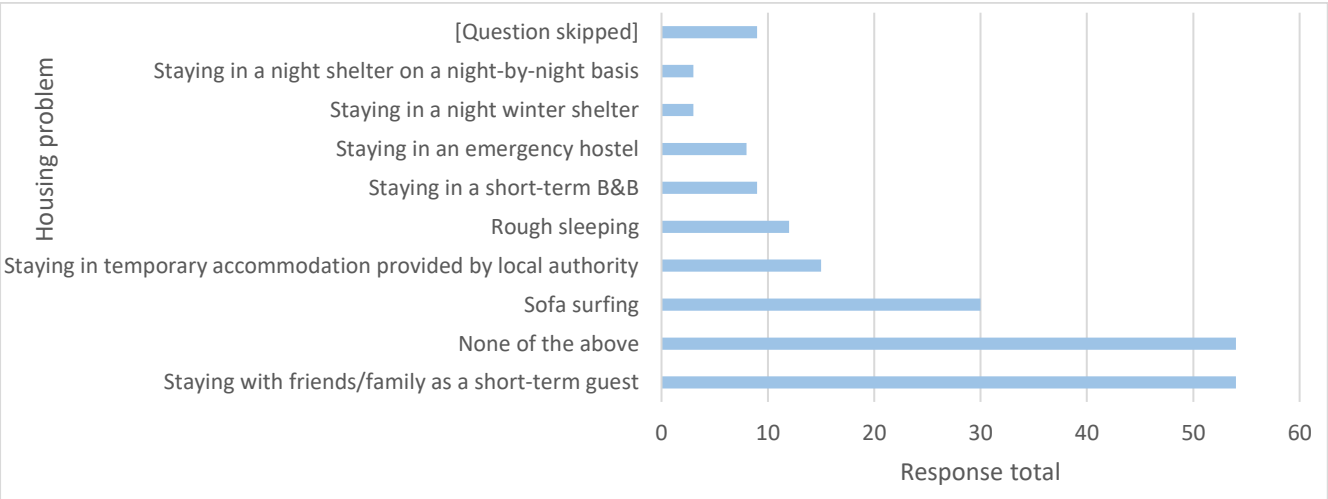
> "Speak to us like the "normal" people we are and you'll see - stop believing the media and stop relying on non-trans people to deliver training etc on trans issues. Ask us to do it for / with you and watch what magic happens!"

5.4 Wider determinants of health

Housing arrangements

- **52% of participants (67/130) had experienced issues with housing in the past** (*Figure 18).*
    - Although research around experiences of housing amongst TGD people is limited, this finding is in keeping with existing literature which highlights that TGD people face difficulty accessing housing services (Hudson-Sharp and Metcalf, 2016).
    - This figure also exceeds national figures: in 2018, 9% of UK adults in private households had experienced housing difficulties in the past (Office for National Statistics, 2020)

Figure 18. "Have you ever experienced one of these housing problems? Tick all that apply."



- Whilst most participants did not report any current housing problems (92%, 119/130), some reported current (5%, 6/130) or urgent (1%, 1/130) issues. However,

these figures may underrepresent true rates of housing difficulties: individuals with housing needs might also have limited internet access, preventing them from participating in the online survey.

Additional issues which emerged from the open-ended questions on housing included:

- Being **denied accommodation** because of their **gender identity**
    - This reflects existing evidence from a survey performed in 2017 which found 25% of trans people reported experiencing discrimination when looking for housing over the previous year (Backmann and Gooch, 2017).

> "I've historically been refused emergency housing due to my identity"

- **Concerns over safety**

> "I would feel fearful if I had to go into shared accommodation, because of my gender identity. I would worry that people wouldn't accept me or may hurt me"

- **Having to leave the home due to family members or partners.**
    - This is in keeping with research by Mitchell and Howarth (2009) which found trans people are at increased risk of homelessness due to exclusion by family and neighbours.

