scottish trans

health conference report

Glasgow Royal Concert Hall
15th November 2012

A partnership between:

NHS Health Scotland

NHS National Services Scotland

Scottish Health Council

Scottish Transgender Alliance

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PDF available for download at:
http://www.scottishtrans.org/our-work/conferences

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Introduction

The first **Scottish Trans Health Conference** was held on the 15th November 2012 at the Glasgow Royal Concert Hall. With 123 delegates, it was Scotland's largest transgender equality event to date. Delegates included representatives of local NHS Boards, NHS Health Scotland, NHS National Services Scotland, the Scottish Health Council, the Scottish Government, equalities organisations, and 64 individual trans people.[1]

The conference provided the opportunity to share vital knowledge and insights into the health needs of trans people and to explore what actions are needed to improve trans inclusion across NHS Scotland following the Scottish Government's publication of the Gender Reassignment Protocol in July 2012.[2]

This report provides a summary of the conference discussions on the way forward for improving access to health services for trans people in Scotland.

[1] This conference report, in common with the Scottish Transgender Alliance and other trans groups and equality organisations, uses the terms **trans people** and **transgender people** as equivalent umbrella terms to indicate the wide diversity of people who experience their gender identity and/or gender expression as differing from the gender they were originally assigned at birth. The use of the umbrella terms is simply to avoid having to repeatedly list a large number of more specific identity terms such as: transsexual people, trans men, trans women, non-binary people, genderqueer people, transvestite people, cross-dressing people and intersex people.

[2] The NHS Scotland Gender Reassignment Protocol can be read online at: http://www.sehd.scot.nhs.uk/mels/CEL2012_26.pdf

Opening Speeches

The conference was opened by James Morton, Manager of the Scottish Transgender Alliance, who welcomed the delegates and thanked NHS Health Scotland, NHS National Services Scotland and the Scottish Health Council for working in partnership with the Scottish Transgender Alliance to organise the conference.

Cath Denholm, Director of Equality, People and Performance at NHS Health Scotland, then added her support for the opportunity the conference provides for progressing work to ensure that trans people experience fairness in health access and health outcomes.

Deirdre Evans, Director of National Services Division at NHS National Services Scotland, provided the keynote presentation exploring the development of the NHS Scotland Gender Reassignment Protocol and how specialist surgery will be commissioned at national level as part of its implementation.

Finally, Laura Hutchison, Senior Enforcement Officer at the Equality and Human Rights Commission (EHRC) Scotland, presented details of the role that EHRC Scotland will take in reviewing the implementation of the NHS Scotland Gender Reassignment Protocol and in supporting trans people to challenge any inequalities of access to healthcare more generally.

Workshop Summaries

The majority of the conference consisted of workshop sessions which were designed to be highly participatory and enabled delegates to share experiences and viewpoints and to offer suggestions for improving health services.

Delegates were able to select from the following options for their first workshop:

- Gender Reassignment (GR) Protocol
- Medical Records: Name, Gender and History
- Reproductive and Sexual Health Services

For their second workshop, delegates had the choice of:

- Equality and Diversity Monitoring
- Emotional and Mental Health Support and Wellbeing
- Cancer Screening Services

The final workshop choice for delegates was between:

- Gender Reassignment (GR) Protocol (Repeat Workshop)
- Dignity and Inclusion within Mainstream Health Services
- Exercise and Maintaining Physical Health

Workshop discussions were scribed by the Scottish Health Council and records kept of points made on flipcharts and post it notes. Recognising that there might be some comments which participants might feel uncomfortable stating publicly in front of other people, participants were also able to submit additional written comments on the workshop topics. All these records have been used to compile the following summaries of the discussions which occurred in each workshop.

Gender Reassignment (GR) Protocol

This workshop discussed how implementation of the new NHS Scotland Gender Reassignment (GR) Protocol is progressing across different health boards and the audit plans for the protocol. Delegates had the opportunity to share implementation concerns and other gender reassignment service provision issues. This workshop occurred twice during the conference to enable the maximum number of delegates possible to attend. The discussion points from both sessions are reported here.

Delegates mainly felt that the Gender Reassignment (GR) Protocol was not yet being implemented properly in their local NHS Board areas (45%). Only 24% felt it was being implemented properly:

Is the GR Protocol being implemented properly in your local Board area?	%
Strongly Agree	7
Agree	17
Neutral	31
Disagree	21
Strongly Disagree	24

Delegates were most concerned about the following implementation issues:

- Unacceptably long waiting times of several months for first appointments at Gender Identity Clinics and for some surgeries.
- The GR Protocol's level of flexibility and inclusion of diverse needs.
- Lack of access to counselling for trans people and their families.
- Where responsibility lies within the NHS for providing access to gender reassignment services.
- Lack of access to breast augmentation and facial feminisation surgeries for trans women due to these still remaining under the Adult Exceptional Aesthetic Referral Protocol rather than the GR Protocol.
- The continuing post-code lottery in levels of NHS funding for facial/genital hair removal.
- Continuing difficulties being faced by trans men seeking access to hormones and chest reconstruction surgeries.
- Difficulties accessing gender reassignment services for trans people living in rural areas.
- Lack of access to hormones and surgery referrals for 16 and 17 year old trans people despite the GR Protocol stating they should have access.

