

# Inside Gender Identity

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

December 2017



Community Innovations Enterprise

# **Inside Gender Identity**

## **A report on meeting the health and social care needs of transgender people in the criminal justice system**

**December 2017**

### **Authors**

Dr Jon Bashford, Senior Partner, Community Innovations Enterprise LLP

Sherife Hasan, Programme Director, Community Innovations Enterprise LLP

Christina Marriott, CEO Revolving Doors Agency

Professor Lord Patel of Bradford OBE, Chair Community Innovations  
Enterprise LLP

# Contents

<b>Foreword</b> .....	<b>4</b>
<b>Acknowledgements</b> .....	<b>5</b>
<b>Authors</b> .....	<b>1</b>
<b>Introduction</b> .....	<b>7</b>
<b>Aim</b> .....	<b>10</b>
<b>Objectives</b> .....	<b>10</b>
<b>Methods</b> .....	<b>11</b>
<b>Trans health</b> .....	<b>13</b>
<b>Assessing needs</b> .....	<b>13</b>
<b>Physical health</b> .....	<b>14</b>
Health screens, prevention and early identification .....	14
Morbidity and mortality .....	15
<b>Substance misuse</b> .....	<b>17</b>
<b>HIV and AIDS</b> .....	<b>17</b>
<b>Mental health</b> .....	<b>19</b>
<b>Self-harm and suicide</b> .....	<b>21</b>
<b>Social risks and needs</b> .....	<b>22</b>
Isolation .....	22
The impact of coming out .....	23
Disability .....	24
Caring responsibilities .....	24
Unemployment.....	24
<b>The health impacts of discrimination and prejudice</b> .....	<b>25</b>
<b>Trans and Criminal Justice</b> .....	<b>27</b>
<b>Victims of crime</b> .....	<b>27</b>
Violence and assault.....	27
Prejudice and discrimination .....	29
<b>Numbers of trans people in the criminal justice system</b> .....	<b>29</b>
Prisons.....	30
Case numbers presenting at Liaison and Diversion Services.....	35
<b>Patterns of offending behaviour</b> .....	<b>38</b>
Sex work.....	40
<b>Preventing Reoffending</b> .....	<b>41</b>

<b>Trans health &amp; Justice .....</b>	<b>43</b>
<b>Safe from harm.....</b>	<b>43</b>
At the point of arrest.....	43
Pre-sentence planning and the courts.....	44
Placement in the prison estate .....	46
Supporting trans prisoners to live in the gender identify role they identify with...	51
Clustering in the prison system.....	52
<b>Managing Risk and vulnerability .....</b>	<b>55</b>
Stigma and discrimination.....	55
Bullying, harassment and violence .....	56
<b>Young trans offenders .....</b>	<b>57</b>
<b>Preventing self-harm and suicide .....</b>	<b>59</b>
Assessment, Care in Custody and Team work (ACCTs) .....	59
<b>Health and social care pathways.....</b>	<b>63</b>
<b>Hormone therapy and related prescribing.....</b>	<b>65</b>
<b>An integrated care pathway .....</b>	<b>67</b>
<b>Gender Identify Clinics and offender health care pathways .....</b>	<b>70</b>
Access .....	70
Experience .....	73
Outcomes .....	77
<b>Social sector support and engagement.....</b>	<b>78</b>
<b>Through the Gate .....</b>	<b>79</b>
<b>Skills and knowledge.....</b>	<b>81</b>
Capacity .....	82
Culture, management practice and leadership.....	83
Addressing discriminatory practice .....	84
Recognising and sharing good practice .....	85
<b>Recommendations .....</b>	<b>89</b>
Competency and skills .....	89
Care and justice pathways .....	90
Gender Identity Clinics and Offender Health.....	91
Involvement and engagement with the trans and LGBT social sector .....	92
Research.....	92
<b>References .....</b>	<b>93</b>
<b>Glossary .....</b>	<b>100</b>

## Foreword

I have often heard the expression ‘hard to reach’ or “invisible communities” but none could be easier to reach or more visible and yet, remain, so beyond basic care and respect than transgender people in the criminal justice system. The lack of understanding, the attempts, however well intentioned, to make people conform to pre-conceived ideas about how identity and ways of being may differ to what many consider the ‘norm’, cannot in any civilised society, explain or justify, the appalling ways in which we seem to treat those whose gender is not a simple binary opposition.

I am comfortable in my gender; I am (I have learnt) cisgender. A term I was not familiar with before doing this work, in simple terms I am happy with the gender and sex that I was born into. But some people are born into a biological body whose sexual attributes, and all the ideas and expectations of gender identity that goes with that, does not match their actual gender identity. I cannot imagine a more difficult way for a person to try and exist – to be born into a body and the expected gender role that was not the one they identified with. And perhaps this is my age, or my gender, or my sexuality – but – I am only just coming to terms with the reality that increasing numbers of young people feel that they are non-binary in their gender identification. I am told, and I usually prefer to learn about things from those who actually know what they are talking about, by that I mean those who have lived experience, that to be non-binary, or gender fluid means being different to the stereotypical ways in which society generally ascribes these identities.

It might surprise some of these young non-binary people and even those whose who are transgender, transsexual, heterosexual, Lesbian, Gay, Bisexual or Queer – but I am well used to other people telling me about my identity, and getting it completely wrong. I am a Yorkshire man, a Hindu, an immigrant, I am British, I am often referred to as South Asian, though I feel little in common with most of the world that that term implies. Amongst polite society I am called various things ‘Asian’, ‘Indian’, ‘BAME’ [Black and Asian Minority Ethnic], amongst the less polite...well I expect most people know. I could fill this report with the various things that make up my identity – but – and this is so important, you will only know me if you ask, and only if I trust you enough, I would tell you. And wouldn’t you too?

This report is challenging – it challenges our ideas about gender and identity, it explores the very real and complex problems that confront trans people in the criminal justice system and those who are charged with their care, management and safe keeping. It puts a spotlight on the real lived experience of trans people in the criminal justice system and asks us a basic question – could we do better? I believe we can, I believe we must, because no matter why someone is in this system, or who they are, our job as a responsible society is to treat all offenders with respect and dignity, to keep them sane and well, to prevent self-harm or worse, death and at the same time to help them to rehabilitate and join the rest of us in making this a world we all want to, and can, live in.

**Professor Lord Patel of Bradford OBE**

## Acknowledgements

Many people have helped make this report possible and it is not possible to name them all. However, special thanks must be given to the team at NHS England who have provided the leadership and commitment to highlighting and addressing the needs identified in this report, in particular, Kate Davies OBE, Mark Gillyon-Powell, Arthur Ling, Chris Kelly, Fiona Grossick and Kay Evans. We would like to thank Dr Linda Harris (Chief Executive, Spectrum Community Health CIC and Chair, Health and Justice Clinical Reference Group) and Denise Farmer (Pharmaceutical Adviser Health and Justice, NHS England). We are also very grateful to James Palmer (Medical Director for Specialised Services) and Jeremy Glyde (Head of Service Transformation Team, Specialised Services) at NHS England for ensuring that the review has been co-ordinated with the consultation on proposed service specifications for specialised gender identity services.

Our thanks also to Dr Éamonn O'Moore (National Lead for Health & Justice, Public Health England & Director of the UK Collaborating Centre for WHO Health in Prisons, European Region) and Dr Jo Peden (Consultant in Public Health, Public Health England) for their support. Also Rupert Bailie, (Acting Head of Health and Wellbeing Rehabilitation Services Group, Rehabilitation and Assurance Directorate, HMPPS), Ann Snowden (Head of Probation Equality, Equalities, Interventions and Operational Practice Group, Directorate of Rehabilitation and Assurance, HMPPS) and Megan Key (Diversity & Inclusion Manager, NPS). We would like to acknowledge the contribution of all the organisations that are represented by the various professional respondents:

Care UK	NHS England Specialist Commissioning Team
Department of Health	Northumberland, Tyne & Wear NHS Foundation Trust
Gender Identity and Research Education Society (GIRES)	Nottinghamshire Healthcare NHS Foundation Trust
Gendered Intelligence	Nuffield Health Leicester Hospital
HMP/YOI Askham Grange	Prison & Probation Ombudsman Service
HMP Frankland	Prison Reform Trust
HMP Forest Bank	Press for Change
HMP Grendon	Public Health England
HMP Leeds	Public Health Wales
HMP Parc	Revolving Doors Agency
HMP Peterborough	Sodexo
HMP Styal	Spectrum Community Health CIC
Her Majesty's Prison and Probation Service	Staffordshire Police
Leicester LGBT Centre	Sussex Partnership NHS Trust
Leicestershire Police	Trans Forum, Manchester
Leicestershire Partnership NHS Trust	University of Cumbria
LGBT Foundation	University of Nottingham
Manchester Metropolitan University	University of Oxford
Mermaids	

The authors would like to particularly thank and acknowledge the advice and support of Jenny-Anne Bishop OBE (Unique Transgender Network), Louie Stafford, (Trans Programme Coordinator, LGBT Foundation), Harri Weeks (Stakeholder Engagement Manager for the National LGB&T Partnership) and also of Juno Roche and Sophie Strachan. We would also like to thank Terry and Bernard Reed (GIRES) for their advice. We are also especially grateful to Professor Stephen Whittle and Fiona Simkiss (Press for Change) for helping to facilitate contact with trans individuals in prison.

We are very indebted to the trans individuals who gave their time to talk to the report authors and shared their experience of being trans in the criminal justice system and for all those on social media and other platforms that suggested sources and contacts for this work in particular Sparkle, Manchester and Trans Pride Brighton.

The case studies have been derived from the real experience of trans offenders and have been compiled with the help of professionals working with the individuals in question. We are particularly grateful to Dr Alison Spurgeon-Dickson CPsychol, CSci, AFBPsS, SFHEA. Senior Lecturer/Postgraduate Lead for Psychology | Department of Health, Psychology and Social Studies, University of Cumbria for help with presenting Case A. The case was based on an in depth qualitative study of one trans prisoner including interviews and reflections from the prisoner's diary. Staff members at the prison were also interviewed.

## Introduction

This report is about the health and social care needs of trans people in the criminal justice system. This is primarily about offenders, though it should be recognised at the outset that trans people are more often victims of crime than perpetrators. But before we can identify and address the health and social care needs of trans offenders, and what might best be done to meet those needs, we must understand what is meant by the term 'trans'.

Firstly, trans is used in this report as an umbrella term that describes a variety of ways of being human that do not fit with, or conform to, stereotypical and/or binary definitions of gender. Secondly, as will be evident from the first statement, trans is a term that is complex to understand and can never do justice to the wide variety of ways of being in the world and identities that it seeks to describe. But this is not entirely unfamiliar territory; the terms Black or South Asian have often been used to describe groups or communities of people that in fact have enormous differences, that make the terms at best unhelpful and at worse a liability.

We often use the terms Lesbian, Gay, Bisexual, Transgender, Queer and put these together under the single acronym LGBTQ, as if all the people and ways of being this represents could account for their combined health and social care needs, not unlike the use of the acronyms BAME/BME (Black Asian and Minority Ethnic/Black Minority Ethnic). The use of this terminology in both the health and criminal justice sectors, has predominantly been as nouns, hence the capitalisation. However, for the purposes of this report, the term 'trans' is being used as an adjective. As authors, our intention is not to denote a specific and defined community or 'person' but rather, to emphasise the fact that, the way in which people identify with and express their gender identity may not fit with the commonly perceived and accepted ways in which gender identity is understood. The term trans is insufficient. It does not go far enough, is not capable of describing the real lived experience of those to whom it refers. And for that we apologise, sincerely. Not just to those who so urgently need recognition of their circumstances and experience but also to those who are genuinely trying to do the best they can, in an imperfect system, to help. But, we are where we are, and for now at least the term trans, however imperfect, will have to suffice. That said, the following lists some of the many terms that are in common usage:

- **Gender identity** – refers to the psychological identification of oneself as either a boy/man or girl/woman. This identification is usually thought of in these binary terms but this may not always be the case. Gender identity is independent of the issue of preference for a male or a female sexual partner (sexual orientation).
- **Gender Incongruence** – has replaced terms such as gender identity disorder, and transsexualism. It refers to the situation where a person's gender identity is not the one typically associated with the birth-assigned sex.



- **Gender dysphoria** - refers to discomfort or distress that is associated with gender incongruence. (This term is likely to become gender incongruence in the revised International Classification of Diseases, ICD 11 in 2018).
- **Gender role** – refers to the social role of gender, how we perform gender in society through our interaction with others.
- **Gender diversity, variance or non-conformity** – while the dominant assumption is that people conform to the gender role ascribed to them by virtue of their anatomy at birth, this is not always the case. This can result in people expressing their gender identity in ways that are perceived by others as acting against cultural gender norms – hence gender diversity. This is often a preferred term for people who object to the pathological connotations and implications of mental illness that are implied by gender dysphoria and the older term of gender identity disorder.
- **Intersex** – refers to atypical sex differentiation that is sometimes evident at birth, but may not be diagnosed until puberty, or adulthood, and in some cases may remain undiagnosed. It was common practice in the past, to undertake surgical procedures on infants with visibly undifferentiated sex characteristics (ambiguous genitalia), that is, an appearance that was neither clearly male nor female, on the assumption that bringing the child up in the gender role that was consistent with the surgically modified genitalia would inevitably lead to a congruent gender identity. This was frequently not the outcome, and many intersex children treated in this way, did not identify consistently with their contrived genital appearance and gender of up-bringing. Intersex people, who only found out in adulthood that they had been subject to this treatment, have challenged this assumption. Many believe this has caused them significant psychological and physical damage. These surgeries are now unlawful in some jurisdictions.
- **Non-binary**– refers to people who do not identify as either men or women. Non-binary people often prefer the use of pro-nouns ‘they’ or ‘them’ rather than ‘he’ or ‘she’.
- **Gender fluid** – refers to people whose gender identity fluctuates.
- **Gender queer** – the word ‘queer’ has largely overcome the association with queer-bashing, a hideous episode of physical attacks on gay men and lesbians. It is now used defiantly, and more flexibly, to include anyone whose gender expression is not cisgender. Sometimes ‘queer’ on its own, is used to embrace the entire LGBT+ communities.
- **Cisgender** – describes the majority of the population, in whom the gender identity is that which is typically associated with the birth-assigned sex.

- **Sex** – refers to the phenotype or the biological development of male/female characteristics. Sex is normally attributed at birth by the appearance of the genitalia. However, other phenotypic factors such as chromosomes are also important, though these are rarely tested unless there is a genital anomaly.
- **Trans** – most commonly used as an umbrella term to cover the wide range of gender diverse identities including both binary and non-binary/gender fluid experiences of gender.
- **Transgender** – commonly used synonymously with ‘trans’, as an umbrella term embracing all those who experience some form of gender diverse identity. Trans and transgender refer to both those who do, and those who do not, seek medical interventions.
- **Transition** - refers to the point at which a person undertakes a public change of gender expression, in all aspects of their life. This involves gender-affirming changes to outward appearance, clothing, mannerisms or to the name someone uses in everyday interactions known as ‘social transitions’. Transition may also be facilitated by medical interventions, some of which can be undertaken before social transition, and other ‘gender affirming’ interventions will continue throughout life. These interventions to masculinise or feminise the appearance enable the individual to align their characteristics with their gender identity.
- **Trans woman** – is a person who was assigned male at birth, and who identifies as a woman. The abbreviation MtF is sometimes used, but is considered impolite by some.
- **Trans man** – is a person who was assigned female at birth but who identifies as a man. The abbreviation MtF is sometimes used, but is considered impolite by some.
- **Transphobia** - prejudice directed at transgender people because of their gender identity or expression.
- **Transsexual(ism)** – is the old definition used in the International Statistical Classification of Diseases and Related Health Problems (ICD-10. F64.0). It still appears in some legal and medical literature. However, the World health Organisation, in its new edition, ICD11, will move this definition out of Mental and Behavioural Disorders, and into a non-pathologising section, using the description ‘gender incongruence’.
- **Transvestism** – refers to individuals who like to cross-dress intermittently for a variety of reasons including erotic factors.

It is not usual to place a glossary of terms as part of an introduction, but this is not an ordinary report. Attempting to understand the myriad terms and ways in which gender diversity is described and referred to in the literature and by individuals in the health and criminal justice system is an essential task of this report.

Because, our first task must be understanding and, however imperfect, we need to have a way of talking about the health and social care needs of offenders who do not fit with the commonly accepted gender norms or whose gender identity is at variance with the way in which the criminal justice system is organised. This is an essential step in ensuring that the wellbeing of these individuals is protected and promoted while at the same time seeking to ensure that they do not reoffend.

Throughout this report, and in the associated literature review, these and other terms will be used frequently. Our hope is that by the end of the report, the reader will have greater understanding about why there is such a complex range of terms and what we mean when we talk about trans health and justice.

## **Aim**

The aim of the review was to provide NHS England, Public Health England and Her Majesty's Prisons and Probation Service (HMPPS) with an appropriate assessment of the evidence base on meeting the health and social care needs of trans people in the criminal justice system. The report on the findings is for the purpose of informing policy and practice in the offender health system, including all ages and the range of provision. This includes an evaluation of the way in which the needs of transgender individuals are included in offender health and social care needs assessments and the implications for service provision and practice.

## **Objectives**

The specific objectives include:

1. A review of the literature from the UK and other countries as relevant, with respect to health and social care needs of transgender individuals in the criminal justice system.
2. An assessment of current practice with regard to meeting the health and social care needs of transgender individuals in health and social care needs assessments within the criminal justice system.
3. An exploration of the issues for practice in meeting the health and social needs of transgender individuals amongst health and social care staff working in the criminal justice system.
4. To make recommendations for action based on the findings of the above for NHS England and related stakeholders e.g. Public Health England, Her Majesty's Prison and Probation Service (HMPPS) and related criminal justice partners.

## Methods

The methods combine desktop analysis and stakeholder engagement, including as appropriate commissioners and providers of health care, criminal justice agencies, transgender individuals and social sector groups or agencies working with transgender people in the criminal justice system. Due to the known issues with respect to accurate and complete data collection on transgender, the programme of work was largely qualitative with a view to identifying key thematic issues of concern and identifying practical actions that could be included in recommendations for strategy and policy.

Specific methods that have been employed include:

- **Desktop analysis of relevant literature**, including grey literature, and evidence from other countries where this is likely to have relevance to the context of criminal justice and health in England. Trans people are also sometimes conflated within the broader description of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) populations and where relevant, this broader based evidence base has been used.

(For further information see *Inside Gender Identity: The Literature Review. A review of the evidence on meeting the health and social care needs of transgender people in the criminal justice system in England (December 2017)* that is published alongside this report).

- **Stakeholder engagement** – a sample of key informants was drawn from across the health and criminal justice system for confidential, one to one interviews. This included a total of **55 individuals** involving practitioners and managers from the NHS, HMPPS, Liaison and Diversion Schemes, Police, Community Rehabilitation Companies, Prisons, Youth Justice, related social sector partners, Trans and LGBTQ organisations and trans people themselves with experience of the criminal justice system including three trans prisoners. In order to protect confidentiality of the individuals concerned no one is identified individually in the report. Respondents are identified as belonging to one of the following:
  - Professional respondent, health care commissioner (11)
  - Professional respondent, health care practitioner (15)
  - Professional respondent, criminal justice (10)
  - Professional respondent, social sector (12)
  - Professional respondent, Academia (2)
  - Professional respondent, Government Department (2)
  - Trans prisoners (3)
- **Quantitative data analysis** – data from the HMPPS, NHS England's Liaison and Diversion services and population data from the ONS and relevant international sources have been used to draw some tentative conclusions on the numbers of trans individuals in the criminal justice system. The lack of inclusion of trans people in most official statistics and many research reports provides particular challenges in identifying accurate and complete data about trans people.

These data are therefore presented as indicative and should be treated with some degree of caution.

- ***Analysis and report writing*** – constant comparative methods have been used to ensure robust data analysis. This includes comparison of respondent views with the evidence from the literature. If only one person has expressed a particular view this is noted, otherwise the quotations in the report are representative of a range of respondent views.

A small Steering Group has overseen the work programme and have also received interim findings for discussion. Bi-lateral meetings have also been held with the team from NHS England responsible for the consultation on proposed service specifications for specialised gender identity services.

## Trans health

*“The NHS is letting down trans people: it is failing in its legal duty under the Equality Act... Trans people encounter significant problems in using general NHS services, due to the attitude of some clinicians and other staff who lack knowledge and understanding—and in some cases are prejudiced. The NHS is failing to ensure zero tolerance of transphobic behaviour... A root-and-branch review must be conducted, completed and published by the NHS.”*

(House of Commons Women and Equalities Committee: Transgender Equality. First Report of Session 2015–16)

Trans individuals are known to experience a wide range of health inequalities that encompass physical, emotional, psychological and social needs. And yet, amongst health and social care professionals in the community and in the criminal justice system there is very little awareness of these needs:

*“Every area of health is affected, it looks like things are happening but they are not, the focus is often on the physical sexual attributes and not the wider health needs.”* (Professional respondent, Social sector)

*“We are conditioned to deal with men’s health or women’s’ health, it is challenging when it is trans health.”* (Professional respondent, Health sector practitioner)

*“The focus is much more on where to place people in the prison estate than on their health needs.”* (Professional respondent, Health sector commissioner)

The complexity of the health and social care needs of trans people needs to be understood before adequate consideration can be made to meeting those needs. This is particularly important for offender healthcare pathways, where the additional barriers and challenges to identifying and meeting needs in the criminal justice system are so acute. What follows is a summary of the available evidence on the health and social care needs of trans people, alongside observations, views and reported experiences from respondents to the review. (For a more detailed assessment of the evidence from the literature, see the report on findings from the Literature Review).

