

“I Carry So Much Anger, and That Is Not Good for My Health”: The Mental Health Impact of Current Gender-Affirming Healthcare Pathways on Transgender Adults in England

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This study aimed to explore the mental health impact of current gender-affirming healthcare (GAHC) pathways on transgender people in England. Trans participants (experts by experience) were recruited through purposive sampling and took part in qualitative semi-structured interviews between October 2021 and January 2022. The data generated were analysed and coded using a thematic framework analysis. Sixteen trans individuals participated. The majority were white, transfeminine, and reported a disability and/or neurodivergence. Four key themes reflecting the mental health impact of GAHC pathways were identified: (1) anticipated or experienced discrimination, (2) long waiting times for treatment, (3) socio-geographic disparities, and (4) the role of psychotherapy and peer support. The mixed and inequitable provision of GAHC contributes to trans minority stress and has

a substantial negative impact on the mental health of trans individuals, with participants describing healthcare avoidance, anxiety, depression, hopelessness, suicidality, anger, and chronic stress-related physical disability. Early access through primary care services to hormone replacement therapy (HRT), voice coaching, laser hair removal, and fertility preservation is likely to improve the mental health of trans individuals, alongside trans-affirmative or trans-led psychotherapy and peer support.

KEYWORDS transgender; gender-affirming healthcare; mental health; healthcare pathways; health inequity
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Transgender is an umbrella term to describe people whose gender is not the same as the gender socially attributed to the sex they were assigned at birth (Coleman et al. 2022). This study focuses on the experience of trans people in England, including men, women, and nonbinary people. The findings may also be relevant to other gender minorities who live in England but have region- or culture-specific gender variant identities, as well as individuals who are questioning or exploring their gender.

Many (but not all) trans individuals seek medical intervention to alter their physical characteristics as part of their care (Coleman et al. 2022). This gender-affirming healthcare (GAHC) should follow a person-centred approach whereby individuals can choose to access all, some, or none of the available gender-affirming interventions available. These interventions could include hormone replacement therapy (HRT) and/or gender-affirming surgery. Appropriate and timely GAHC has the potential to significantly reduce mental health difficulties in trans populations (Coleman et al. 2022; Ellis, Bailey, and McNeil 2015; McNeil et al. 2012).

In order to access GAHC in England, most trans individuals first approach a National Health Service (NHS) General Practitioner (GP) and, if triaged adequately, are referred to a specialist Gender Identity Clinic (GIC) (NHS England 2019). At the GIC they are assessed by a psychiatrist for a diagnosis of “gender dysphoria”, which if given, leads to them being accepted onto the NHS care pathway to access state-funded interventions such as HRT, gender-affirming surgeries, vocal coaching, fertility preservation, and psychotherapy (NHS England 2019). However, the waiting time to be seen by a GIC is long and increasing in length, with the most local GIC to Sussex, England (where this study has been conducted) having a waiting time of 4.5 years for individuals referred in 2018 (Gender Identity Clinic 2022). This means that many trans individuals resort to accessing GAHC through private providers or self-medication (Ellis, Bailey, and McNeil 2015; Mepham et al. 2014).

The General Medical Council (GMC), the body which sets the ethical standards for doctors in the UK, advises that NHS GPs can prescribe “bridging hormones” whilst trans patients await specialist care if they are self-medicating or their mental health is at risk whilst on the waiting list (GMC, n.d.). This guidance is supported by the Royal College of Psychiatrists (2018) and the World Professional Association for Transgender Health (WPATH) Standards of Care (Coleman et al. 2022). In recent years, a small

number of NHS pilot projects have emerged that are primary care-led and provide access to GAHC, including GP-provided HRT prescriptions and/or surgical referrals. These include The Indigo Project (Greater Manchester), CMAGIC (Cheshire and Merseyside), Trans Plus (London) and the East of England Gender Service.