Unacceptably long waiting times

Unacceptably long waiting times were highlighted as a major challenge for current GR Protocol implementation. Some delegates reported waiting for over a year between referral to a Gender Identity Clinic and receiving their first appointment. Delegates reported that waiting many months, usually without any information or support, for a first appointment at a Gender Identity Clinic caused them significant psychological harm by triggering intense depression, anxiety, hopelessness and desperation.

It was stressed that over the last few years the waiting times for a first appointment have been getting longer not shorter because the caseload capacity of the Gender Identity Clinics have stayed static while the numbers of people seeking gender reassignment has been increasing significantly.

Delegates commented that it would be helpful to receive a copy of the GR Protocol and information about sources of voluntary sector support and how to progress their transition prior to attending their first appointment. It was emphasised that more funding and staff time needs to be devoted to the Gender Identity Clinics, especially the Sandyford in Glasgow, to bring the waiting times for a first appointment within the usual waiting guarantee time of 18 weeks.

Delegates were also concerned about the low waiting times between being approved as ready for surgery by a Gender Identity Clinic and actually obtaining surgery and suggested that a commitment to a maximum waiting time would be helpful. Waiting times as long as 4 years were described. Much of the current delays in obtaining surgeries were described as relating to problems obtaining funding approval from local NHS Boards and lack of capacity to provide surgeries within NHS hospitals. The NHS representatives facilitating the workshops clarified that the centralising to NHS National Services Scotland of genital surgery for trans women and chest and genital surgeries for trans men is expected to reduce waiting times for surgery by streamlining funding approval. NHS National Services Scotland will conduct a tendering process to secure contracts with the best quality surgery providers and this will be open to private hospitals as well as NHS hospitals.

Flexibility to accommodate diversity of trans people

Confusion was expressed about whether or not the GR Protocol was meant to be operated in a 'one size fits all' manner. The NHS representatives facilitating the workshops emphasised that the GR Protocol has been designed to be as inclusive and flexible as possible so that interventions are tailored to the specific needs of individual patients. They also clarified that trans people who do not self-identify as transsexual people, such as those with non-binary gender identities, are able to access services via the GR Protocol. For example, there is no need for a trans person to want to undergo any genital surgeries in order to access hormone treatment or other surgeries. Also some trans people might benefit from hormone treatment prior to, or without, social gender role change. It was noted as being particularly important for clinicians and patients to discuss how their pathway has been individually tailored for their specific needs in order to avoid confusion. Due to this tailoring process to fit individuals, it is not possible to be clearer within the GR Protocol about some points of the process.

Language emerged as an issue in relation to the GR Protocol during the first workshop but not the second. Two delegates in the first workshop objected to the terms **trans people** and **transgender people** being used by facilitators and stated that they wanted the GR protocol, legal equality protections and the conference restricted to only transsexual people who seek genital surgery. However, a larger number of delegates spoke out in response to emphasise the importance of the conference and the GR Protocol being fully inclusive and highlighted the offensiveness of individuals who have undergone gender reassignment attempting to prevent other people from having access to clinically appropriate gender reassignment services.

It was clarified that many people who do not personally self-identify as transsexual people and do not undergo all aspects of gender reassignment are still protected by the Equality Act 2010 from discrimination on grounds of gender reassignment. Simply proposing to undergo any part of a process of gender reassignment (such as using different gender pronouns or taking hormones) is sufficient to be protected. The Human Rights Act 1998 further provides all types of transgender people with legal protections relating to privacy, dignity and respect of their identity within healthcare provision.

Lack of access to counselling

Delegates highlighted that at present there is very little access to any counselling services which are knowledgeable enough to provide support to trans people and their families during gender reassignment. The GR Protocol says that the option of accessing such services should be made available to trans people and their families but there is currently little sign of this being offered. It was suggested that existing general NHS counselling services should be provided with transgender training as well as dedicated transgender counselling services being established or expanded at the Gender Identity Clinics.

NHS responsibility for gender reassignment provision

Responsibility and governance were raised by some delegates who asked for clarity around these processes since the need to use services out with their local NHS Board's geographical area created confusion about who to contact about any difficulties. Delegates were also concerned that local healthcare professionals, such as GPs, may not be aware of, or understand, the GR Protocol and wanted to know which part of NHS Scotland is responsible for increasing awareness of the GR Protocol.

They were assured by the NHS representative facilitating the workshops that the responsibility for patient care is definitely located with the local NHS Board for the area in which the patient lives, even if they are referred for gender reassignment services to another area. There is also a timescale for implementation of the GR Protocol. Local NHS Boards are required to produce an implementation plan, and NHS Health Scotland will be auditing the implementation in 2013.

