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FULL/LONG TITLE OF THE STUDY

Meeting the transgender challenge: improving the experience of health services for gender diverse young people and their families.

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1. Summary of Research (abstract)

Background:

Gender Identity Services provide advice and help for people who find themselves distressed by their natally defined gender and who experience themselves as living with a wrongly gendered body. Demand for gender identity clinics is increasing; the Tavistock and Portman Gender Identity Development Service for young people (which is the only NHS funded clinic for gender diverse young people in England and Wales) has an estimated waiting list of 1400 people. This can mean lengthy waits for young people and their families who are likely to have questions, concerns and support needs during this period. Finding balanced online information can be challenging as views about transgender issues vary widely. Little is known about the experiences, information and support needs of young people waiting for gender identity clinic services. Our proposed research will help address this shortfall through a nationwide collection of narrative interviews with gender diverse children, young people and adults, and families.

Our aim is to improve the care and support for young people and their families before and after referral to specialist gender identity services. Our objectives are to:

- Develop a 360 degree understanding of the perspectives and experiences of young people, families and “gateway” professionals (GPs, CAHMS, gender identity clinic clinicians) in gender identity health services.
- Identify ways in which specialist gender identity services can be improved and develop resources to help achieve these improvements.
- Support young people and their families through the development of two new sections on Healthtalk.org.
- Evaluate these Healthtalk sections with patients and their families on the waiting list for services.

Methods:
To meet our objectives we will:

- After updating our literature and field review, we will conduct video and audio recorded in-depth narrative interviews with a diverse nationwide sample of 40 gender diverse young people (up to the age of 25 years[1]), 10 adults over the age of 25 years, and 20 (non-paired) family members. We will audio record interviews with 20 “gateway” professionals (GPs, Child and Adolescent Mental Health Service professionals). (Months 4 to 21)
- Hold a national networking event to present key findings from the research, explore best practice and potential for service improvements and recommendations to help health and care staff to respond effectively to young people and their families. (Month 24)
- The interviews will be used to develop an online resource (as part of the well-established, public facing Heathtalk.org) featuring analyses and balanced video and audio extracts from

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[1] We are aware that some patients up to age of 25 will be transferring out of the Tavistock GIDS (for young people) into adult GIC services. GIDS currently considers transferring patients to adult services at around 16 and ½ years of age, although in practice it may take longer. The Government’s Transgender Equality Report (2016) expressed concern that this process needs improvement.

the interviews, to improve the care and support of patients and families. The material will also be made available to train staff, inform service improvements and develop resources for relationship and sex education in schools. (Month 28)

- Conduct a formative evaluation of the new Healthtalk sections through 3-4 focus groups each with 6-8 young people currently on the waiting list. We will use a modified version of a validated questionnaire on the published sections of the website, to assess their role as a source of information and emotional support for people waiting for specialist services. (Months 26 to 27)

Anticipated impact:
Specialist service providers have identified the need for a reliable resource, featuring an appropriately wide range of experiences, to prepare, inform and support those on the waiting list, currently estimated to be 1400 people at the Tavistock and Portman GIDS alone.
Specialist staff, GPs, Child and Adolescent Mental Health Services (CAMHS), Relationship and Sex Education (RSE) teachers will all potentially benefit from the development of engaging, narrative based resources covering diverse perspectives on transgender issues.

2. Background and Rationale

Gender diverse people often face significant stigma, discrimination, exclusion, violence, and poor health (Winter et al., 2016). It is estimated that 1% of the population is gender diverse to some extent (Equality and Human Rights Commission, 2012). Children and young people who question their gender are particularly vulnerable as they can be facing additional stressors around limited financial resources, discrimination at school or in employment, and gender policing/negative reactions to their gender atypical behaviours (Singh et al., 2014; Grossman and D'augelli, 2006). When young people question their gender identity or realise they are trans, they will often have a lot of questions (Bartram, 2015). A 2017 Stonewell report highlighted the importance of access to good quality resources and information to ensure a young person’s wellbeing, safety and happiness. However, the reality is that many are unable to access such information and support. The consequences of young trans-identified people not being able to access good information can lead to further isolation, mental health problems and detrimental impacts on attainment (particularly in education) (*Ibid*). With the only NHS funded service for gender diverse young people in England and Wales (the Tavistock and Portman Gender Identity Development Service) based in London, Leeds and Bristol (with additional outreach centres in Birmingham, Brighton, Cardiff and Exeter) children and young people (particularly in rural areas) can be geographically disadvantaged. Long waiting times also adversely affect trans-identified people’s mental health (McNeil et al., 2012).

Young trans-identified people face significant isolation and problems accessing information: approximately half of trans-identified young people have not told parents or siblings they are trans, and 28% have not told anybody, including school staff and peers (Bartram, 2015). Almost two in three trans-identified pupils report being bullied for being LGBT at school, one in ten receiving death threats, and more than two in five have tried to take their own lives (Bradlow et al. 2017). Compounding this, one in three LGBT pupils say that their school provides information on LGBT topics and relevant signposting to LGBT resources and organisations, and only one in four say that their school tells them where they can access information online about LGBT issues. Two in five LGBT pupils have not been taught anything about LGBT issues at school (*Ibid*).

Trans-identified or gender diverse people often experience difficulties accessing suitable health care, whether specific to their gender needs or more general in nature (Winter et al., 2016). The House of Commons Women and Equalities Parliamentary Select Committee report on Transgender Equalities (2016) highlighted failings and poor patient experiences in health services for transgender people at key decision-making points including responses from GPs, referrals to Gender Identity Clinics (GIC) which are specialist clinics for adults, and Gender Identity Development Service (GIDS) which are specialist clinics for children and young people and their families, and access to hormone treatment.

NHS policy guidelines recommend that those accessing gender specialist services, be provided with information by their clinicians as part of their Individual Care Plan (ICP). These guidelines suggest that the GIDS and GIC services should (in addition to treatments such as counselling and hormone therapy) provide information for patients' families, partners and carers. It is also advised that if necessary, clinicians should signpost patients' families, partners and carers to external providers and support networks. However, little is known about the experiences, information and support needs of young people. There is a particular need for a reliable resource for those waiting for gender identity clinic services.

It is not surprising that many young people will seek information themselves, often online. They may seek information and support to help explore identity issues, or to consider difficult decisions about transitioning, medical interventions and implications for family relationships, employment, and broader social stigma (Winter et al., 2016). Finding balanced information can be challenging: transgender issues are politically and socially contentious. Disagreement exists about important medical and clinical questions (e.g. the timing of hormone therapies, and the requirement for a diagnosis to access treatments). Moreover, co-applicants at the Tavistock and Portman GIDS clinic and Gendered Intelligence have highlighted the need to represent a diverse range of gender experiences. It is therefore vitally important to direct young people to safe websites with relevant and accurate information, so that they are able to make safe choices (Bartram, 2015). This research will address this problem by providing a well-established, reputable source of information (about the lived experience of gender identity services and help-seeking), online for young people and their families.

Moreover, providing support to families, carers and parents, as well as trans young people, is important because the reactions and behaviour of a gender questioning person's parents and family members can be critical (Hill and Menvielle, 2009). Thus a holistic approach to care needs to include the whole family. Families, parents and carers are likely to have their own questions while facing considerable medical debate regarding diagnosis (and its necessity); the timing and justification of hormone therapies and the contribution of co-morbidities to any treatment plan. Understanding how young people and families navigate and experience these decisions and how they experience health services is vital to better meet their needs. This research will build an important evidence base to understand family perspectives along with young peoples' perspectives, and integrate this into a reliable and trustworthy source of online information.