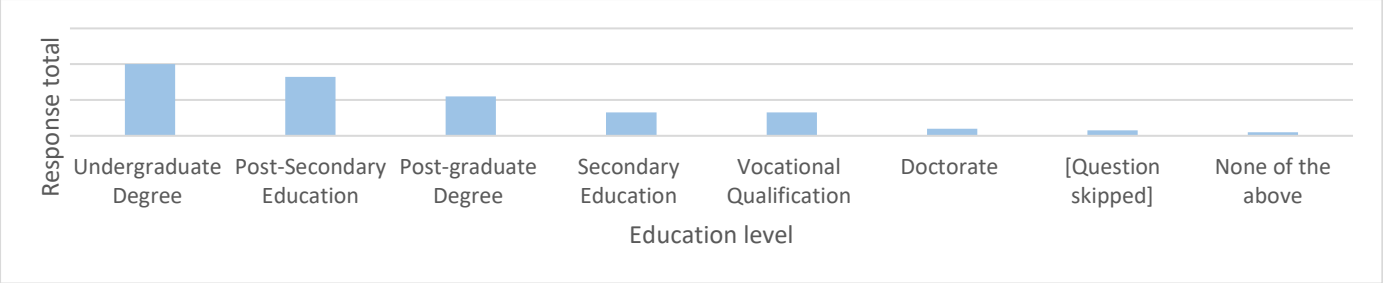
> "I was kicked out by my parents in *** at 19 and again at 20 *** for a few months, I had to travel to [place] to sofa surf with friends"

- **High rental costs, difficulties paying rent** and **poor quality** of available housing
    - This relates to research performed by Mitchell and Howarth (2009) which suggests TGD people might be more likely to live in privately rented housing (Mitchell and Howarth, 2009).

Education and employment

Most respondents held an undergraduate degree (31%, 40/130) or were post-secondary education (10%, 13/130), as demonstrated by Figure 19.

Figure 19. Furthest level of education completed

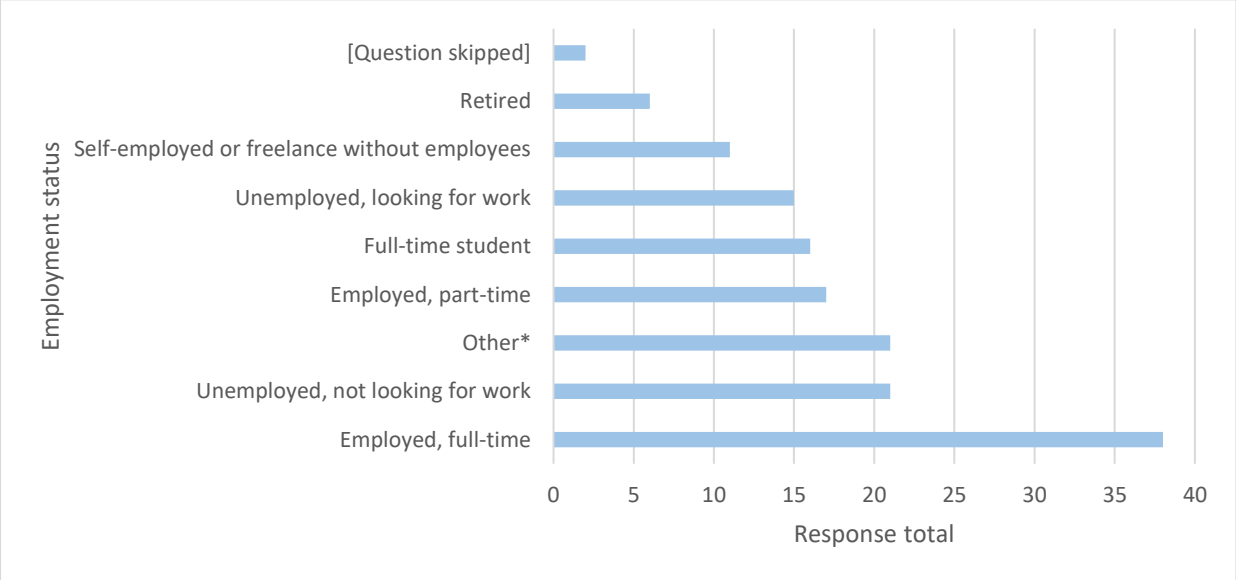


- 51% of participants (66/130) were in either full-time or part-time employment or were self-employed/freelance *(Figure 20)*
    - These rates are lower than findings from the National LGBT Survey which found 63% of TGD respondents were in paid employment in the preceding 12 months (compared with 83% of cisgender respondents) (Government Equalities Office, 2018).