Trans women's lack of access to non-genital surgeries

Prejudice and lack of understanding among healthcare professionals about the medical necessity of gender reassignment provision were problems which delegates still felt would impact their experience of healthcare, even with the GR Protocol in place. In particular, non-genital surgeries for trans women (such as facial feminisation surgery, tracheal shave surgery and breast augmentation surgery) are still under the Adult Exceptional Aesthetic Referral

Protocol (AEARP) rather than the GR Protocol and some delegates were concerned that local plastic surgeons, psychologists and funding decision-makers may be prejudiced against providing such surgeries to trans women or simply not understand the clinical need. The delegates were advised that in the event of experiencing any discrimination, or any other problems with the implementation of the GR Protocol, they should make a formal complaint through their local NHS Board and also let NHS Health Scotland, the Equality and Human Rights Commission Scotland and the Scottish Transgender Alliance know about the issue.

A number of delegates highlighted that the strict Body Mass Index (BMI) requirements within the AEARP were causing difficulties accessing breat augmentation surgeries. There was concern that the strict BMI requirements of the AEARP were not recognising that, for trans women, there are significant gender dysphoria resolution and social integration clinical needs for breast augmentation which goes beyond simply aesthetics. One delegate had been scheduled for surgery only to then have it distressingly cancelled due to their BMI being classified as too high.

Continued postcode lottery for hair removal funding

Delegates welcomed that the GR Protocol states that hair removal is an essential part of gender reassignment for trans women but expressed significant concerns that the lack of specifics within the GR Protocol on how much hair removal funding should be provided by local NHS Boards means that there is a continued postcode lottery. Delegates reported that while some local NHS Boards provide as much hair removal as is clinically needed, NHS Lothian only offers a tiny 6 sessions of hair removal regardless of clinical need and does not take account of the fact that if someone's hair and skin colouring means that they require electrolysis rather than laser then 6 sessions will have hardly any impact. Delegates highlighted the intense gender dysphoria which trans women can experience due to having to shave daily or twice daily and the social phobia which can result when even specialist makeup is not adequately concealing beard shadow.

Access to hormones and chest surgery for trans men

Delegates highlighted that despite the GR Protocol allowing hormone treatment to begin prior to full-time change of social gender role, trans men

attending the Sandyford Gender Identity Clinic were still being given an information booklet advising that they must always live as male for several months before they could be considered for hormones.

Delegates also highlighted that despite the GR Protocol making clear that chest reconstruction surgery for trans men is a clinically necessary surgery rather than an aesthetic surgery, some trans men were being prevented from accessing chest surgery due to rigid aesthetic surgery Body Mass Index (BMI) criteria being used. One delegate recounted being refused chest surgery on grounds of BMI despite having a lower BMI than when they had successfully undergone lengthy spinal surgery the year before.

Access to services for people living in rural areas

Rural inequality of access to gender reassignment services was a significant concern raised by some delegates. It was reported that in rural areas participants did not have the same level of access to gender reassignment information and support. People living in rural areas, especially in the Highlands and Islands, were forced to travel extremely long distances for Gender Identity Clinic appointments if they were able to access them at all. Delegates were keen to seek the introduction of a managed clinical network and use of telemedicine facilities to enable the Sandyford Gender Identity Clinic to support rural GPs to provide gender reassignment assessment for hormones rather than requiring people to travel all the way to Glasgow. Likewise, training counsellors in rural areas to provide support to trans people and their families was seen as important. In addition it was felt that it would be helpful for Gender Identity Clinic specialists to travel out with the central belt so that people living in more remote places had better access.

Access to services for people aged 16 and 17

Delegates were pleased that the Sandyford Gender Identity Clinic has a child and adolescent psychiatrist among its gender specialists and that young trans people starting puberty could be considered for hormone blockers. However, some delegates aged 16 and 17 were concerned about being considered too young for hormones and surgery referrals despite the GR Protocol stating that in Scotland people should be treated as adults from age 16 onwards for the purposes of access to gender reassignment.

Medical Records: Name, Gender and History

This workshop discussed current NHS processing of name and gender changes on medical records, the issuing of new Community Health Index numbers and privacy issues relating to elements of someone's medical history which could reveal their trans status or gender reassignment history. Delegates had the opportunity to share any concerns and any ideas for improving GP and hospital awareness of correct procedures for changing medical records and protecting privacy.

A significant issue which emerged for delegates was that of their previous gender status and history of gender reassignment interventions being readily available in their medical records. It was emphasised that, for paper records, it is essential that new covers are put on all the paper records to ensure that they only show the person's new name and gender. It is an unacceptable violation of privacy if a line is just through the old name and gender with the new details written in next to the old ones. Within paper medical records, on-going health conditions and disabilities may require access to historical medical documents such as old referral letters and lab test results that include references to the previous name and gender. Some delegates strongly wished to be able to completely remove all medical records which mentioned their previous name and gender and also to remove the details of any completed gender reassignment surgeries, however any alteration of past medical history could impact upon future medical treatment. Other delegates wanted reassurances that NHS staff would be fully respectful of their gender identity and carefully maintain their privacy if old documents within their medical records were to reveal their gender reassignment history.