3. Evidence explaining why this research is needed now

This research proposal, in response to the Commissioning Brief for research into how services can better meet the needs of trans-identified youth, is timely and relevant for several reasons.

Health need:

First, the Women and Equalities Parliamentary Select Committee report on Transgender Equalities (2016) highlighted failings in health services for transgender people. Increased demand for gender identity services has increased waiting times and delayed access to treatment. Referrals to Gender Identity Clinics (GICs) for adults are increasing by an average of 25-30% yearly while Gender Identity Development Service (GIDS) referrals for young people increased by 104% between 2014-16 (NHS England, 2015). Our research will produce a comprehensive understanding of how people currently use and experience services, to identify service improvements to better meet the needs of trans-identified youth.

Expressed need:

Second, previous research indicates that transgender people, or those who are gender diverse, experience significant stigma and discrimination when accessing health care. More research is required on how to improve the experience of health services for gender diverse people. With considerable disagreement on many important clinical questions, services like the Tavistock and Portman GIDS, one of the country’s leading centres of care, and others around the country are in urgent need of balanced and targeted support interventions to offer patients, including those on (increasingly lengthy) waiting lists. We will provide a carefully balanced narrative based web resource to help address support and information needs. This will fit with NHS guidelines that suggest GIDS clinicians signpost patients and their families to good quality information.

Sustained interest and intent:

Third, with rising demand for GIDS and GIC services, support needs for trans-identified people are likely to increase. Interest in this area is also likely to increase as providers from other sectors, such as the voluntary, education and health sectors, seeks to fill the gap that exists currently for provision to support people to explore their gender identity and sexuality, and find ways to challenge the stigma that exists. The results of this rigorous research project will remain pertinent to the needs of the NHS by providing a resource that offers ongoing and relevant support.

Capacity to generate new knowledge:

Fourth, there is little knowledge about how children and young people with diverse gender identities and their families navigate and experience health services at key decision points. How do young people cope with long waiting lists? Do parents experience particular ‘crunch’ points when their child is seeking care and transitioning? The importance of listening to patient experiences is central to formulating health policy in the UK (and many other countries) (Gann, 2013). Narrative interviews with transgender people and their families will offer in-depth knowledge and first-hand experiences of gender identity services. Our national sample will include a diverse range of experiences at different stages to reflect variations in gender identity and expression, experiences of different aspects of service provision and different referral pathways.

4. Aims and objectives.

Our **aim** is to improve the care and support for young people and their families before and after referral to specialist gender identity services.

Objective One: Develop a 360 degree understanding of the perspectives and experiences of young people, families and “gateway” professionals (GPs, CAHMS, gender identity clinic clinicians) in gender identity health services.

Objective Two: Identify ways in which specialist gender identity services can be improved and develop resources to help achieve these improvements

Objective Three: Support young people and their families through the development of two new sections on Healthtalk.org.

Objective Four: Evaluate these Healthtalk sections with patients and their families on the waiting list for services.

To meet these objectives we will:

1. After updating our literature and field review, we will conduct video and audio recorded in-depth narrative interviews with a diverse nationwide sample of 40 gender diverse young people (up to the age of 25 years), 10 adults over the age of 25 years, and 20 (non-paired) family members. We will audio record interviews with 20 “gateway” professionals (GPs, CAMHS professionals). (Months 1 to 21)

2: Hold a national networking event to present key findings from the research, explore best practice and potential for service improvements and recommendations to help health and care staff to respond effectively to young people and their families. We anticipate preparing 2 short films for service improvement and staff training initiatives as part of these resources. (Month 24)

3. The interviews will be used to develop an online resource (as part of the well-established, public facing Heathtalk.org) featuring analyses and balanced video and audio extracts from the interviews, to improve the care and support of patients and families. The material will also be made available to train staff, inform service improvements and develop resources for relationship and sex education in schools. (Month 28)

4: Conduct a mixed methods formative evaluation of the new Healthtalk sections, through 3-4 focus groups and a modified version of a validated questionnaire, to assess its role as a source of information and emotional support for people waiting for specialist services. (Months 26 to 27)

5. Research Plan / Methods

Objective one: develop a 360 degree understanding of the perspectives and experiences of young people, families and “gateway” professionals (GPs, CAHMS, gender identity clinic clinicians) in gender identity health services (months 1 to 21)

Our first step will be to update our literature and field review with the assistance of Oxford University’s Bodleian Library health specialists. This field review will guide the selection of study participants and highlight issues for inclusion in the interviews. We will develop the search through an iterative process, using keywords and synonyms for young people, gender identity and information access. We will search a range of health and social science databases, including but not limited to, Medline, Cinahl, PsycINFO and Social Science Citation Index. In addition, we will search the LGBT Archive (http://www.lgbtarchive.uk/) and screen reference lists of relevant papers.

Methodology:

Methodology indicates the choices we make about what to study, the methods to be used for gathering or generating data, and how that data is to be analysed (Silverman, 2016). It involves theoretical as well as methodological issues informing the choice between quantitative and qualitative approaches. To address research questions where people's meanings, perceptions and interpretations of the world are important, a qualitative methodology is likely to be most appropriate and an interpretative (rather than positivist) approach to knowledge production likely to be preferred (*ibid*).

Qualitative research tends to adopt a more relativist view of people's lives and their reality, rather than the objectivist view of quantitative research. Qualitative approaches do not merely examine outcomes and end destinations but the journey and processes involved. In this research we take a qualitative approach because we need a better understanding of gender questioning-young people, -adults and family experiences, to hear their journeys through different services (including experiences of 'gateway' services), as well as the wider social, economic and cultural processes that have shaped these journeys. Narrative interviews allow participants to convey the stories that are meaningful to them and there is often overlap with life history, biographical and oral history interviews (Bryman, 2015). Indeed, the topics covered in Healthtalk interviews always include wider social factors influencing a participant, for example their education, experiences of family, relationships, historical events or happenings (*ibid*).

Qualitative interviews:

Our primary method of data collection is in-depth interviews. This method is intrinsically tied into the production of the Healthtalk site which already features 110 sections of the website ('modules') based on over 4,000 in depth narrative interviews of peoples' experiences of health and illness.

We will interview i) children and young people and adults who have used services ii) (non-paired) family members of gender diverse young people iii) gateway health professionals.

Drawing on the literature review and expertise of our Advisory Group, we will draw up lists of the types of experiences and demographic variables for each of these three collections of interviews. Early recruitment will generally be inclusive, using first-comers to cover the most typical experiences. As the study progresses, recruitment will become more targeted at both anticipated categories that have not yet been covered, and at unanticipated issues which emerge through interviews. Existing recruiters may be asked to focus their efforts on specific categories, and we will purposively seek out new participants.

