Foreword

The Trans Community Health Pro le 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 Pro le is part of a wider series of evidence summaries produced by Birmingham City Council which focus on speci c communities of interest.

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

Contents

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 speci c 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 speci c community both nationally and locally.

To collate and present this information under the key priority areas identi ed 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 Pro le identi es 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 pro le 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 in uences such as educational attainment, economic activity and experiences of work, housing and transphobia.

An evidence-based Community Health Pro le requires robust data on

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 chilTDe is a n.ETEMC /P <</Lang (en-GB)/MCID 260 >>BD1 BT0.825 0 0.448 scn/GS0 gs11 0 0 11 39.685 4

80% of trans people found GDCs dif cult 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%).

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 Healthcar e
- Chapter 4. Medical T ransitioning
- Chapter 5. Pr otect and Detect
- Chapter 6. Behaviours and Lifestyle
- Chapter 7. Wider Deter minants

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).

Methodology

The Community Health Pro le for the trans community in Birmingham is based on a narrative review of the scienti c 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, Green le, 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 elds. 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 speci c 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 Of ce 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 Speci c Sources

A search of national and local LGBT and trans-speci c 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 identi ed from the reference list and citations of the initial search or published article) was used. Additional literature was identi ed 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 ndings 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 ve 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 ndings 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 speci cally related to trans people in the UK was selected for inclusion.

g. Results and Research Synthesis

The ndings of the analysis are presented as a research synthesis under each of the designated topic chapters. Where there are multiple research ndings 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-speci c surveys have methodological drawbacks, and these should be read alongside survey ndings. Among these is the inability to capture a nationally representative sample leading

to sample bias[1]. Thus, the ndings of a survey might be speci c to the self-selected sample of people in the study itself rather than be generalisable to the wider trans population. Survey wording and de nitional 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 ndings. 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 ndings 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-dif culties and clinical needs, with adults in the

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 de ed 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 rst 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 rst sex reassignment surgery was undertaken in 1944[5].

The term transsexualism rst appeared in 1980 in DSM- III (Diagnostic and St and acrp7(ThTm-u Mal ol Dis. In mor) con9 Tegar Eptual dger9 (ic)]TJETEMC /P <</Lang (en-GB)/MCID 565 >>BDC BT11 0 0 11 311485 128.8794-0.orpor ma

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 classi ed at birth [8]. Trans people with gender dysphoria may or may not wish to seek medical intervention (e.g., hor

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marginalisation, discrimination, violence and stigmatisation, having a high prevalence of substance misused and infectious diseases; and as being at signi cantly 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 signi cantly across countries worldwide[16 17 18 19]. Estimates of population prevalence depend on case de nition, i.e. how trans people are de ned[17 20].

Published reviews of studies which estimate the population prevalence of trans people highlight the heterogeneity of de nitions used to capture the trans population[17 20 21]. Studies typically focused on people who have received gender-af rming treatment or a diagnosis of gender dysphoria, people who are awaiting gender-af rming 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 signi cant 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 gure 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 gure 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-af rming treatment[20]. A review of studies by Goodman et al. shows signi cant 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 signi cantly 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-af rming 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 rst time. The results from this Census will enable insight into the number of trans people in the UK and their demographic pro le.

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 Certi cate[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 Of ce (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 signi cant 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 OO8523c underestimate.

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 signi cant under-estimate. GIRES estimated that the prevalence of people who had sought medical care for gender variance was 20/100,000 in 2007, which signi cantly 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 Speci cation for the Gender I foren-GBio60. di851 201.7313 Tm[(Accor)18 (d)t 7cattin.1DS)cor21 0 0 11 393.6117 288.9124 Tm( )TjE

Table 1: Demographic Pro le 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 identi ed 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 identi ed as transvestite or transsexual[31].

Sexuality

In the GEO survey, 36% of respondents identi ed as having an other sexuality and 32% of respondents identi ed as bisexual[1]. Other sexualities included identi cations such as queer , pansexual and heterosexual . In Birmingham LGBT s Survey of 54 trans individuals (not listed), the majority of trans respondents identi ed 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 gures broadly re ect 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 speci c 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 Certi cate (GRC), the possession of which enables them to get a birth certi cate in their acquired gender [35]. The GRC is the only means of changing one s registered sex on a birth certi cate. However, an individual can change their gender on most other of cial 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 certi ed evidence of a gender dysphoria diagnosis and prove that they have been living in their acquired gender for at least two years

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 identi es 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-

It is widely recognised that early experiences shape outcomes in all areas

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-de ning terms is not atypical amongst the trans community[29 30]. The researchers reported that 29% of young respondents identi ed as having a binary gender and that just over half of the respondents (56%) self-de ned 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

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 l3,ope 2ren

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 ndings 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 agged 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 signi cant 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 dif culties and mental health problems[8 68 70 71].