Particular concerns were raised around integrated electronic health records potentially inappropriately revealing someone's gender reassignment history or previous name or gender. Delegates highlighted that most of the time such information will be medically irrelevant and therefore should not be visible on the initial screens of someone's integrated electronic health records. Delegates gave examples of embarrassing and privacy violating occasions where their gender reassignment history had been revealed inappropriately while they were seeking completely unrelated medical treatment for issues such as a burnt hand or a broken tooth. It was highlighted that there should

be no need for receptionists to see private information about someone's gender history.

The workshop also discussed how medical diagnoses and treatments are entered into electronic medical records using different computerised 'READ' codes. These codes then allow the details of the diagnoses and treatments to be automatically inserted by the system into documents such as GP referral letters. The NHS representative facilitating the workshop clarified that it is not possible to get rid of 'READ' codes entirely as they are needed by Health Boards and GP surgeries, however GPs can set particular 'READ' codes to low priority to effectively make those codes inactive. 'READ' codes assigned low priorities do not get automatically inserted into documents such as referral letters. NHS Lothian has already notified all its GP surgeries that all gender reassignment related 'READ' codes should be set as low priority in order to protect the privacy of patients who have undergone gender reassignment. Delegates were keen for all local NHS Boards to likewise notify GPs.

Delegates emphasised that any NHS staff who mismanaged information should be held to account. It was highlighted that where someone has received a gender recognition certificate, it becomes a criminal offence for a member of NHS staff to reveal to another the gender reassignment history of that person without their consent.

The Community Health Index (CHI) is a database in wide use throughout NHS Scotland. The Community Health Index (CHI) number is the national unique number for any health communication related to a given patient. It is a ten-digit number created from a patient's date of birth and four other numbers. The CHI number is used on correspondence including sample bottles and request forms for labs, prescriptions from pharmacy, radiology requests and outpatient and inpatient correspondence. All patients who register with a GP in Scotland are allocated a CHI number. The CHI database is only used in Scotland, so if records need to be transferred to England they have to be printed out and sent. In addition dentists and opticians are not linked into the CHI database. In terms of CHI numbers, there is now a detailed procedure in place to ensure that these are correctly changed over for trans people. However, some delegates who transitioned prior to the procedure being standardised expressed uncertainty over whether or not their CHI number and associated gender had been correctly changed. The NHS representative facilitating the workshop explained that the best way for people to check whether their CHI details has been correctly changed is to ask for a copy of a

"Screen Dump" of their CHI record. This can be done by writing to Practitioner Services, NHS National Services Scotland, Gyle Square, 1 South Gyle Crescent, Edinburgh, EH12 9EB or phoning 0131 275 6000.

Finally, delegates raised concerns about the cost of getting access to the proof required by the Gender Recognition Panel of their diagnosis of gender dysphoria and details of the gender reassignment medical treatment they have received. Some delegates in receipt of means tested benefits had been charged as much as £80 by their GPs to get single-sided letter confirming their gender reassignment medical treatment to support their application for gender recognition. Bizarrely it would have been cheaper to demand a photocopy of their entire medical records since the maximum fee for that is currently £50. Delegates highlighted that the provision of such information is not some kind of luxury but instead is necessary in order for them to access their basic human right of gender recognition and therefore ought not to be charged for by GPs.

Reproductive and Sexual Health Services

This workshop discussed access to fertility services for trans people and also access to trans-inclusive sexual advice, screening and treatment services both within the NHS and the voluntary sector. Participants had the opportunity to share any concerns and ideas as to how to improve awareness and inclusion. The workshop feedback was recorded on flipcharts using post-it notes to enable people to make sensitive comments privately.

Sexual Health Testing and Safer Sex Advice

Positive suggestions were made by delegates as to how sexual health services can be fully inclusive of the needs of trans people. Most importantly, it was regarded as vital that staff treat people with respect, exploring sensitively in partnership with them what their individual needs are and ensuring equitable access to information and services, rather than focussing on them being trans or making assumptions about how they might have sex. Delegates felt that central to this would be training for staff to ensure that they had sufficient knowledge and understanding to engage confidently and appropriately with service users who identify as trans people or who have a gender reassignment history. Delegates highlighted the importance of language, such as using the person's self-identified name and gender pronouns as well as mirroring the way they prefer to self-describe their genitals and other parts of their body.

Ensuring services promoted themselves as accessible for trans people was also regarded by delegates as very important in reducing the fear which prevented many people from engaging. This could be achieved through ensuring that publications and information were gender neutral where possible, and openly included trans people if not. In addition, delegates highlighted that having a holistic positive focus on sex and relationships that was non-pathologising and went beyond a medical focus was very important.

