TRANS COMMUNITY HEALTH PROFILE 2022

A BOLDER HEALTHIER BIRMINGHAM

Foreword

The Trans Community Health Profile was commissioned by Birmingham City Council to review the evidence on the trans community in Birmingham and nationally. The report synthesises evidence on the experiences, needs and outcomes of the trans community across a range of health and well-being indicators, including education, employment, housing, mental health, disabilities, substance (mis)use and physical activity. It illustrates the multi-layered barriers and inequalities faced by trans people in relation to their health and everyday lives and highlights gaps in the existing evidence base. The report demonstrates the public health need for comprehensive monitoring, research, and engagement with trans communities at a local and national level.

The Trans Community Health Profile is part of a wider series of evidence summaries produced by Birmingham City Council which focus on specific communities of interest.

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The BI is an independent research institute and registered charity, founded in 1990.

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Community Evidence Summary

This report contributes to the work of the Public Health Divisions aims to improve the understanding of the diverse communities of Birmingham.

A series of short evidence summaries aims to improve awareness of these communities and their needs.

There are common objectives for each of the evidence summaries which are:

- To identify and summarise the physical health, mental health, lifestyle behavioural, and wider determinants of health-related issues that are affecting the specific community both nationally and locally.
- To identify and summarise gaps in knowledge regarding the physical health, mental health, lifestyle behavioural and wider determinants of health-related issues that may be affecting the specific community both nationally and locally.
- To collate and present this information under the key priority areas identified in the Health and Wellbeing Strategy for Birmingham 2021.
- To promote the use of these summaries for Local Authority and wider system use for community and service development.

Executive Summary

"Transgender", or "trans", are umbrella terms for people whose gender identity does not align with their assigned sex at birth. Trans people typically identify as binary, i.e. as women or men (different to the sex they were assigned at birth) or as non-binary, i.e. they do not identify exclusively as either a man or woman. The terminology used in the trans literature is continually evolving and can be different depending on stakeholder perspectives.

The Trans Community Health Profile identifies and summarises the national and local evidence in relation to the physical health, mental health, access to healthcare behavioural factors and wider determinants of health that affect the trans communities, including trans children, trans adolescents and trans adults. The profile covers health related factors such as health conditions, screening, access to healthcare and to gender identity services, lifestyle factors such as physical activity and substance use, and wider influences such as educational attainment, economic activity and experiences of work, housing and transphobia.

An evidence-based Community Health Profile requires robust data on which to draw. An examination of the trans literature reveals there is no evidence on some aspects of trans people's health and wider determinants of health and limited data with methodological drawbacks in other areas. At both national and local levels, there is no robust data on the size of the trans population, the demographic profile of the trans population or the health of the trans population and limited data on the wider determinants shaping trans people's lives. Health and social care organisations, public bodies, and population-based surveys do not routinely ask people about their gender identity (e.g., their registered/assigned sex at birth), so trans people are not counted.

In lieu of reliable population-level data, the limited evidence on the trans population typically comes from community-based surveys of trans people and clinic-based studies of trans people with gender dysphoria. However, methodological drawbacks of existing studies impede the generalisability of findings and, at times, the validity of conclusions and recommendations.

In 2021, UK Census asked a question on gender identity for the first time. The question posed was '"Is the gender you identify with the same as your sex registered at birth?", with a free text box for those who answered no. This question was in addition to the pre-existing question on sex, designed to capture sex registered/assigned at birth. The 'gender identity' question was voluntary and was posed to respondents over 16 years. The results of the 2021 Census, when published, will provide reliable, rich and novel insight into the trans population, nationally and in Birmingham.

Current estimates suggest that there are approximately 536,648 trans people in the UK and 9,124 trans people in Birmingham.

Existing evidence indicates that trans people fare worse than non-trans people across various indicators. They experience inequalities, transphobic discrimination, abuse and poorer social determinants across a wide spectrum of their lives, including their personal relationships, housing, education, work, physical activities and sport, access to public spaces, access to healthcare and mental health. Evidence also suggests that health needs and outcomes differ between trans people who have a binary trans identity and non-binary trans identity and trans people who are assigned female at birth and those assigned male at birth.

Key Findings

Mental Health

- Trans adults and young people are between 1.5 and 3 times more likely to report self-harming thoughts and behaviours than their non-trans (LGB) peers.
- There is a higher prevalence of mental health problems in young trans people aged 16-25 compared to trans adults and trans children.
- Trans adults: 35% self-harmed and 12% have attempted suicide.
- Trans youth (aged 16-25): 68% self-harmed and 25% attempted suicide.
- Trans adolescents (aged 12-18): 44% self-harmed and 16% attempted suicide.
- Trans children (under 12 yrs.): 15% self-harmed and 2% attempted suicide.
- Trans people assigned female at birth are significantly more likely to experience mental health problems than trans people assigned male at birth.

Health Status and Screening

- Trans people have higher rates of self-reported disability (33%) and poor health than LGB people (14%).
- Only 58% of eligible trans people have ever undergone cervical screening compared with 70% of women in the general population.
- 17% of trans people visited a sexual health clinic in the past 12 months compared with 29% of cisgender LGB respondents.
- In 2017, 178 trans people were living with HIV in the UK. The prevalence of HIV in the trans population (0.46-4.78 per 1,000) is similar to that in the general population (1.7 per 1,000).
- Trans people face multiple barriers to accessing healthcare services, including: a lack of professional understanding about trans issues, having trans specific needs ignored, previous negative experiences and fear of discrimination.

Autism Spectrum Disorder (ASD)

- Trans adults (24%) and young people with gender dysphoria (>13%) are significantly more likely than cisgender people (5%) to have ASD.
- Prevalence of ASD is higher in trans children and adolescents assigned male at birth. This echoes the sex trend of ASD in the general population.
- Prevalence of ASD is higher in trans adults assigned male at birth. This goes against the trend in the general population.

Gender Dysphoria

Adults

- Significant increase in people presenting with gender dysphoria in recent years.
- Over 22,000 adults are on the waiting lists to access gender dysphoria clinics (GDCs) in England, with an average wait time of 4 years from referral.
- Over 80% of trans men and trans women were undergoing or had undergone medical transition. This is compared with 31% of non-binary people.

- 80% of trans people found GDCs difficult to access.
- Barriers to accessing GDCs include GP referral, long waiting lists and geographical access. 30% of trans people in the West Midlands said that their GP did know where to refer them.

Children and Adolescents

- Over 5,000 children and adolescents are on the waiting list to access the Gender Identity and Development Service (GIDS) in England, with an average wait time of 4 years from referral.
- The majority of children and adolescents referred to GIDS were assigned female at birth (70%), white (>90%) and aged 12-18 (84%).

Behaviours and lifestyle

- Trans people (52%) were less likely to meet the recommended physical activity guidelines of 150 minutes per week than cisgender males (62%) and females (60%).
- Barriers to trans people participating in physical activity and sport centre around anticipated transphobia and gendered norms.
- Facilitators to trans people's participation in sport include high self-esteem, high body satisfaction and trans-specific groups.
- Limited evidence suggests that trans people have a high rate of substance misuse.

Wider Determinants

- Young people with gender dysphoria (5%) are more likely to be in the care of a local authority than children in the general population (0.6%).
- Trans people (35%) are less likely than cisgender LGB respondents (51%) to have completed a higher-level qualification.
- Trans people (62%) have a lower rate of employment than cisgender LGB people (83%) and lower annual income.
- A quarter (25%) of trans people have been homeless at some point in the lives compared with 16% cisgender LGB respondents.
- A fifth (19%) of trans people experienced domestic abuse in the past 12 months compared with 11% of all LGBT respondents.
- Trans people face a very high rate of transphobia and transphobic discrimination across multiple areas of their lives, e.g. work, education, housing, physical activity, public spaces, and healthcare.
- 50% of trans people avoid public spaces because of experienced or anticipated transphobia.

Using this Report

This report is divided into six overarching chapters (or themes):

- **Chapter 2. Getting the Best Start in Life**
- **Chapter 3. Health and Access to Healthcare**
- **Chapter 4. Medical Transitioning**
- **Chapter 5. Protect and Detect**
- **Chapter 6. Behaviours and Lifestyle**
- **Chapter 7. Wider Determinants**

Each theme includes a range of health and well-being indicators under which existing evidence has been presented. The indicators presented under each of these overarching themes are interrelated and mutually reinforcing. Some indicators appear multiple times throughout the report, particularly about trans children/adolescents and trans adults.

Cross-cutting themes with trans children/adolescents and trans adults include evidence on mental health in trans young people (section 2.2.) and trans adults (section 3.1), evidence on ASD in trans young people (section 2.3.) and trans adults (section 3.3.1.) and evidence on medical transitioning in trans young people (section 2.1.) and trans adults (chapter 4).

Trans people's experiences of transphobia is a prevalent theme. This includes trans people's experience of transphobia (section 7.5.) and their experiences of transphobia and discrimination at school (section 2.5.), in healthcare (3.5), in finding and undertaking work (7.3.3. and 7.3.4.), in finding housing (7.4.2.) and at home (section 7.6. Domestic Abuse) and in physical activity and sport (section 6.6.).

The barriers that trans people face in accessing services is also a prevalent theme throughout this report. This includes access to general healthcare (section 3.5.), mental health services (3.1.7.), sexual health services (5.1.2.) and trans-specific services (4.4.).

Methodology

The Community Health Profile for the trans community in Birmingham is based on a narrative review of the scientific and grey literature. Below, the search strategy for the review and limitations of the trans literature are outlined.

a. Peer-reviewed Databases

Extensive use of a range of academic databases was made to identify relevant literature on the transgender population. Citation and literature databases which were searched included: Child Development and Adolescent Studies, EBSCO, SocINDEX, Academic Search Complete and CINAHL, Greenfile, PubMed/Medline, Science Direct, SCOPUS, Sport Discus and Web of Science.

Structured searches were undertaken using a range of terms related to 'transgender' and the 'United Kingdom' to capture as much relevant literature within scope as possible. Search strategies were adapted to individual databases, i.e. according to their own structured syntax and search fields. The range of trans related search terms that were used are outlined in Appendix 1. Additional searches were undertaken on these databases using the term "trans*" along with specific indicators.

The literature searches were designed to capture epidemiological, quantitative, and qualitative studies, as well as existing systematic and narrative reviews.

b. Grey Literature

Google Scholar and Google were the main databases used to capture grey literature. Searches were also undertaken on the websites of public bodies, local councils and nationally collected data repositories, including the Office for National Statistics (ONS), NHS Digital, NHS England, Equality and Human Rights Commission (EHRC) and Public Health England (PHE) (accessed via GOV.UK).

c. National Data Sources

National voluntary and community sector websites were also searched, including Alzheimer's Research UK, The British Heart Foundation, British Library ETHOS, The British Lung Foundation, Cancer Research UK, Diabetes UK, The Joseph Rowntree Foundation, Mind, Sport England.

d. Trans Specific Sources

A search of national and local LGBT and trans-specific websites was also undertaken. These included the websites of gender dysphoria clinics and trans-related organisations, such as:

Albert Kennedy Trust, Birmingham LGBT, Galop, Gender and Identity Development Services (GIDS), Gender Identity Research and Education Society (GIRES), Gendered Intelligence, LGBT Foundation, Scottish Trans Alliance (STA), Stonewall, TransActual.

e. Snowball Searching

"Snowballing" (a technique where additional relevant research is identified from the reference list and citations of the initial search or published article) was used. Additional literature was identified from reference lists, where added to the knowledge base of the report.

f. Inclusion and Exclusion Criteria

All retrieved literature were subject to the inclusion and exclusion criteria below.

Inclusion Criteria:

- Focus on transgender and non-binary people
- Minimum of 5 participants for qualitative studies
- Minimum 20 trans participants or trans participants comprising at least 10% of the overall sample for quantitative studies
- The UK based population, with a focus on Birmingham and England
- Published after 1999

Exclusion Criteria:

- Studies with less than 4 participants (qualitative studies)
- LGBT studies which did not disaggregate findings for trans participants
- Intersex participants
- Published before 2000
- Less than 20 trans participants or trans participants as less than 10% of total sample

Due to the known paucity of research on trans people in the UK, it was decided to include qualitative studies with five or more trans participants and quantitative studies with 20 or more trans participants (or at least a 10% sample of trans participants). Whilst it is not assumed that the findings of these studies are generalisable, they do provide some insight into the experiences of trans people across the various themes reported on. Where relevant, studies with smaller sample sizes have been highlighted throughout this report.

Only literature specifically related to trans people in the UK was selected for inclusion.

g. Results and Research Synthesis

The findings of the analysis are presented as a research synthesis under each of the designated topic chapters. Where there are multiple research findings for a particular topic or measure, these are reported individually because of the likely heterogeneity in research design and study population and because of a lack of robust data for comparison.

The comparators used for the 'trans' population include cisgender (i.e. non-trans) lesbian, gay and bisexual (LGB) populations and cisgender heterosexual populations. Comparisons were rarely made between LGB trans people and those trans people identifying as heterosexual. Where relevant, study characteristics will be described (e.g., sample, method), particularly in relation to clinic-based and community-based samples. Percentages reported in studies have typically been rounded up for the purposes of this report.

h. Limitations and Caveats of the Trans UK Literature

Much of the research on trans people has been undertaken outside of the UK, e.g. USA, Australia, Canada and Europe, with rapidly emerging studies in other countries. Systematic and narrative literature reviews of trans studies seldom include more than 2 UK based studies, and typically none.

National LGBT surveys and trans-specific surveys have methodological drawbacks, and these should be read alongside survey findings. Among these is the inability to capture a nationally representative sample leading

to sample bias[1]. Thus, the findings of a survey might be specific to the self-selected sample of people in the study itself rather than be generalisable to the wider trans population. Survey wording and definitional issues may also affect participant responses.

Research with LGBT communities typically involves only a small number of trans respondents. Most qualitative studies have between 2 to10 participants, which impedes the generalisability of research findings. Larger studies which focus on the broad LGBT population also typically recruit only a small number of trans participants to their samples, usually representing less than 5% of the study population. Furthermore, studies of LGBT participants with a trans-sub-sample do not typically disaggregate the views of trans participants in their studies.

Care should also be taken when interpreting findings in relation to the comparators and matched controls for the trans population. Clinic-based studies typically compare trans people with gender dysphoria, who present with a range of existing co-difficulties and clinical needs, with adults in the general population, who do not. Furthermore, clinic-based samples usually match control groups according to age and gender only (at the exclusion of other relevant variables). Similarly, community-based LGBT studies which compare the experiences of trans people (with and without gender dysphoria) and LGB cisgender people rarely reference the pre-existing difficulties faced by each of these populations.

A further drawback of studies is that they do not always clarify how they are operationalising trans identity and sometimes report a confusing outcome of self-identification across multiple categories[2].

1.0 Introduction

1.1 Overview of the Transgender Community

1.1.1 A Brief History of Trans Identity

Trans refers to a broad spectrum of people whose gender identity does not align with their biological sex (or sex assigned at birth). Throughout history and across cultures, people have individually and collectively defied the gender norms of their time and culture. Gender non-conformists have typically been subject to stigmatisation, criminalisation, and medicalisation throughout history and to the present day. In more recent years, some countries have created legal provisions for their protection.

In the West, types of gender non-conformity, especially regarding gender identity and same-sex attraction, have historically been considered part of the same phenomenon. A current manifestation of this aggregation is the acronym LGBT (Lesbian, Gay, Bisexual and Transgender), to which the 'T' was added in the 1990s[3]. An early conceptual distinction between gender identity and sexual orientation was made by Magnus Hirschfeld in the early 20th Century, who coined the terms "transvestite" and "transexual". Hirschfeld also developed the world's first 'sex change' operation the world in the 1930s[4], just after the development of hormones to chemically alter a person's physical primary and secondary sex characteristics. In England, the first sex reassignment surgery was undertaken in 1944[5].

The term "transsexualism" first appeared in 1980 in DSM- III (Diagnostic and Statistical Manual of Mental Disorder, 3rd Edition) and was incorporated by the World Health Organization (WHO) International Statistical Classification of Diseases and Related Health Problems (ICD-10) in 1990. In 1994, the DSM- IV replaced this term with "gender identity disorder" and then again with 'gender dysphoria' in 2013 (DSM- V), as it currently stands. WHO replaced the term 'transsexualism' with "gender incongruence" (ICD-11) and re-classified it from a mental health disorder to a "condition relating to sexual health". Such changes in language and classification were intended to recognise the stigma associated with gender dysphoria and the contemporary consensus that it is not a mental illness. Nonetheless, gender dysphoria remains a highly medicalised and stigmatised condition.

1.1.2 Trans Terminology

The language used to describe 'trans' people is rapidly changing and includes a wide range of terms, typically self-definitional, which fall outside of binary gender classifications.

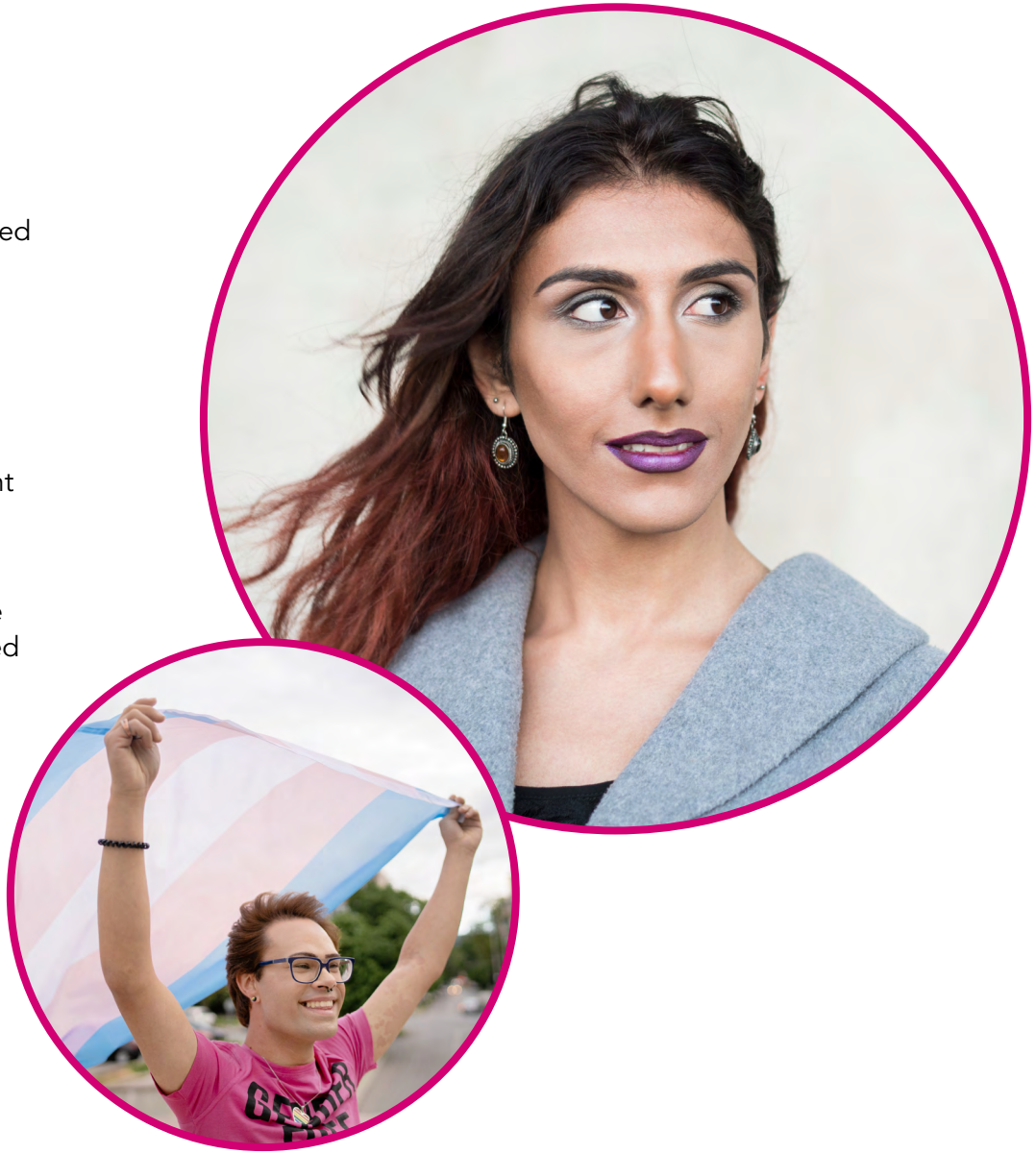
Variations of the term "trans" became popularised from the 1990s[6] and are still in current use. The term "trans" is an umbrella term for people whose gender identity and/or gender expression does not align with their assigned sex at birth, including (but not limited to) transgender, non-binary, or genderqueer. The term 'trans' is typically used alongside or instead of 'transgender', both as a shorthand for the term and inclusive of those who do not identify with a particular 'gender'. The term "transgenderism" was commonly used in the past, but is now considered offensive by many people[7].

Trans people can identify as binary (i.e., women or men), or they may identify as non-binary, where they do not identify exclusively as either male or female (e.g., they may identify as both, as neither, or as falling in between or outside of these categories). Non-binary is therefore also an umbrella term under which a vast array of terms are incorporated, such as gender-diverse, gender-fluid, gender-neutral, and genderqueer, to name a few. Trans identities need not be mutually exclusive, non-binary people may or may not consider themselves to be transgender and vice versa.

Some trans people will experience 'gender dysphoria', which is a medicalised condition referring to "the distress that is caused by a discrepancy between a person's gender identity and that person's sex classified at birth"[8]. Trans people with gender dysphoria may or may not wish to seek medical intervention (e.g., hormone therapy or gender-affirming surgery).

Trans people can transition socially, physically and/or legally to their desired gender identity. Social transitioning involves changing one's appearance, name, or gendered pronouns. Physical transitioning generally entails medical intervention delivered by healthcare professionals who specialise in gender identity services, often alongside mental health services. Legal transitioning may involve gaining a Gender Recognition Certificate (GRC), obtaining a new birth certificate or changing one's name by deed poll. Trans people may choose to undertake some, all or none of these different aspects of transitioning.

In this report, 'trans' will be used to refer to people who identify as both binary and non-binary, although differences between these groups will be highlighted where relevant. (See Appendix 2 for a glossary of terms related to trans identity).