While our research methods will primarily use face to face interviews, the host Health Experiences Research group (HERG) has experience in the use of less conventional ways to include the perspectives of people who may be less likely to be included in research: for example, we have used email interviews and invited participants to make digital video diaries. We draw on the most appropriate methods to generate a diverse range of experiences.

i) Children, young people and adults who have used GICs and GIDS

Qualitative semi-structured interviews, audio and/or video tape recorded with full participant consent or assent (for under 16 year olds), will be conducted with 40 children and young people (CYP) (aged 12-25 years) currently using or recent users of services and 10 adults (aged 25 years+) reflecting on their past experiences, particularly on key learning points. Our information sheets which are sent to all participants prior to taking part, will be tailored to three different age groups: 12-15 year olds, 16-25 year olds and above 25 year olds (who will provide reflections looking back at their experiences). The maximum variation sample will reflect different types of experiences at different points in peoples' journeys, and socio-economic and ethnic diversity. It will include young people who identify as trans girls/women or trans boys/men, non-binary, gender-queer, androyne, bi-gender or other self-identified name within the transgender or gender diverse umbrella. We will include those who would like physical treatment, those who are unsure or don't want any physical intervention. To achieve as diverse a sample as possible within relatively short timescales we have developed a range of recruitment strategies. Participants will be actively sought through co-applicant networks (e.g. Tavistock GIDS and Gendered Intelligence) and social media routes, the HERG national network of GPs, Advisory Group members; local and national support groups; social and print media and snowballing through personal contacts and research participants. We will maintain a database of potential and actual participants and review this at regular intervals to ensure there is sufficient recruitment from people with diverse gender experiences, minority ethnic and socio-economic backgrounds, as well as from a variety of different sources (i.e. not just from social media). From the outset, recruiters are advised of groups of people we already know are typically seldom heard (see also Risk table, page 25).

Experienced qualitative researchers will conduct the interviews, using a narrative approach (Mishler, 1991; Sandeslowski, 2007). This approach allows an oral history to be collected, thus allowing the participants to highlight their own concerns, values meanings and priorities. Supplementary questions will prompt reflection on issues raised in the narrative section as well as participants' experiences of current health service provision especially “gateway” services, how their concerns regarding gender-identity were addressed, and their suggestions for how “gateway” services could be improved. We will explore positive experiences as well as specific problems encountered.

Interviews will take place in people's own homes, or another location if the participant prefers, using methods that have already been approved for national studies by an NHS ethics committee. The interviews will be video or audio recorded (according to the participant's preference). As with all our studies, the interviews we conduct for this project will cover a broad range of experiences and perspectives, not just of healthcare experiences but also wider experiences of living transgender, including schooling, work and careers; friends and family relationships; leisure; sense of self and body image; planning for the future; sources of support and information.

We want to explore the experiences and priorities of trans and gender diverse people and the interviews will therefore resemble a guided conversation in which the researcher has a list of possible topics and prompts rather than structured questions. The researcher will conduct the interview either in one session or two, depending on the preferences and energy levels of the participant and how long they would like to talk. Interviews for our projects have run for between 45 minutes and several hours in the past. This method contrasts with studies where the research team set out to collect information on a narrower range of issues through more structured data collection methods, such as survey questionnaires.

Analysis and data collection will proceed simultaneously and continue until ‘data saturation’ is reached to ensure that the widest practical range of experiences has been included. Data saturation is reached once no new categories can be added and no new major themes are emerging (Silverman, 2016) – see below for a **Detailed Plan of Analysis**. In practice, this means that when a gender diverse person looks at any of the planned outputs (see Objectives 2 and 3 below) they should find that an experience or perspective akin to their own is included, although this may not necessarily be reported by a person of the same age, family situation or social class as themselves. Our experience suggests that around 40-50 interviews will be required to achieve this. The formative evaluation (objective 4) will provide a further check of data saturation by seeking feedback from additional service users, not included in the interviews.

The study will benefit from the experience and tried and tested methods of the HERG in the University of Oxford's Nuffield Department of Primary Care Health Sciences. HERG is a highly experienced group of applied social science and health researchers. The interviews will be video and audio recorded by two appointed researchers who will conduct interviews across the UK with CYP, adults and families. One researcher will focus on CYP, the second researcher on adults, families and the professionals. We will try to offer participants the option of being interviewed by a trained and supported service user-researcher and will work with our Advisory Group to achieve this. In addition, we will work with our co-applicants, and our CYP advisory panel to develop opportunities for trans and gender diverse CYP to be involved either in our interviews (with some training on confidentiality and ethics) or in contributing to the analysis.

ii) family members of gender diverse young people

Qualitative semi-structured interviews, audio and/or video tape recorded with full participant consent, with parents and family members will give insights into family experiences of navigating services. We will seek interviews with around 20 family members, including parents/carers and/or siblings, of gender diverse CYP or adult. We will not seek to interview matched pairs of young people and family members. Interview methods will be similar in all relevant respects to those described above.

iii) Interviews with professionals:

Semi-structured interviews, audio recorded with consent, will be conducted with a purposive sample of 20 "gateway" professionals (including GPs and CAMHS clinicians). Professionals will be recruited through the key contacts at CAMHS Oxfordshire, Buckinghamshire and north-west London (linked to the Tavistock GIDS) and national networks (such as the National Networking Forum). Clinicians from rural and urban settings, of different ethnicity, age and time since qualification will be included. Interviews will cover experiences of working with gender diverse patients, problems encountered, examples of good practice and how patients are supported in decision-making.

Transcript checking

The interviews will be transcribed verbatim. Transcripts will be checked for accuracy against the audio/video recording, and anonymised. The transcript will be returned to the participant to give them the opportunity to review the interview and mark any sections which they would not wish to be disseminated. They will then be asked to transfer copyright of their transcript to the University of Oxford. To maximize best use of the interview data, these carefully anonymised transcripts will also form part of a University of Oxford archive which is available to other *bona fide* research teams for secondary analysis (Ziebland and Hunt, 2014).

Detailed Plan of Analysis:

The multi-disciplinary team will bring a coherent blend of theoretical traditions (medical sociology, health service research, human sciences, anthropology and developmental psychology). Our analytic approach is multi-disciplinary and not anchored in any one trans research paradigm. The research team strongly believes in the need to ground theoretical formulations and insights in empirical evidence. This suggests that theory about the experience of transgender and gender-questioning people will emerge from the data rather than informed by general and external social theories or constructs.

Data analysis will follow a ‘modified’ grounded theory framework using constant comparisons to provide a rigorous approach to the generation of concepts. After transcription (as described above), the analysis of such textual data requires careful and meticulous analysis to work through each narrative and formulate specific categories or themes. The transcripts will be entered into the software package N-Vivo to help organise, sift and code the data for detailed analysis.

The two central features of grounded theory are the development of theory from the data and that it is an iterative or recursive process which means that data collection and analysis proceed in tandem (Bryman, 2015; Charmaz, 2006; Silverman, 2010). Each interview will firstly be openly coded (identifying, examining, comparing, conceptualising and categorising data) and then codes will be reordered into a more formal tree structure allowing the identification of the broader categories and themes (which will be used to write the ‘topic summaries’ for the Healthtalk site, see below)

Using the established method of ‘constant comparison’ the data will be constantly reviewed against the other extracts within each theme and interviewing will continue until data saturation has been reached (this is the point at which new data does not add more detail to the range of material within the analytic themes).

Each Healthtalk section has unique categories that are related specifically to that particular health topic. Our approach to data collection and analysis (described above) is designed to identify what matters to participants and reflect a diverse range of perspectives in a balanced manner. From the identified categories and themes, we will write a series of ‘topic summaries’ on the issues that are important to the participants – not just the ones that health professionals and researchers may think are important. These 20-25 topic summaries for each module (this study will include two modules) are written in accessible language to reflect the most important categories and themes to represent the full range of experiences included in the interviews. We will also include an introduction topic summary on “what is gender diverse/transgender?’ intended for those new to the topic. The summaries will include contextual, evidence-based information and links to other resources and materials. To ensure the quality and balance of the material included in the section each summary is prepared by the researcher, checked against the interview data by a second researcher (the research ‘buddy’/supervisor) and reviewed by at least one suitably qualified member of the Advisory Group before final editing.