The main problems identified, aside from poor provision of sexual health services in rural areas, were related to a failure to treat people as individuals or to approach people with a positive accepting attitude. If staff appear to be making stereotyped assumptions about the sexual relationship and practices a service user might engage in, then it becomes extremely difficult for that service user to share the reality of their lives with them. Delegates also noted the importance of asking only relevant questions rather than out of curiosity.

Delegates highlighted that good practice would mean having visibly trans-inclusive sexual health services with non-judgemental and knowledgeable staff and information resources tailored for trans people, such as the recently developed Terrance Higgins Trust sexual health booklets for trans people.

Sexual Assault

Delegates expressed concerns about accessing support organisations for sexual assault because they were not sure if trans people would be 'allowed' to use those services. Delegates were concerned that trans people who had been sexually assaulted might experience an ignorant or negative response from support services or the police. Where trans people have genitalia that vary from what service providers might assume them to have, the fear of reporting a sexual assault was compounded by the fear of revealing their physical variation. Suggestions for good practice included ensuring staff receive trans awareness training so they are adept in supporting trans people, publicising that a service is trans-inclusive, and projecting a sensitive and non-judgemental attitude.

Aside from training issues, lack of monitoring was highlighted as a potential problem, in that whilst no organisations are collecting information about the number of trans people who experience assaults, it is not possible to truly evaluate need. Therefore delegates suggested that both the NHS and the police should keep records of the numbers of trans people who have experienced physical or sexual assaults, and that trans people are offered appropriate support to help them report these crimes.

Fertility Services

Delegates felt that there was great need for the NHS to provide information explaining what types of fertility assistance trans people could access. Services should focus on telling trans people that their service is accessible, and provide information tailored to trans people's needs, such as concerning methods of preserving fertility, egg/sperm storage, and legal issues. Having a clear NHS fertility treatment pathway that unambiguously includes trans people was seen as essential.

Delegates raised concerns about experiencing poor practice when they had requested fertility assistance, such as being told that special ethics panel

discussion and clearance would be needed before a service could decide whether to assist a trans person. Delegates raised concerns about being asked inappropriate questions about their gender reassignment and gender identity before services would decide whether or not to assist them. Delegates also raised concerns about staff asking inappropriate questions about the genital appearance of the trans person when actually it was their non-trans partner who would be undergoing the fertility treatment procedure. Ensuring that fertility services are knowledgeable and supportive, and promoting trans-inclusive services would ameliorate many of the issues encountered.

Equality and Diversity Monitoring

This workshop discussed NHS data collection methods in regard to monitoring progress on equality and diversity. Participants had the opportunity to share any concerns about being asked various diversity monitoring questions and any ideas for useful data collection.

Monitoring of gender identity was recognised as potentially serving a number of functions. It could enable information to be summarised and provide a useful way of targeting resources and services. It could help to show where trans people were under-represented or experiencing particular problems as well as providing the information services need for improvement. Monitoring could show that staff recognise the existence of trans people and combat invisibility which could otherwise occur.

Delegates were particularly concerned that monitoring should always be voluntary, especially where people may not necessarily identify as trans, and that it should not occur when accessing all health services. Although monitoring is already conducted for other minority groups, delegates were worried that the information could be used to try to demonstrate that gender identity cause lots of problems, or that it might lead to prejudice.

A number of suggestions and important points to consider in monitoring trans people were raised. Key priorities were identified as ensuring the correct wording of questions, staff training, explanations of why the NHS monitor, and robust confidentiality and data storage policies.

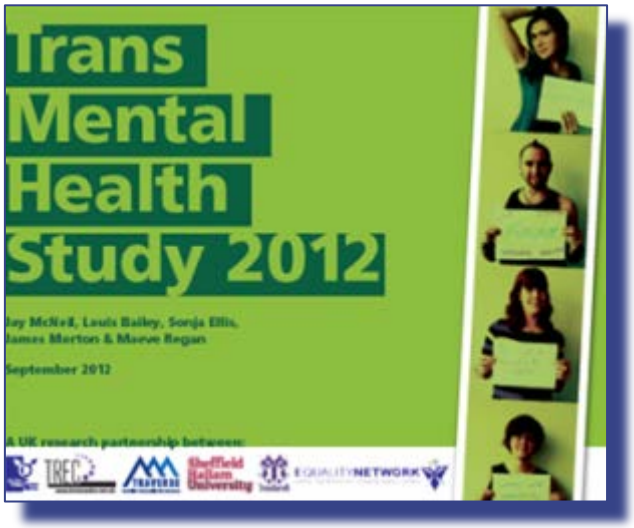
It was felt that clear explanations should be readily available when monitoring was undertaken in order to ensure that trans people fully understood the reasoning behind it, perhaps with procedural examples of how the information will be used.

Training was seen as vital for staff, to ensure that they could provide support in helping complete forms, and to make sure that being trans wasn't seen as a psychiatric condition and that the information would not prejudice treatment. A need for guidance on how to ask monitoring questions relating to trans people was identified. Participants felt it was important to keep monitoring data separate to their records. Finally, when undertaking monitoring, consideration should be given to those with a fluid gender identity.