Studies indicate a high prevalence of mental health problems and associated dif culties 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.

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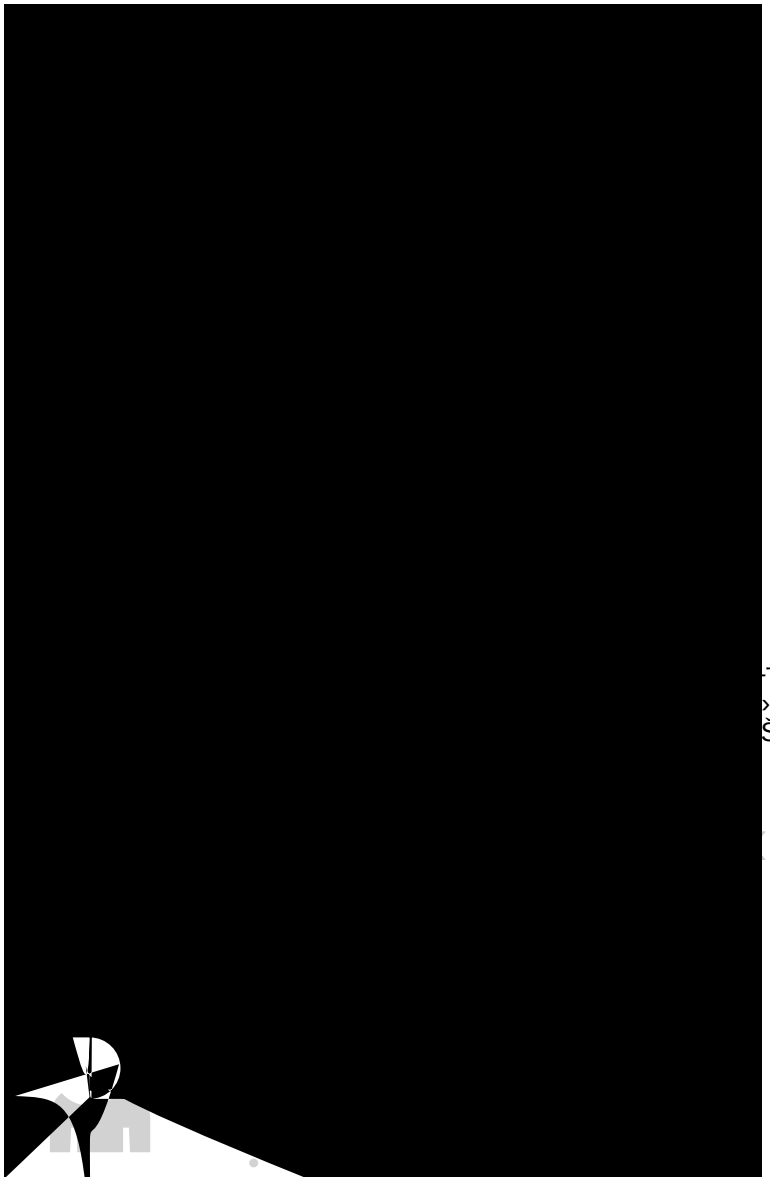
2.6 Children of Trans Parents

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 les of 18 children aged between 3-15 years (mean age of 9 years) in 13



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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 identi ed 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 signi cant 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 signi cant differences between trans respondents and matched control groups disappear.

Signi cant 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-identi cation, 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 selthe trans opulsatio

3.1.5 Gender Identity ‘Conversion Therapy’

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 fth 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

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 de nitions 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 signi cantly by age. Just under a fth (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] 06.0383197.8035 Tm(2)

On the whole, studies in this area report that trans adults assigned female at birth have signi cantly 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 signi cant 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 speci c 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 ndings 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 ndings. 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 speci c 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 ndings 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 gure 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 satis ed/very satis ed 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 speci c 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].

sexual orientation[2]. In the GEO[1] survey, around 8% of trans respondents felt

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 Speci cations for GDCs for both surgical

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 gures 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 rst appointments at different GDCs. The London GDC receives an average of 435 referrals a month and offered 979 rst 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]

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 gure 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 fth 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]

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 dif culty 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-af rming 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-af rming 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 nancial 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 signi cant 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

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5.1. Screening

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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 signi cant differences between trans and cisgender people s substance (mis)use

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/de nitely problematic. The Scottish Transgender Alliance survey reported that 67% of trans respondents have tried drugs at some point in their life[200]. These gures 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 Brie ng[206] on Substance misuse services for men