## Assessing needs

In assessing the health and social care needs of the trans population it is important to recognise the limitations of the available research base and the relative lack of inclusion of trans people in population based health and social care needs assessments. This is largely a result of research and surveys failing to include identification of trans people in data collection and analysis. This may in part explain the mixed understanding about trans health needs that exists amongst professionals:

*“The health needs of trans people are completely individual, you can’t say what this ‘group’ needs; they are all different.”* (Professional respondent, Criminal justice sector)

*“I wouldn’t say the health needs are different to other people, nothing seems particularly more prevalent amongst trans people.”* (Professional respondent, Health sector practitioner)

These contrasting views highlight the importance of increasing understanding and awareness of the specific health and social care needs of trans people.

## **Physical health**

The common perception is that the physical health needs of trans people will be equivalent to those for men or women up to the point at which they enter on a medically supported pathway for transition. However, the physical health needs of trans people may be more complex than is commonly appreciated. For example, intersex people may have specific physical and psychological health needs related to their anatomy, both before and after any medical interventions that may have been undertaken. There is also a social impact on identifying health needs that impacts on trans people, such as a reluctance to engage with health services as a result of fears about discrimination and prejudice that can result in physical health needs not being identified:

*“Lack of awareness and sensitivity, discrimination in accessing health services, and bad experiences are common, including staff expressing their own negative views of trans people to trans service users and trans patients, or trans people being placed on the wrong-gendered hospital ward. Many also report clinicians focusing on their trans status when it is not relevant, including disclosing information inappropriately, and clinicians assuming that being trans or accessing transition-related health care is the cause of an unrelated health problem.”* (LGBT Foundation, 2017)

A study from the USA found that discrimination against transgender and gender-nonconforming individuals in Massachusetts was associated with adverse mental and physical health, as well as delays in accessing health care provision (Reisner, et al. 2015).

### **Health screens, prevention and early identification**

The prevention and early identification of certain health problems are significant for men and women at key points in the ageing process, for example cervical smears and breast screening for cancer in women, prostate and Abdominal Aortic Aneurysm (AAA) screening for men and bowel screening for cancer in men and women. For some trans people, in particular those with gender dysphoria there may be an increased reluctance to engage with certain screening programmes that require acknowledgement and/or intimate examination of their anatomical or natal sex (Williams, et al. 2016):

*“There are many physical health needs, people still need health screening - breast screening, cervical screening, prostate etc.”* (Professional respondent, Health sector practitioner)

*“The broader health needs are more important, for example how a trans man gets a cervical smear or prostate screening for trans women.”* (Professional respondent, Health sector practitioner)

*“I feel uncomfortable talking about my body, it disgusts me, I wouldn’t want to talk to health staff about my boobs or periods.”* (Trans male prisoner)

There are implications in this for the Public Health Outcomes Framework Domain Two: Health Improvement:

*“...gender-specific screening can present particular challenges for trans and non-gendered individuals.”* (Williams et al. 2016. Page 4)

In order to address some of the difficulties faced by trans people around screening programmes, Public Health England have recently published *Information for trans people NHS Screening Programmes* (PHE, 2017), which covers breast screening, cervical screening, abdominal aortic aneurysm (AAA) screening and bowel cancer screening. The leaflet provides specific advice for trans people regarding registration with a GP, as either a trans woman or a trans man and the implications for screening, for example:

*“If you are a trans man aged 25 to 64 who is registered with a GP as male, you won’t be invited for cervical screening. However, if you have not had a total hysterectomy and still have a cervix, you should still consider having cervical screening. This is especially important if you have had any abnormal cervical screening results in the past. If this applies to you, let your GP or practice nurse know so you can talk to them about having the test.”* (PHE, 2017. Page 12)

Public Health Wales, (Screening Division) have also developed a leaflet on breast, cervical, aaa and bowel screening for transgender service users (Public Health Wales, 2015). The leaflet was developed by Public Health Wales with Transgender Awareness Wales, FTM Wales, Unique Transgender Network and the NHS Centre for Equality and Human Rights.

It is important that similar sensitive and appropriate approaches to screening and prevention programmes are taken within prison healthcare pathways for trans individuals:

*“We have a duty of care to keep people well, but how do you engage trans people to talk openly about their anatomy? For example, with a trans man who feels very uncomfortable talking about his vagina, which is still intact, but there is a health need for appropriate screening.”* (Professional respondent, Health sector practitioner)

### ***Morbidity and mortality***

For LGBT populations as a whole the evidence suggests that life expectancy and self reported wellbeing outcomes will be worse than for those in general population groups and for trans people this is likely to be worse (Williams, et al. 2016).



Various factors are thought to impact on this including social determinants of ill-health such as isolation and family rejection, homelessness, unemployment and living with prejudice and discrimination including violence. These factors are particularly relevant for trans people, for example:

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

Other specific factors that are known to impact on the morbidity and mortality of trans individuals include alcohol and drug use, increased risk of HIV and the risks associated with long term use of hormone therapies:

- trans people may be up to four times more likely to be HIV positive than those in the general population (Grant, 2010);
- for transgender adults, hormone therapy has been associated with the potential for worsening cardiovascular disease risk factors (such as blood pressure elevation, insulin resistance, and lipid derangements), although these changes have not been associated with increases in morbidity or mortality in transgender men receiving hormone therapy (Streed, et al., 2017);
- LGBT people are more likely to smoke, drink alcohol and use drugs (see section below on *Substance Misuse*), which increases the risk of cardiovascular disease and so can contribute to premature mortality;
- trans people may be at more risk of osteoporosis if they do not take either oestrogen or testosterone regularly (Guasp, A. 2011);
- trans people may be at a higher risk of cancer due to certain risk factors, such as higher rates of smoking and alcohol consumption (Ashbee and Goldberg, 2006);
- transgender people were more likely than all survey respondents in a survey from Northern Ireland to smoke cigarettes regularly (32% v 27%). (Rooney, 2012).

There is also some evidence to suggest that long-term exposure to hormones can increase the risk of cancer. For example, a transgender woman is at increased risk of breast cancer following breast development and five or more years of hormone therapy. For a transgender man, excessive testosterone can be converted into oestrogen by the body, which leads to increased cancer risk (Ashbee and Goldberg, 2006).

## **Substance misuse**

Local and national research, and needs assessments of trans people have repeatedly demonstrated higher levels of health risk behaviours, such as drug and alcohol use. The evidence indicates:

- 24% of trans people have used drugs within the last 12 months, the most common being cannabis, poppers and ecstasy (McNeil, et al. 2012).
- 62% of trans people may be dependent on alcohol or engaging in alcohol abuse (*Ibid*)
- 10% of trans people indicated signs of severe drug abuse using the Drug Abuse Screening Test (Rooney, 2012).

Respondents who had experience of working with trans offenders, noted that for younger trans people in particular, problematic drug and alcohol use was common:

*“The younger ones often have drug and alcohol problems, it’s a way of coping, chaotic lives.”* (Professional respondent, Health sector practitioner)

However there is very little data from drug services working with offenders on the numbers of trans service users. One respondent thought that there may be reluctance on the part of trans individuals to access drug services and that this may partly account for the apparent lack of awareness about their needs:

*“We know that many women feel uncomfortable in drug services, so probably this is similar for many trans people. There may be a sampling bias in identifying trans people with substance use problems.”* (Professional respondent, Social sector)

## **HIV and AIDS**

A lack of standardised data collection across the UK means that prevalence of HIV in the trans community is still unknown:

*“HIV is a hidden problem amongst trans women, they have been sex workers, some have been raped, some younger trans people don’t know the risks.”* (Professional respondent, Academia)

There is very little comprehensive data on HIV prevalence in the UK as studies are small and rarely use actual test results (Bauer, et al. 2013).

However, estimates based on USA research indicate that trans people may be up to four times more likely to be HIV positive than those in the general population (Grant, 2010). A systematic review and meta-analysis found a pooled HIV prevalence of 19% among transgender women in the 15 countries with available, laboratory-confirmed data. Transgender women had odds of HIV infection 49 times greater than the general population (Baral, et al. 2012). In one study over half of both transgender women (50.8%; 1002/1974) and men (58.4%; 211/361) with newly diagnosed HIV infection were non-Hispanic black/African American (Clark, et al, 2017). A separate meta-analysis of HIV among transgender women sex workers found that these women had a pooled HIV prevalence of 27%, compared with 15% among transgender women who did not engage in sex work. (Operario, et al. 2008).

Trans people are also thought to be less likely to be tested for HIV, for example:

- trans people show lower rates of testing for HIV, with 46% of participants in a Canadian survey never having been tested (Bauer, et al. 2013);
- a survey in the UK, in Birmingham, indicated that 64% of trans respondents had never visited a sexual health clinic (Williams, et al. 2016).

The reluctance to engage with sexual health services amongst trans people was noted by respondents:

*“Many trans women have problems with health services, especially sexual health services, they avoid them because of fears about how they will be treated or past negative experiences, it can have a big impact on their care.”*  
(Professional respondent, Health sector practitioner)

*“Prep needs to be considered – trans people are at risk of HIV.”* (Professional respondent, Social sector)

One of the more recent deaths of a trans prisoner in the UK was the result of bronchial pneumonia associated with AIDS. The prisoner concerned knew that she was HIV positive but had only sporadically agreed to take treatment. This case may not normally be considered amongst others that are classified as self inflicted deaths, however, the reluctance to engage with HIV treatment typifies the evidence base for trans people being at risk of HIV and not engaging with sexual health services:

*“One of the most shocking deaths was due to HIV related pneumonia, how can that happen in this day and age? It shows how trans people struggle to engage with services.”* (Professional respondent, Health sector practitioner)

*“Not all reports into death by natural causes recognise transgender issues.”*  
(Professional respondent, Health sector commissioner)

It has also been noted that a better understanding is needed of how hormones used for transition may affect HIV risk among transgender people (World Health Organisation, 2015).

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

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

## ***Mental health***

One of the most significant areas of health need known to impact on trans individuals is mental health. For example the vast majority of trans people experience symptoms of depression at some point in their lives (Mayock, et al. 2009). There is a wide body of evidence that supports this:

- A national Australian study found that 56% of transgender people had been diagnosed with depression at some point in their lives, four times the rate for the general population. 38% had been diagnosed with anxiety, around 50% higher than the background rate (Hyde, et al. 2014).
- A survey which used a clinically validated scale to identify depression amongst respondents and which was not primarily focused on mental health (therefore reducing selection bias), found that 52% of trans men who have sex with men are depressed (Bauer, et al. 2013).
- Trans women on average are more likely than trans men to report paranoid ideation, interpersonal distrust, anxiety, depression, and obsessive-compulsive complaints (Claes, et al. 2015).

The severity and complexity of mental health problems amongst trans prisoners is particularly noted by respondents:

*“The mental health needs are significant amongst trans people in the prison system.”* (Professional respondent, Criminal justice sector)

*“The mental health problems go hand in hand with physical ones.”* (Professional respondent, Health sector practitioner)

Mental health problems are thought to be particularly associated with the context and reality of being trans, for example challenging family backgrounds and social isolation:

*“A lot of trans people come from a difficult background, this affects our mental health.”* (Trans female prisoner)

*“Isolation is a big factor for trans people, and the impact this has on mental health.”* (Professional respondent, Social sector)

Mental health problems are also viewed as being related to the placement of trans individuals in the prison estate and the related stress and anxiety that this can cause, both pre and post sentence:

*“For a Male to Female trans person in the male estate, the mental health needs can be significant, it is a false environment for them to be in and this can increase stress and anxiety or create more serious mental health problems.”* (Professional respondent, Criminal justice sector)

*“The mental health problems are more often about the problems and stress of living in role in difficult circumstances, being in prison, or if you are in court and may be facing a sentence, can be the real stress for trans people.”* (Professional respondent, Social sector)

Trans people held on remand and those on shorter sentences were thought to be particularly at risk:

*“If they are on remand it is a very difficult time for people anyway, they are vulnerable, don’t know what will happen, it is even more stressful to deal with if you are trans.”* (Professional respondent, Health sector practitioner)

*“Remand is one of the key flashpoints, the system doesn’t respond quickly enough for this, even being on remand for a short time can have significant impacts on mental health and risk of self harm, especially for trans prisoners.”* (Professional respondent, Social sector)

*“There is a significant difference for those serving longer sentences who are more secure or advanced in their gender identity compared to those on remand or short sentences who are still very much afraid about what they should do, whether they should tell anyone. They just keep their head down and get through it, that is why it is so important to start with the basis of what people say their identification is.”* (Professional respondent, Social sector)

Some respondents also raised the issue of trans people in low and medium secure mental health services:

*“NHS England needs to also think about low and medium secure mental health services and how the needs of trans people are met within these. There is less protection than in prison, there is no PSI for these services.”* (Professional respondent, Social sector)

## ***Self-harm and suicide***

Trans people are known to be at greater risk of self-harm and suicide than amongst general population groups and within the wider LGBTQ community:

- 53% of trans people have self-harmed at some point, with 11% currently self-harming. 84% of trans people had considered suicide and half of trans people had attempted suicide (McNeil, et al. 2012).
- Self-harm is more common amongst younger trans people. Three quarters of trans young people have self-harmed and over a quarter (27%) are currently purposely self-harming (METRO, 2014).
- 41% of the participants in one USA study reported attempting suicide, compared with 1.6% of the general population. (Grant, et al. 2011).
- A 2007 report highlighted that 34% of respondents in a survey of 872 trans people had considered suicide one or more times before receiving professional assessment and support, which is higher than the risk in many other groups (Whittle, et al. 2007).
- A 2014 study found that in the face of repeated hate and discrimination, trans people in particular were likely to begin considering suicide a 'pragmatic consideration' (Williams & Tregidga, 2014).
- Some transgender people can remain at increased risk of death, including death by suicide, even after transition (Dhejne, et al. 2011).

Incidents of self-harm and suicide are at high levels within the prison system, according to a recent report by the National Audit Office:

- in 2016 there were 120 self-inflicted deaths in prisons, the highest number on record;
- in 2016 there were 40,161 self-harm incidents reported in prisons, the highest on record;
- more than one third (37% of the average monthly prison population reported having mental health or wellbeing issues at any one time (31,328 people);
- around 10% of the prison population is recorded as receiving treatment for mental health problems;
- 40% of prisons did not provide refresher mental health awareness training to prison staff in the three years leading up to October 2016.

(National Audit Office, 2017)

The National Audit Office report concludes that:

*“The Ministry of Justice, HMPPS, the Department of Health, NHS England and Public Health England need to address the rise in incidents of suicide and self-harm in prisons, as a matter of urgency.”* (Page 12)

Although incidents of self-harm and suicide have been increasing across the prison estate as a whole, there have been particular concerns about trans individuals. Since November 2015 the Prison & Probation Ombudsman (PPO) has investigated four deaths by hanging of transgender prisoners. Each of these deaths was of trans women, and at the time of their death three were held in the male estate. The PPO concludes:

*“Transgender prisoners are among the most vulnerable, with evident risks of suicide and self-harm, as well as facing bullying and harassment. Undoubtedly, managing transgender prisoners safely and fairly poses challenges for prison staff in the “hyper-gendered” world of prisons, but law and policy are unequivocal that this is what is required.”* (PPO, 2017)

## **Social risks and needs**

The social care risks and needs of trans individuals in the criminal justice system are poorly understood:

*“What is social care in this context? It is not clear, with the elderly or disabled people we know what to do, what do social care needs mean for someone who is trans?”* (Professional respondent, Criminal justice sector)

The most common interpretation of social needs concerns access to practical and emotional support for people to live in their gender identity:

*“Social care is about supporting people to live in role, helping them to get wigs, clothing, befriending by other trans people.”* (Professional respondent, Criminal justice sector)

However, there are wider social care considerations that are important to understand in considering the need of trans people.

### **Isolation**

Trans people often experience prolonged periods of social isolation as a result of rejection by family and friends, loss of employment and fears about coming out as trans. The experience of transphobia, violence and aggression can also have greater impacts on health and wellbeing as a result of social isolation and the inability to confide in friends and family (Williams and Tregidga, 2014).

Social isolation amongst trans individuals is thought to be a significant barrier to seeking health and medical support until crises occur and contributes to serious mental ill health and suicidal intent. In addition:



- many young transgender people are particularly vulnerable to transphobia and isolation and, therefore, are less likely to acknowledge their identity to others (World Health Organisation, 2015b);
- evidence strongly suggests that trans individuals will experience significantly higher social isolation than the general population (Williams, et al. 2016);
- in one study, when asked to rate how often they felt isolated due to being trans or having a trans history on a scale of one representing never feeling isolated and 7 representing constant isolation, the average score for trans people was 3.9 (McNeil, et al., 2012).

### ***The impact of coming out***

The social problems of coming out as trans cannot be understated in terms of the potential impact on health and wellbeing:

- 22% of trans people were not permitted to use the appropriate toilet after coming out at work (Whittle, et al., 2007);
- trans people are most at risk of domestic abuse after coming out to a partner and, in turn, telling them of their intention to transition (Viggiani, et al. 2015).

Within the criminal justice system, especially within prisons, being identified as trans can be even more traumatic:

*“Coming out as trans is traumatic at any time, in prison it can be even more difficult, I’m not sure to what extent the prison service, including healthcare, create a safe space for people to do this.”* (Professional respondent, Criminal justice sector)

*“We need to know how to make the conversations happen, so that people can come out as trans, health care and prison staff don’t know how to have these conversations, if we are not asking or not having the conversation then we won’t know, it’s not just a health issue, it’s a much bigger issue about trauma informed conversations and disclosure.”* (Professional respondent, Criminal justice sector)

It is possible that the fear of coming out within the criminal justice system, in particular within prisons is so acute that it may in fact be masking the actual numbers of known deaths and incidents of self-harm by trans offenders:

*“We had a death of a prisoner and it was only after the death, as part of the subsequent inquiry and case review that we learned the person was in fact trans. Given the understandable fears trans prisoners have about coming out as trans in prison, it begs the question, how many acts of self-harm or actual deaths may actually be about this issue?”* (Professional respondent, Criminal justice sector)



## **Disability**

The evidence suggests that trans people experience high rates of disability:

- 58% of trans people were reported to have a disability or chronic health condition, including 8.5% who were deaf and 5% who were visually impaired (McNail, et al. 2012);
- transgender people may be more likely than the general population to have an autistic spectrum disorder (Pasterski, et al. 2014).

One respondent commented on the increasing numbers of trans people with autistic spectrum disorders:

*“We are seeing more trans people with autistic spectrum disorders.”*

(Professional respondent, Health sector practitioner)

## **Caring responsibilities**

There is evidence that many trans people are themselves carers for someone, for example, 18% of trans people were carers with 7% giving significant levels of care in one study (McNeil, et al. 2012).

## **Unemployment**

While most employment statistics do not record trans status of employees, it is known that many trans people lose employment as a result of discrimination and prejudice after coming out as trans. Fears about stigma and discrimination may also deter many trans people from seeking employment or remaining in employment. It is thought that barriers to other forms of employment could lead to some trans individuals finding alternative employment through sex work<sup>1</sup>. Sex work amongst trans people is thought to be most commonly associated with loss of employment as the result of being discriminated against as a trans person:

- the choice of trans women to engage in sex work is likely indicative of the fact that 63% of trans women report difficulty in finding employment (Garofalo, et al. 2006a);
- studies have revealed how transgender women experience pervasive workplace discrimination, which leads them to view sex work as a feasible option (Nadal, et al. 2014);
- engaging in sex work has been identified as a ‘last resort’ for trans people as a result of discrimination experienced in other work places (Nadal, et al. 2012; Sausa, et al. 2007).

The costs associated with transition, alongside loss of employment opportunities could lead some trans people engaging in the sex trade (UKNSWP, 2008). Respondents also thought that sex work was linked to funding for the costs of transition:

---

<sup>1</sup> <http://actionfortranshealth.org.uk/resources/for-transpeople/sex-work/>

*“Many trans women have been sex workers, often enter criminal justice system this way, they need to raise money for transition, for example, lip hair removal can cost £70 for one session and they will need at least ten, it is very expensive and this isn’t covered by the NHS. On top of this there may be unemployment, divorce costs, children, it all adds up.”* (Professional respondent, Social sector)

There are important implications for considerations of access for trans offenders to employment opportunities as part of community treatment orders and support from probation services and Community Rehabilitation Companies (CRCs) and for Through the Gate programmes on release from prison.

## ***The health impacts of discrimination and prejudice***

There is now a wide body of evidence of the health and social harms associated with experience of discrimination and prejudice. In particular, what is known as the minority stress model (Brooks, 1981; Meyer, 1995, 2003). Although originally developed for lesbians, it has been expanded to include gay men and there is supporting evidence for the validity of this model for transgender individuals. For example, some qualitative studies strongly suggest that stigma can negatively affect the mental health of transgender people (Bockting, et al. 1998; White, et al. 2015). This model originates in the premise that chronic stress arises from the experience of stigmatisation. Within the context of an individual’s environmental circumstances, this can be conceptualised as distal and proximal stress processes:

**A distal process** is an objective stressor that does not depend on an individual’s perspective. In this model, actual experiences of discrimination (also referred to as enacted stigma) are distal stress processes. For example, physical violence and assault on trans individuals.