536,648

ESTIMATED NUMBER OF PEOPLE WHO IDENTIFY AS TRANS IN THE UK

The trans population is estimated to make up 0.8% of the total UK population. There has been a significant rise in people who identify as trans nationally and globally

9,124

Estimated number of people who identify as trans in Birmingham

4,910

PEOPLE ISSUED WITH A GENDER RECOGNITION CERTIFICATE

GLOBAL TRANS POPULATION

Estimates based on international data

0.1-2.7%

OF ADULTS GLOBALLY IDENTIFY AS TRANS

1.2-2.7%

OF CHILDREN GLOBALLY IDENTIFY AS TRANS

30%

of trans people in a large survey identified as bisexual

THE SECOND MOST COMMON SEXUAL ORIENTATION WAS LESBIAN OR GAY 23%

50%

OF TRANS PEOPLE IN LARGE SURVEYS IDENTIFIED AS NON-BINARY

This is an umbrella term for people who do not identify exclusively as a man or a woman

1.2 International Context

The health needs of trans people in different countries will to a large extent be shaped by the history and socio-political climate of health and gender non-conformity in different countries, e.g., the legal protections afforded to – or against – gender non-conformity, the language and definitions utilised and the organisation and funding of healthcare systems.

Care should therefore be taken not to impose culturally specific understandings of trans people from one context to another. The demographic profile of trans people, and the wider social, economic and political determinants shaping their lives, will invariably impact the lived experiences of trans people and their community health profile in different countries. Furthermore, a lack of robust research on trans people in many countries impedes reliable international comparison and transferability.

In India, trans and intersex people, or 'hijra', are recognised as a 'third gender' in law but can only legally change their gender upon proof of gender-affirming surgery. In many European countries, trans people have a legal right to gender-affirming surgery and can change legally transition based on self-identification alone. In Japan, trans people are required to go through sterilisation in order to legally transition. In many of the Gulf countries, some forms of gender expression are criminalised and in Hungary trans people can't legally change their gender. In the USA, where only a minority of states have laws protecting trans people from discrimination, the violent murders of trans women, particularly 'trans women of colour', have been a dominant theme in the literature[9].

Despite contextual differences, cross-culturally, evidence suggests that trans people in many countries live at the margins of society and face multifactorial risks for poor health, health determinants and health inequalities[10 11 12]. Trans people are reported as: having poor access to education, employment, housing and healthcare, belonging to low socio-economic classes, facing

marginalisation, discrimination, violence and stigmatisation, having a high prevalence of substance misused and infectious diseases; and as being at significantly higher risk of mental health problems, long-term health conditions and other health problems[10 11 12 13 14 15].

1.2.1 Global Prevalence of Transgender Identity and Gender Dysphoria

Accurate data regarding the size of the trans population is lacking, although the prevalence of transgender identity and people presenting with gender dysphoria has increased significantly across countries worldwide[16 17 18 19]. Estimates of population prevalence depend on 'case' definition, i.e. how trans people are defined[17 20].

Published reviews of studies which estimate the population prevalence of trans people highlight the heterogeneity of definitions used to capture the 'trans' population[17 20 21]. Studies typically focused on people who have received gender-affirming treatment or a diagnosis of gender dysphoria, people who are awaiting gender-affirming treatment, and people who have legally changed their gender or self-reported gender identity. Furthermore, almost all of the studies included in such reviews are based on contexts outside of England. It is also important to note that the estimates provided below are likely to have risen since their publication. Reviews have typically drawn on studies prior to 2015, after which there has been a significant increase in the recognition of trans identities.

Adults

The WHO estimates that trans people comprise 0.3%-0.5% (25 million people) of the global population[22]. This figure is replicated by a review of survey data with trans people, with the authors noting a potential rise to 4.5% of the population[19]. Estimates from population prevalence studies of transgender identity and gender dysphoria vary drastically and indicate a rate between 4.6 and 2,000 per 100,000 (0.005%- 2%) of the population who identify in gender diverse ways or who have gender dysphoria[16 17 20 23].

The prevalence of transgender identity is much higher than the prevalence of gender dysphoria. For self-reported adult transgender identity, a systematic review by Collins et al.[20] suggests an estimated prevalence rate of 355/100,000, whilst the systematic review by Zhang et al.[19] posits this figure as between 300 to 500 per 100,000. A review by Goodman et al.[17] estimates that between 100 to 2,000 per 100,000 of the general population self-identify as trans.

For gender dysphoria, the review by Collin et al., suggests an estimated prevalence of 6.8/100,000 for an adult transgender-related diagnosis and 9.2/100,000 for adults who have sought/received gender-affirming treatment[20]. A review of studies by Goodman et al. shows significant variation in the prevalence of these two indicators (diagnosis and treatment), ranging between 0.7 and 28 per 100,000, and 1 and 35 per 100,000, respectively[17].

Regarding sex ratio, evidence indicates a significantly higher prevalence of trans identity and gender dysphoria in adults assigned male at birth than adults assigned female at birth. For self-reported transgender identity, Collin et al. estimate a prevalence rate of 522/100,000 for trans women (assigned male at birth) and 256/100,000 for trans men (assigned female at birth)[20]. For gender dysphoria, Collin et al. estimate a prevalence rate of 12.5/100,000 for trans women and 5.1/100,000 for trans men who have sought/received gender-affirming treatment, whilst Arcelus[16] estimates a lower prevalence for this indicator of 6.8/100,000 for trans women and 2.6/100,000 for trans men. This sex ratio is echoed by the DSM-V and other reviews[17 18 19 20 23].

Evidence indicates that the majority of trans people are under 24 years old[18 19]. A growing proportion of trans people identifying as non-binary rather than as male or female has also been noted by reviewers[17 18 23].

Children and Adolescents

There is a lack of evidence on the prevalence of transgender identity and gender dysphoria in children and adolescents, particularly amongst pre-pubescent children. Reviews which include trans studies with children and young people suggest a higher rate of prevalence of transgender identity amongst young people than adults, of between 1,200/100,000 and 2,700/100,000 (1.2% to 2.7%)[17 19 23], potentially rising to 8,400/100,00[19].

Evidence indicates a mixed picture in terms of the sex ratio of trans children and adolescents. However, there is a consensus of a shift in the sex ratio of clinically referred adolescents with gender dysphoria, with more young people assigned female at birth being referred in recent years than young people assigned male at birth[17 19 23].

1.3 National and Local Context

1.3.1 Number of Trans People in the UK and Birmingham

There is no reliable data relating to the prevalence of gender dysphoria in adults, young people and children in the UK. In 2021, the UK Census asked a question about gender identity, in addition to sex, for the first time. The results from this Census will enable insight into the number of trans people in the UK and their demographic profile.

Currently, only estimates can be made about the size of the adult trans population in Birmingham and nationally. By 2018, less than 5,000 trans people have obtained a Gender Recognition Certificate[24]. However, this would be a gross underestimate of the number of trans people in the UK.

In 2011, the Gender Identity Research Education Society (GIRES)[25] estimated that around 1% of the adult UK population was trans, although this was not a peer-reviewed publication. In 2012, the Equality and Human Rights Commission (EHRC) research suggested that 0.8% of the population may be trans, although this was based on a small sample[26]. In 2018, the Government Equalities Office (GEO) published a paper in which they "tentatively estimate that there are approximately 200,000-500,000 trans people in the UK"[24].

These estimates do not provide a breakdown of prevalence or size according to sex at birth or age and so must be treated with caution. For example, most survey respondents in the UK are under 35 years old, with international estimates suggesting that most trans people are younger[18].

The EHRC estimate (0.8%), which sits in between the GEO and GIRES, and is the outcome of trials to measure gender identity, will be used to indicate the number of trans people in the UK and Birmingham[26]. Given the significant increase in demand for gender identity services and increased visibility of transgender people in recent years, it is likely that the EHRC estimation produced a decade ago, is an underestimate.

In 2020, the ONS estimates that the size of the UK population was 67,081,000. Applying the EHRC estimated prevalence of 0.8% to the UK population would indicate that there are at least 536,648 trans people in the UK.

In 2020, the ONS estimates that the size of Birmingham's resident population was 1,140,500. Applying the EHRC estimated prevalence of 0.8% to the population of Birmingham would indicate that there are at least 9,124 trans people in Birmingham.

1.3.2 Prevalence of Gender Dysphoria in Adults and Children in the UK and Birmingham

There is no current and reliable published evidence relating to the prevalence of gender dysphoria in adults or young people and children in the UK or Birmingham.

Adults

In Scotland, over 20 years ago, Wilson et al.[27] calculated the prevalence of gender dysphoria in the Scottish population (aged 15 and over) as being 8.18/100,000. This robust estimate was based on a sample of 73% of all GP practices in Scotland but is likely to be a significant under-estimate. GIRES estimated that the prevalence of people who had sought medical care for gender variance was 20/100,000 in 2007, which significantly increased to 600/100,000 in 2011[25]. GIRES[25] estimated that around 80% of those seeking treatment were assigned male at birth but indicated that the sex ratio of gender dysphoria was expected to become more balanced.

A more recent and reliable estimate is not available (see chapter 4 for evidence of the number of referrals to gender dysphoria clinics in England).

Children and Young People

According to the 'NHS Service Specification for the Gender Identity Development Service (GIDS)'[8], the prevalence of gender dysphoria in children and adolescents is difficult to ascertain because of the fluid nature of gender identity in young people. Thus, a snapshot count would not capture young people for whom dysphoria subsequently subsides, evolves into a non-binary identity or is a precursor to an LGB identity.

The Service Specification[8] does reference an unpublished surveillance study of clinical presentation of gender dysphoria in the UK and Irish children aged 4-15 years old, which suggests an incidence (new cases per year) for this age group of 1.6 per 100,000 in the UK. However, no date is cited for this study and given the significant growth in incidence in clinical referrals in gender dysphoria over the last decade in England alone, this figure is likely to be a gross under-estimate (see section 2.1 for the number of referrals for children and adolescents with gender dysphoria).

1.3.3 Demographic Profile of Trans Survey Respondents in the UK

In lieu of available demographic information about the trans population, national surveys provide broad insight into the characteristics of the trans population. The survey with the largest number of trans respondents was undertaken by the Government Equalities Office (GEO). The GEO Survey ('National LGBT Survey') was undertaken in 2017 and had a sample of 14,000 trans people[1]. This survey provides the most reliable insight into the trans population in the UK.

The demographic data of trans participants in 5 large national surveys (> 650 trans respondents) is presented in the table below. The data below relate to trans adults over 16 years old (see section 2.2 for demographic information pertaining to children with gender dysphoria). This data is not representative of the trans population and is not generalisable to the trans population. However, it does provide some information about the demographic profile of trans respondents in large surveys.

Table 1: Demographic Profile of Trans Survey Respondents

	National LGBT Survey	Non-Binary People in the UK Survey	Trans Mental Health Survey	Stonewall survey	TransActual Survey
No. trans respondents	14,320	895	899	871	697
Gender Identity					
Male	22%	N/A	25%*	34%	22%
Female	26%	N/A	40%*	17%	33%
Non-binary	52%	N/A	35%*	48%	44%
Unsure	N/A	N/A	8%*	N/A	N/A
Sexuality					
Heterosexual	9%	5%*	20%*	2%	N/A
Lesbian/Gay	23%	28%*	23%*	58%	N/A
Bisexual	32%	28%*	27%*	30%	N/A
Other	36%	122%*°	81%*	9%	N/A
Ethnicity (White British)	90%	93%	86%	91%	60%
Religion (None)	66%	70%	62%	72%	57%
Disability (Yes)	33%	45%	58%	26%	46%
Age (Range, Majority)	Over 70% aged 16-34	59% aged 25 and under	43% aged 35 and under	N/A	Median age 33 years

* Respondents could choose more than one response. Therefore, these categories do not necessarily represent a proportion of the total sample.

° Participants could choose more than one response. When collated, responses grouped under 'other' amount to over 100%

Sources: National LGBT Survey[1]; Non-Binary People in the UK Survey[28]; Trans Mental Health Survey[29]; Stonewall survey[2]; TransActual Survey[30]

Gender Identity

The main options used in surveys for gender identity have been female, male, non-binary and 'other' categories. 'Other' can include a range of identities, such as genderqueer, agender, or pan-gender. Around 50% of trans respondents identified as non-binary in surveys[1 2 30].

In the Equality Review survey (not listed) undertaken over 15 years ago, the term 'non-binary' was less in use and the majority of respondents identified as transvestite or transsexual[31].

Sexuality

In the GEO survey, 36% of respondents identified as having an 'other' sexuality and 32% of respondents identified as bisexual[1]. 'Other' sexualities included identifications such as 'queer', 'pansexual' and 'heterosexual'. In Birmingham LGBT's Survey of 54 trans individuals (not listed), the majority of trans respondents identified as bisexual (33%), followed by gay/lesbian (24%), heterosexual (19%), queer (9%) and undecided (11%)[32].

Age

Surveys included participants with an age range of 16 years to 78 years old. The majority of participants were under 35 years old.

Ethnicity

Most survey respondents were from a white ethnic background (>90%), and less than 10% of respondents came from a minority ethnic background. These figures broadly reflect the ethnic mix of people in England and Wales, although white respondents are slightly overrepresented compared with the general population (86%).

Religion

Between 60-70% of trans respondents did not identify with a religion. This is much higher than the percentage of people with no religion in England (25%)[33].

1.3.4 UK Legislation

The main pieces of legislation which affect trans people's lives in the UK are the Equality Act (2010)[34] and the Gender Recognition Act (2004)[35].

Equality Act 2010

The Equality Act 2010 stipulates that a person must not be discriminated against because they are 'transsexual', i.e., they are "proposing to undergo, are undergoing or have undergone a process (or part of a process) for the purpose of reassigning the their sex by changing physiological or other attributes of sex"[34]. However, people do not need to have undergone specific treatment to be protected under this legislation. Rather, the process of changing one's gender attributes is regarded as a personal process rather than a purely medical one.

Under the Equality Act, trans people are protected from discrimination and harassment across various spaces and services (with a few exceptions). These include the workplace, public services (education, healthcare etc.), public bodies, business services, public transport, clubs, and associations.

Gender Recognition Act 2004 (GRA)

The Gender Recognition Act 2004 (GRA) allows trans people aged over 18 in the UK to apply for a Gender Recognition Certificate (GRC), the possession of which enables them to get a birth certificate in their 'acquired gender'[35]. The GRC is the only means of changing one's registered sex on a birth certificate. However, an individual can change their gender on most other official documentation (including driving licenses and National Health Service records) without a GRC by writing to the relevant authority. Changing gender on a passport requires at least a letter from a medical professional.[36]

To apply for a GRC, trans people must produce medically certified evidence of a gender dysphoria diagnosis and prove that they have been living in their acquired gender for at least two years[37]. However, non-standard application pathways also exist for trans people without a gender dysphoria diagnosis. Medical transition is not a requisite for a GRC. Anyone who has been issued with a GRC is legally considered to be of their acquired gender. The process of obtaining a GRC has recently been criticised for being harmful, medicalised, bureaucratised, and intrusive for trans people[38]. In 2018, around 5,000 GRCs had been issued[24].

1.3.5 Gender Dysphoria Clinics

In the UK, people with gender dysphoria who seek medical intervention can access gender identity services through the NHS or private practice. Not everyone who identifies as trans will want to access gender identity services. Those that do, are usually referred to a Gender Dysphoria Clinic (GDC), also commonly referred to as a Gender Identity Clinic (GIC), by their GP. Since 2020, individuals should also be able to self-refer to GDCs[39]; although, evidence indicates self-referral is not accepted by all GDCs in the UK[40]. Two GDC clinicians, usually psychiatrists, assesses the patient over two separate appointments. On diagnosis of gender dysphoria or gender incongruence the patient is referred to an endocrinologist for gender-affirming hormone therapy (sometimes known as 'cross-sex hormones'), and in some cases to a surgical team for gender-affirming surgery. For surgical intervention, a clinical expert in gender dysphoria must provide additional approval and confirm that the patient meets certain conditions.

There are currently seven NHS GDCs in England, four in Scotland, one in Wales and one in Northern Ireland. In England, gender dysphoria services are commissioned by NHS England, regulated by the Care Quality Commission (CQC). Although the first GDC in the UK opened in 1966, there remains a lack of transparency in GDC decision-making, a lack of published evidence on treatments and outcomes, and a lack of integration with other NHS services. Long waiting lists and lengthy times to access NHS GDCs have become a defining issue of such services in the UK (see Chapter 4. Medical Transitioning and Gender Dysphoria Clinics).

In the UK, children and young people under 18 years are referred to the child and adolescent Gender Identity and Development Service (GIDS). In England, the GIDS is run by the Tavistock and Portman NHS Foundation Trust. Evidence on children and young people with gender dysphoria will be reported in section 2.1 (below).

375 CHILDREN AND YOUNG PEOPLE REFERRED TO THE GIDS WITH GENDER DYSPHORIA FROM WEST MIDLANDS (2010-2021)

GENDER DYSPHORIA

'Gender dysphoria' is the distress that is caused by a discrepancy between a person's gender identity and their assigned/registered sex at birth

14,646 Children and young people referred to the NHS Gender Identity and Development Service (GIDS) 2010-2021

1,573% Increase in referrals to the GIDS 2010-2021

70% OF ADOLESCENTS REFERRED TO THE GIDS ARE ASSIGNED FEMALE AT BIRTH

1 GIDS provider for children and young people in England

ACCESSING GENDER IDENTITY SERVICES

5,366 children and young people on the GIDS waiting list

2 YEARS average wait time from referral to first appointment

CHILDREN IN CARE

5% OF CHILDREN REFERRED TO THE GIDS ARE IN THE CARE OF A LOCAL AUTHORITY

0.6% OF CHILDREN IN THE GENERAL POPULATION ARE IN THE CARE OF THE LOCAL AUTHORITY

ASD more common in trans young people assigned male at birth than those assigned female at birth

13% CHILDREN AND YOUNG PEOPLE WITH DYSPHORIA

AUTISM SPECTRUM DISORDER

2% Cisgender young people

Trans people are **2-3x** MORE LIKELY THAN CISGENDER LGB PEOPLE TO REPORT SELF-HARMING THOUGHTS AND BEHAVIOURS

16% of adolescents (aged 12-18) with gender dysphoria have attempted suicide

2% of children (aged 5-12)

2.0 Getting the Best Start in Life

Getting the Best Start in Life Key Findings:

- 14,646 children and young people have been referred to the Gender Identity Development Service (GIDS) between 2010 and 2021, with overall referrals increasing by 1,573% over the last decade.
- Only 16% of parents of trans youth believed that their GP was knowledgeable about the needs of their child and only around a quarter (24%) thought that they had received good advice.
- Trans respondents were between 2-3 times more likely than non-trans LGB respondents to report self-harming thoughts and behaviours.
- Clinical studies suggest that prevalence of Autism Spectrum Disorder (ASD) for trans adolescents (14%) and children (12%) is much higher than for young people in the general population (2%).
- 4.6% of young people referred to the GIDS were in local authority care, 0.9% were adopted and 1.8% were in supported or independent accommodation.
- Over 50% of trans students experience bullying and harassment in schools based on their gender identity.

It is widely recognised that early experiences shape outcomes in all areas of adult life. There is a paucity of research on the lived experience, health, and outcomes of trans children and trans young people. The existing literature predominantly relates to children and young people with gender dysphoria who have attended the child and adolescent Gender Identity and Development Service (GIDS). However, there remains a worrying lack of published clinical data even for this cohort. For example, the GIDS does not publish empirical evidence on the number of children and young people diagnosed with gender dysphoria (or not), the types of treatments prescribed, the short-term or long-term outcomes of treatment or the risks and side effects of treatment.

This chapter will explore the literature in relation to trans children and adolescents aged 18 years old and under, presented under the following sections: Gender Identity Development Service, including evidence on referrals, satisfaction and 'puberty blockers'; mental health; Autism Spectrum Disorder; and looked after children (in care). This will be followed by a review of the literature on the experiences of trans young people at school.

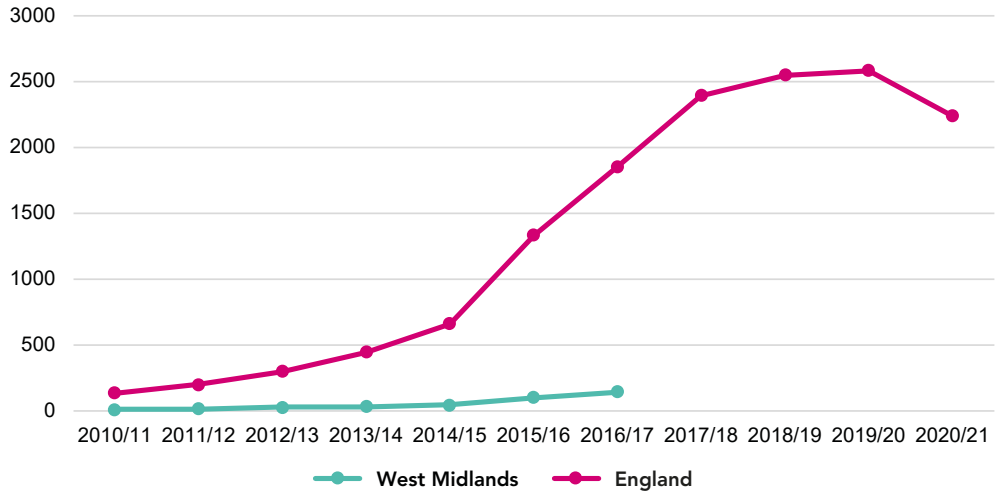
2.1 Child and Adolescent Gender Identity and Development Service

In the UK, children and adolescents under the age of 18 who wish to have a medical intervention because of their gender dysphoria are referred to the GIDS, whilst adults are referred to Gender Dysphoria Clinics (GDCs) (see Chapter 4). Young people typically access GIDS to receive hormones to suppress their puberty ('puberty blockers') but may also access the hormones to change their primary and secondary sex characteristics ('gender-affirming hormones'), depending on clinical discretion.

2.1.1 Number of Children Referred to the GIDS

The number of annual referrals to the GIDS in England has risen by 1,573% over the past decade[41]. Figure 1 below displays the number of referrals to the GIDS from 2010/2011 to 2020/2011 for England and the West Midlands.

Figure 1: Number of referrals to the GIDS 2010/11 – 2020/21, England and West Midlands



Source: Figures for England from the GIDS[41] and figures for West Midlands from the GIDS[42]

These figures only reflect the number of children and young people with gender dysphoria who have been referred to the GIDS and does not include trans children who do not have gender dysphoria or trans children with gender dysphoria who have not accessed services.

Nationally, a total of 14,646 children and young people were referred to the GIDS between 2010/11 and 2020/21[41]. The number of referrals to the GIDS has been rising year on year. The largest rise in referrals to the GIDS was in 2015/16, during which time the number of referrals doubled from the previous year (from 661 to 1,332). In 2020/21 there was a 13% decrease in referrals from the previous year, possibly due to the restrictions brought about by COVID-19.

In the West Midlands, 367 children and young people were referred to the GIDS from the West Midlands between 2010/11 and 2016/17[42]. The number of referrals to the GIDS from the West Midlands has also been rising since 2010, with the largest increase in 2016/17, when the number of referrals more than doubled compared with the previous year (from 46 to 101).