- 12% (15/130) of survey respondents were unemployed and looking for work and 16% (21/130) were unemployed and not looking for work *(Figure 20)*

- During previous or current jobs, most participants worked for a private company (49/130) or a public sector body outside of the NHS (29/130)

Figure 20. Current employment status, n=130 responses



** The most common free text answers amongst those that selected 'other' included being a student or part time student (n=6) or being unable to work due to a disability or medical condition (n=5).*

Safety, job opportunities and unfair dismissal

- **35% of respondents (46/130) did not feel safe and supported by their employer** in their current or previous job

- **25% of respondents (33/130) believed they had been turned down for a job** due to their **trans status or identity**
- **9% of respondents (12/130) had been fired, constructively dismissed or laid off** from a job because of their **trans status or gender identity**

> "It came as a shock when I was laid off for no reason after pressing to know why it was said that my gender doesn't […] portray the company well."

    - These issues are mirrored in a UK survey performed in 2012 which found 35% of TGD people suspected they had been denied a job as a result of being trans (McNeil *et al.*., 2012). Similarly, a survey performed in Scotland in 2019 found 40% of respondents believed their gender identity had a negative impact on their job prospects (Fearnley, 2021).

Experiences of work and employment

Positive experiences at work were described, such as: support from colleagues and employers; encouraging use of pronouns and preferred names and offering new email addresses.

> "I've been quite well supported and accepted during my transition. We support using pronouns, preferred names and supply new emails."

> "In my work within the public sector, I was supported from the moment I disclosed being trans. My employer, HR and direct management have always championed inclusivity and allowed the process of changing my name and gender in the workplace to be [led] by me. Any issues encountered in the workplace were with a minority of individuals, such as invasive questioning or purposeful misgendering. These were dealt with quickly."

However, others described experiencing hostility in the workplace, including: **misgendering; invasive questioning about their gender identity; being denied use of toilets** they felt comfortable using or even being **denied promotions or dismissed** due their gender identity.

Some participants were fearful of applying for new jobs, and lack of visible support for TGD people could contribute to this.

> "I am often scared to apply to jobs as I fear I might be judged for my gender identity. It is difficult to know if employers are trans inclusive, and if I should tell them my legal or preferred name and pronouns. Trans inclusivity needs to be more explicit."

Suggested ways employers could be more inclusive

Participants were asked how employers could be more inclusive of the trans and gender diverse community as an open-ended question. 71 responses were received, including a number of suggestions which are summarised below.

- **Improved equality and diversity training*:*** run by TGD people.

> "One of the key things would be compassionate and accurate training on trans and non-binary people, led by trans and non-binary people, across the various services"

- **Championing diversity:** as well as educating the existing workforce on quality and diversity, ensuring greater representation of TGD employees in the workplace was wished for.

> "They should also actively recruit and support gender diverse talent, celebrating LGBTQ+ events and awareness days."

- **Proactivity around preferred pronouns -** suggested measures included:
  - use of pronoun badges
  - distributing reminders to employees to use correct pronouns
  - including pronoun options into human resources systems (e.g. payroll)
  - including mandatory as opposed to voluntary pronouns into communications

  It was also highlighted that care should be taken not to out trans people who are still known by others as cisgender.

- **Gender neutral spaces** (e.g. toilets) and **dress codes**

> "Have accessible/unisex toilets as solely having male/female excludes nonbinary people + demeans/erases their identity, and support trans people in using the toilets that align with their gender identity."

- **Protection from harassment and discrimination** from transphobic behaviour and ensuring there is a zero-tolerance policy for discrimination was called for by many participants.

> “[…] actual consequences for transphobia. In [the] past, [it] has been treated as [a] simple difference of opinion with me as the aggressor if I make any attempt to address it.”