**Proximal, or subjective, stress processes** depend on an individual’s perception. This would include internalised transphobia, a term referring to an individual’s self-directed stigma, reflecting the adoption of society’s negative attitudes about transgender and the application of them to oneself. Perceived stigma, which relates to the expectation that one will be rejected and discriminated against. Both can lead to a state of continuous vigilance that can require considerable energy to maintain. This can result in the concealment of transgender identity and a build-up of internal stress that can manifest in mental health and/or other behavioural problems. For trans individuals in the criminal justice system, especially in prisons, both distal and proximal or subjective stress processes can be highly significant and detrimental to health. Distal stress, such as the experience of bullying and harassment is a particular health and wellbeing concern for trans prisoners:

*“It’s not just about mental health needs, the risks of self-harm come also from bullying and harassment.”* (Professional respondent, Criminal justice sector)

*“I was bullied for two years, had a complete breakdown as a result and then I was moved...”* (Trans male prisoner)

Proximal stress such as internalised transphobia can also have significant impacts on mental health and increase the likelihood of self-harm and suicide:

*“It often feels as if I have become a masochist with a sign on my forehead which reads “hurt me”, “spit on me”, abuse me”. (Baker, Sarah Jane, 2017)*

Respondents thought that recognising these risks for trans prisoners are essential and still require more considered attention:

*“There are particular concerns about the risk of self-harm compared to other prisoners, only gradually are prisons starting to recognise this, there are still question marks about how we manage the risks of self-harm for such a vulnerable group.” (Professional respondent, Criminal justice sector)*

## Trans and Criminal Justice

*“They walk in the room, and stare right through you, talking like we don’t exist. But we exist” (Arcade Fire, We Exist 2013)*

For many trans people, their first crime is to exist. Being trans is treated as a crime against the so-called natural order of things, our perception of that order, of nature: boy/girl, man/woman, sex, gender. Without our consent, without choice, we are each assigned a given gender role, a physical and emotional place in which we are meant to live. Without choice and without consent, we are each expected to live that role, as others, who though they may love us yet know us not, expect us to be.

To act against this, to be on the ‘other side’ of this expected way of being, to be ‘trans’, both questions and challenges that natural order, boy/girl, man/woman sex and gender. And for this crime, the crime of failing to live up to expectation, a much greater crime is committed, the crime against trans people, the vilification, violence and abuse to which they are so often subject.

### **Victims of crime**

In the UK, respondents in a survey of 872 trans people found that:

- 73% of trans people surveyed experienced some form of harassment in public (ranging from comments and verbal abuse to physical violence);
- 21% stated that they avoided going out because of fear of harassment;
- 46% stated that they had experienced harassment in their neighbourhoods;
- 64% of young trans men and 44% of young trans women experienced harassment or bullying at school, not just from their fellow pupils but also from school staff including teachers and parents of other pupils; and
- 28% stated that they had moved to a different neighbourhood because of their transition.

(Whittle, et al. 2007)

### **Violence and assault**

The experience of actual bodily harm, violence and assault is significant for trans people. For example, the first national survey on violence against trans people conducted in the USA, and the largest sample on record, documents the high levels of violence and abuse that trans people face. The study found that 48% of respondents had been victims of assault, including sexual assault and rape, and 78% had experienced verbal harassment (Genderpac, 1997).

More recent research has found that:

- 19% of respondents reported experiencing domestic violence by a family member because they were transgender or gender non-conforming;
- 35% of individuals who expressed their gender identity or gender non-conformity at any time between the ages of 5 to 18 years fell victim to physical violence;
- 12% become victims of sexual violence;
- 7% of transgender adults had been physically assaulted at work; and
- 6% had been sexually assaulted.

(Grant, et al. 2011)

Other research conducted in the USA found that 43% of the participants had been a victim of violence or crime, with 75% of those attributing a motive of either transphobia or homophobia to it (Whittle, et al., 2007).

Domestic violence and abuse is also shown to be a common experience for many trans people:

- 80% of trans people have experienced emotional, physical or sexual abuse from a current or former partner based on a rejection of their trans identity (Roche, et al. 2010);
- 64% of trans people have experienced domestic violence and abuse, compared to 29% of non-trans respondents (Browne and Lim, 2008).

And yet, these crimes remain often unacknowledged and under reported:

- 97% of transphobic crime goes unreported (Wilde, 2007);
- in 2014/15, in Greater Manchester, a survey of hate crime data listed trans hate crime as the most underreported alongside disability hate crime (Greater Manchester Police, 2015);
- there is a lack of understanding from police services and a lack of faith from trans people that the police will deal with hate crimes with the necessary respect and understanding (Williams, et al. 2016);
- almost all (91%) trans respondents to one study were worried that their gender identity would affect their experiences of using a sexual violence service. Specifically, 40% did not access services for fear of discrimination by workers or other service users, 20% were not aware of services available to them, 78% were worried they would face repercussions from coming out as transgender while using a service (Rymer and Cartei, 2014).

## ***Prejudice and discrimination***

The full impact of prejudice and discrimination against trans people cannot be underestimated, especially at the point of coming out. For example, widespread transphobic behaviours and attitudes result in many trans people changing their dress or presentation:

- 81% of respondents to the Trans Mental Health Study avoided certain situations due to fear of transphobia; and
- of these, over 50% avoided public toilets and gyms, 25% avoided clothing shops, other leisure facilities, clubs or social groups. 51% said that a fear of being harassed, being perceived as trans or outed resulted in avoidance of social situations or public places.

(McNeil, et al. 2012)

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

This reality, that trans people are first and foremost victims of crime, must be in our minds as we consider those who have themselves committed a crime and are in the criminal justice system. Not as an excuse or a justification, but as part of the wider context in which trans people live their lives. That context may help to explain why trans people are distrusting of authority and fear others knowing about their true gender identity. This may, in part, explain why so few trans people have been thus far identified in official statistics about offenders.

## ***Numbers of trans people in the criminal justice system***

As is often the case in addressing the needs of minority groups, the first question is how many are there? Followed by, is it enough to justify a response?

*“What numbers are we talking about? How common is it? It would be useful to know the likely demand and what the specific needs are at different points in the care pathway.”* (Professional respondent, Health sector commissioner)

*“It would help to know the prevalence, we don’t have numbers.”* (Professional respondent, Health sector commissioner)

*“We are trans blind – don’t know level of need and don’t share what experience we do have.”* (Professional respondent, Health sector commissioner)

*“It feels like a hidden population, but in prison they are very visible.”* (Professional respondent, Health sector practitioner)

Leaving aside, for now, the legal imperative from the Equality Act 2010 that all public authorities must have due regard to the rights of those with protected characteristics, that includes gender reassignment, there is a moral and ethical imperative to understand who people are and what their specific needs might be:

*“The statistics are crude, the numbers of trans people in the criminal system are under reported.”* (Professional respondent, Criminal justice sector)

*“Prison healthcare is very general, the argument has always been why focus on this group, the numbers are very small, but there is an argument for decency and this is a core equality issue, it’s about reducing health inequalities and reducing offending.”* (Professional respondent, Health sector commissioner)

*“We need better responses from primary and community care about numbers of offenders in general, it isn’t picked up from a needs perspective, GPs say they don’t have any offenders but they don’t ask.”* (Professional respondent, Health sector commissioner)

In fact, the smaller numbers are even more important because it is so much easier when there are fewer people, to ignore and fail to recognise their needs. And in the case of trans people in particular, it is most likely the case, that however many are currently identified in official statistics the reality will be that there are far more who remain hidden:

*“The numbers have been increasing over the last ten to twenty years, but not sure why? Maybe due to more acceptance in society.”* (Professional respondent, Health sector commissioner)

*“In a custody environment we only ask about transgender if it is self evident.”* (Professional respondent, Health sector practitioner)

*“Trans gender is not routinely asked about anywhere in healthcare or in custody.”* (Professional respondent, Health sector practitioner)

There are no statistics in the UK of the number of trans people who are arrested by the police, dealt with by the courts or are subject to probation orders. However, the Ministry of Justice have for the first time attempted to identify the number of trans people in the prison system.

## **Prisons**

A data collection exercise in March/April 2016 by the Ministry of Justice found:

- 33 of the 123 public and private prisons (27%) in England and Wales said that they had 1 or more transgender prisoners;
- there were 70 prisoners living in, or presenting in, a gender different to their sex assigned at birth;

- of these, 52 reported their gender as male, 14 reported their gender as female and 4 did not state their gender;
- 8 of the 70 prisoners reported their ethnic group as Black, Asian and Minority Ethnic Group; 61 as White and 1 was not stated;
- based on this exercise, there were 0.8 transgender prisoners reported per 1,000 prisoners in custody.

(MoJ, 2016)

While this attempt at identifying the numbers of transgender prisoners in England and Wales is to be welcomed, there are several caveats to interpreting the figures:

- non-binary or gender fluid people were not included; and
- the figure of 70 trans prisoners only refers to those who had a case conference as defined by PSI 07/2011.

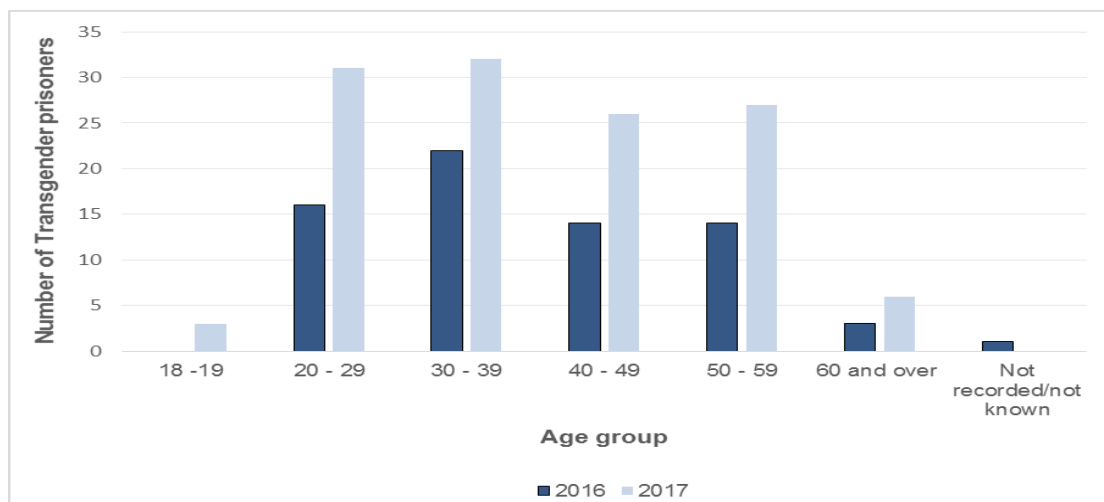
So the conclusion that there are 0.8 transgender prisoners per 1,000 prisoners in custody is almost certainly a significant under representation of the actual numbers. This is born out by the latest statistical bulletin release from the MoJ, which shows a marked increase in the number of transgender prisoners identified as part of the annual equality monitoring report. According to the data collection exercise conducted in March/April 2017:

- 47 of the 124 public and private prisons (38%) in England and Wales said that they had 1 or more transgender prisoners;
- there were 125 prisoners currently living in, or presenting in, a gender different to their sex assigned at birth and who have had a local transgender case board;
- of these, 99 reported their gender<sup>18</sup> as male, 23 reported their gender as female and 3 did not state their gender;
- 12 of the 125 prisoners reported their ethnic group as Black, Asian and Minority Ethnic Group and 113 as White;
- based on this exercise, there were 1.5 transgender prisoners reported per 1,000 prisoners in custody.

This represents a significant increase on the numbers of transgender prisoners identified in the previous year.



## Number of Transgender Prisoners by age-group, March/April 2016 and March/April 2017



(Ministry of Justice, 2017)

However, despite the increasing coverage and inclusion of transgender prisoners by the Ministry of Justice, the general relative, or almost complete, lack of recording of transgender status in any broader population figures, and the differing interpretations and use of the terms relating to transgender, makes it is very challenging to estimate what the likely numbers of trans people in the criminal justice system might be. The most common estimates have been based on numbers presenting for gender identity services. GIRES estimated in 2011 that organisations should assume that 1% of their employees and service users may be experiencing some degree of gender variance. Amongst these about 0.2% may undergo transition at some stage. (GIREs, 2011).

Recent estimates in the USA suggest the transgender population to be 0.6% amongst adults aged 25 – 64 and 0.7% amongst younger people, those aged 13 – 17 years. These figures from the USA are based on responses to the Centre for Disease Control's Behavioural Risk Factor Surveillance System (BRFSS), a national, state-administered survey. In 2014, 19 states included a transgender identity question and an additional eight states collected data on transgender identity in 2015. The question used in the survey by these states was: Do you consider yourself to be transgender? [If Yes] Do you consider yourself to be male-to-female, female-to-male, or gender non-conforming? (Hermann, et al. 2017).

Survey estimates from the Netherlands suggest that the proportion of trans people in the population may be as high as 3.9%.

This study examined the self-reported prevalence of ambivalent and incongruent gender identities and various aspects of gender dysphoria (Kuyper and Wijsen, 2014). Data were taken from a sexual health study among the general Dutch population in 2012 and included weighted adjustments to match the socio-demographics of the population, for example with regard to gender, age, education, and urbanicity.

The final sample consisted of 8,064 participants and the response rate was 20.9%. Participants who indicated at the beginning of the questionnaire that their sex assigned at birth was male were asked the following questions:

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

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

- Do you have a dislike of your male body?" 1=absolutely; 2=somewhat; 3=not really; 4=not at all)
- Would you like to have hormones or surgery to become (more) feminine?'

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

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

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

A study from Belgium (Van Caenegem, et al. 2015) used the same measurements for gender ambivalence and gender incongruence as in the Netherlands study, but this study used a general population health survey with a higher response rate (40% or 1,832 respondents).

The Belgium study found that 2.2% of men identified as gender ambivalent and 1.9% of women. The percentage of males identifying as gender incongruent was 0.7% and amongst women 0.6%. The authors draw a similar conclusion to that of Kuyper and Wijsen regarding population estimates that were based on presentations in clinical settings:

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

There are limitations to all of the above studies including the differing interpretations and definitions of gender diversity that make any extrapolation of the data to the UK population problematic. However, using the data from the Netherlands and Belgium, the following population estimates provides an attempt to indicate the potential numbers of transgender people in England and Wales.

				England & Wales Female Population*	England & Wales Male Population*
				24,139,136	23,155,902
	% Natal Women	% Natal Men	Overall		
Gender ambivalent (based on Kuyper and Wijsen 2014)	3.2%	4.6%	3.9%	772,452	1,065,171
Gender incongruent (based on Kuyper and Wijsen 2014)	0.8%	1.1%	0.9%	193,113	254,715
Gender ambivalent (based on Van Caenegem et al 2015)	1.9%	2.2%	2.0%	458,644	509,430
Gender incongruent (based on Van Caenegem et al 2015)	0.6%	0.7%	0.6%	144,835	162,091

\*Based on ONS Mid-year statistics 2016 for those aged 16+

Using the above data to estimate the likely numbers of gender diverse people in the criminal justice system, is equally, if not more problematic.

For example, it is unlikely that the transgender population is represented in prison on the same basis as the general population due to many of the factors considered in this report. But in the absence of more formal and accurate population figures, if it were to be assumed that the population distribution were the same or similar, the following estimates can be made about the number of transgender prisoners in England and Wales.

				England Female prison Population+	England and Wales Male Prison Population+
				3,974	81,393
	% Natal Women	% Natal Men	Overall		
Gender ambivalent (based on Kuyper and Wijsen 2014)	3.2%	4.6%	3.9%	127	3, 744
Gender incongruent (based on Kuyper and Wijsen 2014)	0.8%	1.1%	0.9%	32	895
Gender ambivalent (based on Van Caenegem et al 2015)	1.9%	2.2%	2.0%	76	1,791
Gender incongruent (based on Van Caenegem et al 2015)	0.6%	0.7%	0.6%	24	570

+Based on HMPPS Prison population figures September 2017

If the above estimates are true, and as noted above these data must be treated with caution, there may well be significantly more transgender/gender diverse people in the prison population than is currently recognised.

### ***Case numbers presenting at Liaison and Diversion Services***

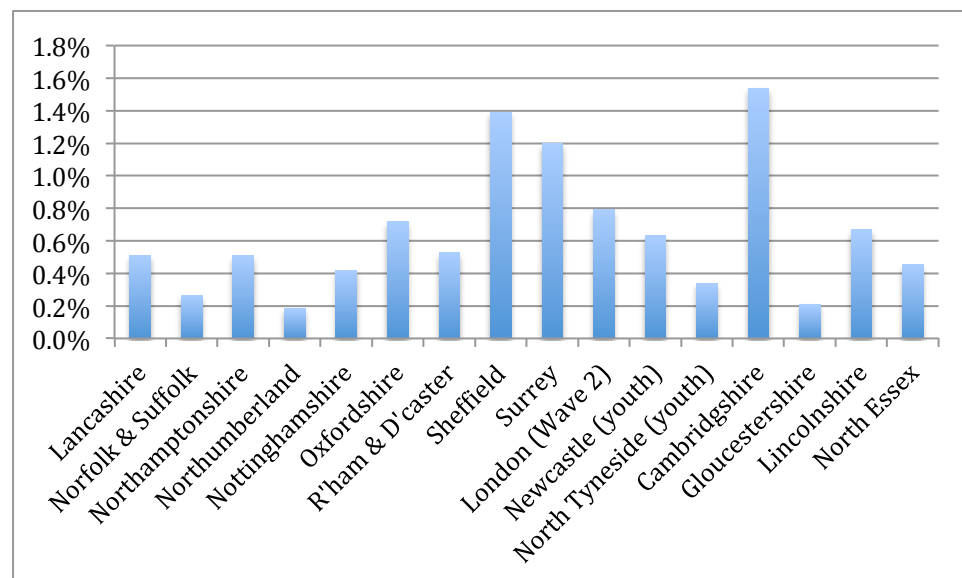
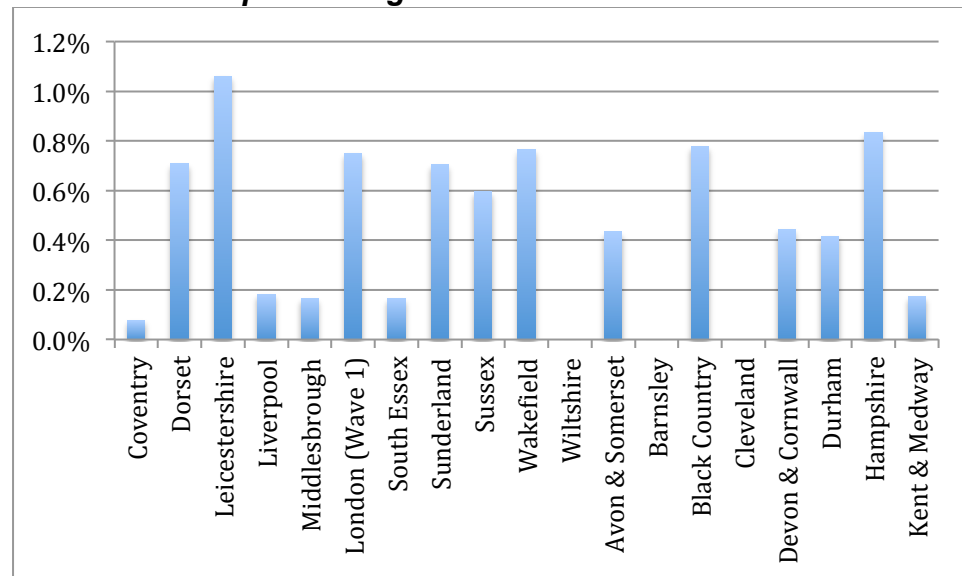
The number of cases identified by individual services remains low; therefore data should be treated with caution:

- In 2016/17 there were 311 cases (0.5%), of service users who identified themselves as transgender. In the previous year it was 303 cases (0.7% of cases).
- The proportion of service users identifying as transgender within a service varies from 1.5% of those seen in Cambridgeshire to less than 0.2% in many areas.

- Other services recording a higher than average proportion of transgender service users are Sheffield (1.4%), Surrey (1.2%) and Leicestershire (1.1%).

This kind of regional variance amongst trans populations has been noted elsewhere. For example, in the USA variances in numbers of people identifying as transgender varied across states from 0.3% to 2.8% (Flores et al. 2016).

### ***Case numbers presenting at Liaison and Diversion Services***



The data for Liaison and Diversion services was not made available by natal gender, but if the population estimates from the Netherlands and Belgium were applied to overall caseload mix by gender, it shows the following:

				England Female L&D Caseload++	England Male L&D Caseload++
				13, 071	45,752
	% Natal Women	% Natal Men	Overall		
Gender ambivalent (based on Kuyper and Wijsen 2014)	3.2%	4.6%	3.9%	418	2, 105
Gender incongruent (based on Kuyper and Wijsen 2014)	0.8%	1.1%	0.9%	105	503
Gender ambivalent (based on Van Caenegem et al 2015)	1.9%	2.2%	2.0%	248	1,007
Gender incongruent (based on Van Caenegem et al 2015)	0.6%	0.7%	0.6%	78	320

++ Data based on the Liaison and Diversion Equality Report 2016/17.

As with prisons, it seems likely that the numbers of gender diverse people identified in Liaison and Diversion Services is an under estimate of the actual figures. However, if it were assumed that those willing to be identified as transgender to Liaison and Diversion services were more likely to be those experiencing gender incongruence, then the identified numbers more closely correlate with the lower population estimates of this cohort from the Belgium study.

One of the more important points that these population estimates reveal, is the need for greater consistency and precision in how transgender is identified and defined in service utilisation data. Formal monitoring of gender identity is needed to identify those that are at greater risk of mental health problems, including self-harm and suicide and also provide a better indication of the likely demand for specialist gender services amongst this population group.