The reasons for the increase in referrals to the GIDS are not known. However, increased awareness of gender identity issues, service availability and de-stigmatisation, may have played a role[8 43].

2.1.2 Demographics of Children Referred to the GIDS

Little is known about the socio-demographics of children and young people who attend the GIDS. The demographic data outlined below is taken from reports and published articles produced by the GIDS and GIDS staff.

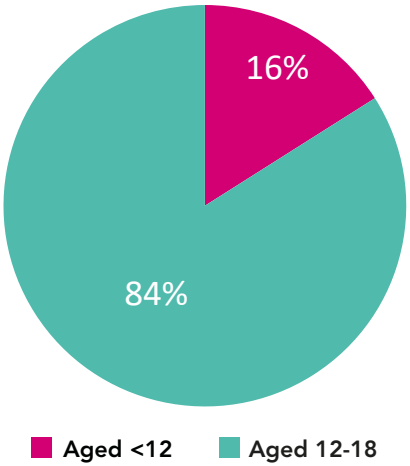
Gender Identity

A pilot survey of 251 GIDS attendees between 2017 and 2018 reported that respondents used 47 different terms to describe their gender identities[44]. Such a wide variety of self-defining terms is not atypical amongst the trans community[29 30]. The researchers reported that 29% of young respondents identified as having a binary gender and that just over half of the respondents (56%) self-defined as 'trans' in some way[44].

Age

The majority of referrals to the GIDS are for young people aged between 13-18 years[41]. On its website, the GIDS reports that between 2010/11 and 2020/21, less than 81 children aged 3-8 years, 326 children aged 9-12 years, 1,788 children aged 13-16 years and around 200 children aged 17-18 years were referred to the GIDS. However, this analysis was for a limited sample of referrals. A peer-reviewed analysis of 4,506 referrals to the GIDS between 2009 and 2016 by de Graaf et al.[45] reported that 16% of referrals were for children under 12, whilst 84% of referrals were for adolescents aged 12-18. Figure 2, below, displays this age breakdown:

Figure 2: Age breakdown of referrals to the GIDS between 2009-2016



Source: Peer-reviewed analysis of referrals to the GIDS[44]

Sex Assigned at Birth

The majority of young people referred to the GIDS are assigned female at birth. The disparity in the sex ratio of children and young people referred to the GIDS over the last decade is illustrated in the table below:

Table 2: Sex ratio of referrals to the GIDS between 2009/10 and 2019/20

Assigned Sex at Birth	Total GIDS Referrals (2009/10 to 2019/20)
All	12,111
Assigned Female at Birth	8,425
Assigned Male at Birth	3,686

Source: The GIDS[41 46]

Of the 12,111 children and young people referred to the GIDS between 2009/10 and 2019/20, 70% were assigned female at birth and 30% were assigned male at birth[41].

Analysis of referrals to the GIDS also reveals significant age effects in the sex ratio of referrals. In their analysis of 4,506 referrals between 2009 and 2016, de Graaf et al.[45] reported that there were slightly more children (aged under 12) assigned male at birth (57%) than female at birth (43%). On the other hand, more than double the number of adolescents (aged 10-18) were assigned female at birth (68%) than male at birth (32%). This pattern mirrors trends in Europe[43]; globally, gender dysphoria is more common among people assigned male at birth [17 19 20 23].

Ethnicity

The ethnicity of young people referred to the GIDS is not published on GIDS or NHS websites. A retrospective study of 995 referrals to the GIDS made between 2012 and 2015 reported that over 90% of young people were white, an over-representation compared with the general population and with Children and Adolescent Mental Health Services[47].

2.1.3 Demand for GIDS

The waiting list and waiting time to access the GIDS are extremely long. At the end of November 2021, the GIDS website reported that 5,366 children and young people were on its waiting list, with 104 first appointments offered, and 221 new referrals received during the month[48]. The average wait time from referral to initial appointment was 30 months (2.5 years).

2.1.4 Satisfaction with the GIDS

The GIDS has been criticised for its service provision by regulators and parents of young children with gender dysphoria.

The Care Quality Commission (CQC), which is responsible for inspecting and regulating the GIDS, rated the service as "inadequate" based on several failings including long waiting lists, poor management of risk and vulnerability in young people, high staff caseloads, a lack of inclusive care plans and a lack of transparency in decision making[49].

Qualitative studies of parents with young trans children also report poor experiences of using the GIDS and of GP referrals to the GIDS[50 51 52]. In a study with 75 parents of trans children (average of 8.5 years old), Rickett et al.[51] found that whilst most parents (65%) felt taken seriously when they consulted their GP, few agreed that their GP was knowledgeable about the needs of their child or themselves (16%) and only around a quarter (24%) thought that they had received good advice. Another study with

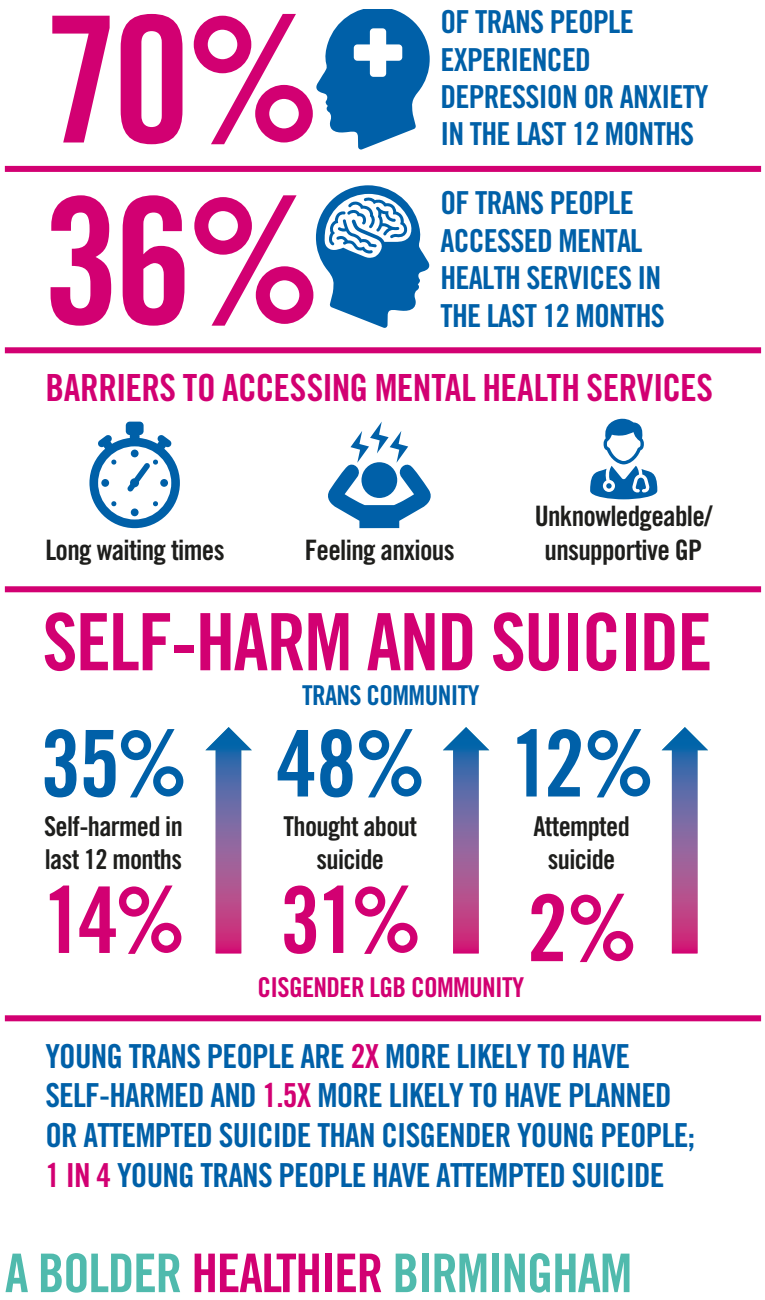
parents of 26 trans children (under 11 years) found that parents felt under scrutiny and pathologised by clinicians at the GIDS, whom they found to be unsupportive and discouraging[52].

Currently, gender identity services for children and young people are undergoing an independent review led by Dr. Hilary Cass OBE. The review will provide recommendations for specialist healthcare professionals and gender identity services working with children and young people. It will also examine issues surrounding the prescription of 'puberty-blocking hormones' and 'hormone replacement therapy' (gender-affirming hormones).

2.1.5 Puberty Blocking and Gender Affirming Hormones

Puberty inhibiting hormones, known scientifically as gonadotrophin-releasing hormone (GnRH) analogues, and colloquially as 'puberty blockers', are prescribed to children and young people with gender dysphoria to suppress puberty [53]. From around the age of 16, teenagers who've been on puberty blockers for about 12 months may be given gender-affirming hormones, also known as cross-sex hormones. These hormones induce the development of physical sex characteristics aligned with the individual's gender identity (either oestradiol or testosterone) [54]. Within the NHS, only GIDS clinicians can prescribe puberty blockers and gender-affirming hormones to young people under the age of 18 for the treatment of gender dysphoria.

Young children's access to puberty blockers in the context of trans healthcare has been subject to significant debate, uncertainty and confusion in the UK, despite them being prescribed to young people without comment in other contexts[55 56 57 58]. In late 2019, a judicial review was lodged against the Tavistock and Portman NHS Foundation Trust GIDS in the UK, centring around whether people under 18 years of age were capable of consenting to puberty blockers (Bell vs. Tavistock and Portman NHS Foundation Trust). In 2020, the High Court ruling severely limited access to gender affirming healthcare for young people. The next year, in 2021, the Court of Appeals overturned the High Court's decision, ruling it was the responsibility of clinicians, rather than the court, to assess young people's competence to consent to receive puberty blockers. A further appeal to the supreme court was lodged by Bell to overturn the 2021 decision, but the supreme court rejected this "on the basis it raised no arguable point of law"[59]. A survey of young trans people found that the High Court judgement and subsequent restrictions of medical treatment, even though temporary, had a major negative impact on the well-being of trans youth and families, the repercussions of which are still felt today[60].



A BOLDER HEALTHIER BIRMINGHAM

2.2. Mental Health of Trans Children and Adolescents

Many studies have been undertaken on the prevalence of self-injurious thoughts and behaviours among trans children and young people in the UK[61]. Below, the literature on trans young people and mental health will be presented, the majority of which focuses on children and young people under 18 years attending the GIDS (see sections 3.1. and 3.1.3. for evidence on trans adults and young people aged 16-25).

With regards to trans adolescents, extremely high rates of self-harming thoughts and behaviour were reported by the community based Stonewall Schools Survey[62 63]. The mean age of respondents was 16 years[63], and so the findings relate more to older trans adolescents than to young trans children. The survey reported that 92% of young trans respondents had thought about taking their own life compared with 70% of non-trans LGB young respondents, that 84% of young trans people had self-harmed compared with 61% of non-trans LGB young people and 45% of trans young people had attempted to take their own life compared with 22% of non-trans LGB young people. Statistical analysis of the Stonewall survey by Jadva et al.[63] reported that trans adolescents were 2-3 times more likely to self-harm, report suicidal thoughts and attempt suicide than non-trans LGB respondents.

There is also an indication that the high levels of bullying faced by trans students in school (see section 2.5, below) contribute to the high levels of self-harming and mental health problems experienced by trans children[64]. For example, the Stonewall Schools Report indicated that more than four in five trans young people had deliberately self-harmed or tried to take their own lives due to being bullied[62].

The figures reported above for young trans people are significantly higher than for young people in the general population. Analysis of the Millennium Cohort Study reported that 17-year-olds had a 16% prevalence of high

psychological distress, 24% prevalence of self-harm (in the past 12 months) and 7% lifetime attempted suicide[65].

The high levels of self-harming thoughts and behaviours amongst trans young people are concerning and necessitate further attention. However, methodological drawbacks with the Stonewall survey[62], such as a non-representative sample and lack of validated measures, require these findings to be treated with caution. Studies with GIDS attendees report lower self-harming thoughts and behaviour rates than the Stonewall survey. For example, clinic-based studies report that 10% of GIDS attendees (aged 4-17) had been flagged as having attempted suicide[66] and that 16% of adolescents had said that they had attempted to take their own life[64].

According to the GIDS website, children and adolescents with gender dysphoria are likely to present with significant psychopathology and broader identity questioning than gender identity alone[67]. GIDS-based studies report that children and young people often present with a wide range of co-existing difficulties and mental health problems[8 68 70 71].

Studies indicate a high prevalence of mental health problems and associated difficulties amongst young people under the age of 18 with gender dysphoria, particularly in young people assigned female at birth[47 64 66 68]. For example, a large study with a sample of 900 adolescents (aged 13-17) attending the GIDS between 2009-2017 found that 44% of young people said that they "sometimes" or "very often" "deliberately try to hurt or kill myself"[68], although self-harm and suicidal attempt were not differentiated in this question.

Another study undertook a retrospective chart review of children and adolescents (aged between 5-18) attending the GIDS in 2012, comprising a cohort of 218 participants[64]. The study found that mental health conditions are likely to increase with age for young trans people. Comparing cohorts of trans 'children' (5-12 years old, n=41) and 'adolescents' (12-18 years old, n=177), the study reported that adolescents (24%) were more likely to display symptoms of anxiety compared with children (17%). Furthermore, half of the adolescents (50%) displayed low mood/depression compared with 7% of children. With regards to self-harming thoughts and behaviours, Holt et al.[64] found that 15% of children had self-harmed compared with 44% of adolescents, 15% of children had experienced thoughts of taking their own life compared with 40% of adolescents, and 2% of children had attempted suicide compared with 16% of adolescents.

Looking at deaths of children with gender dysphoria by suspected suicide, a review of GIDS data reported that 3-4 GIDS patients had died by suspected suicide (two whilst on the waiting list) between 2010-2020[69]. The study found that the proportion of GIDS patients who died by suicide was 0.03%, which is substantially lower than the rates of suicide ideation indicated by national surveys. However, the study also calculated the estimated annual suicide rate for trans young people (over the age of eleven) as being 12 per 100,000, almost six times higher than the suicide rate for young people in the general population (after adjusting for sex composition).

There is also evidence that young people attending gender identity services in the UK have a higher prevalence of mental health problems and poorer psychological functioning than young people attending similar services in European countries[47 69]. In their review of the primary studies undertaken in the UK, the Netherlands, Belgium and Switzerland, de Graaf et al.[68] reported that adolescents with gender dysphoria from the UK had higher levels of emotional, behavioural and peer relationship problems and a high level of internalising and externalising problems compared with their counterparts in other European countries.

Psychological support and puberty suppression have both been found to be associated with an improved global psychosocial functioning in adolescents experiencing gender dysphoria[72 73] .

2.3 Autism Spectrum Disorder

Small-scale clinic-based studies indicate that children and young people with gender dysphoria have a high prevalence of Autism Spectrum Disorder (ASD) compared with young people in the general population. Diagnosis of autism disorders has risen dramatically in the general population over the last two decades[74] in both children and adults (see section 3.3.1. for evidence on ASD in trans adults with gender dysphoria).

A retrospective patient file review of 166 GIDS attendees (mean age of 14 years) reported that 54% of young people scored outside of the diagnostic range for ASD scores, with around half of these participants scoring in the mild/moderate range and half in the severe range[75]. Of the 46% of participants who scored in the normal range for ASD (n=76), 3% had a formal diagnosis of ASD. No differences in ASD were found between individuals assigned female or male at birth.

In the clinic-based study by Holt et al.[64], 12% of children aged 5-11 with gender dysphoria were reported as having an ASD, with a further 5% queried as having ASD. This figure was similar for adolescents (14%) aged 12-18 with gender dysphoria. However, these figures were much higher than for young people in the general population (1.76%)[76]. Furthermore, Holt et al. reported that those assigned male at birth were more likely to have ASD (19%) than those assigned female at birth (10%)[64]. This echoes the sex ratio trend of ASD in the general population, where young males show a higher prevalence (2.8%) compared with females (0.65%)[76].

Literature reviews on gender dysphoria and autism in young people, which include some UK studies, indicate a significantly high rate of co-occurring gender dysphoria and ASD[77 78]. However, reviews also highlight the different measures used in studies, making it difficult to compare study findings. The NHS and GIDS also recognise the high prevalence of ASD conditions in gender dysphoric young people[8 79].

2.4 Looked After Children Accessing the GIDS

Studies report that children in care and adopted children represent a relatively high proportion of children referred to the GIDS.

In the retrospective chart review by Holt et al.[64] 4.6% of children referred to the GIDS were in the care of a local authority and 0.9% of children were adopted. An additional 1.8% of young people were in supported or independent accommodation or their care status was not stated. Matthews et al.[80] reviewed the files of 185 young people referred to the GIDS over two years (2009-2011). The study found that 4.9% (n=9) of referrals comprised children in care, and 3.8% (n=7) of rereferrals were adopted young children, which was significantly higher than for children in the general population (0.58%).

Matthews et al.[80] reported that looked after young people showed no significant differences in overall functioning compared with other young people attending the GIDS. However, the review also revealed that children in care were less likely to receive a diagnosis of gender dysphoria compared with young people living with their birth family. The authors highlight the need to understand the possible complexities in the presentation of looked after children, alongside the established high levels of complexity associated with gender dysphoria.

2.5 Experience of Secondary Education

There is a lack of data on trans pupils and education. There is no literature on markers such as school readiness, school exclusions and absences, or educational attainment rates. The data that exists focuses on trans adolescents experience of school and university. However, this data focuses on ages 16-25 and therefore has not been included here.

The Stonewall Schools Report[62] found that 51% of trans students experienced bullying and harassment in schools based on their gender identity, which rose to 64% when considering those who also experience bullying due to their perceived sexual orientation. This is similar to the percentage of lesbian and gay students (53%) who experienced bullying based on their LGBT identity[81] and to other surveys with trans people over the age of 16[31 82]. However, it is much higher than for school children in the general population (22%)[81].

In the Birmingham LGBT survey, 31% (n=9/29) of trans adults reported being victims of transphobic bullying at school[32]. However, a small sample size negates generalisation. Clinic-based studies also report high levels of bullying amongst gender dysphoric children and adolescents[47 64 83]. For example, in the study by Witcomb et al.,[83] of the 274 participants in the sample, 87% (n=237) reported having been bullied. Around half (51%) of trans students reported skipping school because they were being bullied, rising to 60% for non-binary students. This is compared with 40% of all LGBT respondents.

Qualitative studies, often with small samples of trans participants, also highlight the negative experiences of schooling for trans students. A predominant theme in this research has been the difficulty trans students have in navigating the gendered norms of school clothing and activities, which sometimes lead to their avoidance or exclusion from school activities[84 85 86]. These studies report that students felt unable to present in their desired gender and were restricted by everyday practices which privileged their assigned sex at birth. This included wearing gendered school uniforms, PE kits and swimming costumes, taking part in sports with gendered teams, using changing rooms and navigating the use of single sex toilets. Trans pupils' accounts of bullying in schools, from both students and teachers, are commonplace in these studies.

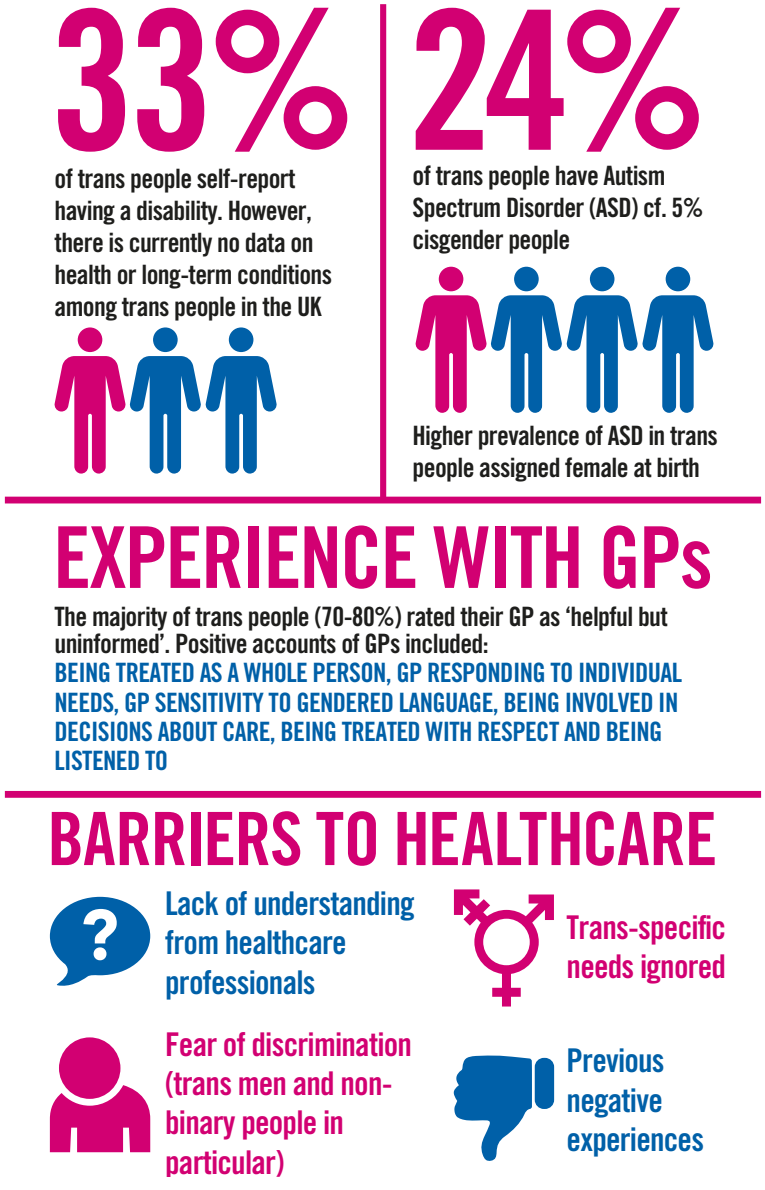
2.6 Children of Trans Parents

Published studies which have focused on children with trans parents conclude that parental gender identity does not adversely impact the development of children, but that it is still relevant to children's experiences within and outside of the home[87 88 89 90].

In 2001, Freedman et al.[87] undertook an audit of child referrals to the GIDS to assess developmental outcomes and gender dysphoria symptomology of children with gender dysphoria who had a parent with gender dysphoria. Of the 196 referrals to the GIDS, 32 cases involved a child of a 'transsexual parent' (22 families in total). The study undertook an in-depth audit of the files of 18 children aged between 3-15 years (mean age of 9 years) in 13 families and reported that 17 of the 18 children did not display features of a gender identity disorder (according to DSM-IV criteria). Statistical analysis revealed that children with a transsexual parent were significantly less likely to be depressed, experience harassment or excessive social sensitivity compared with children without a transsexual parent.