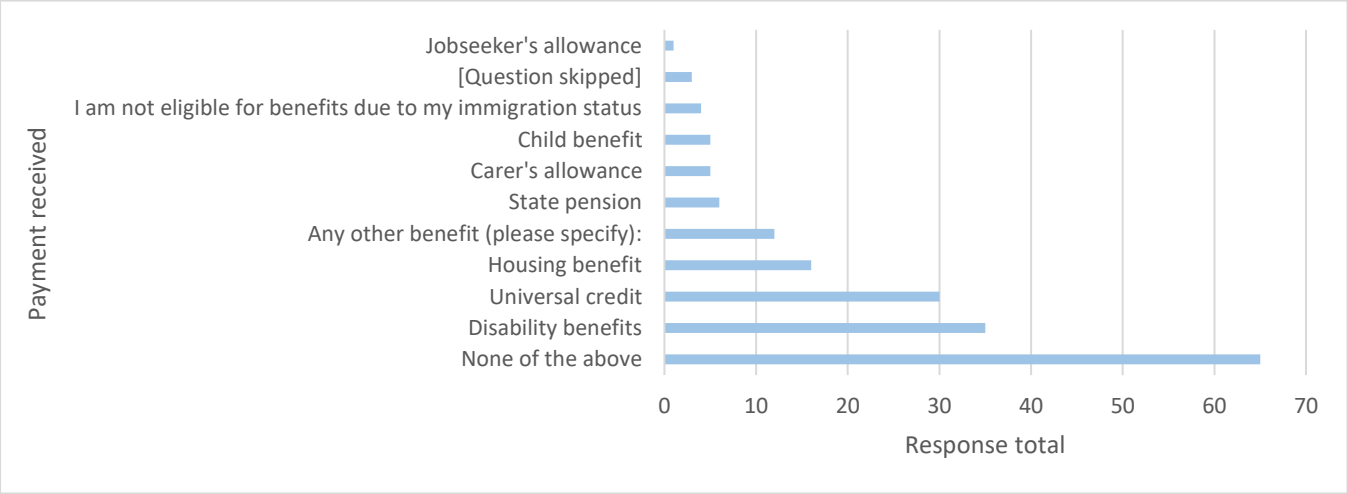
- One participant wished for workplaces to better understand the impacts of hostile political climates on affected communities and their health.

> “To understand the effects of the political hate from society […] and threat of removal of rights and how this can affect anxiety and depression”

Finances, food security and internet access

- **32% of respondents (41/130) were concerned about their level of debt**, with 24% (31/130) having accessed support or advice to deal with these
- 50% of respondents (65/130) had not received welfare benefits in the last 12 months and their eligibility was not affected by their immigration status (*Figure 21)*
- This leaves a significant proportion of the survey respondents who had received social security payments
    - Disability benefits (35/130) or universal credit (30/130) were the most frequently received payments (*Figure 21)*
- These findings reflect current evidence that TGD people may be more likely to be faced with financial difficulties (Mitchell and Howarth, 2009).

Figure 21. “In the last 12 months, have you received any of the following? Please tick all that apply”



- In terms of food security:
    - **Less than half of study respondents (46%) had enough of the kinds of food they wanted to eat in their household** over the preceding 12 months.
    - 34% had enough to eat, but not always the kinds of food they wanted

- 15% sometimes didn't have enough to eat
- 4% often did not have enough to eat.
    - This corresponds with findings from a study in Scotland, which found TGD people were more likely to face financial worries or experience food insecurity than LGB people (Leven, 2022).

> "[…] access to good healthy food is an issue and I need to do sex work in order to pay for good quality food."

- Most respondents had internet access (96%) whilst a small percentage either did not (3%) or skipped the question (1%).

Leisure and fitness facilities

- Some positive experiences in relation to exercise facilities were described.

> "Our local leisure centre has a non-binary 'changing village' which is brilliant!"

- However, the average confidence rating for accessing public leisure and fitness facilities or engaging in organised sports or fitness activities was relatively low, at **2 out of 5** (from a scale of 1 to 5, with 1 being not confident and 5 very confident).
    - This reflects findings from the Trans Mental Health survey which found half of respondents avoided using public toilets or attending gyms, and a quarter avoided other leisure facilities, social groups or clubs (McNeil *et al.*., 2012)

- The following quotation highlights some of the difficulties experienced when accessing leisure and fitness facilities.