The move away from psychiatric assessments to primary care-led assessments is in line with the desires of the trans community that trans identities are depathologized and that there is improved access to care (Ellis, Bailey, and McNeil 2015). However, the pilots still follow the “medical model” of GAHC rather than the alternative “informed consent” model that is increasingly requested by trans writers and research participants (Ashley 2019; Schulz 2018). The informed consent model emphasizes self-determination for trans individuals (that no psychiatric diagnosis is necessary for someone to be “trans enough” to receive care) and shared decision-making between the trans individual and provider, such that the trans individual can access GAHC as long as they understand the risks and benefits of any intervention, regardless of whether they have achieved specific “gender transition” milestones.

No specific data exists comparing trans mental health or GAHC experiences in the different UK nations, despite there being some differences in GAHC service provision (Royal College of General Practitioners 2019). Trans individuals in the United Kingdom as a whole are more at risk of mental health difficulties than their cisgender counterparts, particularly depression, anxiety, self-injury, and suicidal ideation (Bachmann and Gooch, 2018; Jones et al., 2019; McNeil et al. 2012). Reported rates differ with different data collection periods and sample populations. For example, one report found 46% of trans people in the UK had suicidal thoughts in the last year compared to 31% of cisgender LGB people (Bachmann and Gooch, 2018). Another found this rate to be even higher, at 63% (McNeil et al. 2012). Either of these figures is substantially higher than the rate amongst the general UK population, which has been estimated at 5.4% (Baker and Kirk-Wade 2023). This heightened prevalence of mental distress can be attributed to minority stress, which is defined as the impact of hostile social environments and institutional stigma, prejudice, and discrimination on marginalized individuals (Brooks 1981; Hendricks and Testa 2012; Meyer 2003). One UK-based study of 889 trans individuals found that 58% of participants felt their mental health worsened whilst waiting to access GAHC, with 20% wanting to harm themselves due to the long waiting times, being denied care, or receiving inadequate treatment (McNeil et al. 2012). Only 2% of participants had major regrets after accessing GAHC, with the vast majority feeling that access had improved their mental health (McNeil et al. 2012). This evidence, combined with trans experiences of primary care (Heng et al. 2018) and of accessing GICs (Ellis, Bailey, and McNeil 2015; Wright et al. 2021), suggests that barriers to accessing GAHC might contribute to minority stress and poor mental health in trans populations. This is the first study to look specifically at the impact of the current mixed provision of GAHC on the mental health of trans individuals, with a focus on the English population.

METHODS

This qualitative interview study was undertaken following discussions between Sussex-based clinical leaders and academics about the need for more academic research

around GAHC and primary care for trans patients in the area. A Sussex-based trans support organisation was approached for advice and support. A senior worker at the charity (LW) volunteered to design and lead the project as they additionally had a postgraduate research background. The research team included two cisgender senior academics who provided vital input such as support with securing ethical approval and funding and overseeing the research process. A medical student (DH) was also invited due to their previous postgraduate research on trans experiences of primary care (Holland et al. 2023). DH supported the community researcher LW with data collection and analysis. Both LW and DH were financially compensated for their input. LW led the write-up of this article and is the first author of the article. All members of the research team were white. The team included researchers of a range of ages and those who were queer and/or disabled and/or neurodivergent.

Setting

This research was undertaken in Sussex, England. This was the area the research team was based in, but it is also known to be a popular location for the trans community. In the city of Brighton and Hove, it is estimated that there are twice the percentage of trans individuals compared to the average UK city. Approximately 35% of the trans population used terms such as “genderqueer”, “nonbinary,” and “agender” to describe their relationship to gender (Hill and Condon 2015). The local Sussex NHS commissioning service has committed to improving healthcare access to trans populations by training local GPs in how to best support trans patients (Sussex CCG 2021). This population was therefore more likely to experience a mixture of proactive primary care-led GAHC at a local GP practice level. Further NHS GAHC provision is via referral to the closest GIC (London, Tavistock).