Two papers which have been published from a study at the Centre for Family Research at the University of Cambridge also report on the views and experiences of children and adolescents with a trans parent[89] and on the quality of the parent-child relationship and psychological adjustment of children[90]. The studies report that the gender identity of trans parents did not adversely impact the development of children[89] that parents and children had good quality relationships and that children showed good psychological adjustment[90].

The study by Imrie et al.[90] also reported that, taken together, higher parental depression, higher parenting stress, and lower perceived social support, predicted higher levels of child adjustment problems. These markers have been reported to disproportionately affect trans people. Conflict as a result of martial divorce has also been highlighted by studies as a predictor of parent-child relationships and child development outcomes in trans parent families[87 88]. Studies report mixed findings as to whether the age at which children are informed of their parents' transition impacts their subsequent parent-child relationship[88] or not[90].



3.0 Health Status and Access to Healthcare

Health Status and Access to Healthcare Key Findings:

- High prevalence of anxiety (67%-70%) and depression (71%-79%) amongst trans and non-binary individuals.
- Trans and non-binary individuals are more likely to experience an eating disorder than cisgender individuals.
- 12% of trans adults have attempted suicide compared with 2% of cisgender LGB adults and 7% of adults in the general population.
- Young trans people aged 16-25 are at particular risk: 25% of young trans people (aged 16-25) have attempted suicide compared 9% of young people in the general population.
- Overall, trans individuals are more likely to self-report 'average' health compared with cisgender LGB respondents and less likely to report having 'good' health.
- National surveys indicate a high prevalence of self-reported disability ranging between 33%- 58%.
- The majority of trans respondents (79%) report that their GP had little or no knowledge about gender dysphoria.
- Around 40% of trans respondents report having difficulty accessing healthcare.

This chapter presents the literature on the health and access to healthcare for trans people in the UK. Evidence on the mental health of trans adults and young people (aged 16-25) will be presented, followed by the evidence on trans people's health and access to healthcare.

3.1. Mental Health

There are no robust population estimates of the prevalence of mental health disorders in the UK trans population. Surveys and clinic-based studies show that trans people experience high rates of mental health issues and have higher levels of mental health problems than LGB cisgender people and heterosexual cisgender people. Furthermore, there is an indication that the level of mental health problems experienced by trans people differ depending on stage of transition and between trans men, trans women and non-binary people.

Below, evidence on the mental health of trans adults, including young trans people aged 16-25, will be reported, including rates of mental health problems, self-harming thoughts and behaviours, and barriers to accessing mental health services. It is useful to bear in mind that surveys in this area typically investigate mental health through posing unvalidated measures with non-representative community-based samples of respondents whilst published studies typically use validated measures with clinic-based samples of respondents with gender dysphoria, and report on statistically significant differences.

3.1.1 Depression and Anxiety

Several surveys suggest that trans individuals have high levels of depression and anxiety[29] [30] [91]. In the Stonewall survey[91], 67% of binary trans respondents reported experiencing depression, and 71% reported experiencing anxiety in the previous 12 months. These figures were higher than non-binary trans respondents, 70% of whom had experienced depression and 79% of whom had experienced anxiety in the previous 12 months. Non-trans LGB respondents reported lower levels of depression (52%) and anxiety (61%) than trans respondents.

Studies with clinic-based samples of trans participants with gender dysphoria report lower levels of depression and anxiety symptomology than community-based surveys with trans participants. A possible reason for this could be the methodological instruments employed (e.g., non-validated measures used by surveys and validated measures used by clinic-based studies). A large-scale study, undertaken at a GDC in Nottingham, reported higher rates of depression and anxiety in trans adults who were not on gender-affirming hormone therapy compared with adults in the general population[92]. The study reported that almost a quarter of trans participants (24%) had depression symptomology compared with 5% of cisgender participants. Trans respondents had nearly a 4-fold increased risk of having a depressive disorder compared to cisgender respondents and nearly a 3-fold increased risk of having an anxiety disorder compared with matched controls from the general population[93].

Another clinic-based matched control study with 106 trans participants and 135 cisgender participants aged 16-25, also reported that trans participants had statistically significantly higher levels of anxiety and depression and poorer general well-being, than cisgender participants[94].

Evidence suggests that trans adults are more likely to experience depression and anxiety disorders than cisgender adults in the general population (7.8%)[95] [96] [97] [98].

3.1.2. Eating Disorders

Body dissatisfaction is a core part of eating disorders and gender dysphoria. Evidence indicates that trans people have a higher prevalence of eating disorders than their (LGB) cisgender counterparts. A fifth (19%) of binary

trans participants and a quarter (24%) of non-binary trans participants in the Stonewall survey[91] reported experiencing an eating disorder in the preceding 12 months. This is compared with 12% of all LGBT respondents to the survey and 8.4% of women and 2.2% of men in the general population who are estimated to have a lifetime eating disorder[99].

Another study that included 200 people with gender dysphoria, 200 people with eating disorders and 200 control participants, found that trans participants had significantly greater body dissatisfaction and eating disorders than cisgender individuals from the general population[100]. Furthermore, the study found that trans males were at greater risk of having an eating disorder than trans females.

3.1.3 Self-Harm, Suicidal Thoughts and Attempted Suicide

Self-harm and suicidality form a major part of research in trans mental health. Evidence shows a high prevalence of self-reported self-harm, suicidal thoughts and attempted suicide amongst trans adults, and significantly higher rates compared with cisgender LGB respondents and the general population.

Self-Harm

Surveys and clinic-based studies report that between 34%-41% of trans respondents had self-harmed in the preceding year[1 31 91 100]. In the Stonewall survey[91], 35% of transgender respondents had self-harmed in the last year compared with 14% of cisgender LGB respondents.

A clinic-based study with 97 trans participants recruited from a GDC reported that around a fifth (19%) were engaged in current self-harming behaviour[102]. Another clinic-based study reported that trans men (58%) were significantly more likely to engage in self-harming practices compared to trans women (26%)[101]. The rates of self-harm reported by trans people were significantly higher than for adults in the general population in 2014 (6%)[103].

Suicidal Ideation

The majority of respondents to the Trans Mental Health Survey[29] had thought about ending their life at some point (84%)[104]. Other surveys report that 46%-50% of transgender and non-binary respondents had thought about taking their own life in the last year[30 91]. This is compared to 31% of LGB people who weren't trans[91]. Suicide ideation was significantly higher for trans adults compared with adults in the general population, where a fifth of adults (21%) reported that they had thought of taking their own life at some point[103].

Suicide Attempts

Survey findings reveal similar trends in suicide attempts amongst trans people. Around a third (34%-35%) of trans respondents reported having attempted suicide at least once in their life due to their gender identity[29 30 31 91]. Around a tenth of trans and non-binary people (11%-12%) attempted to take their own lives in the last year[29 91]. This is compared with 2% of non-trans LGB respondents[91] and 7% of people in the general population[103]. Women were more likely to report a suicide attempt than men in the general population[29 30 31 91 103].

Young People Aged 16-25

Several studies undertaken with 16-25 year-olds which have focused on the mental health of young trans people show that young trans people are at particular risk of mental health problems (compared with trans adults and children) and that they experience significantly higher levels of mental health problems and self-harming thoughts and behaviour than their cisgender counterparts[83 92 105 106 107 108].

A clinic-based study by Arcelus et al.[105] reported that 46% of young people referred to a GDC had a lifetime presence of self-harming, and 55% had contemplated suicide. A community-based study reported that young trans

respondents were two times more likely than cisgender participants to self-harm and 1.5 times more likely to have planned or attempted suicide[108].

In a community-based analysis, Rimes et al.[107] reported that 68% of trans respondents had self-harmed in their lifetime, 72% had thought about taking their own life over the preceding year, and 25% had attempted suicide. These are much higher rates than in the general population, where 18% of people have self-harmed, 27% have had suicidal thoughts, and 9% have attempted suicide[109].

Furthermore, trans young people aged 16-25 who are assigned female at birth are statistically more likely to experience mental health problems and have self-harming thoughts and behaviours than trans young people who are assigned male at birth[94 105 107]. For example, Rimes et al.[107] report that 80% of trans males and non-binary respondents assigned female at birth had self-harmed compared with 56% of trans females and non-binary respondents assigned male assigned at birth. This sex difference echoes the sex differences in mental health found elsewhere in this report (see section 2.2. for evidence on trans young people under 18) and in the general population[109].

3.1.4 Predictors of Anxiety, Depression and Self-harming

Studies have identified multiple predictors and risk factors for depression, anxiety and self-harming thoughts and behaviours in trans people.

Independent Factors Correlated with Mental Health

Clinic-based studies of trans people with gender dysphoria and matched controls from the general population report several factors as statistically significant predictors of depression, anxiety and/or self-harm for trans people, regardless of stage in transition. When controlling for these factors, studies report that statistically significant differences between trans respondents and matched control groups disappear.

Significant predictors for mental health problems included:

- Younger age for self-harm[101 102]
- Lower self-esteem for depression, anxiety and self-harm[92 93 102]
- Lower social support for depression and self-harm[92 97 110]
- Poorer interpersonal functioning for depression and anxiety[92 93]
- Lower body satisfaction for self-harm[102]
- Being assigned female at birth for self-harm[101 102] and depression[97]
- Being a female, by assigned sex at birth or self-identification, for interpersonal problems and depression[97]
- Socialisation problems for self-esteem but not anxiety[93]
- Being assigned female at birth for mental health problems for young trans people aged 16-25 years old[94 105 107].

Waiting Lists

With an average wait time of 4 years from referral to initial appointment, the role of long waiting lists to access gender identity services has been highlighted as an important contributor to the mental health problems experienced by trans people[111]. Most surveys and published studies report that long waiting times for GDCs are a risk factor for depression, anxiety, and self-harm in the trans population[29 112 113 114 115].

Transphobic Bullying and Discrimination

The transphobia and discrimination experienced by trans people, in everyday life and public services have been reported as having a significant impact on trans people's mental health.

In the GEO[1] survey, 3,602 respondents used the free-text option to discuss topics relating to mental health. Comments typically referenced experiences of bullying and discrimination as contributing factors to experiences of depression and self-harming thoughts. The majority of these respondents were reported as being 'younger'. Another community-based study also reported that trans respondents who had experienced discrimination were statistically more likely to exhibit a higher level of depressive symptomology compared with those who had not[98].

Studies report that young trans people (aged 16-25) who experience high levels of bullying are more likely to experience significantly higher rates of mental health problems[62 63 70 83 105 116]. A clinic-based study by Witcomb et al.[83] with 274 trans participants reported that trans individuals who reported having experienced bullying showed greater anxiety symptomology and also self-reported anxiety, depression, and low self-esteem as effects of bullying. Similarly, Arcelus et al.[105] also reported that general psychopathology could be predicted by transphobic experiences.

A two-wave longitudinal study over 12 months of 358 trans people in England however found no evidence that gender-related discrimination predicted "internalised transphobia" or that internalised transphobia predicted depression, anxiety and stress[117]. The authors drew on methodological explanations to explain the novelty of their findings compared with previous studies, including the use of different measurement scales and a lack of pre-existing longitudinal research.

Non-Binary Identity

A clinic-based study of binary trans (n=56, 15%) and non-binary trans (n=331, 85%) individuals aged 16-25 years found that non-binary trans participants were statistically more at risk of developing anxiety, depression, and low self-esteem compared to binary trans young people[106]. On the other hand, community-based studies report no statistically significant differences in depression and anxiety between trans binary and non-binary participants[63 107 118] with the exception of the Stonewall survey[91].

3.1.5 Gender Identity 'Conversion Therapy'

'Conversion therapy' is based on the assumption that certain sexual orientations or gender identities are inferior to others and consequently seeks to change or suppress these via 'therapy'[119]. Physical 'conversion therapy' is currently prohibited via a range of existing criminal offences. The current use of the term 'conversion therapy' mainly refers to spiritual methods, e.g. exorcisms or pastoral counselling, and psychological methods or talking therapies[120]. Most 'conversion therapy' takes place in religious settings but can also be carried out by mental health professionals and family members.

The GEO[1] survey reported that trans respondents (13%) were much more likely to have undergone or been offered 'conversion therapy' for their gender identity than cisgender LGB respondents (7%) for their sexual identity. Within the trans grouping, respondents from a black African/ Caribbean/British (28%), 'other' (28%), Asian (27%) and mixed (20%) ethnic background were much more likely to have undergone or been offered conversion therapy than respondents from a white ethnic background (11%) (Annex 5, Q142-43).

Furthermore, trans respondents from Muslim (44%) and Jewish (26%) religious backgrounds were significantly more likely to have reported having been offered or undergone conversion therapy compared with trans respondents with no religion (11%). In the Stonewall survey[2], one in five trans people (20%) said that they had been pressured to access services to suppress their gender identity when accessing healthcare services and in the GEO survey, 7% of trans respondents felt pressured to undergo a medical or psychological test compared with 1% of cisgender LGB respondents[1].

There is no evidence that 'conversion therapy' has any therapeutic value. However, evidence indicates that it is likely to cause harm[119 120]. Survey findings show that trans people who have undergone 'conversion therapy' are more likely to report severe mental health problems than trans people who have not, with marked increases in self-harming thoughts and behaviours[1 29 122].

In 2017 (updated in 2021), a Memorandum of Understanding (MoU) was jointly issued by 20 health, counselling and psychotherapy organisations which stated a commitment to ending conversion therapy in the UK[119]. Following a stakeholder and public consultation, the UK government has also committed to banning 'conversion therapy' in relation to sexual orientation and gender identity for young people under 18 years old[120 121].

3.1.6 Mental Health Service Usage

Evidence indicates that trans people are much more likely than cisgender people to access mental health services, often for reasons other than to access GDCs.

Over a third (36%) of trans respondents reported having accessed mental health services in the past 12 months[1 114] (Annex 8, Q75). This is compared with a fifth (21%) of cisgender respondents[1] (Annex 8, Q75). This figure was higher amongst trans men (40%) than trans women (30%). The majority of trans respondents (66%) had accessed mental health services in the Trans Mental Health Survey,[29] with 10% of respondents having been an inpatient in a mental health unit at least once.

3.1.7 Barriers to Accessing Mental Health Services

In the GEO survey[1], 56% of trans respondents said that accessing mental health services was 'not easy' compared with 49% of cisgender LGB respondents. Heterosexual trans respondents (43%) were less likely to report this than trans respondents with a minority sexual orientation (51%-58%). Another, smaller, community-based survey of 74 trans individuals, reported that 75% of respondents found access to mental health services 'not easy'[29].

For respondents to the GEO survey[1], the main barrier to accessing mental health services was the long wait time (74%), followed by respondents' feelings of anxiety, embarrassment or worry (39%). Around a fifth of respondents (20-22%) said that their GP was not supportive, their GP did not know where to refer them or they were unable to attend at a convenient time. Non-binary respondents (20%) were particularly more likely than trans men (13%) and trans women (12%) to report that their GP had not been supportive.

For trans people who had accessed mental health services, the survey found that approximately half (51%) of trans respondents reported having had a 'completely positive' or 'positive' experience[1]. In the Trans Mental Health Study a decade ago, 63% of respondents reported having had a negative experience with mental health services[29]. A fifth (19%) of respondents said they were unsure whether they would use such services again, and 7% of respondents actively stated that they would not.

3.2 General Health and Long-term Illnesses

There is a troubling dearth of information on the physical health and long-standing health of trans people, both generally and in relation to specific conditions. Measures of trans people's generic health status, limiting or long-term illnesses, mortality rates and service usage are not available via the Census, NHS or other national surveys. Data is not available on the prevalence of conditions such as diabetes, cardiovascular disease, Chronic Obstructive Pulmonary Disease (COPD), dementia, cancers or end of life and palliative care in relation to trans people in the UK. The evidence typically relates to the prevalence of developmental disabilities in the trans population and to trans people's experiences of healthcare, particularly in relation to accessing healthcare. Evidence throughout this report indicates that trans people have poorer health and determinants of health than cisgender people.

A review of the literature on the 'Global Health Burden and Needs of Transgender Populations' between 2008-2014 reported that of the 116 papers reviewed which looked at disease burden in transgender populations only two studies were located in the UK[10].

In the UK, healthcare bodies are responsible under the Equality Act (2010) to eliminate discrimination and advance equality for trans people[34]. Professional and regulatory bodies have also issued guidance on trans healthcare[123] [124] [125] [126] much of which relates to trans people's access to gender identity services but includes advice on providing healthcare for trans people in general. For example, the Care Quality Commission's (CQC) 'Adult Trans Care Pathway'[124] sets out what the CQC expects from GPs in providing healthcare for trans patients, with a focus on assessing, referring and caring for trans patients with gender dysphoria seeking gender-affirming medical intervention.

3.2.1 Self-Reported Health

Questions about trans people's self-reported health have generally been asked in local surveys. In Birmingham, trans respondents were more likely to self-report 'average' health than cisgender LGB respondents and less likely to report having 'good' health[32].

Other local surveys report varying levels of self-reported health. A study of the trans population in Brighton found that 69% (n=75/114) of respondents reported their health as 'excellent', 'good' or 'very good', 25% (n=28) rated it as 'fair', and 15% (n=17) rated it as 'poor'[112]. A study of the trans people in Manchester reported lower self-rated health amongst respondents, with 46% of respondents rating their health as 'good' or 'very good' (n=43/93), 28% (n=26/93) rating it as 'bad' or 'very bad' and 26% (n=24) rating it as 'fair'[127].

These figures are lower than the general population, where 81% of people rate their health as 'good' or 'very good'[128].

3.3 Prevalence of Disability

Self-Reported Disability

National surveys which capture evidence on disability in the general population do not collect data on trans respondents. Surveys which focus on LGBT or trans communities report that trans respondents are more likely to report having a disability than non-trans LGB respondents. The rates reported in different studies and the definitions used for disability vary but indicate a higher rate of physical, learning and developmental disabilities in the trans population.

In Birmingham, around a tenth of trans people reported being disabled (11%; n= 5/47)[32]. This was similar to cisgender LGB respondents in the survey. Surveys of the LGBT population (n= >600 trans respondents) indicate a prevalence of self-reported disability ranging between 33%- 58%[1 2 29 30]. In the GEO (Annex 3) survey, the largest of the surveys, 33% of respondents reported having a disability compared with 14% of cisgender LGB respondents[1].

The percentage of people reporting a disability in the general population varies significantly by age. Just under a fifth (19%) of working-age adults report having a disability compared with 44% of people at state pension age and 8% of children[129]. Large surveys report much higher rates of disability amongst trans people compared with the working-age population[1 2 29 30] and rates similar to or higher than people at the age of state pension[2 29 30]. The majority of trans respondents to these surveys were under 35 years old.

3.3.1. Autism Spectrum Disorder

Evidence indicates that the prevalence of Autism Spectrum Disorder (ASD) is higher in trans adults with gender dysphoria than adults in the general population (see section 2.3. for evidence on ASD in trans children with gender dysphoria). Echoing the significant rise in gender dysphoria over the last decade, the incidence of autism diagnosis has risen exponentially in the UK, with a 787% increase between 1998 and 2018[74].

Clinic-based studies illustrate a high prevalence of ASD in trans people attending GDCs, and report that GDC attendees have significantly higher rates of ASD compared with cisgender matched control groups[130 131 132 133]. Furthermore, evidence reviews relating to the UK conclude a moderate to an established link between gender dysphoria and autism[73 78 134 135].

In their review of the published literature examining the prevalence of ASD and Attention Deficient Hyperactivity Disorder (ADHD) amongst individuals with gender dysphoria, Thrower et al.[134] reviewed 22 studies examining the prevalence of ASD or ADHD in people with gender dysphoria (the majority of which looked at ASD) and eight studies examining the reverse. Based on the evidence, the reviewers estimate a prevalence of 6-26% of ASD in the trans population. It is important to bear in mind here that the matched samples being compared in the aforementioned studies were patients at GDCs, who typically present with a range of existing co-difficulties, and cisgender people from the general population, who do not. Therefore, care should be taken when interpreting such comparisons.

Another study reviewed 5 large unrelated datasets (unrelated to GDCs) where information about gender identity and autism diagnoses was reported; the study population contained 641,860 people, mostly adults, including 30,892 with autism and 3,777 identified as trans[135]. The study found that around 5% of cisgender participants had an autism diagnosis compared to almost a quarter (24%) of transgender people. Statistically significant differences remained after controlling for age and education. Furthermore, trans people were, on average, more likely to report having traits associated with ASD, such as sensory difficulties and pattern-recognition skills. The prevalence of ASD in the trans population is significantly higher than in the general population, in which NICE reports the estimated prevalence of ASD in UK adults to be around 1%[136].

On the whole, studies in this area report that trans adults assigned female at birth have significantly higher levels of autistic traits compared with trans people who are assigned male at birth[130 131]. Furthermore, Nobili et al.[130] reported that trans people assigned female at birth were around twice as likely to have clinically significant levels of autistic traits compared to cisgender females. This goes against the sex ratio trend in the general adult population- where the proportion of cisgender males to females diagnosed with ASD ranges from 3:1 to 5:1,[136] and against the sex ratio trend in young people with gender dysphoria.

There is also an indication of a higher prevalence of autistic traits amongst non-binary people with gender dysphoria[131]. A qualitative study is currently being undertaken by researchers at the University of Bath to develop guidelines for NHS services in meeting the needs people with gender dysphoria and ASD,[137] from which papers are currently being published[138].

3.3.2. Multiple Sclerosis

There is also an indication that people with gender dysphoria have a higher prevalence of multiple sclerosis (MS) than people without gender dysphoria. Pakpoor et al.[139] utilised English national Hospital Episode Statistics (HES) between 1999-2012 to compare observed cases of MS in adults with gender dysphoria and a control group of patients without gender dysphoria. The study reported a positive association (seven-fold) between gender dysphoria and subsequent MS in trans females. The authors suggest that low testosterone and/or feminising hormones may play a role in MS risk for trans females and non-binary people assigned male at birth.

3.4. Maternal Health

Many trans men and non-binary people assigned female at birth are still able to get pregnant after medically transitioning. Although testosterone affects fertility, there is no evidence that it has a long-term impact on the ability of trans men to get pregnant.

There has been no published data on trans maternal health, live births, infant mortality rates, or antenatal care in the UK. The CQC[124] has issued guidance on what is expected from maternity/gynaecology services in providing care to trans men and Public Health England guidance states that "trans men who are pregnant should be offered the same antenatal and new-born screening tests as all other pregnant individuals"[140]. However, no specific research in this area has been published in the UK.