Preparation for presentation on the website: The clips and summaries for the website will be prepared according to a careful protocol and delivered to the DIPEx Charity web team (co-applicant Barnett) who will prepare and input all textual data into a content management system. This enables ease of updating and control of the content. Videos will be professionally edited.

Information and resources links: The researchers will identify, in consultation with the stakeholders, a list of reliable websites that provide related, public facing information for inclusion on the site. The Healthtalk team will offer web-links to all such resources. We would also like to include a terminology page here on which we would consult our Advisory Group.

Maintaining and updating the site: The research delivery project manager is responsible for an updating programme that involves review of the content of each Healthtalk site every 3 years in line with the NHS Information Standard accreditation. At this point we consult with the original Advisory Group (including the CYP sub-panel which feeds into the main Advisory Group) and co-applicants for their advice regarding any new treatments, new terminology or if any new interviews should be added. For example, if the Advisory Group tell us that the terminology we use has become out-dated or misleading we would edit the site accordingly. We might also add new links to the resources section. If a new treatment (such as new hormone therapy) comes into practice it may be decided that additional perspectives, through new interviews, need to be added. We have included provision for one month's salary to contribute to updating the site. We would work with our co-applicant networks (particularly Davidson and Stewart) coupled with the usual recruitment methods (posters, leaflets, social media) to recruit specifically for this perspective.

Training Materials:

Professor John Powell, Dr Jay Stewart of Gendered Intelligence and Dr Sarah Davidson from the Tavistock & Portman GIDS will lead the development and delivery of the national networking event (more details on this on page 11). A key aim will be to share networks and best practice; present findings from the analysis of our interviews; and discuss recommendations and potential uses of the material beyond the Healthtalk resources. We will develop the precise format of this event (or events) with input from co-applicants and PPI representatives, seeking to develop a format that will be accessible and appealing to all stakeholders. Smaller or satellite/live streamed events will be considered to make these events more accessible to a wide audience (in line with Reviewer 2's excellent suggestion of holding smaller events or satellite events). We will seek funding (from the Foundation for the Sociology of Health and Illness or the Wellcome Trust) to run this event/these events. If we are unsuccessful with funding, one of the Oxford co-applicants is a Senior fellow at an Oxford college and we would propose to hold the networking event within college facilities, with Skype connections for those unable to attend, absorbing these costs internally.

The team anticipate that two 'catalyst' films will be co-designed to be used in service improvement and teaching. The films will be produced by the DIPEx Charity which has produced numerous films for services improvement with funding from NHS England, ESRC and NIHR (see here: http://healthtalk.org/peoples-experiences/improving-health-care/trigger-films-service-improvement/topics). Specifically, to develop the training materials we will use the same thematic approach to identify key 'touch points' along each care pathway. This analysis will be undertaken by one of the qualitative researchers under the supervision of (CI) Powell and (PI) Stepney, and in discussion with the wider team and our Advisory Group members. The catalyst films will be created drawing on this analysis and feature extracts from the interviews illustrating the touch points identified. We anticipate the films will last between 10-20 minutes each. However, their length can be flexible, depending on the co-design process at the national networking event and we will retain flexibility about other uses the stakeholders will want to make of the material, which may be evaluated in subsequent studies.

Minimising risks during field work (see also page 25, Section 11, risk table)
HERG has a safety protocol for all lone workers and the lead applicant (and HERG co-apps) have undertaken lone worker training. Each interview participant will be offered further sources of help

and information after the interview should they require this – this list will likely include the Mermaids helpline, and Mindline Trans+ support helpline – although it will be decided in collaboration with the Advisory Group. The lead applicant is experienced in working with vulnerable groups and handling sensitive issues – and recruited researchers will also have similar experience and training. As explained in the previous section, participants can review the transcript of the interview and delete any sections they wish giving them control of the data they wish to disseminate. All HERG researchers have a research buddy, many also have a mentor. The co-applicants will also establish a small troubleshooting group to offer advice and support to the researchers when they are doing fieldwork (see also page 25 for more details on this). The researchers will also have access to regular debriefing/counselling sessions with co-applicant psychotherapist Ellie Roberts, who is highly experienced in gender identity services.

Objective two: identify ways in which specialist gender identity services can be improved and develop resources to help achieve these improvements

We will identify and compile a list of potential stakeholders to include young people, family members, voluntary sector, researchers, Royal College of GPs, local service providers from CAMHS, representation from the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and Academic Health Science Networks (AHSN), clinicians, representatives from the funding body and any other interest groups. These stakeholders will be invited to the national networking event (month 24).

From this list, a sub panel of stakeholders will be invited to form the project Advisory Group which will meet 3 times during the project: members of this group will advise on the parameters of the project, the sampling and conduct of the interviews, and will also be asked to contribute to quality assurance of the Healthtalk resource by reviewing the summaries and provide information about associated resources.

Co-applicants John Powell, Sarah Davidson, Jay Stewart and Richard Ma will organise a national networking event in Month 24 to explore emerging findings from the Objective One interviews. JP will lead the organisation of the national networking event. SD and RM will support JP in organising the event providing key networks and contacts from the GIDS and Royal College of GPs. JS will also help with the organisation of the national networking event, providing key contacts and stakeholders within the transgender community. Co-applicants will actively promote the day and invite key people in the field. For example, co-applicants have a combined twitter following of over 20,000 followers. The event will involve discussion of potential service improvements and the co-design of resources that will be published online, for example training films for service improvement. Examples of previous training films, funded by NIHR HS&DR, include those produced for the Intensive Care and Lung cancer modules on Healthtalk which were developed for Locock et al. (2014) and are publically available on the NHS Service Improvement area of Healthtalk (http://www.healthtalk.org/health-professionals).

Objective three: support young people and their families through the development of two new sections at Healthtalk.org.

Using tried and tested methods developed by co-applicants, we will publish the findings from the Objective One interview studies as two new sections on the award-winning website Healthtalk.org. These will comprise of a section for i) children and young people ii) families including parents and siblings (see below). Interview participants will be able to choose how their interview extracts appear on the website (for example as video, audio or written – the latter can provide anonymity if preferred).

Healthtalk is a freely available website based on rigorous qualitative research which features analysis illustrated by hundreds of video and audio clips from interviews with people talking about their experiences of health and social care
The aims of Healthtalk are:
1. To support patients and their loved ones, who may feel alone or ill-prepared for challenges ahead.
2. To support healthcare professionals in providing patient-focused care.
3. To promote better communication between patients and health professionals.
4. To assist policy makers and all stakeholders (such as in education and voluntary sectors) interested in population health needs and behaviours.

Healthtalk.org published its 100th condition-specific section in 2017. There is already a section on young people’s sexual health including LGB experiences. However, transgender peoples’ experiences of health are not yet covered. This module will allow us to respond to clearly identified and urgent need to reduce stigma and discrimination in society against transgender people, including in healthcare.

Objective four: evaluate these Healthtalk sections with patients and their families on the waiting list for services.

The purpose of the evaluation is to gain feedback from young people on the two new sections on Healthtalk.org and based on that feedback modify the sections as appropriate. We will conduct 3-4 focus groups each with 6-8 young people on the GIDS waiting list. We will send a link to the new web resources to participants 48 hours before the focus group so that there is time-limited access. To ensure safe recruitment within the transgender community whilst ensuring a degree of independence, we will ask current participants to snowball our sample (i.e. participant X refers us to person Y and person Z to contact); and also ask our youth panels and People of Colour panel to do likewise to ensure diversity.