Emotional and Mental Health Support and Wellbeing

The workshop discussed trans people's emotional wellbeing and trans inclusion within NHS and voluntary sector mental health support services. Participants had the opportunity to share any concerns about accessing support and any ideas for improvements.

Findings were shared from the Trans Mental Health Study (2012) which led to discussions about participant experiences. In addition, the role of the Transition Support Service (TSS) was explained. The TSS ethos is to help people figure out what their next steps may be. It also seeks to strengthen local community groups through co-ordination, information and support.



Delegates were keen to highlight that whilst some mental health issues were related to being trans, others were not and it should not be assumed that all mental health concerns are due to someone's trans status. Those mental health concerns which did relate to being trans were largely focussed on the extra stress that trans people had to cope with, for example coping with discrimination, poor treatment in services and long waiting lists. The delegates felt it was important that trans people receive support for this understandable distress rather than have it labelled as a mental health issue.

Barriers were identified for trans people in accessing mental health services. Some delegates stated that they felt scared in relation to talking about their mental health concerns for fear it would negatively impact upon any trans related treatment they were receiving. In addition physical barriers were discussed such as the amount of travel it took some rural dwelling delegates to access transgender emotional support. Structural barriers existed within the system too such as funding provision and poor communication between NHS Boards and Gender Identity Clinics.

In terms of service provision some key suggestions were proposed. A more joined up service between voluntary and statutory sector organisations was seen as essential. Many statutory services were seen as not being able to adequately support trans people and therefore trans people were having to rely on the voluntary sector. In order for voluntary sector organisations to provide this support, robust information sharing protocols should be in place and any relationship should benefit both organisations. Voluntary sector support, although much needed, was currently seen as suffering from being isolated, inconsistent and lacking funding.

Support for young trans people experiencing distress was viewed as important, with suggestions made to educate school children about trans issues.

A more general awareness of trans mental and general health was seen as important, so long as it was non-pathologising. Training for health professionals which aimed to improve awareness of trans mental health and how they can help, would be useful in alleviating the issues people felt were present in accessing services. It might be helpful to link training in to NHS and Government targets around suicide and self-harm prevention.

Delegates felt that services also needed to recognise the impact of trans mental health and wellbeing on family and friends, and to be able to provide appropriate support.

Other suggestions were made by delegates for improving trans mental health and removing barriers to engagement, including using the Gender Reassignment Protocol to improve the provision of counselling to trans people undergoing gender reassignment and their families. The suggestions also included training trans people as counsellors, and utilising video conferencing technology to enable those living in remote areas to access specific psychological support. It was seen as important that any support was tailored to take in to account the unique issues which trans people experience.

Cancer Screening Services

This workshop discussed how to improve trans inclusion within NHS Cancer screening services, especially cervical screening and breast screening. Participants had the opportunity to share any concerns and ideas for how to improve access and awareness.

A number of potential issues were highlighted relating to cancer screening, most notably that it is often heavily gendered. For example letters for cervical screening are sent to women (trans or otherwise) and not trans men, who may have a cervix. This issue is also relevant for breast screening. There were also problems at multiple stages of the screening pathway.

Firstly, as highlighted, many people who transition in some way may miss appropriate screening information, or receive inappropriate invitations. This could be being asked to attend screening for organs or body parts which are not possessed, or being sent highly gendered information where someone may identify with a different gender. For example, where someone identifies as male but has not formally changed their details yet, they may receive a letter inviting them to a women's clinic. This can increase feelings of gender dysphoria and thus distress. In addition, letter sent inappropriately may inadvertently 'out' someone as trans.

It is possible for people to self-refer to a clinic however, and the delegates felt that some responsibility lies with the individual person to talk to their doctor about their specific health needs. For example trans women are high risk for breast cancer due to the hormones that are taken, whereas trans men who have had chest reconstruction, as with other men, are low risk. Any trans men with concerns can refer to the breast clinic themselves.

The NHS representative facilitating the workshop advised that there are plans to develop a process of calling trans men in to cervical screening, however this is not due for delivery until 2014.

On attendance at a screening clinic, trans people may then face some specific difficulties. Some delegates reported experiences of discrimination within the clinics, whilst others felt that the heavily gendered clinic environments themselves were off-putting and could increase distress.

Although delegates were specific that having biologically appropriate information was vital to attend necessary screening, some did express that they also wanted information appropriate to their gender, as that affirmed their identity. This highlights how difficult it can be to provide services which all individuals will be happy with, particularly where something so individual as identity is involved. These disparities should not however prevent services from attempting to make positive changes.

Some suggestions were made for improving trans peoples access to and experience of screening. Firstly, avoiding gendering clinics and using gendered language was emphasised as important – so rather than being invited to a women's breast clinic, someone could simply be invited to a breast clinic (Edinburgh breast screening clinic already do this which was held up as an example of good practice). The language should focus on the body someone may have rather than gender.