There is a duty on clinicians who prescribe hormones to discuss possible adverse side effects on individuals' health[39]. The Royal College of Obstetricians and Gynaecologists (RCOG)[141], the General Medical Council (GMC)[126] and the Human Fertilisation and Embryology Authority[142] (HFEA) have each issued guidance advising clinicians to inform trans patients about the impact of hormonal treatment on fertility and options for fertility preservation. The lack of evidence on the effect of testosterone on fertility and reproduction means that clinicians specialising in gender identity are limited in their ability to offer accurate preconception, fertility and pregnancy advice to trans men was shown in a study by Botelle et al[143].

A study recently undertaken by the University of Leeds, entitled 'An International Exploration of Transmasculine Practices of Reproduction', looked at the reproductive practices of people who become pregnant and/or give birth after medically transitioning. To date, published journal articles from this study have included less than 14 trans participants from the UK (and more than 50 participants globally), with little disaggregation of findings by participant location[144 145].

Academics, such as Botelle et al.[143], are also undertaking work at Kings College London on 'Transmasculine Pregnancy and Postnatal Care in the UK.' Drawing on UK policy and international literature, the currently active study reported that barriers faced by trans people in the UK in relation to maternity care include poor provider knowledge about needs, inadequate access to culturally competent services; and feelings of gender dysphoria while pregnant. The authors recommend further quantitative and qualitative research into the outcomes and experiences of trans pregnancy; clear guidance from midwifery and obstetric bodies; trans-inclusive standardised curricula; development of community-led peer support networks; and specialist training materials and roles.

3.5 Access to Healthcare Services

Most of the literature on trans people's health relates to trans people's access to healthcare. In particular, evidence centres around trans people's experience of GPs, particularly in relation to accessing gender identity services and the barriers that trans people face in accessing general healthcare.

The GEO[1] survey reported that 84% of trans respondents accessed or tried to access public healthcare services in the past 12 months. Trans men (89%) were more likely to access healthcare in the last year than non-binary people (79%), who reported similar levels of access to cisgender respondents (79%).

3.5.1 Experiences of GP Services and Referral to GDCs

Trans people's experiences of GP services are a common theme in research studies. In addition to providing primary care, GPs are responsible for referring those seeking gender identity treatment to GDCs and other secondary healthcare services.

The focus below will be on trans people's experiences of GP services in relation to general healthcare and access to gender identity services; these two issues can be related and not always distinguished in survey findings. Evidence indicates a mixed picture of trans people's experience of GPs, in that whilst trans people generally saw GPs as trying to be helpful, they also saw GPs as having a lack of understanding of trans specific health needs and a lack of knowledge about referral pathways to GDCs.

In Birmingham, around seven out of ten (73%, n=24/33) trans respondents who approached their GP to access GDCs experienced a helpful attitude[32]. However, 79% of respondents (n=26/33) reported that their GP had little or no knowledge about gender dysphoria, regardless of how helpful they tried to be. Other local surveys report similar levels of satisfaction with GPs[112].

The South-West regional survey of trans respondents (n=645) echoes the findings in Birmingham, although respondents rated their experience with GPs less positively; 37% of respondents had a 'positive' experience, 26% of respondents had a negative experience, and 34% of respondents feeling 'neutral' or 'mixed'[146]. Non-binary respondents (35%) and a large proportion of minority ethnic trans respondents (42%) were the most likely to rate their experience as 'negative' or 'very negative'.

Surveys with larger samples of trans respondents also report some dissatisfaction with GPs when seeking to be referred to GDCs. In the GEO survey[1], a quarter (25%) of trans respondents said that their GP didn't know where to refer them for access to gender identity services. This was particularly the case for respondents from the West Midlands (30%). Furthermore, 16% of trans respondents reported feeling unsupported by their GP. This figure was much higher (25%) for respondents in the Stonewall survey[2].

The most positive accounts of GPs included those where trans people felt treated as 'a whole person' and not just a trans person, where GPs responded to the individual needs of trans patients, expressed sensitivity to language and a willingness to engage with the patient as an expert about their own body[147]. In the Brighton and Hove Survey, between 64-71% of respondents were satisfied/very satisfied with being listened to, being involved in decisions about their care and being treated with respect[112].

Negative experiences with GPs typically arose from trans people perceiving GPs as having a lack of knowledge about trans health or about the referral pathways for GDCs, being misgendered and going through unnecessary interim referrals to mental health services[112 147]. Despite these negative experiences, most trans participants nevertheless rated their experiences with GPs positively.

Reports of GPs having a lack of information and understanding about trans specific issues have been highlighted by GPs and patients alike[1 2 123]. GPs also recognise their own lack of understanding, experience, and uncertainties in caring for trans patients and feel under increasing pressure to provide specialist care because of overstretched specialised services[123]. In their position statement on the issue, the Royal College of General Practitioners[123] highlight the difficult position of GPs as having to work within their own competency as general experts and having limited access to expert advice.

In response to their negative experiences in accessing healthcare, the GEO[1] survey found that 7% of trans respondents report changing their GP, compared with 1% of cisgender respondents changing their GP for the same reason. This was the case for 19% of trans respondents to a local study in Brighton and Hove, who reported leaving their GP due to their GP's lack of knowledge about or attitude towards trans issues[112].

3.5.2 Barriers to Accessing Healthcare

Trans people face multiple barriers when accessing healthcare, with a significant proportion of respondents reporting negative experiences in relation to their gender identity.

According to national LGBT surveys, around 40% of trans respondents have difficulty accessing healthcare due to their gender identity[1 2]. This is compared with 13% of cisgender LGB respondents who had difficulty accessing healthcare based on their sexual orientation[1]. In the GEO[1] survey, trans men were the most likely to report negative experiences of accessing healthcare (57%), followed by trans women (45%). Non-binary respondents were the least likely to do so (29%).

The most commonly cited barrier to accessing healthcare by trans people across surveys is that their specific needs are ignored or not fully taken into account by healthcare staff. This was the case for around 20% of binary and non-binary trans respondents[1 28] and more the case for trans men (32%) than trans women (24%) and non-binary respondents (14%)[1]. This is compared with 5% of cisgender LGB respondents. In the GEO survey[1], 10% of trans respondents reported experiencing (rather than anticipating) discrimination from healthcare staff.

Trans people report that practitioners tend to be poorly informed about the lived reality of trans lives and trans issues, ask unnecessary and intrusive questions, have prejudicial attitudes and a lack of knowledge about treatment pathways[1 2 30 31 113 127 147 148].

A higher proportion of trans respondents to the Stonewall[2] and TransActual[30] surveys felt that health professionals lacked understanding of their trans-specific needs (40%-55%). This is compared with 9% of LGB respondents to the Stonewall survey who felt the same based on their

sexual orientation[2]. In the GEO[1] survey, around 8% of trans respondents felt they had been inappropriately referred to specialist services (see section 3.1.5. Gender Identity 'Conversion Therapy').

Other barriers to accessing healthcare include anticipated discrimination, openness with healthcare staff, lack of professional training and a lack of suitable communication materials.

Anticipated Discrimination

Reports on the extent to which trans people avoid accessing healthcare for fear of discrimination and intolerance based on their gender identity vary but are nonetheless significantly higher than for cisgender LGB. This was the case for 18% of trans respondents compared with 4% of cisgender LGB respondents to the GEO survey and in particular for trans men (24%) compared with non-binary respondents (15%) and trans women (17%)[1]. A higher proportion of trans respondents (37%) to the Stonewall survey[2] reported avoiding healthcare for fear of discrimination. This is compared with 14% of all LGBT respondents.

Openness with Healthcare Staff

Surveys show a mixed picture in relation to trans people's openness about their gender identity with GPs and other health professionals. In Birmingham, trans people were significantly more likely to be open with their GP about their LGBT identity (65%; n=34/52) than cisgender LGB respondents, such as bisexual (21%, n=12/52), gay (44%, n=120/276) and lesbian (51%, 92/182) respondents[32]. The Stonewall[91] survey reported a much lower rate of disclosure, with 18% of trans and non-trans LGB respondents being open about their gender identity when accessing medical services.

Training for Healthcare Professionals

Studies which have explored medical professional and student perceptions of LGBT healthcare report that whilst most professionals had positive attitudes towards trans patients, they felt uncomfortable during encounters with trans patients and had a lack of confidence, understanding and knowledge of trans specific healthcare issues[149 150 151 152 153 154]. Studies in the field of trans healthcare have been resounding in their recommendation for more training on trans specific healthcare issues for healthcare professionals.

Lack of Communication Materials

Many trans respondents to surveys felt the lack of trans specific communication materials were a barrier to accessing healthcare services[2 28 155]. These respondents wanted to see more healthcare materials with trans specific imagery, language and information.

A trans person may wish to adopt the social, physical and/or legal characteristics of their gender identity rather than their assigned sex at birth. Transitioning typically refers to physical transitioning using medical intervention (e.g. hormones or surgery). Not all trans people seek to medically transition

25-30%
ESTIMATED ANNUAL INCREASE IN DEMAND FOR GENDER DYSPHORIA SERVICES IN THE UK

7
NUMBER OF GENDER DYSPHORIA CLINICS (GDCS) IN ENGLAND. TRANSPORT IS THEREFORE A KEY BARRIER TO ACCESS

ACCESSING GENDER DYSPHORIA CLINICS

>22,871
people on GDCs wait list in England

4 YEARS
average wait time for first appointment

79%
of trans people in Birmingham said their GP had no or little knowledge of gender dysphoria and gender identity services

MEDICAL TRANSITIONING

>80%
of trans men and trans women were undergoing or had undergone medical transition in the National LGBT Survey

THIS IS COMPARED WITH 31% OF NON-BINARY PEOPLE

80%
of trans respondents found NHS GDCs difficult to access.

BARRIERS INCLUDE: LONG WAITING TIME TO ACCESS GDCS, GP LACK OF KNOWLEDGE ABOUT REFERRAL PATHWAYS AND LOCATION OF SERVICES

Some trans people self-prescribing hormones because of a lack of access

4.0 Medical Transitioning and Gender Dysphoria Clinics

Medical Transitioning and Gender Dysphoria Clinics Key Findings:

- There are at least 22,871 people on the waiting lists for the seven Gender Dysphoria Clinics (GDCs) in England.
- In England, the average waiting time to access GDCs from referral to first appointment is 48 months.
- For trans individuals who wish to transition, the majority want access to hormonal treatment (72%), followed by chest surgery (43%) and genital surgery (38%).
- The Trans Mental Health Survey showed that 62% of respondents who used GDCs reported having a negative experience.
- The main barriers to accessing GDCs include long waiting time to access services, GP's lack of knowledge about referral pathways to GDCs and the location of services.
- Nearly half (45%) of respondents said that they didn't have the financial means to afford gender identity services privately.

In the UK, people who want to physically transition can access gender-affirming treatment through the NHS or private practice. Not everyone who identifies as trans will want to access gender-affirming treatment. Those that do, require a diagnosis of gender dysphoria.

There are seven NHS GDCs in England, including two GDCs in the Midlands (Nottinghamshire and Northamptonshire). Although NHS GDCs publish some information in relation to their waiting list, the deficiency of data with regard to the most basic of treatment-related factors is

lamentable (see section 2.1. for limited evidence on gender identity services in relation to children and young people under the age of 18). Information is not currently available regarding the number of people diagnosed and treated through GDCs, the demographics of referrals or attendees, the types of treatments prescribed, the short-term or long-term outcomes of treatment, or the risks and side effects of treatment.

The NHS has issued Service Specifications for GDCs for both 'surgical'[156] and 'non-surgical'[39] interventions. These specifications outline the care pathways for gender identity services, the responsibilities of clinics and clinicians', and the types of therapies/treatments that can be prescribed under the NHS.

People with gender dysphoria may seek treatment using a range of therapies. The most commonly prescribed treatment is gender-affirming hormone therapy, sometimes alongside psychological therapy. Other therapies may include chest surgery, genital surgery, facial reconstruction or voice and communication therapy. The cost of facial reconstruction is not covered by the NHS.

Below, UK evidence in relation to gender identity services and trans people's views and experiences of accessing these services will be presented. This data has predominantly been collected from surveys, published studies and GDC websites and includes: the demand for GDCs; the percentage of trans people who seek to medically transition; trans people's experience of using GDCs; barriers to accessing GDCs; and alternative access to gender-affirming treatments that lie outside of the CQC clinical care pathway.

4.1 Demand for Gender Dysphoria Services

The NHS does not routinely publish data on people who use NHS GDCs. What is known is that the demand for adult GDC services in England is growing at a significant rate, with referrals increasing by an average of 25%–30% a year across all clinics[157].

Individual GDCs and journalists have published some statistics regarding the number of people on the waiting list for treatment. According to NHS data, 8,000 adults were referred to gender dysphoria services in England in 2018/19[158]. Figures published by the BBC in early 2020 found that more than 13,500 adults were on waiting lists for NHS GDCs in England[159] . A more recent analysis for the purposes of this report two years later shows that there are at least 22,871 people on the waiting lists for the seven GDCs in England, with an average wait time of 48 months (four years) from referral to the first appointment.

The table below presents the number of people on the waiting list for the GDCs in England and the waiting time from referral to the first appointment. The figures presented were collated for the time between December 2020 and February 2022.

Table 3: Average wait time from referral to the first appointment at gender dysphoria clinics in England (December 2020-February 2022)

Clinic Location	No. of People on Waiting List	Average Wait Time: Referral to First Appointment (Months)	Date
London	10,684	52	May-21
Devon			
Leeds	3,182	44	Feb-22
Sheffield	1,300	39	Oct-21
Newcastle	1,158	37*	Apr-21
Nottingham	2,216	36	Dec-20
Daventry	839	49	Dec-20
Total	22,871	48	Dec-20 to Feb-22

**By March 2022, this figure was reported as being 50 months[160]*

Sources: London GDC[161]; Devon Partnership NHS Trust[162]; The Newsam Centre[163]; ITV News[164]; Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust[165]; Nottinghamshire Healthcare NHS Foundation Trust[166]; Northamptonshire NHS Foundation Trust[167].

The number of people on the waiting list to access GDCs is high, and the waiting times to access GDCs are long. Despite variation in figures across GDCs, this is true for all of the GDCs in England. The London GDC had the largest number of people waiting for an appointment (n=10,684), making up nearly half of those waiting lists for all GDCs[161].

Limited evidence indicates a mixed picture in terms of the number of monthly referrals and first appointments at different GDCs. The London GDC receives an average of 435 referrals a month and offered 979 first appointments in a single month[161]. In Exeter, 69 patients joined the waiting list in January 2022, and 20 patients had completed their treatment; the clinic has suspended offering new appointments in early 2022[162].

4.2. Trans Respondents who Seek Medical Intervention

Medical transitioning does not have a single meaning, and trans people can opt for varying levels of medical intervention.

The majority of trans respondents (52%-57%) to large surveys had completed or were completing their transition, with little difference between trans men and trans women[1] [2]. However, trans men (82%) and trans women (83%) were more likely to be undergoing/have completed medical transition than non-binary respondents (31%)[1] (Annex 9). Of respondents who had started transitioning or had completed their transition, the majority of trans men (84%) and non-binary respondents (78%) had done so by the age of 24, compared with less than half (44%) of trans women. A tenth (11%) of trans respondents had tried to access specialist gender identity services but were unsuccessful.

Statistics on treatment pathways at GDCs are not published. A review of 617 files of trans patients who attended a UK GDC over a 2-year period reported that the majority of patients (62%, n=380) who accessed the GDC were recommended for gender-affirming hormones, whilst 38% (n=237) of patients were referred for a longer assessment period or were discharged[168]. In the South-West survey of trans people,[146] most respondents who wanted treatment said that they wanted to access hormonal treatment (72%), followed by chest surgery (43%) and genital surgery (38%).

There is also a small body of literature on patient satisfaction with gender-affirming surgery, generally showing positive results[169] [170] [171] and an emerging focus on the experiences of people who wish to 'de-transition'[172] [173].

4.3 Experience of Gender Identity Services

Survey evidence indicates a mixed picture in relation to trans people's experience of GDCs. GDCs were rated positively by 53% of respondents to the GEO[1] survey and 71% of respondents to the Stonewall survey[2]. This figure was lower for respondents to the regional South-West survey (30%)[146]. The Scottish Transgender Alliance report[174], on non-binary people's experiences of GDCs, found around 50% of respondents who had used GDCs reported having had a poor experience due to their gender identity and 29% of respondents had not disclosed their non-binary gender identity to clinicians at GDCs.

Clinic-based studies with smaller but sizable samples of trans respondents also provide insight into trans people's experience of using GDCs. Davies et al.[175] reported that 70% of respondents were 'pleased' or 'very pleased' with their experience at GDCs. However, patients were less pleased with post-operative hormone advice (61%, n=38 respondents) and support from local mental healthcare services (54%, n=86 respondents). An earlier study of GDC patients also reported a high satisfaction rate with GDCs (78%), although the total sample of respondents was low (n=23)[176].

In the Trans Mental Health Survey,[29] undertaken a decade ago, 62% of respondents who used GDCs (n=382 respondents) reported having had a negative experience. Just under a fifth of these respondents (18%) reported feeling uncertain about their gender whilst attending GDCs, and over half of these respondents felt unable to discuss their uncertainty with GDC clinicians. A central concern was the impact of such disclosure on their access to gender identity treatment[113].

Qualitative studies also report that trans people had overarchingly poor experiences at GDCs[115 147]. For example, Wright et al.[147] reported that trans respondents saw GDCs as a space in which gender expression was policed by healthcare professionals and where they had to act according to expected gendered stereotypes. This was particularly the case for non-binary people[28].

4.4 Barriers to Accessing Gender Dysphoria Clinics

Trans people experience a range of barriers in accessing NHS gender identity services. These include long waiting time to access GDCs, GP's lack of knowledge about referral pathways to GDCs and the location of services.

In the GEO survey[1], 80% of respondents who accessed or tried to access specialist gender identity services indicated that accessing them had not been easy (rated 1-3 out of 5, where 1 was 'not at all easy'). Of the respondents who wanted some form of medical intervention but had yet to have it, a fifth (21%) were not personally ready to undertake it. A large number of respondents to the GEO survey[1] also used the free-text option of the survey (n=2,876) to express their frustration with the long wait times to access GDCs and with ill-informed treatment by GPs and other healthcare staff (see sections 3.5.1 and 3.5.2.).

The biggest reported barrier to trans people accessing gender identity services across the literature is the long waiting time to access services at GDCs. Trans people face delays across several stages when accessing gender identity services, including the initial wait to be seen by a GDC clinician and waiting at other referral points, e.g. hormone assessment, counselling, endocrinology.

The experience of waiting to be treated by GDCs is profoundly difficult for trans people, impacting their mental health (see section 3.1.4.), substance use (see section 6.4.) and participation in everyday life[29 30 92 111 112 114 115 118 146 147 177 178].

In the GEO survey,[1] 86% of respondents said that the waiting time to access GDCs was too long. Of the trans respondents in the Stonewall survey[2] who wanted to undergo medical intervention but were yet to have it, almost half (47%) said that the long waiting times to access GDCs prevented them from accessing treatment.

The location of services was one of the most highly cited barriers by trans people in the GEO survey[1], with a third of respondents citing this as a difficulty to accessing services. Respondents have also raised this factor in other surveys[30 146]. Not knowing how to access gender identity services was raised by around a quarter (24%) of respondents in the Stonewall survey,[2] as was fearing discrimination from a healthcare provider.

4.5 Alternative Access to General Identity Treatment

In order to circumvent long waiting lists to access NHS gender identity services, some trans people seek access to treatment through private clinics, by going abroad for treatment or through self-prescribing gender-affirming hormones, all of which have associated risks.

Private Gender Identity Services

Comprehensive data is not available on the number of trans people who use NHS/private gender identity services in the UK. A study by the NHS Audit, Information and Analysis Unit (AIAU) reported that out of 494 trans respondents who were attending an NHS GDC, 26% had accessed private treatment beforehand (cited in Reed et al.[179]). Another clinic-based study of referrals to a GDC found that 34% (out of n=71 respondents) had used a private GP to access gender-affirming hormones[177]. In the South-West regional survey, 17% of trans respondents on the waiting lists for NHS GDCs were also under the care of a private clinic[146].

Nearly half (45%) of respondents to the Stonewall survey[2] said that they did not have the financial means to afford private gender identity treatment due to the cost of treatment and associated expenses (e.g., travel). In the GEO survey,[1] some trans respondents reported in the optional free text box that they had undertaken sex work to pay for quicker private treatment, either in the UK or abroad.

Gender Identity Services Abroad

Figures vary as to the number of trans people who go abroad to access gender identity services, but survey evidence indicates that a significant minority do. This was the case for a tenth (11%) of trans respondents in the Stonewall survey,[2] which included buying hormones over the internet from abroad. The GEO survey[1] reported that 16% of trans respondents had travelled abroad for treatment, with a further 50% having considered doing so. A third (33%) of respondents said that they would not use services abroad.

In relation to why respondents in the GEO survey[1] went abroad, the most commonly cited reason was the long waiting time to access GDCs in the UK (73%, n=1,260). This was particularly the case for trans men (74%) and trans women (75%) compared to non-binary respondents (58%). Of respondents who went abroad, 28% went for better quality of services. Around a quarter (23%) of trans women and non-binary respondents sought treatment abroad because the specific treatment they wanted was not available in the UK. This is compared with 14% of trans men.

Self-Prescribing of Gender-affirming Hormones

There is also evidence that some trans people access non-medically prescribed hormones via the internet. Trans people who self-prescribe hormones do so without medical guidance and often with a lack knowledge about the medications they access, including how to manage the risks associated with them[127 177 180]. Studies report that between 17%-30% of trans people seeking medical intervention self-prescribe gender-affirming hormones[127 177 180].

A clinic-based study found that a quarter (23%) of trans people were using gender-affirming hormones prior to attending a GDC, 69% (n=35/145) of whom sourced their hormones via the internet[180]. Trans women were significantly more likely than trans men to self-prescribe hormones (66% vs. 33% respectively) and to source these from the internet (72%, n=23/96 vs. 33%, n=1/49 respectively).

5.0 Protect and Detect

Protect and Detect Key Findings:

- There are currently no published figures on the uptake of screening by trans people.
- Evidence indicates that eligible trans individuals registered female at birth typically have lower uptake of cervical screening (58%) than eligible women in the general population (70%).
- Evidence indicates a lower uptake of sexual health services in the past 12 months amongst transgender people (17%) compared to cisgender people (29%).
- Of trans individuals diagnosed with HIV in England, the majority were trans women (79%), 7% were trans men and 14% identified as non-binary.

NHS screening programmes seek to protect the health of the population through the early detection of health problems. Screening programmes exist for a range of health conditions and are typically targeted towards specific populations e.g. people in particular age brackets, from particular ethnic backgrounds or a particular sex. Data is not published on the uptake of screening for trans people in the UK. Therefore, there is a lack of evidence on trans people in relation to a range of health conditions, such as diabetes, cancers, COVID-19 and other infectious diseases. Nor is there evidence on trans people in relation to immunisation/vaccination programmes.