## ***Patterns of offending behaviour***

There is very little evidence on the offending patterns of trans individuals, though Poole et al (2002) make the point that offending behaviours amongst trans individuals are likely to be linked to life style and social exclusion, for example, prostitution and drug offences. Poole et al suggested that trans people may engage in acquisitive crimes to fund surgery, however, a literature review on behalf of the Equality and Human Rights Commission found no evidence to support this claim (Mitchel and Howarth, 2009).

In one study of transgender prisoners in male prisons in the USA the most common types of offences were property crime or sex crimes (Sexton, et al. 2010).

There is no evidence to suggest that trans individuals are more likely than any other population group to be sexual offenders. However, amongst respondents to this review there were some concerns about assumptions that trans offenders' motives in seeking recognition as being trans may be suspect and linked to sexual offending:

*“Trans people are stereotyped as a risk for sexual offending, as if they are just seeking access to women, we are in the business of risk assessment but it can be used as a smoke screen.”* (Professional respondent, Criminal justice sector)

*“There is a presumption that trans people’s motives are suspect. The focus is too much on pre surgical issues, if someone still has a penis they are thought to be a risk of sexual assault, but having surgery doesn’t mean someone is not going to be a risk.”* (Professional respondent, Criminal justice sector)

There are also heightened concerns about risk and security for prisoners who are sex offenders and also trans:

*“Some are sex offenders and may be seeking access to victims through a trans route.”* (Professional respondent, Health sector practitioner)

*“There are fears about those with sexual offences, how do we keep people safe?”* (Professional respondent, Health sector practitioner)

*“Sex offenders claiming to be trans can be an issue, some want access to anti-libidinal medications, linked to inability of NHS to prescribe these, if not health related, if it’s only forensic.”* (Professional respondent, Health sector commissioner)

*“Being trans may increase risk factors, female trans prisoners may already be a high risk if have previous sexual offences, they may be seeking access to victims, it is an extremely small number of people but important to separate out the mental health and forensic issues and how to address the risk management.”* (Professional respondent, Health sector practitioner)

While it may be the case that some sex offenders attempt to enter a transgender pathway in order to access victims or receive treatments that they believe will alleviate their sexual libido, there is no evidence to suggest that trans offenders are more likely to be sex offenders.

The generalised distrust of trans offenders' motives and the perception, amongst some professionals in the criminal justice system that they are more likely to be sex offenders, is akin to the way in which gay men were once perceived, erroneously, to be at a higher risk of being involved in paedophilia (Dwyer, 2011). In fact, there is evidence to suggest that LGB and trans people may be more likely to be unjustifiably treated with suspicion of being a sexual risk by criminal justice professionals:

*“LGBT youth are disproportionately charged with, and adjudicated for, sex offenses in cases that the system typically overlooks when heterosexual youth are involved. Even in cases involving nonsexual offenses, courts sometimes order LGBT youth to submit to sex offense risk assessments or undergo sex offender treatment programs based merely on their sexual orientation or gender identity.”* (Majd, et al. 2009)

There is also evidence of a broader tendency by which trans individuals are over criminalised. This occurs through a variety of factors including socio-economic and lifestyle risks that may predispose trans individuals to having contact with the criminal justice system, for example, poverty and unemployment, drug use and sex work. But also, through stereotyping and institutional discrimination within the criminal justice system:

*“Transgender people are also disproportionately affected by discriminatory laws, and are often victims of hate violence and police profiling. For transgender people, and especially transgender people of colour and transgender immigrants, the combined effect of these factors are increased potential interactions with law enforcement and the criminal justice system.”* (Center for American Progress and Movement Advancement Project, 2016).

The literature also confirms these findings:

- an Amnesty International report found that transgender people in particular, as well as LGBT individuals generally, are subject to increased policing because they are perceived to transgress gender norms. For example, police frequently assume that transgender women, particularly transgender women of colour, are sex workers based on their perceived transgender status and their race, as well the fact that they are standing, walking, or driving in a particular area (Amnesty International, 2017);
- the combination of poverty, unemployment, and homelessness contributes to higher rates of incarceration and justice system interactions among transgender people, particularly when transgender people are forced to rely on underground economies to survive, such as trading sex or selling drugs (*Ibid*);



- when transgender people seek assistance from the police, particularly in instances of intimate partner violence or a hate crime, they are often met with a lack of understanding. Sometimes they are even arrested alongside, or instead of, the perpetrator (Stotzer, 2012; Ahmed and Jindasurat, 2014).

### **Sex work**

Some trans individuals, particularly trans females are known to have engaged in sex work:

- 11% (n=694) of respondents to the National Transgender Discrimination Survey in the USA reported having participated in sex work, whilst over 2% (n=135) said they had traded sex for accommodation. The survey also found that Black respondents had the highest rate of sex work participation overall whilst White respondents had the lowest participation rate (Fitzgerald, et al. 2015);
- Canadian research similarly indicated high prevalence of historic and current sex work, with an average of 15% of both trans men and women engaging in sex work, with an average of 2% reporting current employment as a sex worker or escort (Bauer, 2012).

Contact with the criminal justice system and mental health risks for trans offenders who have participated in sex work are higher than for those who have not been sex workers:

- transgender sex workers reported high levels of interaction with the police (79.1% compared to 51.6% of non-sex worker respondents);
- of those who have appeared in court, transgender people engaged in the sex trade were also more likely to report biased treatment by judges and court staff (39.6% vs. 15.5% of non-sex workers);
- many transgender women reported having been profiled as a sex worker, regardless of their involvement in the sex trade;
- transgender respondents involved in the sex trade were more likely than transgender respondents not involved in the sex trade to have a significant physical or mental health disability (40.2% vs. 28.3% of non-sex workers).

(Fitzgerald, et al. 2015)

Rejection by family and friends has been linked to higher rates of sex work amongst trans individuals (Grant, et al. 2011).

Lack of employment opportunities has been identified as a risk factor for trans people after leaving prison, whereby some return to or commence sex work as their one of their only means of finding an income (Simopoulos, et al. 2014).

## ***Preventing Reoffending***

There is very little research on preventing reoffending amongst trans offenders. However, respondents are clear that the identification and recognition of trans status and gender identity must be at the heart of the approaches to preventing reoffending for trans individuals. Prevention and rehabilitation programmes including offender management programmes need to take account of the specific circumstances and conditions under which trans individuals enter the criminal justice system and how they leave it:

*“We need to be able to incentivise people, to give hope.”* (Professional respondent, Health sector practitioner)

*“The staff need to all work as a team, all of them supporting the offender plan as a whole.”* (Trans female prisoner)

*“Trans issues and problems with gender identity are subsumed under other risks and concerns, for example mental health – the gender issues need to be more explicit and addressed as part of the offender management plan, including healthcare.”* (Professional respondent, Health sector practitioner)

In particular, respondents thought that more attention needed to be paid to accounting for transgender issues in Alcohol and Drug Treatment Orders and Mental Health Treatment Requirements:

*“There are issues with Mental Health Treatment Requirements, it is hard to get mainstream mental health services to support this, they can’t deal with the impact on community mental health services. Trans just adds a new level of complexity to this.”* (Professional respondent, Health sector commissioner)

*“A lot of trans people have had drug and/or alcohol problems, we need to be thinking about this more in terms of Drug and Alcohol Treatment Orders and what services are available for trans people.”* (Professional respondent, Health sector commissioner)

This is particularly important for probation services:

*“The Probation Service’s strength is in giving advice to the courts about an offender’s actual needs, so they can make informed decisions at sentencing and placement of people.”* (Professional respondent, Social sector)

*“There is some way to go re trans issues and frontline probation staff, they don’t really understand the significance for mental health and the emotional impact of transition. They are not equipped to deal with the issues, the mood swings, the social impact like rejection from family and friends, hormone imbalances...”* (Professional respondent, Criminal justice sector)

*“Healthcare is not really impacting in probation.”* (Professional respondent, Criminal justice sector)

*“There is no specific policy for healthcare within probation, it works on a local basis with partner agencies in the same way as for non-probation clients.”*  
(Professional respondent, Criminal justice sector)

Offender management plans were also thought to be largely designed and accredited on the basis of single genders i.e. for men or for women and did not take adequate account of the needs of trans offenders:

*“The offender management programmes are accredited for males, there is no account for working with trans prisoners.”* (Professional respondent, Criminal justice sector)

*“Offender managers need to be more aware of what is available for trans people.”* (Professional respondent, Criminal justice sector)

*“... people don't fit easily in terms of their particular point in transition and what this means for sentence planning and interventions.”* (Professional respondent, Criminal justice sector)

One trans female prisoner thought that trans people themselves needed to acknowledge the need to address their offending by engaging with rehabilitation and offender management plans:

*“Trans people still need to do the offender programmes, they think they are immune from it, that they don't need rehabilitation but they do. They need to be on a sentence plan for rehab, to get the risk down, do the course work and work towards release.”* (Trans female prisoner)

However, for most respondents the most significant factor that is thought to influence reoffending is effectively and consistently addressing the complexity of health and social needs associated with trans gender identities:

*“There is a total lack of consistency across the prison and NHS on how to treat a trans person.”* (Professional respondent, Criminal justice sector)

*“We need increased guidance about exploring appropriate pathways once people have been placed in the system.”* (Professional respondent, Health sector practitioner)

*“If it's [gender identity] not visible, it gets ignored, not taken seriously.”* (Trans male prisoner)

*“NHS England and HMPPS should work more collaboratively on a joined up approach to take trans offenders' experiences and needs more seriously.”*  
(Professional respondent, Health sector practitioner)

## Trans health & Justice

*“What is most important is to cease legislating for all lives what is liveable only for some, and similarly, to refrain from proscribing for all lives what is unliveable for some” (Judith Butler, Undoing Gender. 2004)*

For many people, whether they are health and social care professionals, those working directly in the criminal justice system, trans people themselves or those who advocate for and defend trans peoples' rights, what they will be seeking is how to prevent more deaths, stop people self-harming and ensure that trans people receive adequate and responsive health care. These aims translate into three core objectives for trans health and justice:

1. recognising, without prejudice, stereotyping or discrimination the reality of trans peoples' experience in the criminal justice system and ensuring that they are kept **safe from harm**;
2. providing effective, evidence based and integrated **health and justice pathways** that take adequate account of trans people's health and social care needs; and
3. equipping staff with the **skills and knowledge** to provide an environment in which trans offenders can express their gender identity and feel confident that their particular gender expression/identity and needs are recognised, validated and respected.

### Safe from harm

The complex range of health and social care needs and unique circumstances of trans individuals can make them particularly vulnerable in the criminal justice system. These vulnerabilities are especially acute at the point of arrest, in the court system, with respect to pre-sentence planning and placement in the prison system and on release from prison and returning to the community.

#### **At the point of arrest**

The data from Liaison and Diversion Services suggests that there may be more gender diverse individuals in the system than might be expected. This raises some important issues with respect to the classification and identification of transgender individuals and subsequent implications for health care needs, referral pathways and pre-sentence reports. For example, trans individuals with an incongruent gender identity are more likely, though not exclusively, to be already engaged on or contemplating starting a medically supported transition, whether through a prescribed NHS route or informally through the Internet or private prescriptions/treatments.

This group are more likely to fall into the category of strong evidence for transgender status, which may have implications for pre-sentence reports and convening a transgender case board if they are likely to receive a custodial sentence. However, as raised by respondents, would trans people wish to be identified as trans at the point of arrest?

*“Would people feel safe to disclose that they were trans in custody? Probably not.”* (Professional respondent, Health sector practitioner)

*“In police custody there are barriers to people responding honestly about being transgender. How staff explain the question and reassure people is important.”* (Professional respondent, Health sector practitioner)

But at the same time, respondents recognised that the point of arrest could be the first place that people identify problems and that the police in particular are key to identifying needs at an early point:

*“The police are agency of last resort, but it is the most inappropriate place for mental health problems and this is true of trans people with mental health issues just as much as other groups.”* (Professional respondent, criminal justice)

In fact, the police were identified by some respondents, as a key potential referral point and an area where good practice in working with trans offenders is taking place:

*“There are some really good forces that are doing surprisingly good work on this area, they are more real world, deal with things all the time that most other professionals would only come across occasionally, so they have developed experience.”* (Professional respondent, Social sector)

While each case should continue to be assessed on its individual merits, it is important that Liaison and Diversion staff are able to distinguish between the different ways that people identify as transgender and are able to think through the health and social care implications of this.

### ***Pre-sentence planning and the courts***

Trans people can be particularly vulnerable in court settings:

*“Courts are dismal, chaotic places and for a trans person afraid about what will happen to them, where they might end up it can be very frightening, the court cells are also very old fashioned, it's a dangerous place for people to be and so it is important that that health pathways pick people up as early as possible, in the courts, to help reduce risks.”* (Professional respondent, Social sector)

Effective and informed pre-sentence reports and planning and the involvement of multi-disciplinary teams including healthcare are thought to be especially important for the effectiveness of pre-sentence transgender case boards:

*“More needs to be done by probation services at the pre-sentence stage – help stop people going in the wrong prison, if people can self identify this will be easier to manage.”* (Professional respondent, Criminal justice sector)

*“Pre-sentence reports are working, we are able to identify the issues and people are involved in the decision making.”* (Professional respondent, Health sector practitioner)

*“We can’t mandate disclosure but there are seven single points of contacts (SPOCs) across England and Wales – they can convene a case discussion where custody looks likely so that people are identified earlier in the system and a more informed decision can be made about where to place them. A GP or the gender identity clinic can be invited to this discussion, the trans person also has a right to be heard”* (Professional respondent, Criminal justice sector)

However, it can be challenging for health services, in particular specialist gender identity services to be fully involved within the timescales for pre-sentence reports:

*“We need to be able to access information and support from the GICs sooner, if someone is facing a prison sentence we have only three days to get all the evidence together, GICs just can’t respond to this.”* (Professional respondent, Criminal justice sector)

Although a longer adjournment for a case board to meet can be agreed, if the appropriate health services are not involved in time, this can have significant impacts on health and wellbeing for trans individuals entering the prison system:

*“We need more information sharing with GICs, speedier access including access to support and guidance for hormone treatments, if someone has been using hormones from the Internet we need to get them set up for this as part of the pre-sentence report, but it takes too long to get sorted – if the hormones are abruptly withdrawn it has profound impacts on someone’s mental health and physical changes, this needs to be appreciated more.”* (Professional respondent, Criminal justice sector)

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

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

*“Self harm and substance misuse problems can be increased if hormones are abruptly withdrawn.”* (Professional respondent, Social sector)



## ***Placement in the prison estate***

Much of the policy and media attention in the UK and elsewhere has been on where transgender individuals are placed in the prison system:

*“Prisons are not geared up for trans people, the estate is binary, and it’s set up for male or female prisoners.”* (Professional respondent, Health sector practitioner)

*“There are complex issues and security concerns, it can be very difficult to resolve, if we are saying they should have a choice about where they are placed in the prison estate.”* (Professional respondent, Health sector commissioner)

*“There are a lot of politics about allocation, but we need to hold on to the complexity, what people want and need rather than simple messages.”* (Professional respondent, Social sector)

Respondents thought that it could be more challenging for those people that are non-binary or gender fluid:

*“The big issue in prison is deciding whether someone is transgender. In the community it doesn’t matter, they can do what they want, but in prison it’s not always clear, they may be transvestite, people don’t always know the distinctions.”* (Professional respondent, Health sector practitioner)

*“Gender identity can be very fluid, people change what they say is their identification. This matters more in a prison environment.”* (Professional respondent, Health sector practitioner)

*“An increasing number of people classify themselves as non-binary or non-gendered.”* (Professional respondent, Academia)

*“People understand transsexual but not gender fluid or even transvestite – should these be treated the same way in the criminal justice system? How do people know what pro-nouns to use or when?”* (Professional respondent, Criminal justice sector)

*“If the person is gender fluid, my approach is to ask them how they want to be addressed today. It is about being respectful and sensitive to their needs.”* (Professional respondent, Criminal justice sector)

The recent Prison Service Instruction (PSI 17/2016) states that:

*“Transgender offenders must be asked their view of the part of the prison estate (i.e. male or female) that reflects the gender with which they identify. It must be explained to the offender that decisions to locate in part of the prison estate which is not in accordance with their legal gender (or best available evidence of gender where legal gender is not confirmed), can only be made following a local Transgender Case Board (either during pre-sentence report preparation or within three working days of reception into custody).”* (NOMS, 2016. 4.6)

Respondents broadly welcomed the clarity that the revised PSI brought:

*“The PSI has been helpful, it provides a good basis.”* (Professional respondent, Health sector practitioner)

*“The PSI is very helpful, a big improvement.”* (Professional respondent, Health sector practitioner)

*“The PSI has made the process more transparent.”* (Professional respondent, Criminal justice sector)

*“The new PSI is liberating, it makes questions about surgical intervention less important, many trans people don't want this kind of intervention, so not making decisions based on surgical transformations is important for people.”* (Professional respondent, Social sector)

In particular, respondents welcome the move away from the requirement for people to have a Gender Recognition Certificate (GRC):

*“The PSI anticipated the move away from requiring a GRC, as very few trans people actually have one anyway – the PSI doesn't undermine the GRC legislation and policy, but it shows the different ways in which people can self identify as trans.”* (Professional respondent, Criminal justice sector)

*“The PSI provides guidance that helps inform the decisions of the transgender case boards and takes account of the offender's view, it is a more flexible approach.”* (Professional respondent, Criminal justice sector)

*“Many trans people don't want a GRC, it can be negative if you are working, different pension age. A GRC becomes less important as time goes on.”* (Professional respondent, Social sector)

*“NOMS are trying to be less specific about the need for a GRC when deciding where to place people in the estate.”* (Professional respondent, Health sector commissioner)

However, while recognising the improvements made by the PSI, there are some concerns that entry to the system can in some cases still be dependent on birth gender:

*“The new PSI is as good as could be expected, it is very helpful to have the mandated review period on moving people, but people still have to go into the system under their birth gender.”* (Professional respondent, Criminal justice sector)

*“How the PSI is being implemented across the prison estate is very variable, the good places were already doing it before the revised PSI, it hasn't made that much difference really.”* (Professional respondent, Health sector practitioner)



*“Prison staff need to understand the PSI better.”* (Professional respondent, Health sector practitioner)

This is partly thought to be due to confusion about whether someone is permanently intending to live in the role of their gender identity:

*“The PSI doesn’t help, we are not clear about the issues on where to place someone and how to know what their actual gender identity is.”* (Professional respondent, Health sector practitioner)

There are some concerns that the mandated time periods make it difficult for effective engagement of health partners in the decision process:

*“The PSI and health guidance need to be part of the same conversation. The PSI can mandate actions from healthcare that are no longer commissioned.”* (Professional respondent, Health sector commissioner)

*“Need to align the PSI better with health - physical and mental health care needs.”* (Professional respondent, Health sector practitioner)

*“It is difficult to understand how trans people are placed in the prison system, who decides? We aren’t involved in the decision but people are then part of our case load, it can be challenging.”* (Professional respondent, Health sector practitioner)

Respondents also identified issues with respect to the location of trans offenders once inside the prison system:

*“It’s not just where in the estate to place people, it can be challenging to decide on the right Wing for them. They are vulnerable to being bullied and attracting negative attention.”* (Professional respondent, Health sector practitioner)

*“When decisions about location are being made we all have to be more transparent about the conversation, the communication needs to be open.”* (Professional respondent, Criminal justice sector)

*“We have had three referrals out to the female estate from the male estate, one had a GRC, one was waiting for one and the other felt she met the strong evidence, but generally it only works if they have a GRC.”* (Professional respondent, Criminal justice sector)

Movements across the estate in terms of preparation and access to services can be problematic:

*“It is difficult for people as they are moved from prison to prison, it has an impact, changes in services received if they have to be moved somewhere else as part of their offender management programme.”* (Professional respondent, Criminal justice sector)

Particular concerns have been raised about the placement of trans individuals on social care wings, vulnerable prisoner wings or in segregation:

*“People are sometimes placed on the social care wing, these are for older prisoners, more ill, many have learning disabilities, it is not the best place for a younger person.”* (Professional respondent, Health sector practitioner)

*“The vulnerable prisoner wing is not a safe environment for transgender people.”* (Professional respondent, Health sector practitioner)

*“Unfortunately trans prisoners are still being located in the vulnerable prisoner wings, which is not appropriate or safe for them.”* (Professional respondent, Health sector practitioner)

*“The regime punishes people because it can’t adequately meet their needs, for example, placing them in segregation.”* (Professional respondent, Health sector commissioner)

*“It was my first offence, I had no idea what to expect in prison. I was put in healthcare when I came in, they detoxed me but I didn’t have support for my mental distress, I wish they had helped me more to understand what was happening, it was very frightening. I had been living in role for six years, but I had no clothes when I came in.”* (Trans female prisoner)

Good practice is generally recognised as not placing trans individuals in segregation, just because they are trans:

*“We avoid using segregation, it perfectly manageable to have trans prisoners in the normal wings.”* (Professional respondent, Criminal justice sector)

There are also concerns about access to appropriate facilities in prisons such as bathrooms, toilets and showers:

*“...there is less capacity to create safe spaces, provide their own bathroom areas, the facilities can be a key issues in allocation and some prisons are less able to accommodate the high risks and needs.”* (Professional respondent, Criminal justice sector)

*“The facilities in some prisons are the big problem, how to let people have access to a shower if it’s all communal and you have to walk down a crowded landing in your towel to access the shower. It is the everyday issues, practical things that make such a big difference for people.”* (Professional respondent, Social sector)

*“We are doing the best we can in a difficult environment. There are no extra resources to draw on.”* (Professional respondent, Health sector practitioner)

Some respondents thought that trans individuals were better placed in the female estate, where this is perceived to be more accepting and supportive:

*“It can be more operationally harder to manage people in the male estate, they may need to be isolated more for their own protection than in the female estate, the female estate tends to be more tolerant of people.”* (Professional respondent, Health sector practitioner)

*“Most trans people would be better in the female estate, because diversity and equality is embraced more in the female estate, it is more of a community.”* (Professional respondent, Criminal justice sector)

However, respondents also report experiencing difficulties with regard to internal transfers from the male to the female estate:

*“There needs to be a lot of planning and preparation before moving to the female estate, I will need a lot of time to get ready for it, to be safe.”* (Trans female prisoner)

*“A lot of thought and preparation is needed if someone is transferring to another part of the estate, for example, from a male prison to a female prison, they can’t assume they will be well received by the other prisoners.”* (Professional respondent, Criminal justice sector)

*“People think we are being difficult if we refuse to take a trans prisoner, but more often it is about the accommodation and whether we can safely manage someone in this environment, it is an old prison building with little room for adaptation to needs.”* (Professional respondent, Criminal justice sector)

In particular, there is a perception that trans female prisoners who are pre-operative may pose a risk to female prisoners:

*“There are increased risks when thinking about placing people in the female estate, if their penis is still intact.”* (Professional respondent, Health sector practitioner)

Other respondents thought that this risk was exaggerated and that there was an over emphasis on sexual attributes in determining gender identity risks:

*“The prison service is preoccupied with whether people have a penis. The focus is on this as a marker of where to place people, it is a very binary, inflexible view about what makes someone a man or a woman.”* (Professional respondent, Health sector practitioner)

*“It is hard to get people transferred to the female estate, they are overly concerned with the fact that someone has a penis and the risk of a female prisoner becoming pregnant, it shouldn’t all be about the functioning of a penis, there may be other risk factors that matter more. The risk assessment for sexual behaviour is above what would be normally done.”* (Professional respondent, Criminal justice sector)

It should also be noted that there are no female prisons in Wales, which can have a significant impact for Welsh transgender prisoners who may need to be transferred to the female estate.