Participants

Participants had to be 18 years or older, trans, eligible to receive healthcare in Sussex, English-speaking, and able to give verbal or written informed consent. We aimed to recruit a purposive convenience sample of between 10 and 15 trans individuals, in order to reach sufficient information power for in-depth analysis (Malterud, Siersma, and Guassora 2016). An aspirational quota was set to recruit greater than or equal to two trans people who were: older than 50, people of color, trans feminine, trans masculine, nonbinary, and disabled and/or neurodivergent to ensure a variety of voices were represented in this research.

Procedure

Trans community researcher LW distributed the study flyer to Sussex-based community organisations supporting trans people for dissemination via their mailing lists and social media. This included the support charity where LW had a paid role, with a mailing list of 600 trans community members and over 1000 followers on social media. Other organisations contacted included grassroots community groups specifically supporting queer and trans people of color, disabled queer and trans people, and queer and trans people with mental health conditions or who are autistic/neurodivergent. The flyer was also shared using all the researchers’ personal and institutional/organizational social media accounts. Participants were directed to contact LW via email.

Members of the community researcher's immediate personal network (e.g., friends and colleagues) did not participate in this study, and neither did individuals currently receiving individual support from them in a professional capacity. All eligible participants were invited to interview and offered a choice of an online or in-person interview, and a choice of a trans researcher. The trans interviewer was LW, they/them pronouns, and the other interviewer was DH, a medical student, she/they pronouns. Both interviewers were previously trained in qualitative research methodology. All participants were sent a consent form and participant information sheet prior to interview. Further purposive sampling of those with multiple marginalized identities was restricted by the time constraints of the project.

Semi-structured interviews were designed and conducted in accordance with the steps outlined by DeJonckheere and Vaughn (2019). The interview was pilot tested prior to the study. Both interviewers took part in the pilot test, which was also audio recorded and could be re-listened to, to ensure the interviewers developed a shared understanding of the type of language and style of probing to be used. The interview guide included the following domains: experiences of accessing GAHC, the impact of GAHC on health and wellbeing; opinion on the current GAHC pathway; and the role of the GP practice in GAHC. The interview guide consisted of predetermined open-ended questions such as: "What examples of trans affirming healthcare have you experienced in Sussex?" and "What impact has accessing gender-affirming healthcare had on your overall health and wellbeing?" Possible additional follow-up questions and example prompts were included in the interview guide to support the interviewers to have similar approaches to navigating the topics.

Interviews took place between October 2021 and January 2022, either online (via encrypted Zoom), using the voice or video function, or face-to-face as per participants' preference. Each interviewer completed eight interviews. First, demographic questions were asked. Then, the consent form was read through with the participants. The audio recording device was switched on, and participants were asked to state for the recording that they had read, understood, and agreed to the consent form. A maximum time of 60 minutes was set for interviews to support accessibility for disabled participants and researchers.

Ethics

Ethical approval was gained by the Brighton and Sussex Medical School Research Governance and Ethics Committee on 27th October 2021. All participants received a £20 love2shop voucher in thanks for their participation in line with the study's ethical protocol.

Analysis

The audio recordings were transcribed verbatim, by DH, by hand using Microsoft Word. Participants were assigned pseudonyms that were gender-neutral or in keeping with the common gendering of their names. The data was analyzed using Ritchie and Spencer's (1994) thematic framework analysis in six stages: familiarization; identifying a framework; indexing; charting; and mapping and interpretation. Analysis was conducted manually and independently by DH and LW. Audio recordings were listened to, and transcripts were read, multiple times to achieve a holistic sense of the data.

Both DH and LW produced copies of the transcript annotated with ideas for preliminary codes including a priori and emergent categories. The wider research team then met to develop the working analytical framework. Following group discussion, a list of initial codes was agreed upon, including “experiences of psychotherapy” and “impact of waiting list”. DH then recoded the transcripts using the initial working framework. DH and LW then met again to discuss how the framework should be revised to incorporate and refine codes. This process was repeated until no new codes were generated. DH then took the lead in indexing and charting the data using Microsoft Excel. DH and LW then started the mapping and interpretation process by exploring patterns in the data and drawing out key themes. Interpretation of the results were discussed amongst the wider research team to establish a consensus and to validate the findings. There was sufficiently rich data to divide the findings into two sections: the impact of current GAHC pathways on the mental health of the trans community, and the role the trans community wanted primary care services to play in their health. This article summarizes the first half of these findings.