> "I just don't feel that this is a thing for most mature trans, or outwardly non binary people, there is a stigma that we have to live with, and work around, it's hard enough some days without putting ourselves in the firing line."

Participants were asked: "What could increase your confidence in accessing leisure and fitness facilities, or participating in organised sports or fitness activities?". 65 responses were received, including the following suggestions:

- **Gender neutral changing rooms**
- **Inclusive** and welcoming environments
- **Non-gendered** sports
- Greater provision of **information on LGBTQ+ friendly facilities**
- TGD or queer **member groups or specific gyms**
- TGD **swimming and exercise classes**

- **Peer support**
- Allowing **swim shirts/rash vests in pools**
- Support around **makeup and clothing** (including gym and swimwear)
- A '**what to expect' guide for neurodivergent people**

Supporting others

- 7% of respondents (9/130) were parents or guardians of a child under the age of 18
- 18% of respondents (23/130) provided unpaid care to others

Discrimination and Harassment

- **Most respondents had experienced discrimination or harassment** at home (62%, 81/130), at work (63%, 82/130), at school/college/university (62%, 81/130) or in a public place (68%, 89/130) over the previous 12 months.
    - This is consistent with existing evidence which suggests TGD people experience increased levels of discrimination and harassment. A survey in 2017 across England, Scotland and Wales found 41% of trans people had experienced a hate crime or incident in the previous 12 months and 44% of trans people avoided certain streets because they felt unsafe (Bachmann and Gooch, 2017).

- The most commonly reported incidents were **sexual harassment or violence, physical harassment or violence or threat of physical or sexual harassment or violence**, all in a public places *(Table 3).*

- A number of respondents also reported experiencing abuse at home *(Table 3).*
    - This is consistent with current evidence which indicates increased risk of this: 49% of respondents to the Trans Mental Health survey had experienced some form of abuse during their childhood and 17% had experienced domestic abuse because of their gender identity (McNeil *et al.*., 2012). Similarly, Bachmann and Gooch (2018) found 28% of trans people who were in a relationship in the preceding 12 months had experienced domestic abuse from their partner.

*Table 3. "In the past 12 months, have you experienced any of the following?"**

Answer Choices	**At home**	**At work**	**At school/college/ university**	**In a public place**	***Response Total***
	Total (% of response total)				
Verbal harassment, insults or other hurtful comments	21 (16%)	17 (13%)	15 (12%)	75 (59%)	*128*
Physical harassment or violence	4 (12%)	3 (9%)	4 (12%)	22 (67%)	*33*
Sexual harassment or violence	4 (9.5%)	5 (12%)	3 (7%)	30 (71%)	*42*

Threat of physical or sexual harassment or violence	7 (13%)	4 (8%)	6 (12%)	35 (67%)	*52*
Someone disclosing your gender identity to others without your permission	14 (16%)	23 (26%)	18 (20%)	34 (38%)	*89*
Any other inappropriate comments or conduct not listed above	10 (13%)	14 (18%)	10 (13%)	44 (56%)	*78*
None of the above	42 (26%)	41 (26%)	42 (26%)	34 (21%)	*159*
**123 respondents answered, 7 respondents skipped the question*					

Participants were asked to share anything else about their experiences of discrimination or harassment in relation to their gender identity or trans status. 37 responses were received and are summarised as follows.

- Not all participants had experienced harassment, as highlighted by the quotation below:

> "Don't assume we are all victims!"

- Some participants commented on other forms of harassment or discrimination, such as online abuse.
    - Evidence suggests this is a significant issue amongst TGD people: a recent survey found 99% of trans people reported experiencing transphobia on social media, and 97% in the digital and print media (TransActual, 2021).

- Respondents also described living in fear of abuse

> "I have to wear headphones everywhere I go because people often shout slurs at me - I dress alternative so I stand out, but I've tried to dress down before and it still happens. I am scared every day that someone will attack me because of the rise of transphobia in the UK."

- Some participants also commented on not feeling able to report hate crimes to the police due to concerns about not being taken seriously or experiencing transphobia.
    - This is in keeping with evidence which suggests most hate incidents are not reported to the police (Government Equalities Office, 2018).