Secondly, the delegates felt that there was a substantial need for training to ensure that discrimination within these services was eradicated, through enhancing awareness of both trans people's needs in general in healthcare, and in specific relation to attending cancer screening clinics.

Thirdly, delegates felt that it would be useful in general for services to recognise that not all people know what certain medical terms mean or can read letters which are sent out. Although this was not specifically related to trans people, it was an important point for inclusion as it could be particularly embarrassing and violating of a trans person's privacy to get someone else to read a wrongly gendered cancer screening letter they have received.

Finally, some delegates felt that monitoring should be undertaken within screening services. At present there is no way of knowing how many patients accessing different services are trans, and a way of doing so should be developed.

Dignity and Inclusion within Mainstream Health Services

This workshop discussed how to improve dignity and inclusion to trans people within mainstream health services which are not trans-specific, such as attending a GP, phoning NHS 24, receiving urgent treatment at Accident and Emergency, being placed on a single sex hospital ward. Participants had the opportunity to share any concerns and ideas for improvement. The workshop asked participants to share experience re issues when trying to access mainstream services not related to gender management.

A number of key themes emerged from this workshop. Positive experiences were highlighted which demonstrated how well health services could work to support trans people's health needs in everyday health settings. One main feature of these examples was staff approaching trans people's needs with an open attitude of wanting to learn and provide the right kind of support. Taking time to listen, wanting to learn, being non-judgemental and adhering to principles of equality were all considered important.

An example of good practice from services which was discussed was NHS Forth Valley's 2 page document on their web page which was designed to help front-line NHS staff to interact positively with trans people.

Negative experiences focussed on being asked inappropriate questions, having assumptions made about the person either because they were seen as trans, or because their trans status was not recognised, and being treated without respect. An example of this was mental health staff telling a trans woman that her voice was too deep for her to transition. Another person was told that they should not cross-dress because it would scare other people.

Training for staff was seen as key to ensuring appropriate care and dignity. Delegates were keen to emphasise that training should also be available for home and social care workers who may be involved in personal care in an individual's home.

Some delegates highlighted the need for individual trans people to work proactively for change within health services so that services will be informed of issues and solutions designed collaboratively. Trans people were encouraged to join equality groups for example.

Exercising and Maintaining Physical Health

This workshop discussed access to sport and exercise opportunities for trans people, and any trans-specific barriers to maintaining physical health and wellbeing. Participants had the opportunity to share any concerns and ideas for improvement within the NHS, local councils and the voluntary sector. Multiple barriers for trans people in trying to exercise and maintain health were identified. As with other areas where barriers occur some are structural and some are interpersonal.

On an individual level issues such as confidence accessing sports facilities and fear of discrimination in facilities or harassment if exercising alone prevented people engaging with exercise.

Trans people also reported a lack of awareness about health issues particularly with reference to hormone therapy.

Suggestions for improving these issues were the following:

- Holding sports and exercise sessions which focussed on body confidence
- Ensuring staff have adequate awareness of the issues trans people may face in accessing sports and leisure services so that they can provide the right type of support
- Access to trans specific health information, for example the physical health impact of hormone therapy and suggestions for exercise to mitigate this. Also info on health more broadly e.g. BMI and how it changes with transition.

Structurally, poor awareness, inappropriate service provision and inappropriate facilities were significant barriers. A number of suggestions were made for improving these issues. It was felt that training for staff to ensure that they are supportive of trans people accessing facilities, and that they are able to challenge discrimination from other people using them, would help significantly. It was noted that awareness training for all people involved in sports facilities, supported by sustainable funding, was necessary to reduce the significant barriers that participants faced. Improving access to people in rural areas was identified as being important.

Some delegates highlighted the importance of changing facilities with cubicles where trans people could get changed in a locked area to ensure privacy and dignity, as well as shower cubicles with locks rather than open communal showers were seen as having a large impact on trans people's ability to engage in exercise settings. This reduces the risk of harassment and would promote trans engagement by reducing fear of disclosure.

It was also regarded as necessary to ensure adequate time was allocated for trans people to get changed as some people may need more time than others. Access to trans specific exercise sessions to enable people who are concerned or who lack the confidence to attend mainstream facilities was vital at enabling them to engage in healthy behaviours. The trans and LGBT swimming sessions run by the LGBT Centre for Health and Wellbeing and Edinburgh Leisure were referenced by several delegates as a good practice example, although people in rural areas had struggled to benefit due to travelling distance.

Being able to use mainstream groups however was also seen to be essential for people who felt comfortable doing so. To facilitate this, delegates felt that they needed to have confidence that staff were appropriately trained and would respond to any harassment swiftly. Once accessing services, improving understanding of individual rights as a trans person would be useful, for example what facilities can you use, how to address issues e.g. where may be refused access to gendered facilities. This should also include information about becoming involved in competitive gender segregated sports activities and how being a trans person, and potentially taking hormones, may affect involvement in competitions.