A modified version of the e-HIQ questionnaire will be put up on the two new sections on Healthtalk.org once live (on the young persons and parent/carer modules) to generate additional feedback. This will be monitored by the DIPEx charity and the team will review this 3 months after the site has gone live.

In order to maintain interest and contact with the young people taking part in this project we will incorporate Reviewer 2's suggestion of a prize draw for the evaluation. We also will invite gender diverse CYP to contribute a guest article/blog on the News and Blog section of the Healthtalk site.

6. Dissemination, Outputs and anticipated Impact

What do you intend to produce from your research?

The following outputs will be produced:

a) Two new Healthtalk sections for i) children and young people and ii) families of transgender people to be published in month 28 of project. AUDIENCE: gender diverse young people and their families, the wider public, media, teachers, researchers and policy makers.

b) Co-designed recommendations, shared best practice and resources from our national networking event. We anticipate preparing 2 short films for service improvement and staff training initiatives as part of these resources. Month 24. AUDIENCE: voluntary sector, patients and the public, service providers, policy makers.

c) Conference presentations: findings will be presented at annual national and at least one international conference (e.g. WPATH, 2020 or similar transgender conference in 2020/21). AUDIENCE: specialist clinical academic and transgender community.

d) NIHR HS&DR final report. AUDIENCE academics clinicians, managers and policy makers.

e) Academic papers: research findings will be written up as 2 or 3 peer reviewed papers in open access social science, clinical and HSR journals. AUDIENCE: academics, clinicians, managers and policy makers.

f) Addition of the two interview collections to the HERG archive, University of Oxford. These will comprise a collection of (anonymised, according to the participants wishes) interview transcripts and associated materials, copyrighted for teaching, publication, broadcasting and secondary analysis for research and health policy (Ziebland and Hunt, 2014). The archive is available to *bona fide* researchers under data sharing agreements. AUDIENCE academic researchers and health policy makers, (future) historians, social scientists and other scholars.

g) The lead department in Oxford is also currently the lead academic department for the NIHR Oxford CLAHRC. Co-applicant JP is the primary care lead within the 'patient experience' theme of the CLAHRC, while the PI currently works in the 'Early intervention and service redesign' theme. This proposed project would be 'adopted' alongside the existing CLAHRC-funded activity in the patient experience theme. In practical terms this means the proposed project would stand to benefit from CLAHRC/ARC dissemination networks (focussed on translating knowledge into action) both locally and nationally.

h) RM has a track record of engaging primary care audience on sexual and reproductive health issues and will facilitate dissemination of outputs to a primary care audience in a variety of ways, including:

    i. A blog post on the new primary care sexual health research website which has already received over 200 hits to date since its launch in late December. https://primarycaresexualhealth.wordpress.com/
    ii. Submission to the RCGP conference – for an oral presentation or workshop idea
    iii. Engagement through social media such as Twitter (two accounts – @GP_SexualHealth and @Richard_GP – combined count of nearly 6000 followers).
    iv. Dissemination and engagement through GP Facebook groups.
    v. A commissioned article in a GP magazine such as *Pulse* or *GP.*
    vi. As a member of All Party Parliamentary Group on Sexual and Reproductive Health, he is able to discuss findings with key policy makers.

- **How will you inform and engage patients, NHS and the wider population about your work?**

To meet Objective 1 we will need to engage with the children and young people, adult trans-identified people and the families of young people who are using gender identity services. Young people using the services will sometimes have complex family and health backgrounds and may not be easy to engage through conventional NHS routes. Our co-applicant team which includes the transgender voluntary sector, specialist clinical and qualitative research expertise, supported by an Advisory Group, are particularly well placed to help us to disseminate information about the project through articles, newsletters and social media. The transgender community is in danger of ‘research fatigue’ – our co-apps tell us that they are approached by several hopeful researchers each week. Their willingness to commit to this project is because the findings will be disseminated direct to the target group and will provide a much needed, comprehensive resource for the community: we anticipate that this will also be a factor for the young people and adults who we approach. In other words, while much academic research is published in journals rather than in a form that is useful, the outputs from this project will be durable, accessible and supportive to people’s quality of life. Our co-apps tell us that having an official, trustworthy source of information to point people to will also help counter any sensationalised and misinformed stories on transgender issues that frequently circulate in the media. The new Healthtalk sections will be publicised on social media platforms including Facebook and Twitter, and via GIDS. They will offer transgender people and their families practical and emotional support and information, through hearing and seeing other people talk about their experiences.

Our transgender voluntary sector, GP, specialist and CAMHS co-applicants are also uniquely well placed to ensure that the study findings are taken up in all these sectors. This will allow us to reach a broad audience and maximise the impact of the resources we produce:

Sarah Davidson has worked as a consultant clinical psychologist at the GIDS for 12 years during which time she has: established groups for gender diverse young people as well as parents attending the GIDS; established the service's stakeholder groups of young people who coproduce service user involvement strategies and activities, including research; led on research with young people and their families from the service; and provided consultation to professionals and service user groups across Europe. GIDS regularly runs conferences and CPD events for professionals (including for specific groups such as GPs, Psychologists, CAMHS and school teachers) and third sector organisations. In 2018 GIDS will host a conference organised by the European Society of Paediatric Endocrinologists' on gender diversity in young people. They also regularly provide papers and sessions to a wide variety of national and international conferences and events including EPATH and WPATH. Each of these will be relevant networks to share our learning from this project. Sarah is part of the Executive of the GIDS and has extensive experience and all-embracing networks which she can draw upon to support this project.

Richard Ma is a GP and has established networks across professional groups (including primary care practitioners, academics, GUM/HIV /sexual health practitioners, commissioners), patient groups (people living with HIV, LGBT community and women’s rights/pro-choice groups) as well as policymakers (e.g. All Party Parliamentary Group on HIV and Sexual Health). He is an active member of professional organisations including Royal College of General Practitioners, British Association of Sexual Health and HIV, and formally Faculty of Sexual and Reproductive Healthcare and is active on social media (with over 2500 followers on Twitter). He has an impressive track record of using established networks to improve sexual and reproductive healthcare. Examples include education and training packages for healthcare professionals, NICE guideline development and more recently high profile debates on sexual orientation monitoring.

Jay Stewart is founder and CEO of Gendered Intelligence (GI) and has extensive networks which will be utilised for recruitment and dissemination. In detail, GI run monthly groups in London, Bristol, Leeds, Stevenage, Hemel Hempstead and Bishop Stortford for trans and gender questioning young people. In 2017, GI's established youth group programme delivered 74 sessions attracting over 1150 attendances from more than 400 individuals. Jay and his colleagues at GI also work with about 80 parents and carers each year. GI regularly offers insight into trans inclusion and gender diversity at government and Parliamentary Level. They sit on the Parliamentary Forum on Gender Identity, were advisers on the Ministry of Justice's transgender prisoner review and continue to have a place on the National Transgender Advisory Group for prisons. GI is among the biggest provider of trans awareness and gender diversity training the UK, advising and partnered with major national institutions, including the Football Association, the Welsh Assembly, The Science Museum and Tate, among others. We will work with Jay to reach the widest possible audiences through these established networks.

With the active engagement of stakeholders at the networking event, the applicants will develop recommendations and narrative based resources (for training and service improvement) (Objective 2). This research proposal responds to a widely recognised need for reliable online resources to support, inform and help prepare children, young people and their families who are on the ever-increasing waiting list for specialist services. We will develop (Objective 3) and evaluate (Objective 4) the two Healthtalk sections to meet this expressed need.