## ***Supporting trans prisoners to live in the gender identify role they identify with***

There are variations in responses by particular prisons to supporting trans people to live in role. Some prisons have no difficulty with this and have made adaptations to Canteen lists to ensure trans prisoners can access appropriate items of clothing, makeup, binders and prosthesis' etc.:

*"It needn't be a problem for people to live in role in prison. It is doable, it depends on the individual and the circumstances and the attitude of the prison."* (Professional respondent, Health sector practitioner)

*"We have made changes to the Canteen list so that they can buy items they need like clothes, everything is also starred to show which items are gender neutral."* (Professional respondent, Criminal justice sector)

*"We haven't had any problems with people living in role in the prison."* (Professional respondent, Health sector practitioner)

*"No other prison has listened as much on how to work with trans people, the staff do a lot of work behind the scenes, they understand and take time to listen to us."* (Trans female prisoner)

Other prisons find it more challenging to provide appropriate support:

*"It is hard to accept people are living in role while they are in a prison."* (Professional respondent, Health sector practitioner)

*"It can be a problem for people to access hair removal treatments if they are in prison."* (Professional respondent, Health sector practitioner)

*"It is a problem for people to live in role in the prison system."* (Professional respondent, Health sector practitioner)

*"It's very much about the culture set by the Governor."* (Professional respondent, Social sector)

Although the impact of not supporting individuals to live in the role of the gender they identify with are recognised:

*"If the prison can't support people to live in role, then it falls down, we can't help them effectively."* (Professional respondent, Health sector practitioner)

*"There is a dramatic impact if people are prevented from living in role."* (Professional respondent, Health sector practitioner)

## **Clustering in the prison system**

In some respects there is a degree of informal clustering in the prison system, as some prisons have half a dozen or more trans prisoners at any one time and others none. Whether a formal system of clustering for trans prisoners would be useful, for example, as a means of reducing risks and providing additional support, is subject to debate. There were mixed views amongst respondents on this, with several recognising the potential benefits:

*“Personally, I am not in favour of ghettoising, but we do need to cluster, it is a way of providing more support and would make it easier for services to go in to the prison.”* (Professional respondent, Criminal justice sector)

*“Clustering would enable more resources to be focused on people, there would be peer support and we could create centres of excellence.”* (Professional respondent, Criminal justice sector)

*“Clustering would make it easier to bring specialist help in, it would save time and money on escorting, with 5 trans prisoners in one prison they estimated the escort days would be 300 a year.”* (Professional respondent, Social sector)

*“Clustering helps create a peer environment and it can be inclusive of non-binary people. It also enables higher level training with officers and increased contact with local support groups.”* (Professional respondent, Social sector)

*“Clustering would move people away from their local areas, some have questioned if this would be detrimental to accessing support but for many trans people friends and family have cut them off and returning to their home area may not be a good option.”* (Professional respondent, Social sector)

However, other respondents saw pitfalls and possible problems with clustering:

*“Clustering is not the only way to go, the offender still needs to be able to exercise choice about where they are placed.”* (Professional respondent, Social sector)

*“Clustering has benefits but also pitfalls, we don't want a trans prison ghetto – some trans offenders are very disturbed, some have false motivations for wanting to be seen as trans so this would all need managing effectively and safely.”* (Professional respondent, Health sector practitioner)

*“Clustering is a response in the prison service to different vulnerable groups, for example, older prisoners but the question of autonomy and prisoner choice remains. We don't have the evidence for how clustering would work for those who are more gender fluid or less advanced in their trans journey, there is a balance to be had in this.”* (Professional respondent, Criminal justice sector)

*“It rings some alarm bells for me, it can be more about the prison needs than those of the prisoners, the prison service always thinks when it has a group that they should be put together, but it isn’t the real world. We need to pause and ask questions, what is the normalcy principle here? Would it be like this on the outside? It can also make resettlement harder, moving people a long way away from what they know.”* (Professional respondent, Social sector)

One female trans prisoner, while recognising the support of being with other trans prisoners in her current prison did not support the idea of clustering:

*“It makes a big difference having other trans prisoners here, you feel supported, recognised. A separate prison for trans people wouldn’t work, it’s a no-no, it wouldn’t help.”* (Trans female prisoner)

### **Case study A**

*She identified a number of positive aspects of her experience, these included:*

- *Officers very genuine, very respectful, and ask for her preferences, e.g. personal pronouns, he/she etc.*
- *She says she is happy at her current prison and that her needs are being very well met.*
- *Happy with LGBTQ awareness overall at current prison.*
- *Healthcare sorting out her medical issues and hormonal imbalance, which had not been effectively addressed at her previous prison.*
- *She states that she is proud that she is a trusted prisoner.*

*Through interviews and analysis of personal diaries there seems little emphasis upon issues around gender variance, she prefers to focus upon more general prison issues, as well as her external affairs. However, she does state that her experience at her current prison has made a significant difference to her mental health and overall happiness, and potential for a new start upon release. In particular, she feels that at her current prison she is able to express, and to feel valued for, her feminine side. She feels that she achieves this by mending clothes for other prisoners, playing the piano, bonding well with female staff, and in finding serenity, peace and sustenance through prayer and her faith. She states that she is respected by prisoners, plays a pastoral role on the wing and often listens to their problems – ‘some of the younger lads look upon me as a mother figure – it is quite reassuring of their acceptance’.*

*More negative experiences were expressed with respect to the previous prisons where she had been placed, including:*

- *Inability to correct hormonal imbalance through lack of correct medication.*
- *Problems with gluten intolerance and prisons not being able to effectively cater for this.*
- *Being housed on a sex offenders wing and being approached inappropriately (transit prison).*
- *Fears while overnight in one prison where another trans prisoner had recently committed suicide.*



*She did express having had some anxieties about the transfer to her current prison and how they would support her to 'blend in'. However, she also mentions that in an equality meeting, she was pleased to be able to voice her opinion on trans gender issues, which 'proves that this prison is engaging with minority prisoners'.*

*She does talk about a few incidents, which she perceived as being discriminatory. For example, she had an issue regarding problems with some prisoners not wanting to work with her. However, she does concede that this could have been more related to ageism rather than gender issues, and she points out that she would have struggled to fit in as they were all younger prisoners.*

*She has mentioned frequently that she would like to have her name changed on the prison information system. She wishes to be formally known as an abbreviated version of her full name (which is gender neutral), and feels that if she were to be released to a Therapeutic Community under her full name, this would rule out possibilities of blending in, and defining herself in a more neutral way."*

### **Reflections on staff attitudes and behaviours**

*"Compared to my experience of transgender prisoners in other prisons, they have done very well preparing for her reception at the prison. The prison have gone out of their way to accommodate her, not giving special attention as such, but CARE"*

*"The staff at the establishment are very understanding, respectful, listen and are responsive – this has helped staff to follow protocol, and has enabled her to excel here, to feel comfortable, and to blend in".*

*"There was some initial confusion about her gender identity; this was first described as being 'intersex' rather than transgender or gender fluid, which was the actual case. This is important to get right for safety and security purposes."*

## ***Managing Risk and vulnerability***

There is a complex range of factors that intersect and can co-exist in such a way that transgender individuals can become very vulnerable within the criminal justice system:

*“People are vulnerable in different ways, there are safeguarding issues, we need to ensure that people are safe.”* (Professional respondent, Health sector practitioner)

*“A key aspect of health need is vulnerability.”* (Professional respondent, Criminal justice sector)

*“Trans people are just one of many groups of vulnerable prisoners, we need to identify the risks for vulnerable prisoners, the trigger points and then what to do rationally and logically.”* (Professional respondent, Criminal justice sector)

*“The experience in prisons for all vulnerable groups is poor – mental health problems, increasing numbers that are self-harming, more suicides, difficulty accessing health services – for trans people it would be even more challenging.”* (Professional respondent, Social sector)

Some of the specific factors that increase vulnerability of trans offenders include:

### ***Stigma and discrimination***

Transgender individuals often experience high levels of stigma as a result of being trans, with frequent rejection by friends and family members. This can be further compounded by having become an offender, and the additional stigma that this may bring:

*“Rejection from family members and friends for being trans can be very bad, but it is made much worse by becoming an offender.”* (Professional respondent, Social sector)

Discrimination, both direct and indirect is common, for example, mis-gendering whereby people misuse personal pro-nouns:

*“Small, off-the-cuff comments can have a big negative impact on people, even just using the wrong pro-nouns”* (Professional respondent, Criminal justice sector)

*“My identity was ignored from day one, I was called ‘she’.”* (Trans male prisoner)

As transgender people are frequently placed in facilities that do not reflect their gender identity, they may be subject to cross-gender searches and monitoring.



Failure to be treated with appropriate respect and dignity, for example, with respect to body searches can cause particular discomfort and embarrassment. Transgender people in prison have reported high levels of unnecessary searches, including strip searches, which are demeaning and can increase the risk of harassment and violence by other prisoners and staff (Bassichis, 2007). One trans prisoner respondent thought that better procedures would protect both trans prisoners and staff:

*“There should be more clarity about searching procedures, a clear standard that protects the dignity and privacy of the prisoner but also the staff members.”* (Trans female prisoner)

### ***Bullying, harassment and violence***

Many trans people, in particular younger trans individuals report experiencing high levels of bullying and harassment while detained in custody settings. This can come from fellow detainees, but also from staff. For example, evidence from the USA shows the following:

- 24.1% of transgender people in prisons and jails reported being sexually assaulted by another inmate, compared to 2.0% for all people (Beck, 2014).
- Of the transgender women who reported being incarcerated at some point during their lives, nearly half (47%) reported being harassed or assaulted in prison or jail; Black, Latina, and mixed-race transgender women were more likely to be victimized than White transgender women (Reisner, et al. 2014).
- In a survey of transgender women placed in men’s prisons in California, more than half (59%) had been sexually assaulted compared to 4.4% of all male respondents — meaning that transgender people were 13 times more likely to be assaulted than incarcerated men (Jenness, 2009)
- A survey found that 16.7% of transgender people in prisons reported being sexually assaulted by facility staff in the previous 12 months compared to 2.4% of all incarcerated adults (Beck, 2011).
- In a survey of transgender women in men’s prisons in California 14% reported being sexual assaulted by a correctional staff member (Jenness, 2009).

LGBT prisoners are at significantly higher risk of violence while incarcerated (Dunn, 2013). Research also suggests that there is a tendency by prison staff to overlook transphobic abuse and victimisation and a lack of effective challenging of prisoners with discriminatory attitudes and behaviours, particularly in male prisons:

- Prison officers were less likely to be aware of the incidents involving transgender people (29% compared to 61% of incidents involving all incarcerated people in the same facilities) (Jenness, 2009). In a follow-up study two years later, researchers found that almost the same percentage of transgender people reported sexual victimization (59%).
- 20% of substantiated assaults in immigration detention facilities involved transgender detainees (United States Government Accountability Office, 2013).

While these risks are present in community settings, they are particularly acute within criminal justice settings. For example, some trans individuals report feeling that their complaints go unheard or are not taken seriously and that they are somehow thought to be ‘bringing it on themselves’.

The Prisons & Probation Ombudsman identified 10 complaints relating to transgender issues from 2012/13 onwards, of which seven were eligible for investigation. More recently, the Prisons & Probation Ombudsman has reported that from April 2012 to end of August 2016, they received 33 complaints related to transgender equalities issues (Prisons & Probation Ombudsman, 2017). In 2015 the Ombudsman noted:

*“Given the paucity of official information available, it is difficult even to know whether the small number of complaints to the Ombudsman from transgender prisoners is an issue in itself. It may be that the number is proportionate to the number of transgender prisoners within the prison system or that their gender goes unrecognised because it is not apparently relevant to the complaint or that complaints are being satisfactorily resolved at a local level. Without better data this will remain uncertain.”* (Prisons & Probation Ombudsman, 2015).

It is very possible that the true extent of bullying, harassment and violence against trans prisoners in the UK is under reported and poorly recognised:

*“Protestations and official complaints against transphobia abuse or attacks have, on the whole, been futile, especially when staff do not want to admit to their line managers that they have ‘diversity problems’ on their wings, which could be looked on unfavourably at the yearly audit.”* (Baker, Sarah Jane 2017)

## **Young trans offenders**

There are very little data on the numbers of young trans people in the criminal justice system. However, there are concerns that this may be a growing and hidden population with particular vulnerabilities:

*“There needs to be more focus on young people, we aren’t reaching young trans offenders, need to think more about what support for them would look like, it is on the radar but there still needs to be more thought about this, how to protect young people in hostile environments, professional lack of awareness, it all needs to be addressed.”* (Professional respondent, Social sector)

*“There is no evidence yet of more trans young people, but would expect this to start. But kids are very reluctant to talk about these things. They don't want to discuss sex and gender.”* (Professional respondent, Health sector practitioner)

*“We are seeing trans young people in the Secure Children's Homes.”*  
(Professional respondent, Health sector practitioner)

*“We have seen young trans people in the Youth Offender Institutions and it will become more prominent as the population grows, the Tavistock [Clinic in London for Gender Diverse Adolescents and Children] have seen significant increases in referrals in recent years and some will come through in offender pathways. They are at particular risk of bullying and harassment in the system and need protection, they are very vulnerable.”* (Professional respondent, Social sector)

Complex lives and dysfunctional family relationships are seen as key factors for young trans people:

*“We had a young trans person, 23 years, very chaotic lifestyle, drink and drugs, risky behaviours – street work, inconsistency in role, very volatile family relationships. Confusion in gender role”* (Professional respondent, Health sector practitioner)

*“A lot of trans young people come from dysfunctional family backgrounds, they are not very literate, poor awareness about what support exists, transition amongst friends rather than seeking professional support, often involved in sex work but don't see it this way, drug use, living on an edgy basis, money issues often lead to criminal justice involvement.”* (Professional respondent, Academia)

Lack of family contact, unemployment and isolation are thought to be particular risk factors for young trans people:

*“A lot of young trans people have no contact with their immediate family, many feel isolated, have been homeless, they struggle to get work because of being trans or can't keep a job because pressure of body dysphoria is too much - even if they haven't yet got in to trouble with the police they have the risk factors.”* (Professional respondent, Social sector)

## ***Preventing self-harm and suicide***

The experience of both stigma and discrimination alongside complex health problems and mental health needs within criminal justice settings can result in an increased sense of isolation and fear and heighten the risk of self-harm or suicide. However, one of the key observations from respondents regarding preventing self-harm and suicide amongst trans offenders is that responses are too reactive, after the event:

*“We are too reactive, responses to prison deaths, but no national strategy for meeting health needs, there are some good staff working in this area but we need to be more pro-active.”* (Professional respondent, Health sector commissioner)

*“The reaction chain means that issues are escalated too high up the hierarchy, it misses the middle people. We need small start points for change makers with simple practical solutions.”* (Professional respondent, Social sector)

*“We are reactive when a major incident happens, it puts the highlight on the issue, but it can be too late.”* (Professional respondent, Health sector commissioner)

### **Assessment, Care in Custody and Team work (ACCTs)**

The most common theme that can be identified from the PPO reports and recommendations concerns risk assessment and in particular procedures relating to the ACCTs (Assessment, Care in Custody and Team work), process, in particular:

- the need for a comprehensive assessment to be undertaken by a trained ACCT assessor within 24 hours of the ACCT being opened, even if the person concerned refuses to participate;
- the need for multi-disciplinary involvement in ACCT reviews, with particular emphasis on involvement of the healthcare team and continuity of care;
- the need for risk assessments to take account of all factors including the impact of bullying;
- the need for a care map with specific actions that are meaningful and encompass all of the issues identified through risk assessment and in case reviews;
- the need to review progress against the care map, in particular to ensure it is updated with new actions as new issues arise or are identified;
- the level of observations should reflect the level of risk, including undertaking observations at unpredictable times;

- consistency and accuracy in record keeping so that all members of the multi-disciplinary team concerned with care are informed of any changes in status or risk; and
- the need to ensure that all relevant information and ongoing risks are identified and addressed in case reviews and in post closure reviews.

Other common themes identified in the PPO reports include:

***Use of segregation*** – this should only be used in exceptional circumstances and when all other options have been considered and excluded. In particular:

- a segregation health screen should be held before a segregation review board; and
- prisoners identified as at risk of suicide and self-harm should have a mental health assessment within 24 hours of their initial segregation.

***Training and awareness of transgender and equality and diversity*** – in particular that Governors should ensure that staff are aware of the specific needs of transgender prisoners and manage them in line with national Prison Service instructions, for example PSI Training and instruction in transgender/gender diverse awareness including the relevant equality and diversity training. Healthcare managers should also ensure that healthcare staff members participate in education and training in respect of the needs of transgender persons in custody and, in particular, they should be familiar with their responsibilities in respect of the HMPPS instruction on transgender prisoners.

***Continuity of care*** – healthcare staff should promptly request relevant community health records for newly arrived prisoners and fully assess the needs of those who have been subject to mental health care in the community. In particular:

- the Head of Healthcare should ensure that in all instances where a prisoner self-harms and healthcare staff attend, it should be noted within the SystmOne healthcare record in order to inform members of the healthcare team in their subsequent work with that prisoner; and
- there should be a comprehensive healthcare assessment in respect of physical and mental health, and prisoners should be seen by a GP and a member of the mental health team as soon after admission as practical.

***Violence, bullying and intimidation*** - the Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence or threats from other prisoners should be effectively protected.