RESULTS

Twenty-one trans individuals contacted the research team in the time period. Two did not respond to an email regarding an interview, one did not attend their interview, one dropped out prior to interview, and one contacted the research team after we had ended recruitment. Sixteen participants were therefore included in the study. Interviews had a median duration of 50 minutes.

Table 1. Participant Characteristics

Participant Characteristics	<i>n</i>
Age (years)	
18–29	7
30–39	5
40–49	2
50+	2
Ethnicity	
White	15
Black / person of color	1
Gender	
Trans woman / transfeminine	10
Nonbinary / genderfluid	3
Trans man / transmasculine	2
“Still figuring it out”	1
Disability / neurodivergence	
Yes	9
No	6
Prefer not to say	1

The aspirational quota set was met for the following categories: being older than 50, being transfeminine, transmasculine, and nonbinary, and being disabled or neurodivergent (Table 1). A large proportion of participants were either white and/or transfeminine and/or between 18–39 years of age and/or disabled/neurodivergent. Further purposive sampling of communities of color would have been preferred, but the research team was restricted by the allocated time period. This is further discussed in the limitations section.

Four key themes reflecting the mental health impact of current GAHC pathways in Sussex were identified: (1) anticipated or experienced discrimination, (2) long waiting times for treatment, (3) socio-geographical disparities, and (4) the role of psychotherapy and peer support (Table 2).

Anticipated or experienced discrimination

Trans participants described anxiety around accessing GAHC due to fears that they would experience discrimination, that they may have to educate their healthcare provider, that they would have to wait a long time to access any support, and that they might have to find alternative means of accessing GAHC outside of the NHS.

I was kind of expecting to have an appointment with someone who didn't understand what it really meant, the route, would like hand me off to the generalist clinic and then be on a waitlist for five years and probably have to self-medicate. –Sophie

When they did access care, some participants had more positive experiences than they were anticipating. Others did experience discrimination, rejection or dismissal of their issues, or denial of access to appropriate support. Some participants had difficulty defining key positive or negative experiences but rather described their experiences as an absence of overt negativity.

I saw a specialist physio at [closest hospital] and again he was already aware when I turned up that I was trans... there was no hostility there, which I was very relieved about. –Emily

Experiences of negative healthcare interactions led to feelings of frustration and sadness and reinforced feelings that trans patients were seen as less important than cisgender patients and that their healthcare was too complex to be supported by primary care providers. For some trans participants, negative healthcare interactions led to a general avoidance of all healthcare interactions.

It makes me really anxious about going, because then it's – and become quite depressed about it because then it's like what's the point? Which is then kinda like a negative spiral because then you're stuck in this position of not being able to, you know, not feeling like you can get help because I'm so anxious about accessing it because I feel like if I try, it's not gonna turn out well anyway. So, it makes me feel a little bit hopeless about it. –Amber

Experiences of negative healthcare interactions were more common amongst trans participants who had multiple marginalized identities, which in turn led to a greater number of these participants reporting healthcare anxiety and avoidance. In particular, those with mental health issues, disabilities or neurodivergence described not accessing support for these issues out of fear that they would then be denied GAHC.