> "This wasn't in Lancashire so I'm not sure how relevant this is, when a group of trans people I was with were physically assaulted in Leeds, we were informed by a security guard at a fast food place nearby that the people responsible had been doing this for the last few nights, that the police had been made aware every single night, and that they had done nothing. I've heard similar stories from others on the rare occasions they consider getting the police involved, if not worse (for example, the police deciding we are somehow responsible.) No trans person I know really considers informing the police for that reason. We are, at best, seemingly considered deserving of violence against us."

> "I feel there is no point reporting any violence/harassment against me to the police, because they do not take transphobic attacks seriously and/or the police officer I speak might hold transphobic views and choose not to help me."

- Existing legislation and how this protects the rights of the TGD people was called into question.

> "The Equality Act (2010) doesn't do enough to protect transsexual, transgender, intersex and gender diverse members of society."

5.5 Final thoughts

Participants were asked: "If you could wave a magic wand, what one thing would you wish for that would make your life easier as a trans person/in your preferred/acquired gender?" as an open-ended question. 96 participants responded.

A key issue that emerged was the **politicisation of the rights of TGD people** as well as the impacts of this on wellbeing, as demonstrated by the quotations below.

> "Government are trying to irradiate me and cause me to lose my mind and give me so much anxiety because they want to stop me from being me."

> "For there to be no government agenda to seemingly use our experiences of challenges against us and to create further divisions in society. Value and celebrate all differences, don't use them to divide and conquer like is happening at the moment!"

Many participants wished for **acceptance** along with **safety and freedom from abuse**, with some participants wishing for **safe spaces** for TGD people.

> "To feel safe in society, more acceptance and to feel loved"

Participants wished for **improved access to gender affirming surgery and gender identity clinics**, including reduced waiting times. Improved **support with mental health** was also wanted.

> "Better healthcare, waitlist that were months instead of years, more mental health support and just overall just a better world for transgender people and queer people"

Further wishes included:

- **Equal treatment** without discrimination
- **Social connections** with other TGD people
- Improved **education on equality and diversity across the general public**
- **Acceptance of pronouns**
- **Social and legal recognition of non-binary genders**
- More **support in changing name and gender** legally
- Improved **employment**
- **Improved healthcare**:
    - Improved access to NHS healthcare
    - TGD friendly spaces – including in waiting rooms
- **Protection from harassment** on social media

6.0 Key findings

	Challenges experienced	Wishes/suggestions
Mental health, suicide and self-harm	A majority of participants suffered from a long-term mental health condition (54% of respondents) and most participants (84%) felt their mental health negatively affected their day-to-day life. Rates of deliberate self-harm and suicide are a cause for concern, with 65% of respondents having deliberately harmed or hurt themselves, 73% ever having suicidal thoughts and 43% having attempted suicide in the past. Unmet need with regards to mental health was notable, with 13% of respondents unable to access mental health services over the past 12 months and 10% not trying because they thought they would not be successful. Long waiting times appeared to be the main barrier to accessing these services.	• Improved access to mental health care • Wider provision of talking therapies: trauma-informed, trans-informed, focus on relationships/family dynamics, psychosexual therapy • Timely provision of gender-affirming care • Action to reduce discrimination and transphobia

Access to gender-affirming care	Unmet need around gender affirming care was marked, with 34% of participants on a waiting list for GIS.
	
	Hormone treatments were most frequently obtained via NHS GPs (22% of respondents) or purchased online (16% of respondents).
	
	36% of respondents felt they wanted more information about how to access gender affirming surgery and support to do so.
		• Improved provision of GIS
		• More gender outreach workers
		• Information on:
		  • How to access gender-affirming care
		  • Harm reduction information around unregulated online hormone treatments
		• More support around transition
		  • Support groups around transition: online and in-person
		  • Peer support (including buddy systems)
		  • Support with social transition (e.g. voice training, make-up and hairstyles)