The limited evidence that exists on trans people's uptake and experience of screening services, i.e., cervical, sexual health and HIV screening, will be presented below.

27%

of trans people avoided cervical or prostate cancer screening checks

ONLY 58%

OF ELIGIBLE TRANS PEOPLE HAVE EVER UNDERGONE CERVICAL SCREENING

BARRIERS TO CERVICAL SCREENING

- GP's lack of understanding of trans health
- Discrimination from healthcare professionals
- Increased gender dysphoria from screening process

SEXUAL HEALTH SERVICES

Trans people are less likely to access sexual health services than cisgender LGB people. Trans women (10%) and trans men (15%) were less likely to attend compared with non-binary people (22%).

17% Trans

29% Cisgender LGB

IN 2017 THERE WERE 178 TRANS PEOPLE LIVING WITH HIV

This gives an estimated prevalence of 0.48-4.78 per 1,000.
This rate is similar to that of the general population (1.7 per 1,000)

HIV AND STI RISK FACTORS

For Trans Population in England	TRANS	CISGENDER
LIVING IN LONDON	57%	43%
UNDER PSYCHIATRIC CARE	11%	4%
BEING A SEX WORKER	7%	0.3%

5.1. Screening

Public Health England has created guidance on behalf of the NHS for trans people on screening, including for breast cancer, cervical cancer, abdominal aortic aneurysm (AAA) and bowel cancer[140]. This guidance advises trans people who are registered with their GP as their desired gender to attend screening protocols based on their assigned sex at birth.

5.1.1. Cervical Screening

In the TransActual Survey,[30] over a quarter (27%) of respondents said that they 'always' or 'often' avoided their GP for cervical cancer or prostate screening checks. Trans men were more likely to avoid accessing 'sex-related' care through their GP (17%) than trans women (6%).

A clinic-based survey of 137 attendees at a GDC, who were assigned female at birth, found that of the 64 participants who were eligible for cervical screening only 58% (n=37) had undergone screening[181]. This is compared to 70% of eligible women in the general population[182]. Over half of respondents reported that not having appropriate information about cervical screening was a barrier to screening (n=34/61) although most respondents were aware that being registered with their GP as male meant that they would not routinely be called for cervical screening appointments (61%, n=82)[181].

In the free-text comments of the survey, pervading themes around barriers to uptake of cervical screening included increased dysphoria related to the screening procedures, poor provider understanding of trans health, and experienced or anticipated stigma or discrimination from health professionals.

A systematic review of the literature on the barriers and facilitators to cervical cancer screening among transgender men and non-binary people 'with a cervix' included 27 research articles on the topic,[183] not one of which was undertaken in the UK. The UK-based reviewers concluded that most studies, which were predominantly based in the USA, were not necessarily generalisable to the UK context due to variations in healthcare systems, call and recall systems, screening guidelines and referral pathways.

5.1.2. Sexual Health Screening and Access to Sexual Health Services

Surveys suggest a lower use of sexual health services by trans people than LGB cisgender and heterosexual cisgender people.

In the GEO survey,[1] 17% of trans people reported having accessed sexual health services in the 12 months preceding the survey compared with 29% of cisgender LGB respondents. Furthermore, trans women were less likely to have accessed sexual health services (10%) compared with non-binary respondents (22%) and trans men (15%). In a survey of 500 trans and 3,007 cisgender respondents there was a statistically significant difference between trans (27%) and cisgender (36%) attendance at sexual health clinics[184]. A virtual clinic-based study found that trans people comprised 0.42% (n=504) of a comprehensive cohort of attendees (n=119,329) at an online sexual health service based in London[185].

Evidence indicates that trans people feel they have relatively good access to sexual health services. The GEO survey[1] explored the barriers faced by trans people when accessing or trying to access sexual health services in the 12 months preceding the survey. Most respondents (66%) found it easy or very easy to access services and rated their experience of services as 'positive' or 'very positive' (78%). Respondents to the Trans Sexual Health Survey also rated sexual health services positively (73%) and reported that they generally felt confident about maintaining good sexual health and negotiating sex with partners (80-90%)[186].

A qualitative study of 20 sexual health service providers highlighted professional attitudes and lack of professional awareness of trans issues as barriers to trans people accessing sexual healthcare,[187] although such attitudes are not reflected in the literature with trans people.

5.2 Prevalence and Risk of HIV

Until recently, there has been no count or reliable estimate of the number of trans people living with HIV in the UK[188]. In 2017, a review of the evidence on trans people and HIV in the UK concluded that "the available data has severe limitations. There is no UK specific data"[189]. Public Health England started collecting data by gender identity in the HIV and AIDS Reporting System (HARS) from 2017.

One of the few reliable estimates of HIV prevalence among trans people in England has been provided by Kirwan et al.,[190] who estimate prevalence as being is 0.46–4.78 per 1,000 people in 2017 using national HIV surveillance data. The authors note this to be a similar rate of HIV prevalence to the general population in England in 2017 (1.7 per 1,000).

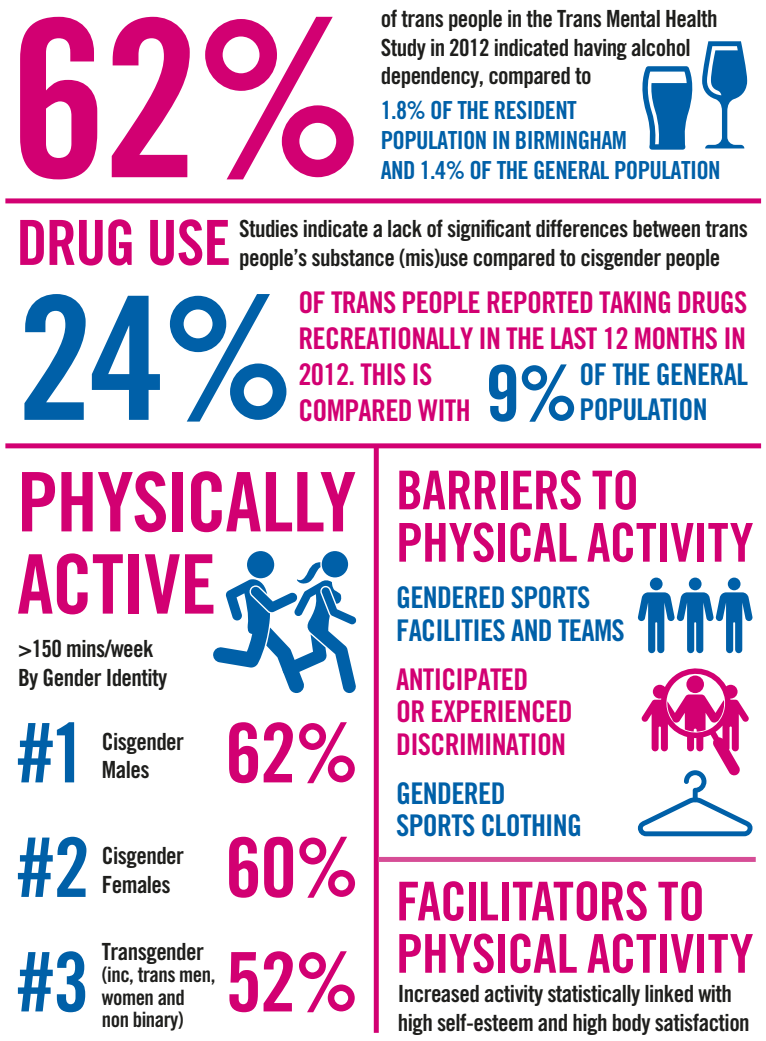
In 2017, the number of trans people diagnosed with HIV in England was 178 (representing 0.19% of all people living with HIV)[190]. The majority (79%) were trans women (n=140), 7% were trans men (n=12) and 14% identified as non-binary or in some other way (n=23). There was an overrepresentation of minority ethnic people in this population, in which just over half (61%, n=108) were white and 37% (n=65) were minority ethnic.

Based on analysis of the characteristics of trans people living with HIV in England, the study identified statistically significant risk factors for trans people in relation to HIV[190]. Risk factors included living in London (57% trans vs. 43% cisgender), being under active psychiatric care (11% trans vs. 4% cisgender), being a sex worker (7% trans vs. 0.3% cisgender) and being younger (trans median age 42 years vs. cisgender median age 46 years).

The likelihood of trans people, predominantly trans women, engaging in risky sexual behaviour has also been identified as a risk factor for HIV and sexually transmitted infections (STIs) in the trans population. Studies which focus on men who have sex with men (MSM) have increasingly identified or included trans women and non-binary people in their samples, having previously conflated these two groups[191]. Evidence suggests that trans women who have sex with men share similar risk factors for HIV with MSM[192 193 194].

A sexual health clinic-based study found that of the 302 trans people who had requested an HIV testing kit in 2019, 20% were assessed as being more likely to engage in significant levels of high-risk sexual activity than non-trans people, including sexualised drug use (chem-sex), group sex or sex work[185]. Another survey of 500 trans people recruited from community settings found that 50% of respondents had engaged in condom-less anal intercourse and had never had an HIV test[184].

The use of pre-exposure prophylaxis (PrEP) is increasingly being promoted for use amongst trans women with particular risk factors, as recommended by the British HIV Association and British Association for Sexual Health and HIV in a joint position statement[195]. Studies indicate a low awareness of PrEP by trans women[184 192 196 197].



6.0 Behavioural and Lifestyle Factors

Behaviours and Lifestyle Factors Key Findings:

- The limited survey data that exist on alcohol and illicit drug (mis)use amongst trans people shows significant variation in prevalence but indicates a higher rate than in the general population.
- Survey data also indicates that no significant differences between trans respondents and non-trans respondents in substance misuse.
- The Trans Mental Health Study in 2012 reported that 62% of trans people had an alcohol dependency and 24% had taken illicit drugs in the past 12 months.
- The study also reported that the rate of smoking in the trans population is similar to that of the general population (19%).
- There is some indication that some trans people use alcohol and illicit substance as a way of dealing with transphobia, gender dysphoria and mental health problems.
- Trans people are slightly less likely to have met the recommended weekly recommendation for physical activity (52%) compared with non-trans females (60%) and males (62%).
- The key barriers faced by trans people when accessing sport are gendered sports clothing, gender-specific facilities, gendered sports teams and experienced or anticipated discrimination.

National surveys which monitor rates of alcohol, illicit drug use and smoking of the nation do not typically collect data on trans people nor is data published by the Office for National Statistics (ONS) or NHS Digital.

Although the annual Global Health Survey does count trans respondents, disaggregated data is not available in relation to trans respondents from the UK. Nor are the anonymised datasets available for analysis. The limited evidence that exists on substance misuse predominantly comes from non-representative survey data with LGBT or trans populations. Care should be taken when making direct comparison between studies as individual surveys tend to use heterogeneous measures and have varying sample sizes.

Whilst, on the whole, evidence suggests that trans people have higher rates of substance misuse than the general population, studies also indicate a lack of significant differences between trans and cisgender people's substance (mis)use[91 107].

Sport England, which measures physical activity rates, has recently included a question on gender identity in its Active Lives Survey. There is no data on the diet, nutrition, eating habits or food poverty/insecurity for the trans population in the UK. Nor are these topics mentioned in reviews of the literature on LGBT and trans populations[198 199].

6.1 Alcohol Misuse

The limited survey data that exists on alcohol misuse amongst trans people shows significant variation in prevalence and is based on heterogeneous measures. However, evidence indicates a higher rate of alcohol dependency amongst trans people than in the general population.

The most in-depth survey into the trans population's use of alcohol and other drugs in the UK and their experience of accessing specialist services has been undertaken by the Scottish Trans Alliance's (STA) community-based 'Transgender Inclusion in Drug and Alcohol Services' survey[200]. However, the sample of respondents was small (n=202) and the survey focused on trans people in Scotland.

The survey found that around a third (35%, n=68/194) of respondents in Scotland reported that their drinking had become problematic at some point in their lifetime. This figure was lower for respondents in the South-West regional survey (17%)[146]. A decade ago, the Trans Mental Health Study reported a much higher rate of self-reported drug or alcohol dependency issues, with 62% of respondents indicating a drinking dependency[29]. Despite the variation in problematic drinking rates, survey findings indicate that the estimated prevalence of alcohol dependency is significantly higher for trans people than for the general population for England (1.4%) and Birmingham (1.6%) in 2018-19[201].

Systematic reviews by UK researchers on the prevalence of alcohol dependency within the trans community do not contain any studies from the UK but indicate higher prevalence of alcohol dependency in the trans population[202 203]. These reviews typically highlight methodological problems with international studies in this area, including a lack of information about how gender identity was operationalised, the use of sex specific alcohol measures and a lack of analytical study designs.

A large-scale exploratory survey, which aims to recruit more than 400 trans participants, is currently being undertaken in the UK[204]. The study seeks to understanding alcohol consumption in UK trans communities, including prevalence of drinking, drinking behaviours, motivation for drinking and experience of discrimination and alcohol related harms.

6.2 Illicit Drug Use

Substance misuse in the general population varies significantly by age[205]. However, surveys with trans people do not typically disaggregate their findings in relation to the age of respondents. The limited survey data that exists on substance (mis)use amongst trans people shows significant variation in prevalence, but much higher rates than in the general population.

In the Trans Mental Health Survey,[29] a quarter (24%) reported using recreational drugs in the preceding 12 months. Of these respondents, 23% thought their drug use was sometimes/definitely problematic. The Scottish Transgender Alliance survey reported that 67% of trans respondents have tried drugs at some point in their life[200]. These figures are much higher the general population, where 9% of adults in England and Wales reported taking a drug in the preceding 12 months of March 2020 and 3% of adults showed signs of dependence on drugs in 2014[205].

There is also indication that rates of 'chemsex' (the use of drugs in sexualised contexts) are high amongst trans women[185 191 194]. However, the Public Health England Briefing[206] on 'Substance misuse services for men who have sex with men involved in chemsex' makes no specific mention of trans women, other than to note that it would be good practice to apply the recommended guidance to the LGBT community.

6.3 Smoking

Reviews of the literature on trans people and smoking typically conclude that evidence in this area is limited, alongside citing the risk of the adverse side effects of smoking for trans people seeking medical interventions[198 207 208].

The limited evidence that exists on smoking in the trans population in England, and across UK, indicates that there is little difference in the rates of smoking between trans people and cisgender people. The Trans Mental Health Study[29] reported that over half of respondents (56%) had smoked at some point in their lives, with 19% of respondents being current smokers. A Manchester survey reported that a third of respondents (33%, n=30/92) had smoked at some point in their lives and around 21% (n=19/92) were current smokers[127]. A study of LGBT people in Northern Ireland reported higher rates of smoking amongst trans respondents (32%), who were slightly more likely to smoke than the whole sample of LGBT respondents (27%).

The rate of smoking amongst trans respondents is similar to the estimated prevalence of smoking in the general population in 2013, which was 19% for adults in Great Britain[209].

6.4 Contributing Factors to Trans People's Substance Misuse

Survey findings show that trans respondents misuse of alcohol or illicit drugs is linked to issues relation to their gender identity, including gender dysphoria, transphobia, mental health problems and a lack of access to gender identity services[29 114 200 210].

In the Scottish Transgender Alliance Survey, 50% of respondents (n=66/131) reported that their non-binary gender identity had affected their alcohol or drug use[200]. A quarter (25%) of these respondents used alcohol or other drugs to deal with social and/or sexual anxiety due to being trans and 9% of respondents used substances to cope with mental health problems related to being non-binary. The GEO survey[1] did not ask a question specifically on substance use, although open text responses to the survey indicate that "it is the negative experiences of being LGBT, such as abuse, discrimination and marginalisation, that cause alcohol and drug abuse/misuse".

6.5 Barriers to Accessing Drug and Alcohol Services

The Scottish Transgender Alliance survey found that trans people perceived multiple barriers to accessing drug and alcohol services in Scotland,[200] some of which are relevant to the English context. Around a third (n=44/137) of respondents to the survey worried that their GP would not know enough about trans issues to be able to help them, 25% (n=34/137) of respondents worried that addiction services would not know enough about trans issues to help them and 21% (n=29/137) of respondents worried their access to trans specific healthcare would be stopped if they disclosed their addiction status to their GP. Of the 58 respondents who had engaged with services about their drug or alcohol use, two had experienced hurtful or demeaning language.

6.6 Physical Activity and Sport

Evidence from surveys shows that transgender participants engage in similar/slightly less levels of physical activity than their cisgender counterparts. Evidence also indicates that trans people waiting to go on gender-affirming hormones typically report lower rates of physical activity than trans people on gender-affirming hormones.

6.6.1 Physical Activity Rates

The Active Lives Survey measures the activity levels across England[211]. In 2020-2021, the survey had 172,970 respondents, 0.26% (n=449) of whom identified their gender as being 'other' (i.e., not 'male' or 'female'). Trans ('other') respondents were slightly less likely (52%) to have met the recommended weekly recommendation for physical activity (150+ minutes a week) compared with non-trans females (60%) and males (62%). This is compared with around 62% of the general population in England and 53% of the West Midlands population[212].

A survey by the LGB&T Partnership[213] explored the physical activity rates of 101 trans people in England. The study found that only 16% of trans people met the recommended weekly requirements (150 minutes or more) for moderate intensity activity, with similar rates reported for the other cisgender LGB participants in the study. The survey also found that unlike in the general population,[212] there was 'little difference in rates of physical activity between male and female LGBT respondents.

A published study by Jones et al.[118] compared levels of physical activity and its statistical predictors amongst a large cohort of people with gender dysphoria attending a GDC in the UK (n=360) and a community sample of cisgender people (n=314). The study also included a sub-sample of those who were taking gender-affirming hormones (n=102) and those who were not (n=241), and a matched control sub-sample of 137 transgender participants and 137 cisgender participants. The study found that transgender participants engaged in significantly less physical activity compared to cisgender participants. This was the case for both trans women and trans men. Furthermore, transgender participants who were on gender-affirming hormones engaged in significantly more physical activity than transgender participants who were not.

6.6.2 Barriers and Facilitators to Participation in Physical Activity

Barriers to Physical Activity

Evidence indicates that transgender people face multiple barriers in participation to sport. The relationship between physical activity and public spaces has been highlighted as a significant barrier to trans people's participation in physical activity, whereby inequalities in access to public spaces for trans people in general translate into a significant part of trans people's inequalities of access to physical activities[214] (see section 7.5.3. Public Space and Avoidance).

The barriers faced by trans people in participating in physical activity and sport are common across all age groups, albeit in relation to their relative age-specific institutions. Qualitative studies with small samples of trans people have found that trans people's barriers to participation in physical activity and sport include:

- Gendered sports clothing[168 215 216]. Swim wear was highlighted as of particular concern by some trans people, particularly trans men[168 214]. Over a third (36%) of transgender students reported being 'put off' engaging in sports because of the gender-specific sports clothing[215].
- Gender-specific facilities, such as showers and changing rooms[86 168 214 215 217 218]. Over a third of transgender university students (36%) said that gender specific facilities prevent them from engaging in physical activities.

- Gendered sports teams[215 218]
- Previous experiences of discrimination at school[218]
- Anticipated (not experienced) discrimination[118 217]

Small qualitative studies report that the period of transitioning, is a particularly vulnerable time for trans people as they are required to use the changing facilities of their desired gender but feel uncomfortable doing so because they have not completed their transition[168 217]. These individuals felt unable to 'pass' as their desired gender and therefore withdrew from physical activities and avoided public spaces and facilities for fear of hostile reactions[168 217 218].

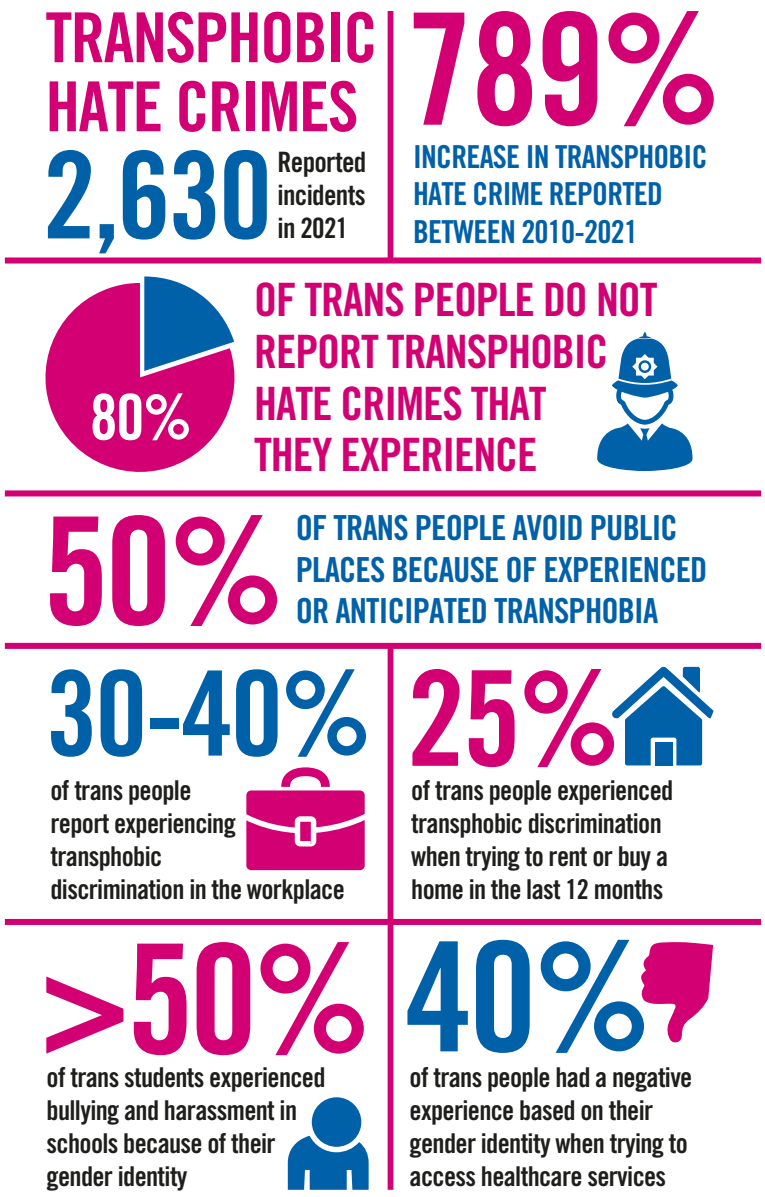
Recognising the barriers that trans people face in participating in sports, the UK Sports Councils' Equality Group (SCEG) commissioned an international review into transgender people's inclusion in domestic sport. The subsequent report, 'Guidance for Transgender Inclusion in Domestic Sport', is intended to inform the development of guiding principles and policy in the UK[219].