Table 2. Key Themes

Themes	Description	Example
Anticipated or experienced discrimination	Anticipated and experienced discrimination impacted on trans participants' mental health, including experiences of anxiety, depression, and healthcare avoidance, particularly for those with multiple marginalized identities.	"I was kind of um, scared to go to the GP about any mental health problems because I thought oh if I have any mental health problems, they're gonna um, take away my referral um, so I put that off for a very long time." – Jamie
Long waiting times for treatment	Long waiting times for GICs caused trans participants stress, hopelessness, anger, suicidality, and chronic stress-related physical health conditions. People who had managed to access GAHC through primary care providers instead reported better mental health.	"I thought I'd done my two years and I'd be at the top of the list for the gender clinic and then being told it's going to be at least another 2 or 3 years... the impact that has on you, you don't realize until that's not there anymore and talking to [a trans-affirmative GP] I just feel more like me. And I feel calmer and the anxiety levels... it's like if you know if you have a pain and you take a pill, and the pain goes away it's like that. Um, everybody that knows me has noticed how different I am." –Jo
Socio-geographic disparities	Trans participants reported that there is a socio-economic and geographical divide between who can access GAHC in the UK currently. Alternative GAHC models to the current GIC-orientated model led to improvements in participants mental health.	"I think a big part of that is uh down to the uh area of the UK that you're in there is definitely a big gap in a level of um, care and services available um depending on where you live which is quite significant um, and definitely needs uh adjusting I think." –Fern
Psychotherapy and peer support	Trans-affirmative or trans-led psychotherapy and peer support services led to participants experiencing euphoria, sometimes for the first time. However, there were concerns about confidentiality and experiencing discrimination, particularly from non-trans providers.	"I saw a private um trans therapist... he was amazing just like meeting with a therapist who is trans who can relate speak from experience just reassure and like any really specific or nuanced concerns like the mental loops you get stuck in when you're like trying to work these things through so yeah, that as very affirming and just really helpful in understanding my gender so like having that, trans therapy or trans mental health services like run by trans people it just, yeah, similarly just affirming and like, qualitatively different." –Melody

I haven't disclosed any of my disabilities or mental health issues... 'cause I'm aware that they are much less likely to uh, allow me to continue along the medical path I've gone down it's also prevented me from getting myself properly tested for autism even though I've been advised to... I know it might make it harder for me to continue to procure hormones if I do so. –Sam

Long waiting times for treatment

The long waiting times for GICs were perceived by trans participants to be an important risk factor for poor mental health, as GICs were seen as the only NHS (and therefore free) pathway to accessing GAHC. Participants who were on waiting lists reported that they and their peers experienced stress, hopelessness, anger, suicidality, and chronic stress-related physical health conditions. The lack of clear communication from GICs about the length of waiting times and uncertainty as to where people were on the referral list, also contributed to feelings of hopelessness.

And I swallow so much anger. I carry so much anger, and that is not good for my health, I've, I've plenty of other disabilities that have developed over the years, fibromyalgia, IBS, other things and how much of that I can never really be sure... I can't help but feel that a lot of that would've been relieved had I been... If I had prompt access in 2013 when I had asked for, how much better my health in other ways would be now.

–River

Some trans participants had taken matters into their own hands, either by self-medicating, accessing private healthcare, accessing new pilot GAHC clinics that use an informed consent model of care, asking their GP to provide bridging hormones, or moving GP practices to be closer to known trans affirmative health care professionals. Those who had been able to access GAHC more quickly reported significant improvements in their mental health.

I think if I ended up waiting [on the NHS waiting list] I would've uh, probably at least attempted suicide, 'cause that was definitely yeah, like yeah, absolutely enormous once I got my [privately funded] top surgery done it was like, a, being able to breathe again... everything is better after that. –Robin

Socio-geographic disparities

Participants reported that currently there is an unofficial “postcode lottery” determining which trans individuals are able to access a GP that will prescribe bridging hormones. Several participants choosing chose to move to a GP practice far away from their home address in order to access this care. This particularly involved individuals living in rural areas either changing GP practice to one within Brighton city center or even moving house to be closer to Brighton city center. Participants also reported that the current system led to a class disparity whereby trans individuals who were financially comfortable were able to start transition quickly and others were not. Several put themselves under considerable financial stress in order to access private GAHC.

I mean just a few months ago... I had to pick hormones over eating properly. I was just eating rubbish because I was like it's cheap, so I

could actually survive but then get my hormones which you shouldn't have to make that sort of decision when you need something. –Candice

Trans participants suggested that GPs should be able to prescribe bridging hormones and refer for vocal coaching, laser hair removal and fertility preservation, using an informed consent model of care, in order to shorten GIC waiting times and improve the mental health of the trans community. Those who had accessed a GP willing to do this reported life-changing improvements in their mental health.