Respondents when talking about the recent deaths in prisons of trans prisoners noted the issues with respect to ACCTs procedures:

*“The challenge is how to manage the risks of self-harm and suicide, it affects all agencies not just healthcare, there is a pressing need to review how we manage this, the procedures are not up to date, ACCTS procedures are not fit for purpose, not just for trans people but for all vulnerable prisoners.”*

(Professional respondent, Criminal justice sector)

*“The health provider wasn’t involved in the ACCTS, this is managed differently in different prisons, it can be a capacity issue for the health provider to attend.”* (Professional respondent, Health sector commissioner)

However, preventing self-harm and suicide is also identified as something that must be recognised much earlier in the system, taking full account of the overall vulnerability of trans offenders:

*“No one takes responsibility – the people who have died in prison were known somewhere in the health system.”* (Professional respondent, Academia)

*“Pre assessment is not good enough, people don’t get the right support early enough.”* (Professional respondent, Health sector practitioner)

## Case study B

*A Serious Incident review took place after a female trans prisoner removed her testicles using a razor blade and flushed them down the toilet. She was immediately transferred to hospital where she received emergency treatment and shortly afterwards was returned to the prison. The incident was initially referred to as 'self-harm' but after talking with the prisoner, she was very clear that it was a deliberate and well thought out act of 'self surgery' and not an attempt at self-harm nor a cry for help. The emergency consultant who treated it in the first instance said that 'she had done a good job.' A Multi-disciplinary team case conference was held under ACCT procedures and chaired by the mental health provider. The primary emphasis was on how to best help the person, to meet their individual needs and keep them safe.*

*Some initially thought that she should be transferred to a psychiatric unit, but on reflection this was questioned as the best response, as the person concerned had already spent time in such a unit and had returned to the prison after it did not work out. So, an independent psychiatric consultant with experience of gender identity was brought in to conduct a review of the case. It was established that the prisoner had never actually received a formal diagnosis of gender dysphoria and had been primarily regarded as someone with an unstable personality disorder with no real recognition of her gender issues. A Gender Identify Clinic (GIC) had previously rejected her for treatment as she was regarded as not being able to 'live in role' in the community as a result of being in a male prison. She had in fact been living in role consistently for more than two years within her 'community' - the prison community and attended education, visits and work in female role.*

*The consultant, having reviewed her case, went back to the GIC and requested that they re-assess her on the basis that she did in fact have real life experience. She is now awaiting an appointment with the GIC. The report and findings of the case review and decisions made have been shared with the prisoner in an open and transparent way. Concerns about her safety and wellbeing remain for example, she has expressed ideas of suicide and feelings of hopelessness that anything can change for her.*

*Despite having been under mental health care provision for a long time, this had not addressed her gender identity as a trans woman and what additional support services could be provided. As a result of the case review there have been three significant developments: a review of her sentencing pathway and parole is considering the viability of transfer to the female estate; a trans advocate has been identified from a local LGBTQ agency and training is being introduced for health staff and officers.*

*The specific learning from the case review highlights the need for consideration of gender identity alongside any underlying psychiatric disorders.*



## ***Health and social care pathways***

One of the key insights from respondents and in the literature is that the health and social care pathways for trans offenders are reactive, disjointed and lack co-ordination:

*“We need joint work between the prison and healthcare, to be less reactive”*  
(Professional respondent, Health sector practitioner)

*“We need more integrated work for these very complex issues.”* (Professional respondent, Health sector practitioner)

*“There is a lack of co-ordination between agencies.”* (Professional respondent, Social sector)

*“We need to avoid fire fighting.”* (Professional respondent, Social sector)

*“We are too reactive, things happen when it goes wrong.”* (Professional respondent, Criminal justice sector)

In particular, respondents thought that there was excessive gatekeeping for trans offenders, often resulting in care pathways being fractured:

*“There is a lot of gate keeping, it is a double punishment, too many barriers are put in the way...it's not equality.”* (Professional respondent, Social sector)

*“It's not just about having healthcare involved, all management weaknesses come into play.”* (Professional respondent, Criminal justice sector)

*“Trans care needs are drowned out by the other health needs in prison.”*  
(Professional respondent, Health sector practitioner)

*“We don't have consistently good services. There is recognition on health and security side that we need to improve.”* (Professional respondent, Health sector commissioner)

*“The cases are very complex, it takes a lot of effort to sort out the care needs and it's complicated by where people come from, the geographic disbursement of people and who pays for what care. HMPPS and healthcare need to be more joined up to ensure continuity of care.”* (Professional respondent, Criminal justice sector)

*“Trans people in prison are only given access to parts of the pathway, but can't access hair removal or surgery, so it's incomplete.”* (Professional respondent, Health sector practitioner)

*“There are a lot of gatekeepers when it comes to trans health care, whether it's about social transition or medical transition.”* (Professional respondent, Social sector)



*“There are enormous differences in health service responses across the prison estate, all kinds of barriers are put in place, attitudes about trans people, how to handle their care and treatment – some prisons won’t accept self identification of gender identity and insist that someone has to have a medical assessment to prove they are actually trans, this is wrong.”*  
(Professional respondent, Health sector practitioner)

The need for an integrated care pathway that takes account of gender identity and other health and social care and justice related needs and issues, is required at the level of policy:

*“Need focus on this in mental health policy.”* (Professional respondent, Government Department)

*“There are parallels with BME policy, it’s about culture change and how policy affects different population groups.”* (Professional respondent, Government Department)

*“The policy context keeps changing in general and this impacts on what is known and how things develop, information is in a constant state of flux.”*  
(Professional respondent, Criminal justice sector)

But more fundamentally, in practice:

*“We need to cascade policy to operational practice in this area, that is the challenge now, simple things like using appropriate pro-nouns, not mis-gendering people, we need more work to make services appropriate in their responses and how they deal with trans people.”* (Professional respondent, Criminal justice sector)

*“There is a lot of uncertainty on the health side, there needs to be clear guidance, standards of practice in this area.”* (Professional respondent, Criminal justice sector)

*“There needs to be specific health standards for trans people in the criminal justice system.”* (Professional respondent, Health sector commissioner)

*“There would be value in having an overall specification that takes account of the needs of trans prisoners – a PSI equivalent for the NHS.”* (Professional respondent, Health sector practitioner)

*“We need to build the case for what a good model of quality and excellence looks like for trans healthcare in the criminal justice system.”* (Professional respondent, Health sector commissioner)

## ***Hormone therapy and related prescribing***

One of the more complex and challenging areas raised by respondents relates to prescribing of hormone therapies and related medicines to support transition:

*“We need to empower people on the ground to manage and access medicines better.”* (Professional respondent, Health sector commissioner)

*“There are NICE standards on hormonal treatment but these are not specific to trans people.”* (Professional respondent, Health sector commissioner)

*“We need to understand the issues for reception, on transfer and for release in terms of specialist medications and other hospital treatments.”*  
(Professional respondent, Health sector practitioner)

In particular, respondents raised concerns about trans individuals being able to continue hormone and related therapies on entering prison:

*“There are continuity of care issues re hormone therapy, understanding why certain medicines are being taken, professionals need to be prepared for this.”*  
(Professional respondent, Health sector commissioner)

*“We need more clarity on the continuity of care issues for medicines like hormone therapy, how to get these to people in a reasonable time, being able to provide reassurance if there are no risks re not being prescribed these medicines, it can be a real cause of anxiety for trans people.”* (Professional respondent, Health sector commissioner)

*“We have two or three trans individuals in the female estate, one is going through transition, has been doing it on her own with no support, so there was no history or previous health notes on this, she had been buying hormones on the Internet and was very distressed when these were stopped, staff can feel inept at dealing with needs, physical and psychosocial – in prison it is especially challenging.”* (Professional respondent, Health sector practitioner)

The issues can be especially complicated when individuals have been self-prescribing through the Internet or private prescriptions:

*“If people are self medicating in the community, there are no routes to continue this in prison.”* (Professional respondent, Health sector practitioner)

*“Prescribing can be a challenging issue for prisons, if someone has been self prescribing or have received medications from a GP that is too quick to prescribe. It can be difficult to know what our responsibilities are.”*  
(Professional respondent, Health sector practitioner)

*“I had been taking hormones for 12 months, but because I bought them myself, the prison wouldn’t prescribe, it was stopped because not NHS. When stopped my mental health became worse and my joints swelled up.”* (Trans female prisoner)

*“It is hard when they have been buying hormones off the Internet, we can’t prescribe...”* (Professional respondent, Health sector practitioner)

There is reluctance amongst health professionals including amongst medical staff and the wider health team to prescribe hormone therapies for trans individuals:

*“There is a reluctance to prescribe because they are on higher doses than normal prescriptions.”* (Professional respondent, Health sector practitioner)

*“The medical staff are supposed to prescribe the hormones, senior people in the prison system didn’t realise this – there needs to be more awareness of this and the need for bridging prescriptions, health staff in prison need to be more confident in this area of prescribing.”* (Professional respondent, Social sector)

*“Prescribing hormones is a problem, they aren’t licensed, we need specialist guidance.”* (Professional respondent, Health sector practitioner)

*“Healthcare staff need to be aware of the issues and differences, not be afraid of prescribing at higher doses. The dosages and pathways may be different but the meds are run of the mill.”* (Professional respondent, Health sector commissioner)

This is an issue that is also common in the community:

*“The GMC said that GPs were not happy to prescribe hormones, that most GPs were unfamiliar with the medications and doses, didn’t have the expertise, they were backed by the BMA but the issue is still with NHS England to make things clearer.”* (Professional respondent, Health sector practitioner)

However, trans individuals in the prison system are thought to be at particular risk with respect to missed doses and cessation of prescribing:

*“Missing doses can cause people a lot of stress, professionals need to understand this and be able to reassure people.”* (Professional respondent, Health sector commissioner)

*“We need to pick up medication needs at reception, so we don’t disrupt the pathway, pick up needs and verify as soon as possible.”* (Professional respondent, Health sector practitioner)

Being able to ensure continuity of treatment, however it has been prescribed or obtained, is thought to be a priority for healthcare:

*“Continuity of hormone treatment is a big issue, it is bad enough being in prison but it is unthinkable how the interruption of treatment can affect people. Even if medical people are willing to prescribe from compassionate grounds, the system doesn’t support them to do this.”* (Professional respondent, Social sector)

*“We need to reduce the trauma of when first placed in the system – bridging prescriptions for hormones would help.”* (Professional respondent, Criminal justice sector)

The General Medical Council, Royal College of Psychiatrists, GIREs, the Welsh Government, some CCG's and Action for Trans Health recommend that medical professionals take a harm reduction approach to trans people who are self-medicating and focus on ensuring the safety and efficacy of the medication they are taking, rather than advising the trans person to stop taking the hormones altogether. This can include ensuring the patient has access to clean equipment and providing 'bridging prescriptions' for medication (Royal College of Psychiatrists, 2012; GMC, 2016). However, for most health professionals, this will only be undertaken with the involvement of a Gender Identity Clinic (GIC):

*“If someone came in with a prescription of hormones we would ensure it was continued, the continuity of care would be important. But, if they wanted to start after coming in to prison we would only do that under the guidance of the GIC.”* (Professional respondent, Health sector practitioner)

This issue is discussed further under the section on care pathways and Gender Identity Clinics below.

## ***An integrated care pathway***

One of the most commonly cited issues by respondents, and in the evidence base, for trans offenders is the capacity and ability to access an integrated care pathway. This is often due to the conflation of or confusion about gender identity with other related health problems:

*“The doctors put my state of mind down to other disorders, they refused to recognise my gender dysphoria.”* (Trans male prisoner)

*“Being an offender can detract from getting the right healthcare at the outset.”* (Professional respondent, Health sector commissioner)

*“Trans issues are subsumed under mental health, it can be mis-diagnosed as mental health.”* (Professional respondent, Academia)

*“People say they are just being trans to access better care, but it is a distraction from looking at their real needs.”* (Professional respondent, Social sector)

Care pathways can be particularly challenging for trans people with complex needs including gender identity, mental health and/or substance use problems:

*“It's not just about gender identity – the whole cycle of pathology can create conflicts for people.”* (Professional respondent, Health sector practitioner)

*“It’s hard to give direct support in this context, nothing is clear, they are dealing with mental health problems and the impact of not getting specialist support.”* (Professional respondent, Health sector practitioner)

*“It is a big ask of health teams, dealing with the complexity.”* (Professional respondent, Health sector practitioner)

*“Liaison and Diversion is crucial, thinking about prevention and initial assessments, also Drug and Alcohol Requirements criteria and what is done with respect to these. Need the right level of risk assessment and mitigation at bail and sentencing and need to understand the individual offending patterns and contributory factors.”* (Professional respondent, Health sector commissioner)

*“In the broader context trans people experience a range of service providers, GP, Gender Identity Clinic, HIV consultant – all are fractured.”* (Professional respondent, Social sector)

*“Services need to be more holistic to compensate for the lack of integrated care that trans people experience.”* (Professional respondent, Social sector)

One of the key issues identified by respondents is that trans individuals cannot access more than one care pathway at a time, for example, treatment programmes for mental health and/or substance use do not take adequate account of gender identity issues including gender dysphoria:

*“Need to join up mental health care with transgender issues, but mental health services say they must deal with mental health issues first, it’s a recipe for disaster.”* (Professional respondent, Social sector)

*“Mental health is not equipped to deal with the issues – mental health, trans and forensic – in any depth, there are very few practitioners who could deal with this.”* (Professional respondent, Health sector commissioner)

*“Prison disrupts care pathways. It feels like we get it wrong more often than we get it right and when it does go wrong, it is catastrophic.”* (Professional respondent, Health sector commissioner)

*“The care pathways are inconsistent, it increases the risk of self-harm, mutilation – healthcare need to work more closely on these issues with ACCTs.”* (Professional respondent, Health sector practitioner)

Particular issues have been identified with respect to personality disorder pathways, which can be especially challenging with respect to trans offenders:

*“The personality disorder pathway is for a specific group of offenders who are at high risk of future violence and offending – it becomes complex when interacts with trans issues, we need to separate these out in the pathways.”* (Professional respondent, Health sector commissioner)

*“Need better recognition of where forensic and mental health needs and pathways come together. Prison, probation and healthcare need to work more closely on this.”* (Professional respondent, Health sector commissioner)

*“The personality disorder pathway may not be best one, but it is where the therapies are. If it get results then that is good, but it pigeon holes people.”* (Professional respondent, Health sector commissioner)

*“If people are supported to transition, does this resolve the personality disorder issues?”* (Professional respondent, Health sector practitioner)

*“Some personality disordered people are also gender disordered.”* (Professional respondent, Health sector practitioner)

*“A number have personality disorders, very complex behaviours.”* (Professional respondent, Health sector practitioner)

*“Identity disturbance is part of personality disorder but it can be hard to sort out the differences with gender identity disorder.”* (Professional respondent, Health sector practitioner)

*“Presentation in prison can be similar for personality disorder, self-harm, mood swings, etc. People can be trans and be personality disordered at same time. We need to try and sort out what is happening, the risk is that personality disorder becomes a catch all label.”* (Professional respondent, Health sector commissioner)

This can become particularly problematic with respect to therapeutic communities for prisoners with personality and other mental disorders and trans individuals:

*“In the therapeutic community there was no accounting for transgender, I was there for a year and there was no equality, no compliance with the PSI, I started to seriously self-harm there and I haven’t done any of that since being back in a normal prison.”* (Trans female prisoner)

*“It can be difficult for trans people on a personality disorder pathway or environment like a personality disorder wing in prison, the staff say they can’t deal with trans issues at same time as personality disorder.”* (Professional respondent, Health sector practitioner)

*“The therapeutic treatments on offer, whether it’s for personality disorder or in a therapeutic centre environment for psychological therapies, won’t allow two treatments at once. Working through gender dysphoria should go well with therapies, but trying to have two separate pathways doesn’t work well.”* (Professional respondent, Criminal justice sector)

*“It can be difficult for trans people in a therapeutic community, the therapists say that they can’t address therapeutic issues at same time as treatment for transition, but it isn’t logical – they wouldn’t say same thing about cancer treatment or other life saving treatments.”* (Professional respondent, Health sector practitioner)



While care pathways can be complex to navigate and ensure appropriate continuity for all trans people, one of the most challenging is with respect to access to Gender Identity Clinics (GICs).

## ***Gender Identify Clinics and offender health care pathways***

This review of the health and social needs of trans offenders has taken place at the same time as a formal public consultation on proposed service specifications for the specialised services delivered by Gender Identity Clinics (GICs), as commissioned by NHS England:

*“They need to take account of offender pathways in the Gender Identity Clinic consultation.”* (Professional respondent, Criminal justice sector)

*“It is important that the consultation on the GICs takes account of offender pathways.”* (Professional respondent, Social care sector)

Close liaison has taken place between the respective commissioning departments for offender health and specialised services within NHS England, in the expectation that this review and report will be considered alongside the responses to consultation and will inform NHS England’s understanding of the issues that are relevant to a successful implementation of the new specification in offender health settings. In order to provide a considered response to the particular issues that arise in the context of offender health care pathways for trans individuals seeking the services of a GIC, the following issues have been identified.

### **Access**

In common with those in the community trans people in the criminal justice system experience long delays for appointments as a result of the waiting lists for GIC appointments:

*“The waiting times for the GIC are very long.”* (Professional respondent, Health sector practitioner)

*“The GICs are under immense pressures from increasing demands, they are small services, not set up to manage this level of demand.”* (Professional respondent, Health sector practitioner)

*“There are significant barriers for prisoners to access GICs, we struggle with this.”* (Professional respondent, Criminal justice sector)

*“They [the GIC] said come back when I am released.”* (Trans female prisoner)

However, for trans people in prison there can be additional issues related to where they are placed in the prison estate:

*“The distance of a prison from a GIC will affect the likelihood of receiving a service.”* (Professional respondent, Criminal justice sector)

*“The main problem, due to where the prison is located, is access to a specialist GIC service, this can raise issues for someone who has come in to the prison and they are already under a GIC then they can be worried about whether they will be able to continue with their appointments.”* (Professional respondent, Health sector practitioner)

*“Continuity of care can be difficult if the prisoner has come from further away and had treatment under the GIC in that area.”* (Professional respondent, Health sector commissioner)

*“NHS England needs to do more to support the transfer process, especially with regard to access to GICs, if the person is being moved far away from this.”* (Professional respondent, Criminal justice sector)

There are also particular issues with respect to the capacity and resources in the prison system to ensure escorts for appointments at a GIC:

*“Access to GICs is an issue as many are based a long way and it can create problems if escorts are needed.”* (Professional respondent, Health sector practitioner)

*“People are being punished twice – if they miss a GIC appointment then they are put back to the bottom of the queue, regardless of the reason. This is particularly difficult for people in prison where they have no control over their attendance.”* (Professional respondent, Social sector)

One of the ways that respondents found to be most useful, is if the GIC comes in to the prison:

*“It would be helpful if the GIC came into the prison, rather than prisoners having to go out.”* (Professional respondent, Health sector practitioner)

*“The GIC come in, it makes it easier, they work together with the offender, the prison staff and healthcare.”* (Trans female prisoner)

*“If the GIC comes in it can save escort days for the prison and avoids the harrowing disappointment for trans offenders missing key GIC appointments because no escort is available.”* (Professional respondent, Social sector)

*“The In-Reach service can make a big difference, it works both ways, we can share risk assessments and knowledge about the prisoner and they can support us, help to inform our decision making and management of the person.”* (Professional respondent, Criminal justice sector)

*“The relationship with the GIC really helps, the in-reach service has enabled a joined up approach across health, psychology, offender management and gender. It improves understanding about risk and enables to meet needs holistically.”* (Professional respondent, Criminal justice sector)

*“We need GICs to go into prisons, it is even more important for those that are far from a GIC.”* (Professional respondent, Criminal justice sector)



Having an In-Reach service from the GIC is also thought to be important from the perspective of dignity and privacy:

*“If prisoners are attending a GIC they have to be escorted, in handcuffs, it would be better for the person in terms of dignity and respect if the GIC came in.”* (Professional respondent, Health sector practitioner)

There are very few examples of GICs coming in to prisons and where this service does exist it is normally outside of the normal contract arrangements for example it is commissioned on a local or regional basis:

*“In-reach to the prison has worked well, but it is not clear what will happen in the future.”* (Professional respondent, Health sector practitioner)

In-reach provision can also be problematic for the GIC in terms of the impact on waiting times and resources:

*“It takes longer to work with people in prison, the psychological assessment can be longer, more complex issues, people’s motivations in prison may be different so we have to be cautious but going in to the prison works.”*  
(Professional respondent, Health sector practitioner)

*“The 18 week wait is a problem, GICs struggle with this in the community and it is even worse for prisoners – very hard to meet it in the community, impossible for people in prison. It takes a very long time just to set up one appointment and people miss them due to security lock downs or other things – but it impacts on the broader service targets. In reality why would a GIC want to do prison work? There are no incentives, it’s actually a disincentive.”*  
(Professional respondent, Health sector practitioner)

*“It can be very difficult doing a clinic in a prison – you would only have two people booked in rather than 3 or 4 in the community, so if they don’t turn up it has a significant impact on waiting times – various things affect this, lock downs, security, if people have a legal appointment or court case then they don’t attend the clinic.”* (Professional respondent, Health sector practitioner)

There is also some confusion about the contracting arrangements for GICs with respect to the care and treatment of trans offenders:

*“There is confusion about who is responsible for what care, there used to be a separate arrangement for prisons, but it was expensive, it can be very difficult to get prisoners out to the clinics but this is what would happen if it was mainstream, like other community services.”* (Professional respondent, Health sector practitioner)

*“The GICs are all commissioned differently, if on a block contract it can be hard to manage the demand.”* (Professional respondent, Health sector practitioner)

*“Why should prisoners have a fast track to a GIC? It is important, but not more so than for someone in the community. There are ways round it, can do assessments by video or get the GIC to come into the prison.”* (Professional respondent, Health sector commissioner)

Some respondents thought that there should be specific contracting arrangements for GICs to cover prisons:

*“There needs to be a service level agreement with the GICs, a formal agreement on how to decide on the care pathway, how to access the specialist help that is needed.”* (Professional respondent, Health sector practitioner)

*“We need some facility locally to improve access to more specialist care and treatment, it needn’t be in-reach, it could be about being able to access a more local setting.”* (Professional respondent, Health sector practitioner)

*“If the GIC contract is clear then it is easier, can follow same protocols for someone who is in prison, but GICs are not geared up to work in prisons, it would work better on a fee for item basis rather trying to fit this in as part of a block contract, this would allow a more comprehensive service for the prisons.”* (Professional respondent, Health sector practitioner)

## **Experience**

There are mixed reports on the experience of GICs within criminal justice care pathways:

*“The GICs spend a very limited amount of time with people, for those in prison the GIC would only see those who have recently started to transition or decided to do so while in prison.”* (Professional respondent, Health sector practitioner)

*“The GIC is located in the mental health unit, it can be a poor experience for people to attend.”* (Professional respondent, Health sector practitioner)

*“There is poor communication with the GICs”* (Professional respondent, Health sector practitioner)

*“I had a very long wait for the GIC, but I fell out with the doctors and had to be referred to another GIC.”* (Trans male prisoner)

The involvement of a GIC is viewed as important with respect to the prescribing of hormone and related therapies:

*“The prison GP is not happy to prescribe hormones without instruction and guidance from the GIC.”* (Professional respondent, Health sector practitioner)

*“The prison doctors will only prescribe if the GI Clinic is involved.”* (Professional respondent, Health sector practitioner)

However, the waiting times for referral and assessment to a GIC can have an impact on this:

*“It can be a four month wait to get a re-assessment for hormone therapy.”*  
(Professional respondent, Health sector practitioner)