Facilitators to Physical Activity

Studies report that trans people who are waiting to go on gender-affirming hormones engage in less physical activity than trans people waiting to go on gender-affirming hormones is echoed by other studies with trans adults and young people attending gender identity services[29 86 118 216].

In the clinic-based study of people with gender dysphoria by Jones et al.,[118] reported that trans people who were taking gender-affirming hormones were more likely to engage in physical activity than those waiting for treatment. The study found that the best (independent) statistical predictors of physical activity between these two groups of participants were self-esteem and body satisfaction. That is, those with low body satisfaction and/or low self-esteem were significantly less likely to engage in physical activity. The researchers conclude that the use of gender-affirming hormones raises body satisfaction and self-esteem and therefore physical activity levels. However, little attention is given to other non-medicalised routes to improving body satisfaction and self-esteem in trans people with gender dysphoria.

Transgender people who participate in sport generally report having positive experiences[214 215 218] and highlight the impact of physical activity in improving their own well-being and health[214] and feelings of allyship and friendship[218]. Over 60% of trans university students who participated in sport said that they were open about their gender identity[215]. However, over a quarter (28%) of trans respondents were worried that coming out might result in verbal or physical abuse in some way.



7.0 Wider Determinants of Health

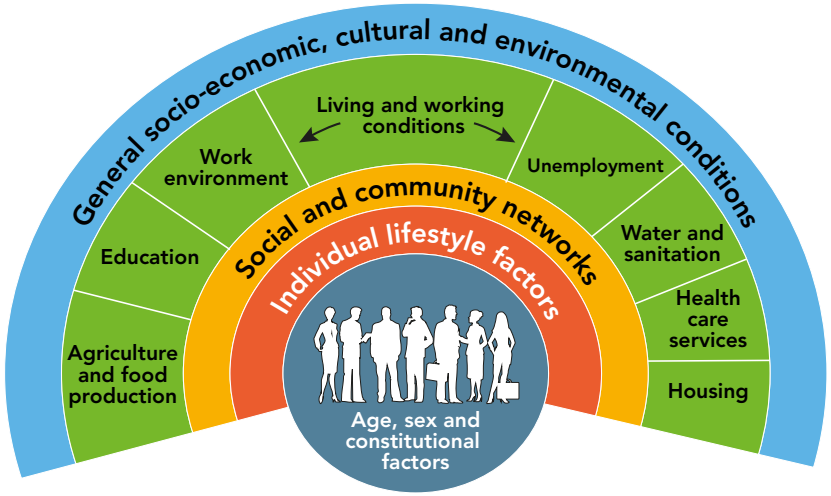
Wider Determinants of Health Key Findings:

- Life satisfaction amongst trans individuals (5/10) is lower than the cisgender LGB population (7/10).
- In Birmingham, trans individuals were less likely to have gained a degree than non-trans LGB respondents.
- Trans individuals aged 16-64 were less like to have been in a paid job in the past 12 months (62%) than the general population (75%).
- Between 50% and 72% of trans people have hidden their gender identity in the workplace.
- Around 40% of trans people have experienced discrimination in the workplace.
- Binary and non-binary trans people are more likely to be discriminated against because of their gender identity when looking to buy or rent a home (25% and 20% respectively) compared with cisgender LGB individuals (16%).
- There is a high prevalence of homelessness amongst the trans population, with around a quarter (25%) of trans people having experienced homelessness at some point in their lives.
- There has been a 789% increase in transphobic hate crime since 2012, with 2,630 transphobic incidents reported in 2021.
- Over 50% of trans people report avoiding public spaces such as cafes, bars and gyms.

Wider determinants, or social determinants, are a diverse range of social, economic and environmental factors which impact on people's health and determine the extent to which individuals have the physical, social and personal resources to identify and achieve their goals and meet their needs[220]. Variation in the experience of wider determinants is a fundamental cause of health outcomes; in particular, there is a well-established link between social inequalities and disparities in health outcomes[221 222].

The 'Dahlgren and Whitehead Model', or 'Rainbow model', of the main determinants of health, provides a social ecological framework which maps the relationship between the individual and their environment (Figure 3)[223].

Figure 3: The Main Determinants of Health



Source: Dahlgren and Whitehead, 2021[223]

The limited evidence that exists on the wider determinants which shape trans people's health in the UK, namely life satisfaction, educational attainment, economic activity, housing, domestic abuse and transphobia, will be presented below.

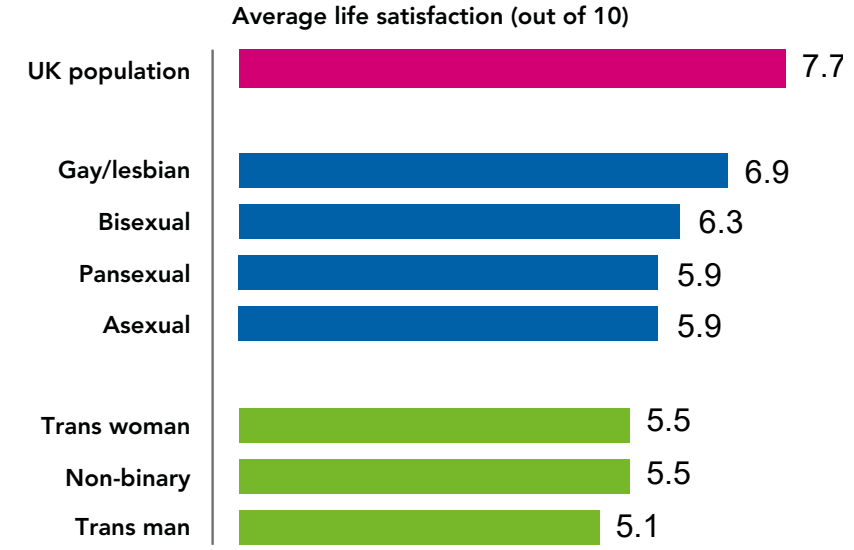
7.1 Life Satisfaction

Self-reported levels of life satisfaction are regarded as an important measure of subjective well-being and are part of the metrics for the government's national levelling up indicators[224].

Survey findings indicate that trans people are less satisfied with their lives than cisgender people. Around half (55%) of respondents to the Trans Mental Health Survey[29] reported feeling satisfied with their life. In the GEO survey[1], trans respondents scored their life satisfaction on average as 5/10 compared with cisgender LGB respondents who scored their life satisfaction as 6/10 on average, and the general population who scored their life satisfaction as 7.7/10.

A breakdown of the life satisfaction scores for the general population, cisgender LGB respondents and trans respondents can be seen by Figure 4.

Figure 4: Average life satisfaction in the UK



Source: National LGBT Survey[1]

Published studies comparing clinic-based samples of trans people with gender dysphoria and matched control groups from the general population also report that trans respondents reported lower life satisfaction and quality of life than non-trans respondents[110 117]. However, these studies did not control for confounding variables and the negative impact of gender dysphoria on life satisfaction (i.e. they only matched age and gender).

7.2 Educational Attainment

Data is not collected at a national level with regards to trans people's educational attainment.

Looking at a robust population sample (n=2,532,390), the Higher Education Statistics Agency[225] reported that in 2019-2020, 0.15% of newly enrolled students identified their gender identity as 'other' (n=3,875). For that same year, the Office for National Students reported that 0.9% of all undergraduate entrants to English higher education providers were trans[226]. In a survey of trans workers, 22% of respondents had completed an undergraduate degree[227]. In the GEO survey[1], transgender respondents (20%) were more likely than cisgender LGB respondents (13%) to leave education after completing secondary school and less likely (35%) than cisgender LGB respondents (51%) to have completed a higher-level qualification.

In Birmingham, trans respondents were less likely to have gained a degree than non-trans LGB respondents[32].

7.3 Economic Activity and Employment

Most of the literature on trans people and employment has focused on trans people's experience of the workplace in relation to their gender identity. Data on trans people's economic activity rates is not collected in the UK. However, survey evidence indicates that trans people have lower rates of employment than their cisgender peers. Despite the legal protections afforded to trans people in the workplace, survey evidence suggests that they suffer high levels of harassment, bullying, abuse and transphobic discrimination based on their trans identity.

In Birmingham[32], there is indication that trans people have a higher rate of unemployment (26%, n=14/54) compared with their cisgender LGB counterparts (14%).

Nationally, 62% trans respondents aged 16-64 had been in a paid job in the 12-months preceding the survey and 38% of respondents had not[1]. This is compared with 83% of cisgender LGB respondents and 75% of the general population aged 16-64 who were in paid employment[1 228]. A similarly low percentage of trans respondents (56%-57%) were employed in other national surveys[29 30 114] although each survey defined 'employment' in different ways, e.g. as full-time or part-time or as including/excluding volunteering or studying.

Reporting on intersectional differences, the TransActual survey[30] found that only 27% of trans disabled people were in full time employment compared with 56% of non-disabled trans people. This is compared with an employment rate of 53% for disabled people in the general population and 82% of non-disabled people[229]. Furthermore, intersectional analysis from the GEO survey[1] also revealed that heterosexual trans respondents had the highest rate of employment (74%), which was similar to cisgender LGB respondents, and higher than LGB trans respondents (63%), asexual trans respondents (50%) and trans respondents with an 'other' sexual orientation (54%).

7.3.1 Income

Surveys indicate that trans people have lower income and savings compared with cisgender LGB respondents.

In Birmingham, 43% of trans respondents earned £15,000 or less compared with 25%-30% of cisgender LGB respondents[32]. The median earnings of trans respondents were in a range of £5,000 less than lesbian and gay respondents (but similar with bisexual respondents). Furthermore, 60% of trans people said they earned less than £20,000 per annum[230].

Similarly, in the GEO survey[1], 60% of trans respondents earned less than £20,000 per annum (before tax) compared with 45% of cisgender LGB respondents. Around 38% of respondents in the TransActual and Total Jobs surveys earned less than £20,000[30 231]. Intersectional analysis also indicates that trans people from minority ethnic backgrounds (30%) are more likely to earn under £15,000 a year than their white counterparts (15%)[30]. The average pay for employees in Great Britain in 2017 was approximately £26,600[228].

7.3.2 Openness at Work

On the whole, a significant proportion of trans people do not feel able to be open about their gender identity at work. Surveys report a wide variation in the extent to which trans respondents had hidden their gender identity in the workplace (between 19% and 65%)[1 2 227 231].

Surveys indicate that most trans people (64%-65%) are not open about their gender identity with other employees in the workplace[1 227.] Non-binary respondents (72%) were more likely to avoid being open about their gender identity at work than trans women (61%) and trans men (53%)[1]. In the Stonewall survey, half of trans respondents (51%) had disguised their LGBT identity at work because they were afraid of discrimination[210]. This was a similar figure for non-binary respondents (52%) to the Scottish Transgender Alliance survey of non-binary people[28].

7.3.3 Discrimination in Finding Work

In the TransActual survey, most trans people (63%) report facing transphobia whilst seeking employment, rising to 73% for minority ethnic trans respondents[30]. In the Total Jobs survey, 33% of respondents said they had experienced discrimination at the interview stage of applying for jobs and job interviews[227].

7.3.4 Discrimination and Harassment at Work

Trans employees are more likely to report being subject to discrimination, harassment and abuse in the workplace based on their LGBT identity than cisgender LGB respondents. Examples of types of transphobic bullying and discrimination that transgender people report include misgendering, being outed without consent, being excluded from events, not being able to use toilets according to their desired gender, name calling, physical assault or threat, and sexual assault.

In the Birmingham, 40% of trans people reported experiencing discrimination at work[32]. This is compared with 27-29% of LGB respondents. National surveys also show that approximately 30-40% of trans people report having experienced transphobic discrimination or abuse in the workplace[1 31 227].

In the TransActual Survey, the majority of non-binary (80%) and binary trans (73%) respondents reported experiencing transphobia from colleagues at work[30]. This figure was higher for trans respondents from minority ethnic backgrounds (88%) than those from non-minority ethnic backgrounds (73%). The Total Jobs (2021) survey reported a decrease in the discrimination trans respondents experienced from line managers compared with a previous Total Jobs (2016) survey from 25% to 17%[227 231]. Surveys also report that around 10% of trans employees are unable to use the toilet at work according to their desired gender[227 232]. Before the Equalities Act[34], this figure was around 20%[31].

Evidence from surveys indicates that trans employees are more likely to report bullying in the workplace than cisgender LGB respondents. The Stonewall survey reported that 20% of transgender people had reported bullying in the workplace compared with 12% of cisgender LGB respondents[232]. The GEO survey also found that 22% of trans respondents had reported an incident in the workplace compared with 17% of cisgender LGB respondents[1].

7.3.5 Impact of Discrimination on Work Opportunities

In the Stonewall survey, 24% of trans respondents said they didn't get a promotion they were up for at work in the past year because of their LGBT identity[210]. This is compared 7% of LGB people who weren't trans[232]. This figure was lower for respondents (14%) to the Total Jobs (2016) survey of trans employees[231].

The bullying, abuse and harassment that trans people face at work also impact their career aspirations, progression and stability. Because of transphobic experiences, around a quarter of trans employees in the Equality Review Survey reported that they felt obliged to change their job[31]. More recently, the Total Jobs (2021)[227] survey reported that 43% of trans employees said that they had left a job because the environment was unwelcoming, which was an increase from 36% in their 2016 Survey[231]. Furthermore, around a tenth of trans employees in the Stonewall survey reported losing a job in the preceding 12 months because of being LGBT[232].

7.4 Housing

There is no published data on the housing conditions and circumstances of trans people. Large surveys seldom ask about trans people's physical housing conditions or home ownership. The focus of surveys in this area has been on trans people's risk of homeless and their access to support services.

7.4.1 Home Ownership

In Birmingham, 50% (n=27/54) of trans people owned their own home, which was a similar rate to the whole sample of LGBT respondents[32]. This is similar to 2011 Census data for the resident population of Birmingham (56%)[233].

7.4.2 Discrimination in Finding Housing

In the Stonewall survey, a quarter of binary trans people (25%) and a fifth of non-binary trans people (20%) reported being discriminated against because of their gender identity when looking to buy or rent a home in the preceding year[2]. This is compared with 16% of cisgender LGB respondents (based on their sexual orientation). In the TransActual Survey, 40% of respondents said that they experienced transphobia when seeking housing[30].

7.4.3 Homelessness

No published data is available on the rate of statutory homelessness for trans people. National and local surveys provide some insight into the level of homelessness and housing security experienced by trans communities and indicate that trans people experience higher rates of homeless than cisgender people. However, measures of homelessness vary between surveys, and do not reflect statutory homelessness.

Surveys show that around a quarter of trans people in the UK (25-27%) have experienced homelessness at some point in their lives[2 30 234]. This is compared with 16% of LGB cisgender respondents[210]. Intersectional analysis from the TransActual Survey found that minority ethnic (36%) and disabled (26%) trans respondents were more likely to report experience of homelessness than non-minority ethnic (26%) and non-disabled (21%) trans respondents[30].

7.4.4 Access to Services whilst Homeless

Few studies have explored trans people's knowledge of and access to services in relation to being homeless.

The Albert Kennedy Trust survey of 16–25-year-olds who had experienced homelessness found that 43% (n=18/42) of trans respondents had experienced discrimination or harassment based on their gender identity when accessing services[155]. Furthermore, the survey reported that more than two thirds (68%) of trans young people would like to see more inclusive language used in communication materials from support services, compared to 32% of non-trans LGB people.

7.5 Transphobia

7.5.1 Rates of Transphobic Hate Crime

Evidence illustrates the high rates of transphobia that trans people face in their daily lives. Trans people experience transphobic discrimination, harassment, and abuse in various areas of their lives, e.g. at work, in education, at school, in healthcare, in public places.

Hate Crime Statistics, which are recorded by the police and published by the Home Office, are one of the few officially collected statistics on the experiences of trans people in England and Wales[235]. In 2021, 2,630 transphobic incidents of hate crime were reported. This is a rise of 789% since 2012, and a rise of 3% from 2020. However, there are no studies to confirm the extent to which this increase represents an increase in transphobia in the general population, an increase in confidence of people reporting transphobic hate crimes, an increase in numbers in the trans population or some mix of these and/or other factors.

The table below presents the annual number of reported hate crimes from 2020-2021.

Table 4: Transphobic Hate Crime Statistics: England and Wales, 2012-2021

Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
No. recorded transphobic hate crimes	296	352	538	572	820	1,195	1,165	2,185	2,542	2,630

Source: Allen and Zayed[235]

Between 2020-21 there was a 3% increase in transphobia hate crimes, and a total increase of 79% from 2012-21[235] .

Evidence from surveys indicates a high underreporting of transphobic hate crimes, and illustrates the high rate of hate crime, transphobic harassment and abuse that trans people face in public spaces and communities.

The majority (81%) of respondents in the Galop Transphobic Hate Crime Survey said that they had experienced a transphobic hate crime over the preceding 12 months[114]. This figure was lower for binary (41%) and non-binary (31%) trans respondents in the Stonewall Hate Crime Report, in which it was also reported that young trans respondents aged 16-24 years (53%) were the most likely to experience a hate crime[236]. Trans respondents were significantly more likely to experience a hate crime based on their gender identity (41%) than LGB respondents who weren't trans (16%) were to experience a hate crime based on their sexual orientation.

However, evidence indicates that the official rate of transphobic hate crime is severely underreported, with the vast majority of trans people saying that they have not reported transphobic hate crimes to the police. This was the case for 86% of respondents to the Galop Transphobic Hate Crime Survey[114] and 79% of respondents to the Stonewall survey[236].

Trans people who do report hate crimes often report having a poor experience. Half (50%) of respondents to the Galop Survey felt that their experience had been unsuccessful or very unsuccessful[114]. Free-text responses to the GEO Survey (n=202) also highlight negative experiences of reporting, where respondents 'frequently described not being taken seriously and being made to feel as if the incident had been insignificant, unimportant, or not a matter for the police'[1].

7.5.2 Transphobic Harassment, Abuse and Discrimination

Survey evidence reveals the high rate (over 70%) of transphobic harassment, abuse and discrimination that trans people are subject to in the community and in public spaces[29 30 31 114]. Most trans respondents (93%) in the Galop Transphobic Hate Crime Survey[114] and non-binary respondents (97%) to a Scottish Transgender Alliance Survey[28] of non-binary people said that they had experienced transphobia in the past 12 months. The TransActual Survey reported similarly high rates of transphobic street harassment from strangers, particularly for trans women (85%), followed by trans men (71%) and non-binary respondents (73%)[30].

In the National LGBT Survey around half of trans respondents (53%) had experienced at least one incident of harassment, violence or abuse based on their LGBT identity from someone they were not living with[1]. This is compared with 38% of cisgender LGB respondents. Almost half (47%) of trans respondents to the GEO survey said that they had not experienced any of the incidents listed by the survey from someone that they were not living with[1].

Another common theme in the literature was the marginalisation of trans peoples within LGBT communities. More than a third of trans people (36%) report that they have experienced discrimination or poor treatment in their local LGBT community because of being trans[114 235].

7.5.3 Public Space and Avoidance

As a consequence of experiencing transphobic harassment and abuse, or for fears of their own safety and well-being, survey findings show that some trans people avoid going to public spaces such as gyms, parks, cafes, bars, restaurants, leisure facilities and sporting venues, either presenting in a way which aligns with their gender identity or at all[29 114 210 236]. For example, 68% of trans respondents to the GEO survey[1] said that they avoided being open about their gender identity in the street or public venues for fear of a negative reaction from other people and 44% of respondents to the Stonewall survey[2] avoided certain streets altogether.

Analysis of the Trans Mental Health Survey reported significant differences in the situational avoidance of trans people according to their gender identity[178]. The study reported that non-binary respondents (67%) and trans men (65%) had significantly higher levels of avoidance than trans women (24%). Statistically significant differences were also reported on stage of transition, with those waiting to undergo transition/in the process of transition having significantly higher levels of avoidance than those who did not intend to undergo physical transition/who have already physically transitioned. However, the non-representative nature of this survey requires that any statistical analysis is treated with caution (as recommended by the Government Equalities Office[1].

The Stonewall Hate Crime and Discrimination Survey reported that over 50% of respondents avoided public spaces such as cafes, bars and gyms[236]. Surveys also report that public toilets are particularly problematic spaces for trans people to negotiate and that avoidance of public toilets was high[1 31 237] with around 50% of trans people reporting that they didn't feel comfortable in or avoided public toilets[2 114]. This is compared with 14% of LGB respondents who are not trans[2].

7.5.4 Public Attitudes towards Trans people

Surveys measuring the British public's attitudes towards trans people reveal a broadly positive, but mixed picture, of attitudes towards trans people. In the British Social Attitudes (BSA) Survey[237] and the Equality and Human Rights (EHRC) Survey[238], 82%-83% of people said that they were "not prejudiced at all" towards transgender people. Just under half (49%) of respondents in the BSA Survey[237] however thought that prejudice against trans people was 'rarely' or 'never' wrong compared with 5% of in the EHRC Survey[238].

With regards to public feelings towards transgender people, the EHRC Survey[238] report noted regional differences in positive feelings towards trans people. Positive feeling towards transgender people was reported as being the lowest in the West Midlands, where 37% of people said that they felt respect for transgender people compared with around 49% of northern and southern regions in England. It is important to note here that bias can be unconscious and as data from these surveys is self-reported, it may not accurately reflect the true attitudes of the population.

7.6. Domestic Abuse

Statistics on the rate of domestic abuse (from a relative or intimate partner) in the trans population are not collected by the Crime Survey for England and Wales or by the police. Survey evidence indicates that trans people experience high rates of domestic abuse, including emotional, physical and sexual abuse. The reported rates of domestic abuse in UK based surveys vary significantly, between 20%-80%. According to the ONS[239], 6% of adults in England and Wales are estimated to have experienced domestic abuse in the 12 months preceding March 2021, 73% of whom were female.

In Birmingham, a third of trans respondents in a survey mapping LGBT lives in Birmingham (35%; n=15/43) had experienced domestic abuse[32]. This is amongst the lowest level reported locally and nationally in the UK, although the number of respondents was small. In another local study in Manchester, 40% of respondents reported controlling behaviour from a partner (n=42/105) and 36% reported transphobic behaviour (n=38)[127]. In Brighton, 63% (n=70/114) of respondents had experienced domestic abuse[112].

The Stonewall survey reported that a fifth (19%) of trans people faced domestic abuse from a partner in the preceding year[210]. This is compared with 11% of all LGBT respondents. Two other national surveys, which looked specifically at LGBT/trans peoples experiences of domestic abuse, reported a much higher rate of domestic abuse (80%), although these studies had relatively small samples of respondents[240 241].