- **How will your outputs enter our health and care system or society as a whole?**

Our public engagement/PPI will allow us to reach wider patient networks within the trans-identified community beyond those people who have taken part in the research directly. The broader stakeholder group, the project Advisory Group, study Facebook group[2] and co-applicant networks as well as wider social media channels (such as Twitter) will be used to engage and inform those who were not able to take part in the study and/or those who could benefit from the outputs. For example, our co-applicant Twitter accounts reach over 20,00000 followers. In addition, the GIDS run regular events for patients and their families ('family days') which will allow us to reach a wider network. Co-applicant SD (Consultant Clinical Psychologist at the Tavistock and Portman GIDS) is involved in running Continuing Professional Development events for health professionals and professionals from across sectors relating to children, young people and their families.

The website Healthtalk is visited more than 5.9 million times per year. Of these visits, 85% find the website by searching for key phrases on search engines such as Google and Bing. We believe this happens because the content provides a high level of detail, giving it a good chance of matching the queries people enter into search engines, in relation to the topics that are covered on the site. DIPEx (the charity who own and run the website) also holds a voluntary sector grant from Google which can be used to promote the Healthtalk resources in online searches.

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[2] We will set up an online group to engage with a larger audience during the project and to reach young people who feel less comfortable with the formality of an Advisory Group. Whilst a Facebook group would seem a good choice, we are also aware that Facebook groups have issues around privacy and disclosure for members. In consultation with the Advisory Group and co-applicants we will therefore consider using a closed patient support group that is already established if this is deemed more suitable.

The other 15% of our traffic comes from various external sources such as social media, health/social care information websites and mainstream media. NHS Choices and charities that provide health information link extensively to the content on Healthtalk and Jo Kidd, Communications Manager at Healthtalk is responsible for updating these organisations when new HT sections are published. The involvement of relevant charities on the Advisory Group and through the (reinstated) networking event will support the promotion of the resource on their own website and social media channels.'

In terms of reach, approximately 1/3 of visits to healthtalk.org come from the UK (2 million people per year). There are a number of factors to consider when trying to project the number of people who may be reached by this resource. The exact number of trans or gender questioning young people is unknown although 1% of the population (or 90,000 people aged 14-24 years) are thought to be transgender. However, this number is likely to be larger as the resource could benefit any person who is gender-questioning (so not just those young people who identify as trans) in addition to all the audiences identified above. In addition, there will be family members and many others who wish to learn more about the subject.

The Healthtalk section on Motor Neurone Disease is one of the most popular on the website and receives 110K visits per year while only 6,000 people are diagnosed with the condition each year. The GIDS website itself provides information for young people and parents including a selection of personal accounts of those who have used the GIDS service. The website was visited 36,381 times between January and July this year which indicates a high demand for this kind of resource. We would hope to reach at least 20,000 visits in the first 12 months after the site's launch.

DIPEx will disseminate the resource through their own Facebook, YouTube and Twitter channels and join forces with relevant charities and advocacy groups to share the resource directly to potential beneficiaries. A press release will be issued to the mainstream press and other relevant publications, websites and blogs. Healthtalk has links from most of the most popular news sites including BBC, The Guardian, The Telegraph, The Times and Daily Mail (the news archive section on Healthtalk has further details). In addition, our co-applicant networks will be used to disseminate and gain feedback on the new Healthtalk sections, which will be evaluated with young people and families waiting for a referral and other specialist services. Co-applicant SD will help recruit young people and families attending the Tavistock clinic youth/family group days and those on the waiting list, thus ensuring we gain feedback and continued engagement with patients (and their families) beyond the completion of the formative evaluation and publication of the new Healthtalk section in month 28 of the project.

A carefully constructed press release[3] will be developed with guidance and advice from the University of Oxford News & Information Office and issued to relevant publications, websites and blogs, for example, META magazine – a digital publication devoted to gender and transgender news. We will also explore other 'Pink media' such as PinkNews and HuffPost UK LGBT Living; as well as promotion at LGBT Pride events and LGBT centres.

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[3] Our co-applicants and Advisory Group have highlighted how any press releases will need to consider our response to anti-trans activists and the significant number of anti-trans stories/campaigns frequently generated in the media. We will consult with our Advisory Group and co-applicants at all stages in collaboration with getting advice from the University of Oxford News & Information Office (see risk table on pg. 25).

A core way we will engage with healthcare professionals and the NHS will be through the national networking event. JP, SD and RM will organise the day with our co-applicants and their networks to invite key stakeholders. Trans-identified people recruited through our PPI/Advisory Group networks will be invited to attend the national networking event and we will engage with our study Facebook/online (closed) group so that we can hold Q&A intervals for those unable to attend[4]. The networking event will firstly describe and show some of the main findings from the narrative interviews (Objective 1) including those with GPs and CAMHS professionals. We will then identify potential service improvements and recommendations for practice and delivery. From this we anticipate preparing 2 short films for service improvement and staff training initiatives as part of these resources.

- **What are the possible barriers for further research, development, adoption and implementation**?

This proposal arises from identified needs (social and clinical) for a more thorough understanding of experiences of gender identity services. The study will only have credibility with trans and gender diverse people if we are able to represent a diverse range of experiences: this is important to ensure we are reaching all the people who need to be reached. Therefore this will be a touchstone throughout the study guiding the appointment of research staff, recruitment strategies, and checking for data saturation through the formative evaluation.

There are other online support and information resources for the community, and it is likely that more will arrive during this study. Our aim is to produce a balanced and comprehensive resource. The co-app team has unique experience in this field and through their voluntary sector, clinical and academic links are well placed to establish a trustworthy resource.

- **What do you think the impact of your research will be and for whom?**

The main beneficiaries of the research are likely to be the children and young people (and families) preparing to attend specialist services. Specialist service providers have identified the need for reliable resources, featuring an appropriately wide range of experiences, to prepare, inform and support those on the waiting list, currently estimated to be 1400 people at the Tavistock and Portman GIDS alone. The new section on Healthtalk will be published in month 28 of the study. There may be benefits for specialist services if children, young people (and their families, if relevant) are better prepared and supported while waiting for treatment.

We anticipate benefits for healthcare staff through providing new training and service improvement films, based on the narrative interviews. GPs, CAMHS staff, RSE teachers and school based health services will all potentially benefit from the development of engaging, narrative based resources covering diverse perspectives on transgender issues.

The project may generate changes in NHS services although we do not plan to evaluate the service-facing resources and recommendations as part of the proposed study (our formative evaluation Objective 4 will concentrate on people on the waiting list).

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[4] A live Twitter feed was considered, but members from the Advisory Group advised it would likely be ‘swamped’ by anti-trans activists. We therefore feel engaging with our FB/online group would be more suitable as such groups have greater control of membership.

The Healthtalk sections will have wider relevance for health and social care professionals and students, schools, undergraduate and post-graduate learning and teaching. Over 80% of British medical schools currently use Healthtalk in teaching students about patient's perspectives on health and social care.

In terms of benefit to patients and healthcare professionals, Healthtalk have administered surveys to gather feedback from website users, who report that they feel better informed (81% of 904 respondents); feel less alone (71% of 886 respondents); feel better able to discuss their situation with others (56% of 633 respondents), better prepared for seeing health professional; (81% of 243 respondents), agree that we provide information that's not available elsewhere (83% of 246 respondents).