*“People self prescribe from the Internet or a private doctor because they can be left in no-mans land while waiting such a long time for an NHS service.”*  
(Professional respondent, Health sector practitioner)

Having been previously rejected for treatment by a GIC is also reported by respondents as a reason why people self prescribe. In these circumstances, it is unlikely that the GIC would support continuing the prescription:

*“There are problems if people have been self medicating, or if refused treatment for transition by the GIC.”* (Professional respondent, Health sector practitioner)

*“I proved it to myself, I bought hormones on the Internet because the GIC wouldn’t prescribe them for me – the hormones worked, I felt better, my mental health problems were better and everything fell into place.”* (Trans female prisoner)

*“The person was quite young, mid twenties, first time offender, had been living in role several years and was self medicating having sourced hormones on the Internet, the doctor wanted to help so prescribed hormones, but on exploring the primary care record further, the GIC had said they were not suitable for hormones. We have to protect ourselves and the patient, so it has been stopped.”* (Professional respondent, Health sector practitioner)

Some respondents felt that the care pathway for offenders into GICs could be too restrictive, with trans offenders being rejected for treatment due to having a range of complex needs:

*“The GICs refuse to treat people if they have mental health problems, substance problems – they expect people to sort these out first, but that can be difficult if it is all tied up with their gender dysphoria.”* (Professional respondent, Health sector practitioner)

*“The GI Clinics won’t take people if they are using alcohol or drugs, it would be better if they worked more closely with people on resolving the problems, rather than a blanket refusal to work with them.”* (Professional respondent, Health sector practitioner)

*“We had a trans female, she had been rejected by the gender identity service, because of using drugs and alcohol.”* (Professional respondent, Health sector practitioner)

*“The GICs need to recognise and acknowledge the need for a clear pathway for offenders.”* (Professional respondent, Health sector practitioner)

Exclusion criteria for non-surgical treatment at a GIC under the current consultation on the procurement of GICs states that:

*“Referrals will not be accepted of individuals:*

*With acute physical or mental health problems that may affect capacity or the individual’s ability to engage in the assessment process...” (NHS England, 2017. 3.1)*

With respect to specialised, specific psychological interventions, the draft consultation states:

*“Psychological interventions will not be offered in the case of any unmanaged acute or severe and enduring mental health problems; active risk to self or others; problematic or unmanaged substance misuse; neurodevelopmental problems; or a person’s unwillingness to engage in psychological interventions.” (Ibid. Appendix I: Specialised, specific psychological interventions)*

Furthermore, the guidance states that:

*“Where a person is engaged in psychotherapy with non-specialist services and psychological needs related to gender dysphoria are identified, both services will, in collaboration with the individual, agree on the priority of psychotherapy interventions.” (Ibid. Appendix I: Specialised, specific psychological interventions)*

With respect to prescribing of hormones, the guidance states:

*“If significant medical or mental concerns are present, they must be reasonably well-controlled.” (Ibid. Appendix J: Current arrangements for prescribing)*

Amongst professionals and trans offenders, there appears to be poor or uncertain understanding about these criteria and the implications for trans people in the criminal justice system, especially prisons:

*“The GICs don’t work well with complex needs, the referral process stalls and people are left in limbo. As service providers we are left to pick up the pieces.” (Professional respondent, Criminal justice sector)*

*“If someone is on ACCTs, if they are self-harming, acting out all the time then they need to be told that, to have it more clearly explained that can’t get on to transition if they carry on like that.” (Trans female prisoner)*

Experience of GICs for offenders can also be affected by criteria with respect to living in role:

*“The GICs won’t accept people living in role while they are in prison.” (Professional respondent, Social sector)*

*“The GICs aren’t the gender police, they may not agree with someone entering a treatment pathway but they wouldn’t stop them expressing themselves in the gender they identify with.”* (Professional respondent, Health sector practitioner)

The NHS guidance states that:

*“It is not a requirement for access to endocrine and other pharmacological interventions to undertake a change in social role.”* (Ibid. Appendix J: Current arrangements for prescribing)

However, referral for surgical interventions requires:

*“12 continuous months of living in a gender role that is congruent with their gender identity...”* (Ibid. 2.18: C Criteria for genital surgery - metoidioplasty or phalloplasty, and for feminising genital reconstruction, with or without vaginoplasty).

Respondents reported that trans individuals in the prison system, whether or not they are seeking surgical interventions, can be refused treatment at a GIC on the basis that they cannot be living in a gender role that is congruent with their identity while in a prison:

*“The GICs can be too risk averse to prisoners living in role, they are afraid to get it wrong.”* (Professional respondent, Social sector)

*“We need reassurance that GICs are not prejudiced against prisoners/offenders – there needs to be an opportunity to challenge them on this.”* (Professional respondent, Social sector)

The GIC guidance goes on to state that the 12 month requirement for living in role:

*“...must not entail a requirement for the individual to conform to externally imposed or arbitrary preconceptions about gender identity and presentation; this requirement is not about qualifying for surgery, but rather preparing and supporting the individual to cope with the profound consequences of surgery; where individuals can demonstrate that they have been living in their gender role before the referral to the Provider, this will be taken into account.”* (Ibid. 2.18: C Criteria for genital surgery - metoidioplasty or phalloplasty, and for feminising genital reconstruction, with or without vaginoplasty).

Although the 12 month requirement relates to referral for surgical procedures, respondents thought that there needed to be a more shared understanding about the criteria and support for people to live in role while in prison:

*“HMPPS can be very rigid about people living in role, but they have their own limitations, nevertheless it impacts on healthcare. Healthcare providers don't always fight against this as much as they could, they can become institutionalised in this context.”* (Professional respondent, Health sector commissioner)

*“The rule for Chest Reconstruction surgery for Trans Masculine people can be as short as 3-6 months living in role /cross sex hormone treatment at some NHS GIC’s.”* (Professional respondent, Social sector)

## **Outcomes**

Effective contact with a GIC for offenders is viewed as having a positive impact on health, wellbeing and reoffending:

*“GICs should be less judgemental, people have got into trouble as a consequence of being trans, problems they encountered when coming out and the pressures of bad treatment in the past – dealing better with this will help prevent them offending in the future.”* (Professional respondent, Criminal justice sector)

*“We can take comfort that someone is engaging with a GIC, that they have a true desire to live in this role and its not manipulation. It helps assess and manage risks, supports us in making decisions about where to place someone, providing treatment.”* (Professional respondent, Criminal justice sector)

There is no hard data on outcomes for trans offenders engaging with GICs. However, respondents do call for a more joined up approach between healthcare, GICs criminal justice agencies and offender healthcare providers to enable more effective outcomes for trans offenders:

*“There needs to be a prompt response to gender dysphoria and it needs treatment in tandem with mental health and other care pathways, not being treated as something else or as something that is not as urgent and relevant.”* (Professional respondent, Social sector)

*“NHS England need to acknowledge that management of trans people in prison is not easy, it needs partnership across a range of agencies and services, the GICs, HMPPS, prison healthcare.”* (Professional respondent, Health sector practitioner)

*“There needs to be more joint working between the GICs, prisons and probation. The strong evidence in the PSI asks for proof that someone is engaged with medical services, but there needs to be a much closer relationship to make this work.”* (Professional respondent, Criminal justice sector)



## **Social sector support and engagement**

Alongside the need for appropriate and integrated health care pathways there is a need for greater involvement and engagement with the trans social sector:

*“There needs to be third sector involvement, something to bridge the gap between the specialist services, the GICs and other services, a more community based model with satellite clinics.”* (Professional respondent, Social sector)

*“There is a lot of scope for peer support, getting trans people involved.”* (Professional respondent, Social sector)

However, respondents point out that this will not take place without appropriate funding and support:

*“It makes a big difference having trans support people coming in, they are a local group, but they don’t have any funding to do this work so its hard for them.”* (Trans female prisoner)

*“We need the trans community involved more, but there are a lot of groups out there and they aren’t all saying the right things, the NHS and the prison service need to know who they can work with. Who is safe and knowledgeable?”* (Professional respondent, Social sector)

*“Trans social sector involvement is important, groups are keen to be involved, just need to be a little bit careful about what people are asked to do and what evidence there is that they are capable and competent. NHS staff could help train more people in the trans social sector.”* (Professional respondent, Social sector)

*“It can be difficult to get the trans community involved, some people have their own agendas and it is hard to manage this, they try to persuade people that their way is the best way but this is not always the case.”* (Professional respondent, Criminal justice sector)

*“There is a need for some form of accreditation for people providing training and support services, but who would do this?”* (Professional respondent, Criminal justice sector)

Two of the particular benefits that involvement of the trans sector could bring are in terms of befriending and advocacy:

*“Buddying helped, I had this in one prison, a trans person came in to the prison to talk to me, support me, it worked, there should be more trans people coming in to prisons to buddy people.”* (Trans male prisoner)

*“Befriending would be good, if people could come in to the prison to support real life experience.”* (Professional respondent, Criminal justice sector)

*“There is a need for Real Life Experience support in the system, independent of the GICs or any formal counselling, it would be a way that trans people could express any doubts they have safely.”* (Professional respondent, Criminal justice sector)

*“Trans advocacy would provide a quick win – this kind of support should be explicit and up front, rather than reacting to problems when something serious happens.”* (Professional respondent, Health sector practitioner)

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

## ***Through the Gate***

Continuity of care for trans individuals leaving the prison system and the appropriateness and effectiveness of Through the Gate services, has been raised by respondents as an area of concern:

*“There are so many issues on leaving prison – housing, benefits, integrated drug treatment system support, registering with a sympathetic GP – it all needs sorting out in a way that takes account of their trans status.”* (Professional respondent, Criminal justice sector)

*“Trans people are very vulnerable when they come out of prison, they are often isolated, if transitioned while inside they could have lost all contact with family and friends, they desperately need support at this stage.”* (Professional respondent, Social sector)

*“There needs to be something post prison, better aftercare, something that can support trans people appropriately.”* (Professional respondent, Social sector)

*“I don't know where I will be on release, I am worried about being in a probation hostel, how I will be treated.”* (Trans male prisoner)

The relative lack of attention to trans health and social care needs while inside prison can have an increased impact on release:

*“Prisons try hard to not look at the issues for trans prisoners. So the full impact hits people when they go out.”* (Professional respondent, Health sector practitioner)



*“The judge said that the person’s trans issues needed to be addressed in prison, but they came out having had no treatment despite being seen at the GIC for several years – the GIC wouldn’t accept that being in prison constituted real life experience in the gender they identified with.”*  
(Professional respondent, Criminal justice sector)

There is also a concern that some of the complications and challenges of placing trans people appropriately within the prison estate can impact on their subsequent release, for example, reduced opportunities to be placed in a resettlement prison:

*“Some open prisons won’t accept trans prisoners, they think the need for security concerns would be too high, but it means that trans prisoners are having to be released from higher security prisons without proper preparation for living outside and resettlement.”* (Professional respondent, Social sector)

*“Prisoners normally only have a few days in a local before they are released, it is not much time to prepare people.”* (Professional respondent, Criminal justice sector)

*“Transgender prisoners need transfer to an open prison for preparation for release but this can be problematic, some trans prisoners face difficulties in being able to transfer to an open prison, which can be a barrier for trans people to enter an appropriate resettlement pathway.”* (Professional respondent, Social sector)

Inappropriate or poorly defined care pathways on release are also thought to have a negative impact on reoffending for trans people:

*“Care and treatment needs to encompass prevention of reoffending – helping people to settle back into the community.”* (Professional respondent, Social sector)

*“If the trans pathway is stopped in prison then the economic needs that may have led to crime remain relevant on release.”* (Professional respondent, Social sector)

## Skills and knowledge

Although it is undoubtedly improving, there is an acute lack of awareness and understanding about the health and social care needs of trans people in the criminal justice system:

*“The experience for trans people in the community can be bad, there is not a good understanding about the health needs of trans people. There is more general awareness, more in the media but for the average NHS practitioner, they can as clueless of the person in the street about what services are needed and what the duties are under the law.”* (Professional respondent, Health sector practitioner)

*“Even if professionals are doing the right things, out of instinct, they lack confidence and need advice, reassurance.”* (Professional respondent, Social sector)

*“There are not enough people in the prison system with experience of these issues.”* (Professional respondent, Health sector commissioner)

*“People need training on how to speak with trans individuals, how to ask question about transgender.”* (Professional respondent, Health sector commissioner)

*“People’s awareness and competence depends on whether they have had any contact with other trans people. There is only limited understanding about this as a specialist need.”* (Professional respondent, Health sector commissioner)

*“There is a need to raise awareness about these issues.”* (Professional respondent, Government Department)

*“It is hit and miss with nursing and medical staff. We need guidance, what questions to ask, what to do, how to help people – need to increase confidence.”* (Professional respondent, Health sector practitioner)

*“If 11 year olds can get awareness raising why not professionals?”*  
(Professional respondent, Health sector practitioner)

Lack of confidence amongst staff can relate particularly to helping people understand gender identity and how processes and care pathways work:

*“Staff need confidence to work through gender role issues, they can be reluctant to deal with it, unsure how to be clear with people if they are unsure about the direction they want to go in.”* (Professional respondent, Health sector practitioner)

*“We need to educate staff more, they don’t know the process, how to advocate for and support trans people, we need to explore and discuss the clinical pathways more.”* (Professional respondent, Health sector practitioner)

*“Staff don’t understand the process, they don’t know what to push for in terms of a clinical pathway, most staff thought people had to have a GRC.”*

(Professional respondent, Health sector practitioner)

*“We have no training on transgender, our background is healthcare but we don’t know what we don’t know, I would like to see training on this area.”*

(Professional respondent, Health sector practitioner)

*“Staff don’t understand the transgender pathway, what care looks like.”*

(Professional respondent, Health sector practitioner)

*“Generally healthcare staff try hard, they mean well but just need additional support and advice about trans issues and healthcare of trans people.”*

(Professional respondent, Social sector)

*“Frontline staff in probation, prison and healthcare need more understanding about the emotional and mental health impacts of transition, they don’t have this currently.”* (Professional respondent, Criminal justice sector)

*“Staff need training on understanding trans issues, gender disorder, they need educating on these things.”* (Trans male prisoner)

*“Just meeting a friendly and confident trans person can do much to remove the fear of getting it wrong and debunk many of the myths around gender diverse people.”* (Professional respondent, Social sector)

*“There is a lack of knowledge, what kind of support people need, about medications, how to refer people to specialist services.”* (Professional respondent, Criminal justice sector)

## **Capacity**

However, it is not a simple case of providing training, as there are particular capacity issues in enabling health and justice staff to attend training:

*“It’s hard to get professionals to training, they are too busy, could make this a bigger focus as part of equality training, but as it is, that is only a half day.”*

(Professional respondent, Health sector commissioner)

*“It is unrealistic to say training is the answer.”* (Professional respondent, Health sector practitioner)

*“Staff self select for training so it is mostly the converted that go on it, they are already more accepting and want to treat people in the right way – the challenge is to get the people that need the training more because of their attitudes, culture, beliefs, prejudices.”* (Professional respondent, Criminal justice sector)

*“The proof will be whether the prison allows the officers to attend the training, it can be problematic in the current staffing crisis to get people freed up to attend training.”* (Professional respondent, Health sector practitioner)

*“There is no routine training in trans issues, in equality training it only gets a mention.”* (Professional respondent, Health sector commissioner)

Respondents suggested that there needs to be a more creative and responsive approach to training and education that recognises the limited capacity and willingness of people to engage with training on these issues:

*“We need to inform the wider NHS, not just in prisons. Need to have more gender awareness as much as cultural awareness.”* (Professional respondent, Health sector practitioner)

*“Need to get simple messages out to people, key principles about not making assumptions.”* (Professional respondent, Social sector)

*“Training can take many forms, visual cues, theatre, experiential learning – we need to be more creative in training approaches with staff on this area, it has worked well in others such as addressing violence and aggression and bullying.”* (Professional respondent, Criminal justice sector)

*“There is no point trying to train GPs, they are too busy, focus on the practice managers, create clear guidelines and interventions for each GP centre so there is something for GPs to refer to.”* (Professional respondent, Social sector)

*“Liaison and Diversion have a newsletter that goes out to all schemes, we could include a case study on trans offenders and health needs in this.”* (Professional respondent, Health sector commissioner)

*“There needs to be a transgender template for health staff that takes account of the body dysphoria and reluctance to talk about their anatomy.”* (Professional respondent, Health sector practitioner)

*“There needs to be an aide memoire for reception staff, helping them to navigate a different pathway and how to make informed decisions about appropriate care.”* (Professional respondent, Health sector practitioner)

*“The E-learning package for GPs on the Royal College of General Practitioners website is a very useful, practical tool and it would make a good package for those working in prisons. NHS England could look at this in terms of their wider work on training packages, trans healthcare needs to be in all curricula.”* (Professional respondent, Social sector)

### ***Culture, management practice and leadership***

For many respondents, a far bigger challenge is to change the culture and management practices that inform practice:

*“We throw everything at training, it can be overkill, it’s not all a matter of training, it can be more about cultural and management change which takes longer.”* (Professional respondent, Government Department)

*“We need to include culture and the environment in education and training, including other prisoners and how to keep people safe.”* (Professional respondent, Social sector)

In particular, respondents highlight the need for the most senior people to take account of trans issues and needs and provide leadership on this area:

*“It all depends on the Governor and if they are healthcare orientated.”*  
(Professional respondent, Health sector practitioner)

*“I am mostly optimistic, but there is still a need for support from the top, leaders need to be clear that discrimination is not acceptable.”* (Professional respondent, Criminal justice sector)

### **Addressing discriminatory practice**

The capacity, confidence and skills to challenge poor and inadequate or discriminatory practice is seen as important:

*“Feedback from equality staff in prisons is that other staff are not really on board, not being compliant with the PSI or legal duties, there is poor practice and it is not being challenged enough, though it is still early days, there is a long way to go.”* (Professional respondent, Social sector)

*“Prison officer attitudes can be challenging, it can be hard for them to manage a trans person in a male environment or in a female prison, there are low numbers of transgender prisoners so they don't have the experience.”*  
(Professional respondent, Health sector practitioner)

*“In society people are more accepting, but in a Category B or a Reception prison, it is much harder, the prison population are less tolerant of trans people, less sympathetic. It is hard to keep people safe, they are vulnerable to violence and aggression and it is confusing for other prisoners and staff.”*  
(Professional respondent, Health sector practitioner)

*“It all comes back to education and the need to not just understand the medical side but how to have respect for people and understanding how the social needs interact with emotional and mental health needs, it's about supporting wellbeing.”* (Professional respondent, Social sector)

This needs to be part, not only of equality training, but induction and supervision of staff:

*“How do we induct people? Need to ensure we have the right cultural sensitivity and attitudes. How do we address unconscious bias?”*  
(Professional respondent, Health sector practitioner)

*“Awareness raising needs to be done in the context of broader equalities work.”* (Professional respondent, Social sector)

*“Build it into supervision, make sure staff are okay to deal with this.”*  
(Professional respondent, Health sector commissioner)

It also needs to include work with prisoners and ancillary staff:

*“There is a need to educate other prisoners.”* (Trans male prisoner)

*“Need to train ancillary workers too, admin and reception staff not just healthcare professionals.”* (Professional respondent, Social sector)

### **Recognising and sharing good practice**

Although there are clearly some significant gaps in skills, knowledge and experience in working with the health and social care needs of trans offenders there are also some areas of good practice:

*“There are a lot of good staff in the prison service who have developed sane and practical ways of dealing with the issues, they have to, you can’t look away in a prison, you have to deal with it and most staff will be practical about it.”* (Professional respondent, Social sector)

*“The mental health team here have been brilliant, they understand me and help, this is the first place where I haven’t been continually on an ACCT, I used to secretly self-harm, I haven’t done that since I’ve been here. There is more sympathy, more understanding, things are joined up.”* (Trans female prisoner)

There are a variety of national and regional resources that could help inform best practice in offender settings:

- The National LGB&T partnership has issued a series of 16 fact sheets covering many of the relevant topics that could apply well in offender settings (<https://nationallygbtpartnership.org/publications/trans-health-factsheets/>).
- The Gender Variance e-learning course, developed and funded by the Gender Identity Research and Education Society (GIREs), is available to use on the Royal College of General Practitioners (RCGP) website (<http://elearning.rcgp.org.uk/course/info.php?popup=0&id=169>).
- Working in partnership with GIREs, Surrey and Borders Partnership NHS Foundation Trust has created an e-learning course to help professionals and families understand the needs of gender non-conforming young people (<https://uktrans.info/transition/76-resources-for-other-or-all-organisations/424-e-learning-caring-for-gender-nonconforming-young-people>) GIREs are also in the process of providing e-learning for all NHS Wales staff.
- With funding from the Department for Communities and Local Government, GIREs have produced a three module e-learning resource for Transgender Awareness for Employers & Service Providers (<http://www.gires.org.uk/e-learning/transgender-awareness-for-employers-service-providers/>).



- With support from the Learning and Skills Council (LSC), Department for Business, Innovation and Skills (DBIS) and the Forum for Sexual Orientation and Gender Identity Equality in post school education, GIRES have produced an online training and development course for promoting trans equality in Further Education (<http://www.gires.org.uk/e-learning/promoting-trans-equality-in-further-education/>).