In the GEO (Annex 5) survey, 48% of trans respondents had experienced an "incident" from someone they were living with[1]. This is compared with 26% of cisgender LGB respondents. The most common 'incidents' that trans respondents experienced were verbal harassment, insults or other hurtful comments (27%), being outed without consent (27%) and coercive or controlling behaviour (19%). The most common perpetrators of 'serious incidents' experienced by trans people (from someone they had lived with)

were parents/guardians (50%), siblings (16%), housemates (14%), other older family members (12%), an ex-partner (10%) and a current partner (7%).

There is also indication across surveys that trans men are more likely to experience domestic abuse from family members or intimate partners than trans women[1 210 240 241].

The varying rates reported by surveys may be due to differences in the phrasing of questions, including definitions of abuse and type of perpetrator or sampling bias. Therefore, it is difficult to rely on a single figure or to draw comparison between figures. It is useful to bear in mind here that people with ASD and mental health problems (which have a high prevalence among trans people) also experience higher rates of domestic violence[242].

7.6.1 Barriers to Accessing Services

Evidence shows that trans people do not typically report their experiences of domestic abuse. In the GEO survey, only 5% of trans people reported the most serious incident they experienced from someone that they were living with (not necessarily a partner or relative)[1]. The estimated rate of underreporting of domestic violence is also 'particularly acute' in the general population, with the ONS reporting that 79% of victims of partner abuse in the Crime Survey for England and Wales did not report the abuse to the police[243].

Small-scale qualitative studies which have looked specifically at the provision of domestic abuse services for trans people report multiple barriers to accessing services[244 245]. From a study with 15 trans people, Rogers reported that professionals had fixed views about gender as binary and that services were orientated towards heterosexual cisgender women (who represent the majority of service users)[244]. Trans people's own perceptions of the severity of the abuse they experience may also deter them from reporting it. In a survey by the Scottish Transgender Alliance, of the 80% of people who experienced domestic abuse, 60% identified this as 'abuse', 18% saw it as 'okay' and only 50% of respondents saw it as a crime.[240]

Studies with professionals who work in domestic abuse services also highlight barriers to trans people accessing services. These include some women's services not accepting trans women[245] and concerns about doing or saying the 'wrong thing'[2].

Generally, health and social care organisations, public bodies and population-based surveys do not collect data on people's gender identity. Nor is local data on the Birmingham context published. UK Census 2021 data will provide reliable and relatable insight into the trans population

INEQUALITIES WITHIN THE TRANS COMMUNITY

Within the trans community, limited evidence indicates that needs, outcomes and inequalities differ between

ASSIGNED SEX & BIRTH

BINARY AND NON-BINARY IDENTITIES

ETHNICITY, AGE, RELIGION, SEXUAL ORIENTATION

NO DATA CURRENTLY EXISTS ON TRANS LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY IN THE UK

EVIDENCE BASE

The identification and redressing of inequalities requires a robust evidence base on which to draw. In the UK, there is no evidence on some aspects of trans people's health and wider determinants of their health, and limited evidence with methodological drawbacks in other areas

8.0 Conclusion and Gaps

A comprehensive community health profile, that would allow for an understanding of the UK trans population and their health needs, requires a robust and valid evidence base on which to draw.

A particular challenge when studying the trans population is that they have not historically been included in population-based data collection. Therefore, there is no nationally available data or local data, that would allow a robust understanding of this population and therefore a reliable assessment of their public health needs. In many areas there is no specific literature at all. In other areas the available data is limited and prone to methodological drawbacks.

The UK picture echoes the international evidence on trans people's health and wider determinants of health and shows that trans people in the UK face multifactorial risks for poor health and well-being. Existing evidence indicates that trans people fare worse than non-trans people across a range of indicators. They experience inequalities, transphobic discrimination, abuse and poorer social determinants across a wide spectrum of their lives, including their personal relationships, housing, education, work, physical activities and sport, access to public spaces, access to healthcare and mental health.

The high rates of substance abuse, domestic abuse, mental health problems, disabilities, poor access to trans specific healthcare, physical and verbal transphobic threats and assaults, lack of social support and

discrimination which are prevalent in the trans population, are inherently intertwined and mutually reinforcing.

Getting the Best Start in Life

There has been an exponential rise of children and young people referred to the GIDS over the last decade. The majority of children and young people who present to the GIDS are white, assigned female at birth and aged between 12-18 years. However, there remains a lack of research in relation to trans children and young people with and without gender dysphoria, including data on the treatments and outcomes of young people attending gender identity services.

The limited evidence that exists is based on clinic-based samples of young children with gender dysphoria and indicates that this group experiences high rates of mental health problems, Autism Spectrum Disorder (ASD), bullying and being in local authority care compared with non-trans children and young people. Trans adolescents assigned male at birth have a significantly higher prevalence of ASD and mental health problems than trans adolescents assigned female at birth. Evidence on areas such as educational attainment, school exclusions, childhood poverty and obesity, is not available.

Health Status and Access to Healthcare

There is little published evidence on the health status and long-term health conditions of the UK trans population. Data is not available on the incidence or prevalence of conditions such as diabetes, cardiovascular disease, COPD, dementia, cancers or COVID-19 infections. Nor is there reliable published data on trans people's life expectancy, end of life/ palliative care, or mortality rates, or their use of generalist or specialist healthcare services. Limited evidence suggests that trans people report higher rates of disability than cisgender LGB people and present with a higher prevalence of ASD than non-trans people in the general population.

Evidence also indicates that trans people face multiple barriers to accessing healthcare services, including not having their trans specific needs recognised or taken into account.

Evidence indicates that trans people have a high prevalence of mental health problems. Trans people report significantly higher levels of depression, anxiety, self-harming behaviour, suicidal thoughts, and suicide attempts than non-trans LGB people and the general population. Young trans people aged 16-25 years are at particularly high risk of mental health problems. Independent predictors of trans people's mental health include age, self-esteem, social support and low body satisfaction. Long waiting lists to access gender identity services and experiences of transphobic bullying and discrimination also have a negative impact on trans people's mental health. Trans people assigned female at birth are at higher risk of mental health problems and self-harm than trans people assigned male at birth. Trans people were more likely to access mental health services than their cisgender LGB counterparts.

Medical Transitioning and Gender Dysphoria Clinics

The demand for NHS and private gender identity services has risen enormously over the last decade. A lack of published data from NHS GDCs impedes understanding about trans people who use these services. Data is not published on the clinical diagnosis, treatments, outcomes, risks or on the public cost of child/adolescent or adult gender identity services.

Over 22,000 trans adults are on the waiting list to access GDCs in England. Those on the list have an average four year wait from referral to initial appointment. Non-representative national LGBT surveys report that just over half of trans respondents have sought medical intervention to transition. The main treatment sought by trans people with gender dysphoria is gender-affirming hormones. Most trans people who use GDCs report having a positive experience, although some trans people also reported being unable to openly discuss concerns about their gender

identity with clinic staff or having their gender expression policed by clinic staff.

The main barriers to trans people accessing gender identity services included the long waiting list, GPs lack of knowledge about referral pathways and the location of services. To circumvent barriers to services, some trans people have accessed private gender identity services in the UK, gone abroad or self-prescribed gender-affirming hormones, all of which are associated with risks.

Protect and Detect

There is no evidence on screening for trans people in the UK in relation to a range of health conditions, such as diabetes, cancers, COVID-19 and other infectious diseases. Nor is there evidence on immunisation/ vaccination programmes. Despite being at higher risk of STIs and HIV, evidence suggests that trans people have a low uptake of cervical screening and sexual health screening compared with non-trans people. Trans people who do access services report positive experiences of this. The prevalence of HIV in the UK trans population is estimated to be similar to the general population.

Behaviours and Lifestyle Factors

Data on the behavioural and lifestyle factors of trans people in the UK has been not collected at a national level. There is no evidence on diet, nutrition, eating habits, food poverty or level of engagement with environmental issues for the trans population in the UK. Nor is robust data available on the rates of alcohol, illicit drug use, smoking in the UK trans population. Existing evidence suggests somewhat of a mixed picture. Survey evidence indicates that trans people have higher rates of substance misuse than non-trans people in the general population but not compared with non-trans respondents to surveys. Furthermore, the existing national

evidence on trans people's substance misuse was collected 10 years ago. Evidence also indicates that trans people's substance misuse is impacted by their mental health, experience of transphobia and lack of access to gender identity services.

Transgender participants engage in slightly less levels of physical activity than their cisgender counterparts. Clinic-based studies trans people waiting to go on gender-affirming hormones engaged in less physical activity than those already on gender-affirming hormones. Trans people's actual and anticipated experiences of transphobia in public spaces and their subsequent avoidances of public spaces is a fundamental barrier to trans people's participation in physical activity. The gendered nature of sporting behaviours and activities, such as clothing, teams and changing facilities, have also been posited as barriers to trans people's participation in sport and physical activities.

Wider Determinants of Health

The lack of nationally collected data on the wider determinants of trans people's health impedes a comprehensive Community Health Profile for the trans population in Birmingham. Population based evidence (such as national household surveys) do not collect information about the socio-economic status, educational attainment, economic activity and housing circumstances of trans people. Limited evidence suggests that trans people may have lower educational attainment rates, are more likely to be unemployed, and to earn less money in employment, and are more likely to experience homelessness than their LGB cisgender counterparts.

Trans people's experience of transphobia across different spheres of their lives shapes their everyday experiences. Rates of transphobic hate crime have risen enormously over the last decade, with survey evidence indicating a severe underreporting of such crimes. Trans people report experiencing transphobia and transphobic abuse in all aspects of their lives, including in their personal relationships, in school, at work and in their everyday lives.

The high level of transphobia experienced and anticipated by trans people has a negative impact on their mental health, is a contributing factor for substance misuse and inhibits trans people from participating in public spaces and institutions.

Closing the Gaps

Robust analysis of sub-groups under the trans umbrella and their specific experiences has not been published. Where available, evidence indicates a mixed picture in relation to trans men, trans women and non-binary people and suggests that trans people who occupy other marginalised groups face poorer outcomes. With regards to ASD, prevalence among trans adolescents assigned male at birth is higher (in line with the trend in the general population) whilst prevalence among trans adults assigned female at birth is higher.

A lack of data and analysis also prevents an intersectional analysis in areas such as ethnicity, age, sexuality, disabilities and socio-economic background. Thus, whilst it is known that those with minority identities are more likely to experience inequalities and poorer outcomes, how these identities intersect to form the experiences of trans people with multiple minority characteristics is not known. However, small numbers of trans people, particularly at local level, may impede the recruitment of the large samples needed for robust analysis.

A specific local or regional analysis, related to the context of trans people in Birmingham and the West Midlands, has not been possible due to a lack of evidence. Evidence from the GEO survey indicates that, on the whole, trans people in the West Midlands report similar experiences to the national sample of respondents[1]. The forthcoming analysis from the 2021 Census will be transformative in providing national and local data on the health, lifestyle, and wider health determinants of transgender individuals for the first time. This will also enable insight into the national demographic profile of trans people, sub-groups under the trans umbrella and the local profile of trans people in Birmingham.

It is clear that the transgender population's health needs are poorly served by a paucity of reliable data. Any public health planning for trans communities should recognise the need for reliable, robust and effective monitoring and research to identify, understand and meet the specific needs of trans people at a local, regional and national level.

9.0 Appendix

Appendix 1: Search Terms and Databases

Database	Search String
Greenfile, Sport Discus, Child Development and Adolescent Studies.	All fields- ((Trans*) OR (Transsex*) OR (Transvestite*) OR (“gender dysphoria”) OR (“gender variant*”) OR (“gender identity disorder”) OR (“gender minority*”) OR (“sexual minority*”) OR (“gender Fluid”) OR (genderfluid) OR (“non-binary”) OR (“nonbinary”) OR (“Genderqueer”) OR (“gender queer”) OR (“intersex”) OR (“inter-sex”)OR (“gender incongruence”) OR “LGBT*”) AND ((united kingdom”) OR (“UK”) OR (“U.K”) OR (“England”) OR (“Britain”) OR *”Scotland”) OR (“Ireland”) OR (“wales”) OR (“united kingdom”) OR (“UK”) OR (“U.K”) OR (“England”) OR (“Britain”) OR (“Scotland”) OR (“Ireland”) OR (“wales”) OR (“NHS”))
PubMed	((“transgender persons”[MeSH Terms] OR “gender dysphoria”[MeSH Terms] OR transsexualism[MeSH Terms] OR sex reassignment procedures[MeSH Terms] OR sex reassignment surgeries[MeSH Terms] OR “Transgender*”[Title/Abstract] OR “Transsex*”[Title/Abstract] OR “transex*”[Title/Abstract] OR “trans-sex*”[Title/Abstract] OR “Transvestite*”[Title/Abstract] OR “gender dysphoria”[Title/Abstract] OR “gender variant*”[Title/Abstract] OR “gender identity disorder”[Title/Abstract] OR “gender minority*”[Title/Abstract] OR “gender Fluid”[Title/Abstract] OR “genderfluid”[Title/Abstract] OR “non-binary”[Title/Abstract] OR “nonbinary”[Title/Abstract] OR “Genderqueer”[Title/Abstract] OR “gender queer”[Title/Abstract] OR “gender incongruence”[Title/Abstract] OR “trans* man”[Title/Abstract] OR “trans* woman*”[Title/Abstract] OR “trans people”[Title/Abstract] “gender identity”[Title/Abstract]) AND (UK[Affiliation] OR united kingdom[MeSH Terms] OR “united kingdom”[Text Word] OR “UK”[Text Word] OR “U.K”[Text Word] OR “England”[Text Word] OR “Britain”[Text Word] OR “Scotland”[Text Word] OR “Ireland”[Text Word] OR “wales”[Text Word] OR “NHS”[Text Word] OR “GIDS”[Text Word] OR “Birmingham”[Text Word] OR “west midlands”[Text Word] OR “united kingdom” OR “UK” OR “U.K” OR “England” OR “Britain” OR “Scotland” OR “Ireland” OR “wales” OR “NHS” OR “GIDS” OR “Birmingham” OR “west midlands” OR “united kingdom”[Title/Abstract] OR “UK”[Title/Abstract] OR “U.K”[Title/Abstract] OR “England”[Title/Abstract] OR “Britain”[Title/Abstract] OR “Scotland”[Title/Abstract] OR “Ireland”[Title/Abstract] OR “wales”[Title/Abstract] OR “NHS”[Title/Abstract] OR “GIDS”[Title/Abstract] OR “Birmingham”[Title/Abstract] OR “west midlands”[Title/Abstract] OR “united kingdom”[Text Word] OR “UK”[Text Word] OR “U.K”[Text Word] OR “England”[Text Word] OR “Britain”[Text Word] OR “Scotland”[Text Word] OR “Ireland”[Text Word] OR “wales”[Text Word] OR “NHS”[Text Word] OR “GIDS”[Text Word] OR “Birmingham”[Text Word] OR “west midlands”[Text Word]))
SCOPUS	((TITLE-ABS-KEY(“transgender*” OR “non-binary” OR “gender dysphoria” OR “gender identity disorder” OR “transex*” OR “trans-sex*” OR “trans* men” OR “trans* man” OR “trans* female” OR “trans* woman*” OR “gender minority*” OR “gender fluid” OR “gender queer” OR “gender incongruence”)) AND ((TITLE-ABS-KEY(“united kingdom” OR “England” OR “Britain” OR “Scotland” OR “Ireland” OR “wales” OR “NHS” OR “GIDS” OR “Birmingham” OR “west midlands”)) OR (AFFIL(“united kingdom” OR “UK” OR “U.K” OR “England” OR “Britain”)))) AND (LIMIT-TO (AFFILCOUNTRY, “United Kingdom”))
SocIndex, Academic Search Complete and CINAHL	(SU (“Transgender*” OR “Transsex*” OR “transex*” OR “trans-sex*” OR “Transvestite*” OR “gender dysphoria” OR “gender variant*” OR “gender identity disorder” OR “gender minority*” OR “gender Fluid” OR “genderfluid” OR “non-binary” OR “nonbinary” OR “Genderqueer” OR “gender queer” OR “gender incongruence” OR “trans* men” OR “trans* man” OR “trans* female” OR “trans* woman*” OR “gender identity”) OR AB (“Transgender*” OR “Transsex*” OR “transex*” OR “trans-sex*” OR “Transvestite*” OR “gender dysphoria” OR “gender variant*” OR “gender identity disorder” OR “gender minority*” OR “gender Fluid” OR “genderfluid” OR “non-binary” OR “nonbinary” OR “Genderqueer” OR “gender queer” OR “gender incongruence” OR “trans* men” OR “trans* man” OR “trans* female” OR “trans* woman*” OR “gender identity”) OR KW (“Transgender*” OR “Transsex*” OR “transex*” OR “trans-sex*” OR “Transvestite*” OR “gender dysphoria” OR “gender variant*” OR “gender identity disorder” OR “gender minority*” OR “gender Fluid” OR “genderfluid” OR “non-binary” OR “nonbinary” OR “Genderqueer” OR “gender queer” OR “gender incongruence” OR “trans* men” OR “trans* man” OR “trans* female” OR “trans* woman*” OR “gender identity”) OR TI (“Transgender*” OR “Transsex*” OR “transex*” OR “trans-sex*” OR “Transvestite*” OR “gender dysphoria” OR “gender variant*” OR “gender identity disorder” OR “gender minority*” OR “gender Fluid” OR “genderfluid” OR “non-binary” OR “nonbinary” OR “Genderqueer” OR “gender queer” OR “gender incongruence” OR “trans* men” OR “trans* man” OR “trans* female” OR “trans* woman*” OR “gender identity”)) AND (SU (“united kingdom” OR “UK” OR “U.K” OR “England” OR “Britain” OR “Scotland” OR “Ireland” OR “wales” OR “NHS” OR “GIDS” OR “Birmingham” OR “west midlands”) OR AB (“united kingdom” OR “UK” OR “U.K” OR “England” OR “Britain” OR “Scotland” OR “Ireland” OR “wales” OR “NHS” OR “GIDS” OR “Birmingham” OR “west midlands”) OR KW (“united kingdom” OR “UK” OR “U.K” OR “England” OR “Britain” OR “Scotland” OR “Ireland” OR “wales” OR “NHS” OR “GIDS” OR “Birmingham” OR “west midlands”))

Appendix 1: Search Terms and Databases *continued*

Database	Search String
Science Direct	Transgender OR Transsexual OR "gender dysphoria" OR "gender variant" OR "gender minority" OR "non-binary" OR "nonbinary" OR "gender identity" OR "gender identity disorder". PLUS filter for Affiliation to UK Institutions
Web of Science	TS=(("Transgender*" OR "Transsex*" OR "transex*" OR "trans-sex*" OR "Transvestite*" OR "gender dysphoria" OR "gender variant*" OR "gender identity disorder" OR "gender minority*" OR "gender Fluid" OR "genderfluid" OR "non-binary" OR "nonbinary" OR "Genderqueer" OR "gender queer" OR "gender incongruence" OR "trans* men" OR "trans* man" OR "trans* female" OR "trans* woman*" OR "gender identity")) AND ((TS=(("united kingdom" OR "UK" OR "U.K" OR "England" OR "Britain" OR "Scotland" OR "Ireland" OR "wales" OR "NHS")) OR ((AD=(("united kingdom" OR "UK" OR "U.K" OR "England" OR "Britain" OR "Scotland" OR "Ireland" OR "wales")) OR CU=(("united kingdom" OR "UK" OR "U.K" OR "England" OR "Britain" OR "Scotland" OR "Ireland" OR "wales" OR "NHS")))))) PLUS Filter- Limit to UK based institutions

Appendix 2: Glossary

Gender Identity	A person's internal sense of their own gender.
Gender Identity	A person's internal sense of their own gender.
Trans	An umbrella term for people whose gender identity does not align with their registered sex at birth, including (but not limited to) transgender, non-binary, or genderqueer.
Transgender Man	A term used to describe someone who is assigned female at birth but identifies and lives as a man. This man be shortened to trans man. You may also see FTM, an abbreviation of female-to-male.
Transgender Woman	A term used to describe someone who is assigned male at birth but identifies and lives as a woman. This man be shortened to trans woman. You may also see MTF, an abbreviation of male-to-female.
Non-binary	An umbrella term for people who do not identify exclusively as a man or a woman. Terms include genderfluid, genderqueer, agender, nongender.
Gender Dysphoria	The feeling of distress that is caused by a discrepancy between a person's gender identity and that person's registered sex at birth.
Transsexual	A term some consider outdated or offensive that was/is used to describe those trans people who have undergone surgical or hormonal intervention. "Transsexualism" was previously the diagnosis used for trans adults who experience gender dysphoria and "transsexual" is used in the context of the Equalities Act 2010 and related materials, to refer to someone with the protected characteristic of "gender reassignment".
Transitioning	To adopt the social, physical and/or legal characteristics of the gender one identifies with (rather than their registered sex at birth).
Cisgender ('Cis')	People whose gender identity matches their registered sex at birth – people who are not trans.

Appendix 3: Birmingham Trans Organisations Contact Details

Organisation Name	Target Audience	Contact Information
Trans Masculine Birmingham	Trans males and trans-masculine non-binary individuals.	Support and social group. https://www.facebook.com/transmasculinebirmingham/
Trans Central	Trans women	Community support group. https://www.facebook.com/groups/1951549675112110/
Birmingham Non-Binary	Non-binary individuals	Regular meet up. https://www.facebook.com/Birminghamnonbinarygroup/
Emerge	Young trans people aged 13-19	https://blgbt.org/directory/emerge/
Outskirts	Trans people in Birmingham (mainly trans women)	http://www.outskirtstg.co.uk/
Trans Spectrum	Safe space for all trans people in Birmingham	https://transpectrum.wordpress.com/
Birmingham LGBT	All LGBT+ identifying individuals	Charity with wide ranging local resources and services on offer. https://blgbt.org/

Appendix 4: Raw Data Table of Figure 1: Number of referrals to the GIDS 2010/11 – 2020/21, England and West Midlands

Region	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
West Midlands	10	14	25	29	46	101	142	N/A	N/A	N/A	N/A
England	134	201	299	445	661	1332	1858	2395	2552	2585	2242

Source: Figures for England from the GIDS and figures for West Midlands from the GIDS[41] [42]

Appendix 5: Raw Data Table of Figure 2: Age breakdown of referrals to the GIDS between 2009-2016

Age Group	Percentage of Referrals to the GIDS
Under 12	16%
12-18	84%

Source: Peer-reviewed analysis of referrals to the GIDS[44]

Appendix 6: Raw Data Table of Figure 4: Average life satisfaction in the UK

Demographic Group	Average life Satisfaction Out of 10
Gay/Lesbian	6.9
Bisexual	6.3
Pansexual	5.9
Asexual	5.9
Trans woman	5.5
Non-binary	5.5
Trans Man	5.1
UK Population	7.7

Source: National LGBT Survey[1]

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