Qualitative feedback we have received backs up the figures. For example, a visitor to the 'young people & depression' section of the website emailed Healthtalk to say:

"I'm 20 years old and have been struggling with depression since I can remember, and have struggled even more with trying to get those around me to understand how I feel. I would try to explain it to them and they still wouldn't get it, making me feel more alone. I sent my parents the link to this page and had them watch the videos, and now they (and I) know that I am not alone with my illness and the way it makes me feel. Now instead of shaming me for the way my depression makes me live, they understand that it can be crippling and have decided to help me. Thank you so much, this information saved my life."

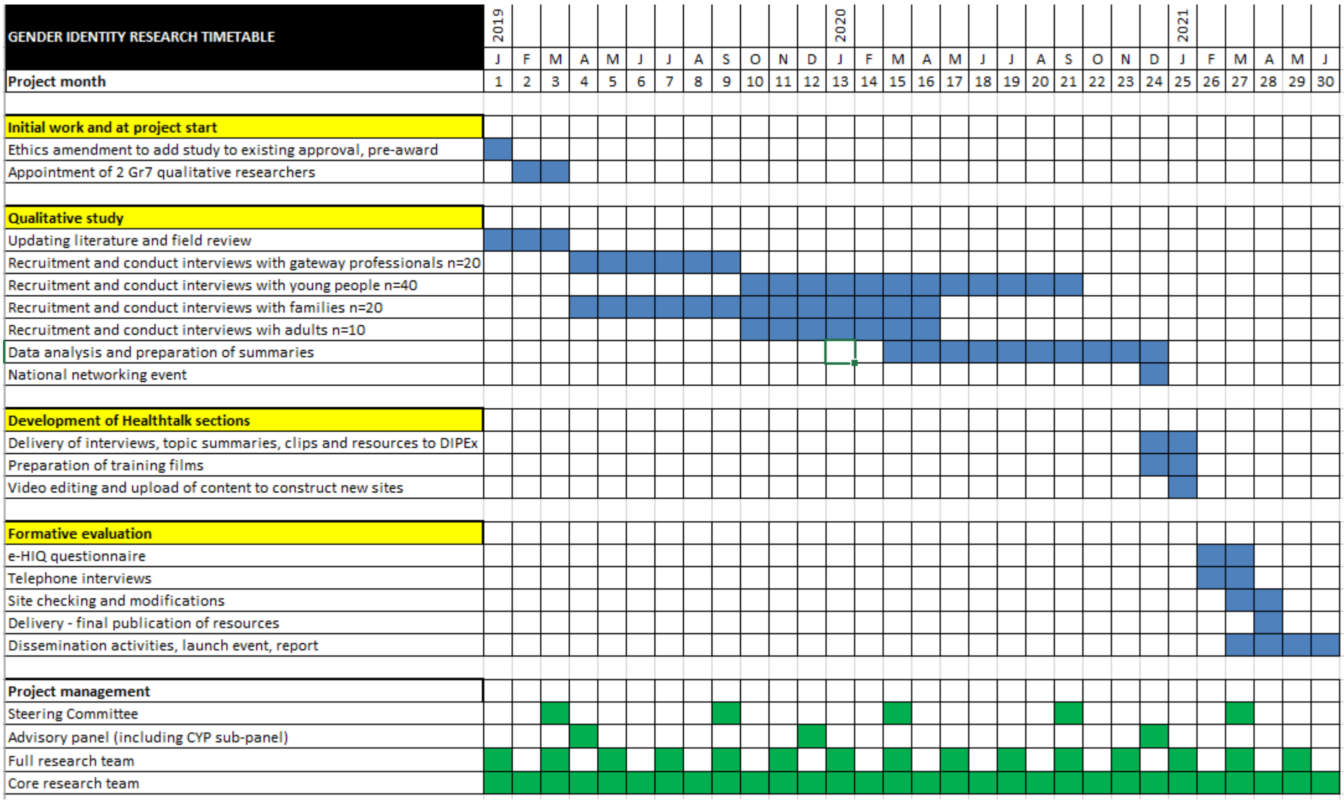
In another example, Alan whose wife Elizabeth had Motor Neurone Disease. She was able to continue communicating long after she lost the ability to speak, up until the day she died, because they found out about a device called a 'lightwriter' from watching another couple who were interviewed on the MND section. *"It was a very small and pragmatic thing that made really a lot of difference, but no-one else mentioned them, the doctors, the clinics didn't mention them. The idea came from healthtalk.org"*

The website is also used extensively for training health professionals in the UK and beyond. Research has shown that the use of the HT videos can improve medical students' learning (Snow et al., 2016*). Finally, the data generated in HT projects have been extensively used for secondary analysis and service improvement projects. For example, a recently completed NIHR funded study to address the problem of noise in the ICU drew on secondary analysis of the interviews collected for the intensive care project to develop very successful staff training and new approaches to monitoring noise levels.

Our academic dissemination will include at least two peer-reviewed journal papers, conference presentations (including one international) and small launch event. Dissemination will be international; findings will be distributed by colleagues in UK, as well as US/Europe (e.g. two Advisory Group members are US-based).

7. Project/ research timetable – see page 20 (below)

7. Project / research timetable



GENDER IDENTITY RESEARCH TIMETABLE	2019												2020												2021					
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
Project month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Initial work and at project start																														
Ethics amendment to add study to existing approval, pre-award	🟦																													
Appointment of 2 Gr7 qualitative researchers		🟦	🟦																											
Qualitative study																														
Updating literature and field review	🟦	🟦	🟦																											
Recruitment and conduct interviews with gateway professionals n=20				🟦	🟦	🟦	🟦	🟦	🟦																					
Recruitment and conduct interviews with young people n=40										🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦									
Recruitment and conduct interviews with families n=20				🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦														
Recruitment and conduct interviews wih adults n=10										🟦	🟦	🟦	🟦	🟦	🟦	🟦														
Data analysis and preparation of summaries															🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦						
National networking event																								🟦						
Development of Healthtalk sections																														
Delivery of interviews, topic summaries, clips and resources to DIPEx																								🟦	🟦					
Preparation of training films																								🟦	🟦					
Video editing and upload of content to construct new sites																									🟦					
Formative evaluation																														
e-HIQ questionnaire																										🟦	🟦			
Telephone interviews																										🟦	🟦			
Site checking and modifications																											🟦	🟦		
Delivery - final publication of resources																												🟦		
Dissemination activities, launch event, report																											🟦	🟦	🟦	🟦
Project management																														
Steering Committee			🟩						🟩						🟩						🟩						🟩			
Advisory panel (including CYP sub-panel)				🟩								🟩												🟩						
Full research team	🟩		🟩		🟩		🟩		🟩		🟩		🟩		🟩		🟩		🟩		🟩		🟩		🟩		🟩		🟩	
Core research team	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩

8. Ethics / Regulatory Approvals

The qualitative methods have been approved by NRES Committee South Central – Berkshire (REC reference number 12/SC/0495) for all health conditions involving participants aged 10 years and over. Our studies do not require NHS sites to act as 'Research Sites' (under the new National Research Ethics service guidelines), but only as 'Participant Identification Centres (PICS)'. Research that is conducted using these methods and for dissemination on Healthtalk is included on the National Institute for Health Research Network (NIHR CRN) Portfolio (IRAS Ref: 112111. Study ID: 13550).