Other resources include:

- Information on Screening for Trans people (<http://www.screeningforlife.wales.nhs.uk/transgender-information>), which includes a booklet, FAQ's and several videos.
- Fair care for trans patients – An RCN guide for nursing and health care professionals (<https://www.rcn.org.uk/professional-development/publications/pub-005575>) (Second edition. The Royal college of Nursing).
- Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Non-binary People (Center of Excellence for Transgender Health, Department of Family & Community Medicine' University of California, San Francisco. 2nd Edition – Published June17, 2016 (<http://transhealth.ucsf.edu/pdf/Transgender-PGACG-6-17-16.pdf>).
- World Professional Association for Transgender Health Standards of care for the health of transsexual, transgender and gender nonconforming people. (V7. 2012. ([http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=3926](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926)).
- UK Standards of Care and Guidance CR181 Royal College of Psychiatrists Good practice guidelines for the assessment and treatment of adults with gender dysphoria ([http://www.rcpsych.ac.uk/files/pdfversion/CR181\\_Nov15.pdf](http://www.rcpsych.ac.uk/files/pdfversion/CR181_Nov15.pdf)).
- Trans, A practical guide for the NHS Department of Health (<https://www.gires.org.uk/department-of-health-literature-project/> and <http://www.gires.org.uk/wp-content/uploads/2017/03/doh-trans-practical-guide.pdf>)
- NHS Direct England: Gender Dysphoria guidelines (<http://www.nhs.uk/Conditions/Gender-dysphoria/Pages/policy-guidelines.aspx>).
- Transgender Health (<http://www.nhs.uk/LiveWell/Transhealth/Pages/Transhealthhome.aspx>).
- The Endocrine Society - Clinical Practice Guideline Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons (<https://academic.oup.com/jcem/article/102/11/3869/4157558> and <https://doi.org/10.1210/jc.2017-01658>).

- Unison Transgender Factsheet (<https://www.unison.org.uk/content/uploads/2016/09/Transgender-workers-rights.pdf>).
- Working with Tran Children and Young People - Tavistock and Portman NHS Foundation Trust ([www.tavistockandportman.nhs.uk](http://www.tavistockandportman.nhs.uk))
- Gender Identity Development Service (<http://gids.nhs.uk/working-therapeutically>)
- Working with Older Trans/Gender Diverse people Age UK - Transgender Issues and Later Life ([http://www.ageuk.org.uk/Documents/ENGB/Factsheets/FS16\\_Transgender\\_issues\\_and\\_later\\_life\\_fcs.pdf?dtrk=true](http://www.ageuk.org.uk/Documents/ENGB/Factsheets/FS16_Transgender_issues_and_later_life_fcs.pdf?dtrk=true))

In addition, the TranzWiki directory of support groups lists most of the National and local support groups by geographical location ([www.gires.org.uk](http://www.gires.org.uk) and [www.gires.org.uk/support-group-wales](http://www.gires.org.uk/support-group-wales))

Respondents called for greater sharing of good practice across the criminal justice system:

*“We need to get better at sharing learning and best practice, to reduce risks.”* (Professional respondent, Health sector practitioner)

*“We need to share learning more.”* (Professional respondent, Criminal justice sector)

*“Some teams have someone with a special interest in this area and that can help. We should have this focus, but can’t have a special focus on every group.”* (Professional respondent, Health sector practitioner)

*“There is good practice but is hidden.”* (Professional respondent, Health sector commissioner)

*“We need to identify where good practice is, look at training needs under Service Level Agreements, contracts for baseline under the Equality Act etc.”* (Professional respondent, Health sector practitioner)

*“Take some time to find and use the personal experience of staff, they often have personal experiences of things, similar issues that they can draw on and it really helps other staff to understand., it can be a very strong way to give them confidence.”* (Professional respondent, Social sector)

*“Work more with prison governors, they know what is going on and have some real experiences that can be valuable in helping with this area, take them on board as partners and you will be pleasantly surprised.”* (Professional respondent, Social sector)



Building on the good practice and experience that exists in the system could be done through development of trans offender healthcare champions:

*“We need healthcare champions, regional pathway managers. Create a network, train people and then they can share their knowledge.”* (Professional respondent, Social sector)

The importance of lived experience and the active engagement of trans people themselves is also recognised as being essential:

*“Get trans people involved in making changes and recommendations.”* (Professional respondent, Social care sector)

*“There should be a national resource, a network – something that brings trans experience and healthcare closer together, recognising the importance of real life experience.”* (Professional respondent, Social sector)

*“We need a contact number, a single place to get advice and support.”* (Professional respondent, Criminal justice sector)

*“Champions are needed, people who can provide information and support.”* (Professional respondent, Criminal justice sector)

*“There should be a network – national and regional – a forum for support and advice, guidance.”* (Professional respondent, Criminal justice sector)

## Recommendations

The report has highlighted the wide range of ways in which health and social care needs for trans individuals in the criminal justice system can result in heightened risk and vulnerability, particularly with respect to mental health, wellbeing and the experience of fractured and disjointed care pathways. The following recommendations take account of the evidence from the literature review and from respondents' views and experiences.

In large part the recommendations are addressed to NHS England and the providers of offender healthcare. But it is important to also recognise that this is an integral part of, and not separate to the wider criminal justice system. With that in mind, recommendations have been included that require co-operation and joint action from health and justice partners, working together to ensure that trans individuals in the criminal justice system are kept safe from harm, are enabled and supported to live their lives fully and in the gender in which they identify, while also ensuring that the risks of reoffending are reduced.

### ***Competency and skills***

There is a need to increase the competency and skills of offender healthcare practitioners in working with trans offenders. This needs to include education and awareness about the full range of trans identities but also the specific health and social care needs of trans individuals in the criminal justice system.

#### **Recommendation 1: Equality and Diversity Training**

Healthcare providers need to review their equality and diversity training to ensure that adequate account is taken of trans gender identities and the associated health harms and risks that come from the experience of prejudice and discrimination against transgender people. This should include adequate time for healthcare practitioners to reflect on their own unconscious bias with respect to gender diverse people and ways in which they can overcome this. The active involvement of trans individuals with skills and competence in delivering equality training, who are appropriately funded to do so, would greatly enhance the ability of staff to address these issues. NHS England should ensure that this is adequately addressed in contract monitoring and procurement arrangements for healthcare providers in the criminal justice system.

#### **Recommendation 2: Practice guidance**

There is a need for concise, evidence based practice guidance on working with gender diverse individuals in the offender healthcare system. This could take the form of several practice guidance notes that address particular health issues and be based on some of the excellent resources that have already been developed for general health care and non-criminal justice settings. For example, prescribing of hormones and related therapies (including pre and postoperative care for trans people), supporting trans people experiencing acute gender incongruence and related emotional and psychological problems.

Practice guidance should also consider the public health needs of gender diverse individuals including sexual health, HIV prevention and drug and alcohol use.

NHS England could work with related partners such as the Royal Colleges, National Institute for Health and Care Excellence (NICE), Public Health England, the National LGB&T Partnership and the LGBT and transgender social sector to develop practice guidance for offender healthcare settings.

### **Recommendation 3: Expert Champions**

There is a need to concentrate expertise in a way that is accessible across the offender healthcare system. This could be achieved through the creation of expert champions in the area of trans offender health and social care needs. This exists to a degree through those healthcare practitioners and justice staff, who have already built up expertise and competence in working with trans individuals. However, this is ad hoc and not widely accessible to people elsewhere in the system that may need particular advice and/or support. NHS England and HMPPS could support the development of expert champions by convening a national or regional network of those individuals with this expertise. For such a network to be effective it would require the support of providers in the health and justice systems to enable staff to take time to attend meetings and to develop their expertise further through training.

This could mirror the single points of contact that have been established in the National Probation Service divisions or the Regional Psychology Leads or the equality leads that are in each prison to enable more effective working across NHS and HMPPS. In the community (and possibly prisons) development of GPs with a special interest in transgender could also assist in developing the availability of appropriate clinical expertise.

### **Care and justice pathways**

Trans individuals in the criminal justice system can have complex health and social care needs that require a range of interventions across different care pathways. However, these are not always co-ordinated or integrated in a way that enables gender identity to be fully recognised and, where needed, supported.

### **Recommendation 4: Appropriate and integrated care pathways**

NHS England needs to work collaboratively, internally and with external partners and providers, to ensure that trans individuals in the criminal justice system can access an appropriate, integrated care pathway where and when this is needed. This applies particularly to mental health, substance use and specialist offender therapeutic pathways. The views and experiences of transgender individuals should be included in assessing ways in which these pathways can be made more accessible and beneficial for transgender people.

### **Recommendation 5: Offender management treatment programmes**

It is important that NHS England works closely with HMPPS to ensure that trans individuals in the criminal justice system can make full use of offender treatment programmes that will support sentence planning and reduce the likelihood of reoffending. HMPPS are already engaged in a process of review of some existing programmes and this could be further supported by the NHS commissioners and providers and also by taking on board the experience and views of trans offenders who have accessed these programmes.

## ***Gender Identity Clinics and Offender Health***

This review has taken place at the same time as NHS England's consultation on proposed service specifications for the specialised services delivered by Gender Identity Clinics. Although this review concerns much wider issues and implications for trans offender healthcare, there are some observations that are relevant for the consultation on GICs.

### **Recommendation 6: Gender Identity Clinics**

NHS England should take account of the findings of this review as part of the consultation on proposed service specifications for the specialised services delivered by Gender Identity Clinics. These include:

- the need for the procurement of GICs to take adequate account of the needs of trans individuals in the criminal justice system including access and recognition of the specific constraints on access for trans people in prison;
- greater consistency across GICs in terms of recognising the particular circumstances of trans people in prison, in particular with respect to living in role within a prison establishment and that for longer term prisoners this is their normal environment and therefore equivalent to the work/study/volunteering environment in which service users are expected to live in role outside prison;
- the need to provide clinical guidance and support to medical staff in prisons on prescribing hormones and related therapies, taking account of the need to ensure continuity of care and reducing the risks and harms that can result from the abrupt cessation of prescribing in prisons; and
- the views and experiences of transgender offenders should be included in the development of new service specifications and models of care for gender identity services.

NHS England may also wish to consider the potential value in providing in-reach services to prisons for gender identity services and/or whether this can be done on a regional basis.

## ***Involvement and engagement with the trans and LGBT social sector***

Involvement and engagement of the trans/LGBT social sector in offender health is largely sporadic and voluntary. This is despite the clear value and importance of having trans people involved in the care and wellbeing of trans offenders, in particular with respect to support and befriending while someone is in prison and in providing support on release from prison. Practitioners also need to be able to identify the resources and potential support that exists for trans offenders in the community more easily.

### **Recommendation 7: Trans social sector involvement in support**

NHS England and related health and justice partners including HMPPS and Public Health England could establish a fund to support and enable the involvement of the trans social sector (including the LGBT sector where there is a lead trans function or role) in providing practical support and befriending to trans people in the criminal justice system.

This could be done on the basis of establishing lead agencies at a regional level, who were adequately funded and supported to provide practical and emotional help for trans individuals in the community as part of community treatment orders, visiting trans individuals in prison and providing Through the Gate support, liaison and advice.

### **Recommendation 8: A national trans health and justice network**

NHS England and related health and justice partners including HMPPS and Public Health England could establish a national trans health and justice network, led by the trans and/or LGBT social sector. Such a network could review progress on meeting the needs of trans offenders, maintain a database of available support and act as a key reference point for issues related to trans health and justice. This would need to be supported by the HMPPS Transgender Advisory Board and the Health & Justice Commissioning National Support Team (Specialised Commissioning, NHS England).

## ***Research***

There is a need to increase research activity for transgender health and social care needs, particularly in the criminal justice system.

### **Recommendation 9: Funding for research**

Research Councils and other research funding bodies should take steps to ensure greater recognition of gender diversity in grant applications and awards. This could include a specific research call and funding for investigation of the health and social care needs of transgender offenders and effective interventions that can support the rehabilitation of transgender offenders.

## References

- Ahmed O, Jindasurat C. (2014) *Lesbian, Gay, Bisexual, Transgender, Queer and HIV-Affected Hate Violence in 2013*.
- Amnesty International, (2017) *Amnesty International Report 2016/17 The State of the World's Human Rights*. London: Amnesty International Ltd.
- Arcade Fire (2013). We Exist lyrics © Sony/ATV Music Publishing LLC
- Ashbee, O. & Goldberg, J.M. (2006) *Trans People and Cancer*. Vancouver: Transgender Health Programme
- Baker, Sarah Jane (2017) *Transgender Behind Prison Walls*. Hampshire: Waterside Press
- Baral S, Poteat T, Strömdahl S, Wirtz A, Guadamuz T, Beyrer C. (2012) Worldwide burden of HIV in transgender women: a systematic review and meta-analysis. *Lancet Infect Dis*; **13**: 214–22.
- Bassichis, D.M. (2007) *It's war in here: A report on the treatment of transgender and intersex people in New York State men's prison*. New York: Sylvia Rivera Law Project (SRLP).
- Bauer, G.R., Redman, N., Bradley, K. & Scheim, Al. (2013). 'Sexual Health of Trans Men Who Are Gay, Bisexual, or Who Have Sex with Men: Results from Ontario, Canada'. *International Journal of Transgenderism*, 14(2)
- Beck, A.J. (2014) *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12 – Supplemental Tables U.S.* Washington: Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Bockting W, Robinson B, Rosser B. Transgender HIV prevention: A qualitative needs assessment. *AIDS Care*. 1998;10:505–526;
- Bradley, J., Webb, L., and Williams-Schultz, G. (2015). *Falling Through the Cracks: Non-binary people's experiences of transition related healthcare*. UK: Action for Trans Health. <http://actionfortranshealth.org.uk/wp-content/uploads/2015/11/Falling-through-the-cracks-final-with-cover.pdf>
- Browne, K., McGlynn, N, and Lim, J. (2009) *Drugs and alcohol - Additional Findings Report: Count me in to LGBT lives in Brighton and Hove*. Brighton: Spectrum.
- Brown, G. R. (2010). Auto castration and auto penectomy as surgical self treatment in incarcerated persons with gender identity disorder. *International Journal of Transgenderism*, 12(1), 31-39. doi:10.1080/15532731003688970
- Browne, K., & Lim, J. (2008). *Trans people: additional findings report. Count Me In Too: LGBT Lives in Brighton and Hove*. Brighton: Spectrum.

Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington, MA: Lexington Books.

Butler, Judith (2004) *Undoing Gender*. New York: Routledge

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

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

Clark H, Babu AS, Wiewel EW, Opoku J, Crepaz N. (2017) Diagnosed HIV Infection in Transgender Adults and Adolescents: Results from the National HIV Surveillance System, 2009-2014. *AIDS Behav.* 2017 Sep;21(9):2774-2783. doi: 10.1007/s10461-016-1656-7. PMID: 28035497

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

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

DSM IV TR, American Psychiatric Association (2000) Arlington: American Psychiatric Association

Dwyer, A (2011) Policing Lesbian, Gay, Bisexual and Transgender Young People: a Gap in the Research Literature. *Current Issues In Criminal Justice* Volume 22 Number 3.

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

Fitzgerald, E; Patterson, S; Biko, C and Tobin, H J (2015) *Meaningful Work: Transgender experiences in the sex trade*. Washington: National Centre for Transgender Equality

Flores, A R; Herman, J L; Gates, G J and Brown, Taylor N G (2016) *How many adults identify as transgender in the United States*. Los Angeles, CA: The Williams Institute.

Garofalo, R., Deleon, J., Osmer, E., Doll, M. & Harper, G.W. (2006) 'Overlooked, Misunderstood and At-Risk: Exploring the Lives and HIV Risk of Ethnic Minority Male-to-Female Transgender Youth', *Journal of Adolescent Health*, Volume 38



GIRES (2011) *The Number of Gender Variant People in the UK - Update 2011*. Surrey: GIRES

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

Grant, J. (2010) *National Transgender Discrimination Survey Report on Health and Health Care* Washington DC: National Centre for Transgender Equality and National Gay and Lesbian Task

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

Greater Manchester Police (2015) *Transphobic Hate Crime: A study in the under-reporting of transphobic hate crime, and police interactions with the trans community, 2013-2015* Manchester: Greater Manchester Police:

Haas, Anne P; Rodgers, Philip L and Herman, Jody L (2014) *Suicide Attempts among Transgender and Gender Non-Conforming Adults Findings Of The National Transgender Discrimination Survey*. Los Angeles, CA The Williams Institute.

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

Herman, J.L., Flores, A.R., Brown, T.N.T., Wilson, B.D.M., & Conron, K.J. (2017). *Age of Individuals who Identify as Transgender in the United States*. Los Angeles, CA: The Williams Institute.

House of Commons Women and Equalities Committee (January 2016) *Transgender Equality First Report of Session 2015-16 HC 390* London: The Stationery Office Limited

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

International Statistical Classification of Diseases (ICD - 10) (2010) and Related Health Problems 10th Revision On line resource: <http://apps.who.int/classifications/icd10/browse/2010/en>

Jenness, V. (2009) *Transgender Inmates in California's Prisons: An Empirical Study of a Vulnerable Population*. Irvine: University of California

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



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

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

Majd, K., Marksamer, J., & Reyes, C. (2009). *Hidden injustice: Lesbian, gay, bisexual, and transgender youth in juvenile courts*. New York, NY: The Center for HIV Law and Policy.

Mayock, P., Bryan, A., Carr, N. & Kitching, K. [2009]. *Supporting LGBT Lives: A Study of the Mental Health and Well-being of Lesbian, Gay, Bisexual and Transgender People* Dublin: Gay and Lesbian Equality Network

McNeil, J; Bailey, L; Ellis, S; Morton J and Regan, M (2012) *Trans Mental Health and Wellbeing Study 2012* Edinburgh: Scottish Transgender Alliance.

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

Meyer, I.H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior*, 36, 38-56.

Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129, 674-697. doi:10.1037/0033-2909.129.5.674

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

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

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

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

National Audit Office (2017) *Mental health in prisons* London: NAO

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

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

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

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

Pasterski, V., Gilligan, L. & Curtis, R. (2014). *Traits of Autism Spectrum Disorders in Adults with Gender Dysphoria*. Archives of Sexual Behavior. 43. Pp. 387-393.

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

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

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

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

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

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

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

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

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

Royal College of Psychiatrists, (2012). *Good practice guidelines for the assessment and treatment of adults with gender dysphoria*.

[https://www.gires.org.uk/assets/Medpro-Assets/CR181\\_Nov15.pdf](https://www.gires.org.uk/assets/Medpro-Assets/CR181_Nov15.pdf)

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

Sausa L, Keatley J, Operario D. Social networks among transgender women of color who engage in sex work in San Francisco: Implications for HIV interventions. *Archives of Sexual Behavior*. 2007;36:768–777

Sexton, L; Jenness, V; and Sumner, J (2010) Where the Margins Meet: A Demographic Assessment of Transgender Inmates in Men's Prisons; *Justice Quarterly*, 27 (6) 835-866.

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

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

Stotzer, R.L., Herman, J.L. and Hasenbush, A. (2014) *Transgender Parenting: A Review of Existing Research*. Los Angeles: The Williams Institute

UKNSWP, 2008 *Response To Home Office "Tackling The Demand For Prostitution: A Review"* (2008) & *Policing And Crime Bill* (2008) Manchester: United Kingdom Network of Sex Workers Project

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

Van Caenegem, E; Wierckx, K; Elaut, E; Buysse, A; Dewaele, A; Van Nieuwerburgh, F; De Cuypere, G and T'Sjoen, G (2015) Prevalence of Gender Nonconformity in Flanders, Belgium *Arch Sex Behav*. 2015 Jul;44(5):1281-7. doi: 10.1007/s10508-014-0452-6. Epub 2015 Jan 15.

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

White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). *Transgender Stigma and Health: A Critical Review of Stigma Determinants, Mechanisms, and Interventions*. *Social Science & Medicine* (1982), 147, 222–231.  
<http://doi.org/10.1016/j.socscimed.2015.11.010>

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

Wilchins, R A (1997) *The first national survey on transviolence*. Michigan: GenderPAC

Wilde, Berkeley. 'A Lifestyle Choice? Myths and Facts about Lesbian, Gay, Bisexual and Trans People' London, Camden LGBT Forum, 2007

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

Williams, M.L. & Tregidga, J. 2014. "Hate Crime Victimization in Wales: Psychological and Physical Impacts Across Seven Hate Crime Victim Types". [Online]. *British Journal of Criminology*. 56(2). Pp. 1-22.

World Health Organisation (2015a) *Transgender People and HIV*. Geneva: Word Health Organization  
[http://apps.who.int/iris/bitstream/10665/179517/1/WHO\\_HIV\\_2015.17\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/179517/1/WHO_HIV_2015.17_eng.pdf?ua=1)

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

WPATH (World Professional Association for Transgender Health) (2011) *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. Internet:  
[http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage=3926&pk\\_association\\_webpage\\_menu=1351](http://www.wpath.org/site_page.cfm?pk_association_webpage=3926&pk_association_webpage_menu=1351)

## **Case law**

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

## Glossary

ACCT – Assessment, Care in Custody and Teamwork

BME – Black and Minority Ethnic

BAME – Black, Asian and Minority Ethnic

CCG – Clinical Commissioning Group

CRC - Community Rehabilitation Company

DH – Department of Health

FtM – Female to Male transition

GIC – Gender Identity Clinic

GP – General Practitioner

HMPPS - Her Majesty's Prison and Probation Service

LGB – Lesbian, Gay and Bisexual

LGBTQ – Lesbian, Gay, Bisexual, Transgender and Queer

MtF – Male to Female transition

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

NOMS – National Offender Management Service (now part of HMPPS)

PHE – Public Health England

PPO - Prison and Probation Ombudsman

PSI – Prison Service Instruction

Community Innovations Enterprise LLP  
Bradford, December 2017.

[www.ciellp.com](http://www.ciellp.com)