Screening programmes	Issues with accessibility to screening programmes were apparent. 10% of respondents felt they had not received the appropriate invitation to cervical cancer screening and 11% felt they did not receive	• Improved accessibility of screening programmes • 'Body part based' rather than 'birth sex based' screening • Psychological/emotional support: for anxiety, gender

	the appropriate invitation to breast cancer screening.	dysphoria or for those with history of sexual trauma • For cervical screening: home testing kits, offering smaller sized speculums
Documentation of gender in general practice	Though many positive experiences in general practice were described, 42% of participants were not registered with the same gender as their gender identity at their GP surgery. The most common reason for this was not wanting to discuss this with staff. The binary nature of electronic recording systems for gender also presented a barrier and was noted to impact subsequent access to healthcare, such as screening programmes for example.	• Improved documentation of gender and sex affirming surgeries on electronic health records
Discrimination, harassment and cultural competence	Issues with discrimination and harassment were widespread. Most participants had experienced discrimination or harassment at home (62%), work (63%), school/college/university (62%) or in a public place (68%) over the previous year. A quarter of respondents believed they had been turned down for a job due to their trans status or identity. Some respondents also felt they had been denied accommodation because of their gender identity. In terms of healthcare services, instances of discrimination or lack of cultural competence were described: this was most apparent with respect to hospital inpatient services.	• Equality and diversity training led by TGD people for the general public and across all services • 'Signalling': making services more clearly welcoming and inclusive to TGD people • Suggestions for employers: o Championing diversity o Being proactive around pronouns o Provision of gender-neutral spaces o Gender-neutral dress codes o Improved protection form harassment and discrimination
Physical activity	Challenges in accessing physical activity were evident, with low levels of confidence in accessing public leisure and fitness facilities/engaging in organised sports or fitness activities	• Inclusive environments and policies • Provision of information on TGD friendly facilities • TGD-specific gyms, swimming and exercise classes

7.0 Recommendations

- **Building a bigger, safer world for TGD people**
    - Creating a more open, safer world for TGD people
    - This includes 'signalling' (ensuring spaces are visibly welcoming) and committed to improving inclusion for TGD people
        - Encouraging use of 'kite marks' in healthcare settings and larger employers, such as those available from Spectrum Inclusion Rossendale or Lancs LGBT)
    - Asset mapping and promoting awareness of services available to the TGD community (e.g. social prescribing), facilitating a 'no wrong door' approach
    - Link in with local 'one stop shop' buses to include targeted services for TGD people (e.g. mental health and screening)
    - Creating or building on peer support offers
    - Introducing TGD champions in organisations and services for example in general practice and local authorities
- **Celebrating progress and positive stories**
    - Sharing good news stories, including at occasions such as Trans Visibility Day
    - Collating and sharing case studies of good practice for employers or employees
    - Continuing the Lancashire TGD HNA steering group, and widening membership to other organisations
- **Designing in inclusion**
    - Encouraging gender inclusive facilities in both public areas and workspaces
    - Considerations around commissioning/decommissioning:
        - Including TGD competencies in commissioning of mental health services as a condition
        - Consideration of TGD people (e.g. within HIA/EIA), during decommissioning decisions
    - Including TGD competencies in job descriptions for relevant roles e.g. mental health posts
    - Advocating for improved documentation of gender and sex in general practice
- **Creating a confident and inclusive workforce**
    - Equality and inclusion training for relevant partners
    - Introduction of an employer network for those who have completed LGBTQ+ training
    - Use of identifiable lanyards (e.g. rainbow lanyard)
    - Voluntary use of pronoun badges and pronouns in email signatures

8.0 Appendices

Appendix 1: Glossary

This glossary is not exhaustive nor proscriptive. I am indebted to the glossaries of Hill and Condon (2015) and the Government Equalities Office (2018), although both have been adapted to my own understanding based on wider research.

For those unsure of terminology, particularly on an individual level, two key rules apply:

1. If you are not sure, **ask rather than assume.**
2. **Use the same terminology, pronouns or form of address** for someone as they use for themselves.

Acquired gender: This is the gender in which a person lives, identifies and presents to the world. This usually refers to a gender that is not congruent with the sex assigned at birth. Some simply refer to this as their true gender.

Agender: Someone who considers themselves not to be of any gender. Sometimes spelt "Agenda".