Finally, enabling NHS staff to have up to date information about health and exercise for trans people including local groups or services, and weight issues for trans people would be of benefit, as they could encourage individuals to engage with those services.

Filmed Panel Discussion

The panel was chaired by Maruska Greenwood, LGBT Centre for Health and Wellbeing, and comprised:

Katherine Burrows, Engender Women Thinking Trans Issues Group
Deirdre Evans, NHS National Services Scotland
Laura Hutchison, Equality and Human Rights Commission Scotland
Mike Lyon, NHS Scotland
James Morton, Scottish Transgender Alliance

During this final panel discussion, some queries and points were made about the GRP and its implementation. To summarise, the protocol is not obligatory although the action plans which boards are requested to formulate following the audit are compulsory. The Health Boards will be responsible for their action plans, which will allow comparable information to be gathered across the Boards. Although the current financial climate is difficult, the NHS still has a responsibility to effectively support the health of trans people.

Overall the NHS gender reassignment process has been designed to evolve and to be a person-centred and person-led pathway. This means that it is difficult to specify all areas of the pathway, and what will or will not always be funded or agreed on as this should vary from person to person depending upon need. It was emphasised that everyone is entitled to dignity, equality and healthcare inclusion regardless of which, if any, particular trans terminology they self-identify with. Access to NHS gender reassignment services is based upon individual need and does not require service users to seek any particular surgeries or to self-identify with any particular terminology. Any issues, such as inequitable treatment, should be reported to the NHS and also to the Equality and Human Rights Commission and the Scottish Transgender Alliance.

Conclusions

A number of key issues and suggestions were highlighted repeatedly throughout the workshops, which would improve trans health outcomes and engagement with health services and behaviours. To summarise, these were:

Training

Training concerning trans health needs, for all staff involved in statutory and non-statutory services was repeatedly cited as having the greatest impact in terms of trans people's outcomes. This should be embossed into mainstream training and should be mandatory. Most of the issues which delegates reported occurred because staff lacked understanding or awareness of trans people, specific issues which may arise, and what language and approach is or is not appropriate. Training would ensure that staff understood the barriers trans people may face and would enable staff to feel competent in working with them. This it is hoped would ensure that trans people always enter a welcoming and respectful environment where their health and wellbeing needs can be addressed sufficiently and holistically.

Gender Reassignment Protocol

A number of issues with the Gender Reassignment Protocol were highlighted, which emphasises the need for a robust audit to be undertaken. These should ensure that they adequately capture the experiences of trans people across Scotland so that it can be determined whether the protocol is being fully implemented and the postcode lottery of treatment access reduced. Information about the Gender Reassignment Protocol and trans people's rights should be disseminated amongst the trans community and to health care staff.

Rural Inequalities

Substantial inequalities were noted for people living in rural areas. These were in gender reassignment provision, staff attitude and understanding, and in access to health services generally. Strategies for removing this barrier should be explored, such as telemedicine, or enabling gender specialists to travel out-

with the central belt. Emphasis should be placed on ensuring that the Gender Reassignment Protocol is understood by staff in remote areas.

Monitoring

Appropriate monitoring needs to be undertaken to fully understand the needs of the trans community. At present there is no information about which services trans people are accessing to show areas of need, or potential areas of inequity in access. In undertaking monitoring, key priorities were identified as ensuring the correct wording of questions, staff training, explanations of why the NHS monitor, and robust confidentiality and data storage policies.

Accessibility

Where services are welcoming or accessible to trans people (i.e. where staff have undertaken training and are conversant with the specific issues which may arise for trans people), services should advertise this. Strategies to do so include directly engaging with trans communities, and ensuring that literature or promotional materials produced or used by the service are either gender neutral or represent trans people. This would enable trans individuals to feel comfortable accessing a service without the fear that currently prevents many trans people from doing so.

Equality

This does not mean treating all people the same, because many groups have specific needs. Trans people are no exception. In this case, equality refers to ensuring that trans people are fully included and considered in general, with specific policies and health services being in place where their needs are different to others. This could include, for example, sending out a generic leaflet for all people who may be engaging in a fertility service (providing it does not make any assumptions about the gender identity or sexual orientation of those involved), with an additional leaflet about methods of preserving fertility for trans people prior to hormonal therapy, or information about preserving eggs/sperm on commencement of surgical interventions.

Funding

Finally, issues of funding were discussed as vital to ensuring trans people's health and wellbeing are supported. Where generic services are unable to meet those needs, other third sector agencies often step in. These agencies should receive adequate and on-going funding to ensure trans people are not adversely affected. For example, many trans people are fearful of accessing sports facilities due to experiences of harassment. This can negatively impact upon health. Trans specific swimming sessions have been held in the past to address this, however funding does not currently exist for this service.

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scottish trans

health conference report

A partnership between:

NHS Health Scotland

NHS National Services Scotland

Scottish Health Council

Scottish Transgender Alliance