6.6 Physical Activity and Sport

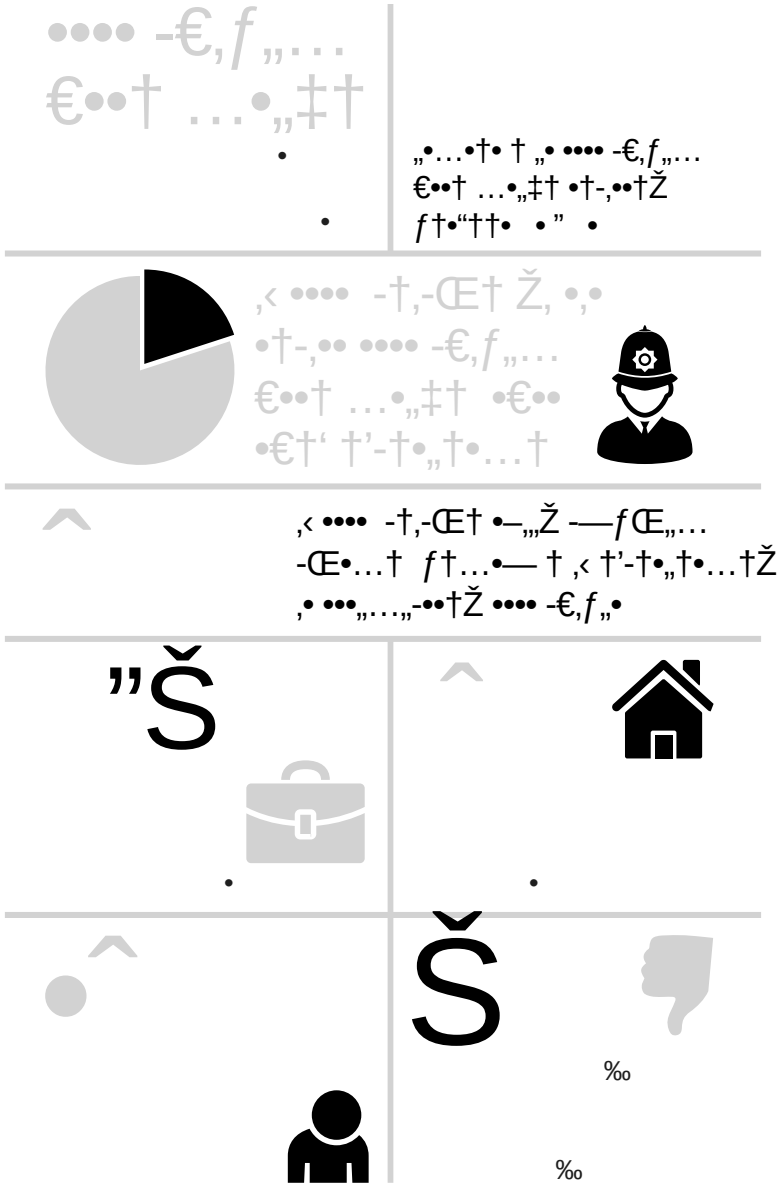
Evidence from surveys shows that transgender participants engage in similar/slightly less levels of physical activity than their cisgender counterparts. Evidence also indicates that trans people waiting to go on gender-af rming hormones typically report lower rates of physical activity than trans people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

Gendered sports teams[215] [218]

Previous experiences of discrimination at school[218]



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 monegl-5[(Widt596 4)-0.9 (hen t)-1 (he)enderalpopul

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 T-65 513.2589 81 (ivi8 E.)/MCID ruere3)-n71i397 R7t T- 513.255TmJET782513798 >>BDC39 >>BDC BT11 0 0 11 366.1

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 identi ed their gender identity as other (n=3,875). For that same year, the Of ce 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 quali cation.

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]

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 signi cant 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 gure 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 gure 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 work9.4489 173.9

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 gure 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 fth 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 re ect 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

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 Of ce, are one of the few of cially 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 con rm the extent to which this increase represents an increase in transphobia in the general population, an increase in con dence 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

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.

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 de nitions of abuse and type of perpetrator or sampling bias. Therefore, it is dif cult to rely on a single gure or to draw comparison between gures. 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 speci cally 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 xed views about gender as binary and that services were orientated towards heterosexual cisgender women (who represent the majority of service users)[244]. Trans peoples 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% identi ed 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 womens services not accepting trans women[245] and concerns about doing or saying the wrong thing [2].

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 signi cantly 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 speci c needs recognised or taken into account.

Evidence indicates that trans people have a high prevalence of mental health problems. Trans people report signi cantly 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-af rming hormones. Most trans people who use

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

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-af rming hormones engaged in less physical activity than those already on gender-af rming 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 Pro le 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

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 speci c needs of trans people at a local, regional and national level.

9.0 Appendix

Appendix 1: Search Terms and Databases

Appendix 3: Birmingham Trans Organisations Contact Details

10.0 Acknowledgements

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