Cisgender or Cis: Someone whose gender identity matches the sex they were assigned at birth i.e. a non-trans person. Cis and trans derive from the Latin for "on the same side" and "on the opposite side".

DSD (differences in sex development): Refers to individuals with sex characteristics (hormonal, anatomical or chromosomal) that differ from those typically associated with males and females. DSD can also stand for diverse sex development, and alternative terms include variations in sex development or characteristics (VSD/VSC). Some individuals with DSD may also use the term intersex. They may or may not consider themselves to be trans or otherwise gender diverse.

Gender dysphoria: A medical diagnosis of severe distress due to the perception of incongruence between gender identity and sex characteristics. Not all TGD people experience dysphoria, and the diagnosis of dysphoria is not a diagnosis of "being trans".

Gender identity: An individual's internal sense of their own gender.

Gender expression: How an individual outwardly presents, expresses or performs gender. This may reflect their gender identity, but may also differ from it or vary.

Gender fluid: Refers to people whose gender identity is not fixed, but flexible or fluctuating. They may identify with or express different genders or multiple genders at different times.

Genderqueer: Refers to people with gender identities that are not exclusively masculine or feminine, who may identify between genders or as neither male or female. This term is used by some, but not all, people in this category. As with queer, some people may find this an offensive term if they do not use it themselves.

Gender reassignment: This is a protected characteristic under the Equality Act 2010. Someone 'has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex'. Outside of the legal context, some prefer "gender confirmation". Terms like "sex change" should be avoided.

Gender variance: Refers to all variations from expected gender norms, and therefore covers a wider range of phenomena. This is often poorly defined.

Intersex: Another term used by some people with DSD, considered by some to be less medicalised.

LGBT/LGBTQ+: An abbreviation used to refer to lesbian, gay, bisexual and trans people, sometimes also including queer or questioning, or a + to represent other identities. There are a range of versions of this abbreviation, and usually these are taken to include all minority gender identities and sexual orientations.

Non-binary: People who do not identify exclusively as a man or woman. This category may include those who identify as agender, genderqueer, gender fluid or other identities outside of a strict gender binary.

Pronoun: A part of speech that stands in for a noun (a person, place or thing) including "me", "she", "her", "his", "theirs". In English, many pronouns are gendered (for example "him" and "her") and so it is polite to refer to people with the appropriately gendered pronouns. Some people prefer gender neutral pronouns like "they".

Queer: Usually refers to anyone with a minority gender identity or sexual orientation. Preferred by some for its wide inclusivity, others consider this to be an offensive term, due to its historical derogatory use.

Sexual orientation: This describes the gender(s) a person may be emotionally, romantically or sexually attracted to. This is distinct from gender identity. TGD people may be of any sexual orientation.

Trans and Gender Diverse (TGD): This is the preferred term used in this document to refer to everyone whose gender identity differs from their sex assigned at birth. This term is used to make explicit the inclusion of non-binary people.

Transgender or Trans: Also refers, in the widest definition, to people whose gender identity differs from their sex assigned at birth. Non-binary people may or may not consider themselves to be trans.

Transitioning: Refers to the process by which an individual changes their gender presentation to one that differs from that assigned at birth, and accords with their gender identity. Social transition may involve a change in pronouns, forms of address, attire or other forms of gender presentation. Transition may also involve medical or surgical interventions, but may not.

Trans man: Someone who was assigned female at birth but identifies and lives as a man. A trans man may be at any point in his process of transition. The term "FtM" is still sometimes used, but is no longer preferred. The term "transman" without a space should not be used, as "trans" is an adjective modifying the noun "man". A similar term, preferred by some, is 'transmasculine'.

Transphobia: Dislike of or prejudice against trans or gender diverse people.

Transsexual: An older term referring to someone who has undergone a process of transition. It is usually better to avoid this term, but it is still sometimes used clinically to refer specifically to TGD people who have undergone a medical or surgical transition.

Trans woman: Someone who was assigned male at birth but identifies and lives as a woman. A trans woman may be at any point in her process of transition. The term "MtF" is still sometimes used, but is no longer preferred. The term "transwoman" without a space should not be used, as "trans" is an adjective modifying the noun "woman". A similar term, preferred by some, is 'transfeminine'.

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