Our researchers do not recruit on clinical premises and interviews are usually conducted in people's homes, so honorary NHS contracts are not required. Before the interview commences, the way in which audio and video clips are used on the site will be demonstrated to participants on a laptop computer and they will have ample opportunity to have any questions they have answered. They will then be asked to complete an informed consent form and to give permission for the interview to be video and/or audio recorded. Names of health care staff and hospitals, and the names of family members and other identifying information, will be removed from the transcripts. Participants will be asked what name (their own or an alias of their choosing) they would like to be used on the website. A copy of the transcript will be sent to the participant and they will be invited to indicate any sections that they do not want to appear on the internet. After they have approved the interview content and chosen whether they want their clips to appear in video, audio or completely anonymised written version, a form is signed which gives copyright to the University of Oxford to use the material in research, teaching, publications and broadcasting.

Our ethical approval allows us to i) interview 16 years olds and older who can reflect on their previous experiences of being under 16; ii) interview 12-15 year olds with consent from a parent/carer. The Healthtalk site includes young people’s interviews about experiences of ‘drugs and alcohol’, ‘depression and low mood’, ‘eating disorders’, ‘sexual health’ and ‘psychosis’ for example, where researchers have conducted interviews with young people over 16 who have talked openly reflecting back about earlier experiences and in this way we are able to include a wide range of experiences from a younger age. We therefore would be able to capture experiences where young people may have been unwilling to disclose gender identity issues to their parents and/ or families at that time. For the formative evaluation phase, ethical approval is already in place for conducting 'market testing' focus groups with a pre-launch version of the two new sections on Healthtalk.org.

As with all of our Healthtalk studies with young people we would make sure that the young person has considered the possibility that other people (including wider family members) may see extracts from their interview on the Healthtalk website. In doing so we would also discuss the option of a written-only or audio interview with a pseudonym. Moreover, should they wish to continue with a video interview, there are subsequent steps which allow significant control for the participant whatever age (to review the transcript, remove parts of the interview or all of the interview from the site at a future date, if required).

9. Success criteria and barriers to proposed work

The success criteria for our work are:

1. Patient experience: the diverse experiences of CYP, adults and families are used to produce a tangible outcome of two healthtalk sections for CYP and families.
2. Quality assurance: the Healthtalk sections are evaluated with patients and their families to measure their effectiveness and success.
3. Stakeholder engagement: creation of transgender networks through the Advisory Group and national networking event lead to long-term collaboration and greater awareness of current provision.
4. Knowledge exchange: stakeholders acquire transferrable skills through sharing knowledge of best practice and identification of service improvement (at national networking event), encouraging more effective responses to CYP and their families.
5. Research excellence: contribution to the wider literature/field of transgender studies is achieved through writing of 2-3 journal papers; dissemination at national and international conferences.

The following **risks** have been identified, with corresponding solutions.

Possible barriers to research, development, adoption and implementation	**Solutions**
Difficulties in recruiting participants with a wide range of gender experiences or those who are marginalised (i.e. people from minority ethnic background; those who live in remote locations or are not on social media)	We will use a variety of routes to contact potential participants so that we cover the widest possible reach and geographical area. We will achieve this through using our co-applicant networks and mailing lists, in addition to social media and our study Facebook group (as well as charity groups) to ensure we advertise the study to seldom heard voices within the trans community. Although snowballing is commonly used in qualitative research, we will be mindful that this does not lead to only representing the most dominant/prominent voices in the trans community. We will actively state that we are keen to interview people who have not participated in research projects before. Stewart our co-applicant at Gendered Intelligence runs a quarterly Black Asian and Minority Ethnic group in London called ‘Colours’ which is specifically for BAME trans youth. He also runs seven other monthly groups which BAME trans and gender diverse young people do attend. We will use these and other networks that become available during the course of the research to recruit and disseminate to BAME youth at these groups. In terms of interviewing, we also have researchers within the HERG group from BAME backgrounds who have extensive experience of engaging with ethnic minorities and intersectional dimensions. We will aim to include in our Advisory Group BME trans and gender diverse participants who we would seek for advice on cultural translation. In doing so, we will ensure that our interview guide is sensitive to the concerns and needs of different cultural groups in terms of age, generation, language, literacy, migration history, and country of birth At all stages of recruitment, we will gain advice from our Advisory Group and co-applicants in contacting marginalised groups. During recruitment we will maintain a database of potential and actual participants and review this at regular intervals to ensure there is sufficient recruitment from people with diverse gender experiences, minority ethnic and socio-economic backgrounds.

Stigma in relation to the public dissemination section on Healthtalk	HERG has considerable experience in handling participant anonymity sensitively. One example is our recently NIHR funded project on experiences of Women’s Experiences of Domestic Violence and Abuse which includes various anonymised accounts. Healthtalk contains many sections on health issues/conditions which could be considered stigmatising. These are among the site sections with the heaviest traffic and most appreciative feedback. As detailed earlier in the Research Plan, participants are able to review their interview transcript, delete sections should they wish and can choose how their interview appears on the website (video, audio or written only). Thus, if somebody chooses a written-only option with a pseudonym this provides anonymity. A participant is also fully within their right to ask at any later stage to have data extracts removed from their interview or in rare cases, their whole interview. This has happened very rarely, which we believe is because our research interview and consent processes are always participant led.
Trans-community receive frequent requests for research (“research fatigue”) –our co-applicants tell us that they can feel bombarded with research requests.	Our co-applicant Jay Stewart suggests signposting the benefits of taking part to those potential participants clearly – that this is a national study with the potential to deliver real benefits to the trans community - we will therefore produce (along with the participant information sheet) clear recruitment letters/posters/emails introducing the study to potential participants. The Advisory Group members will review the wording and content of these materials, advising of necessary changes before they go to potential participants.

How interviews will be managed and any associated risks mitigated.	Interviews will follow a clear and established protocol (including participant information sheet, and obtaining informed consent). Our Advisory Group (with sub-panel of CYP) will review these materials. For the youngest age bracket of 12-15 year olds we provide information for parents in addition to the information sheet for young people and do require consent from a parent/carer. Our ethical approval allows us to i) interview 16 years olds and older who can reflect on their previous experiences of being under 16; ii) interview 12-15 year olds with consent from a parent/carer. Participants will be able to review their transcript and delete any sections they wish not to be used – see **Methods** in the **Research Plan**). In consultation with the Advisory Group, each participant will be offered and signposted further sources of information and help which are likely to include the Mermaids helpline, Mindline Trans+, web chats and further third sector information and guidance. In addition, a small troubleshooting group will be formed for the two main researchers. This group will comprise of one or two people who have expertise in the transgender community and will be on hand to troubleshoot any immediate potential issues that arise through the interviewing process. The PI has worked with vulnerable groups and is experienced in dealing with sensitive topic areas. We will ensure that the recruited Gr7 researchers will also be experienced in this area. The researchers themselves will also go through regular debriefing sessions with co-applicant Psychoanalytic Psychotherapist Ellie Roberts, who is highly experienced in this area and available to support the research process particularly during the fieldwork phase.
Dealing with negative press/anti-trans activists	We are aware of the possibility of negative and controversial coverage of this project such is the level of discrimination and stigma experienced by trans populations, a problem amplified by certain sections of the media. We are aware of the potential for negative/controversial press surrounding the project given the frequency of anti-trans activists targeting social media accounts and the number of anti-trans stories circulated. Our press release will therefore need to be carefully constructed and thought out in consultation with our department Communications Manager and the University News & Information Office. For example, the University advise only contacting trusted media outlets, or placing an exclusive, if a story is complex, controversial or likely to be misunderstood. Having sensible coverage in one major outlet first can set the tone for other coverage. The PI and researchers will endeavor to undertake media training within the University to effectively manage and anticipate news coverage.

10. References

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