Having a positive um, experience just you know, had this huge effect throughout the rest of my life where suddenly there, the sun was shining again you know?... I could acknowledge that life can be good. Um, and not just sort of being a well of depression. So, the GP has an incredible amount of power there. To just, you know, suddenly make everything seem a lot brighter. –Ellie

Whilst the current GIC-orientated model of care still exists, trans participants stressed the importance of adequate mental health support and trans-led community support, in order to help prevent suicide, depression, anxiety, and social isolation of trans individuals on the GIC waiting list.

Experiences of psychotherapy and peer support

Several trans participants had sought psychotherapy and counselling whilst exploring their gender identity and waiting for GAHC. It was important for participants to have an openly trans-affirmative practitioner. For some participants, an affirmative practitioner had allowed them to feel gender euphoria for the first time, and this was experienced as deeply beneficial to their mental health.

She said to me all right well then, next week when I call you, I'll greet you as [new name], it just, it felt so good, I, I can't rationally explain it, it's as if she had pressed a button and she sent me home on a cloud. –Alex

Accessing psychotherapy was seen as risky by some participants due to anticipating or experiencing discrimination as reported above with other healthcare providers. Participants were clear that psychological therapy should not act as an assessment for accessing GAHC and feared that if the information they disclosed in therapy was not kept confidential, they may be at risk of losing their access to GAHC.

It can't be um it cannot actually be um connected to uh whether a patient um, will be signed off for other treatments such as uh HRT or surgery because um, that would get in the way of any, in, that, that creates an instant power dynamic between the therapist and the, the, and then the person who, any patient who wishes to get these things. –River

Trans participants had also accessed peer and community networks for support. Community advocacy services were seen as very important, as were social groups, including online social groups and community forums.

I've loved the online groups the uh, yeah, I've really loved that. I've come off and I'm literally like beaming, I'm literally like euphoric about two days after. –Ashley

These peer and community support networks were identified as particularly beneficial if these services were trans-led or explicitly trans-affirmative.

DISCUSSION

This is the first study to look specifically at the mental health impact of the mixed provision of GAHC in England on the mental health of trans people. Previous studies have focused only on the experience of accessing primary healthcare (Heng et al. 2018), mental healthcare or GICs (Ellis, Bailey, and McNeil 2015; Wright et al. 2021). This study also obtained a sample from a population that was more likely to have accessed trans-affirmative GAHC, such as “bridging” HRT, from primary care providers due to the presence of a Transgender Locally Commissioned Service in Brighton and Hove, East and West Sussex (Sussex CCG, 2021).

The findings that trans individuals experience anxiety, depression, hopelessness, and suicidality when accessing the standard NHS GAHC pathway back up findings from a previous study done ten years ago (McNeil et al. 2012). In addition, this study found that some trans individuals relate their chronic illnesses, such as chronic pain, irritable bowel syndrome, and fibromyalgia, to their experience of struggling to access NHS GAHC. Participants attributed these mental and physical health issues to fears of discrimination, long and uncertain waiting times for treatment, and the need to rely on self-medication or private healthcare with the subsequent financial implications. These findings are coherent with Hendricks and colleagues’ model of minority stress in trans populations (Hendricks and Testa 2012). The long and uncertain waiting times for GICs could be seen as part of a “hostile and stressful social environment” that trans individuals experience in England. The target maximum waiting time for non-urgent specialist treatment on the NHS is 18 weeks (NHS 2019) – the waiting time for GICs can be over 200 weeks (Gender Identity Clinic 2022), constituting a systemic institutional neglect of the trans population, and an objective distal source of minority stress. Examples from previous research show that long waiting times can increase mental distress, with individual participants linking this experience directly to an increase in their suicidality and self-harm (Harrison, Jacobs, and Parke 2020; Wright et al. 2021). Anticipation of discrimination is a more proximal source of minority stress. This study backs up previous research in this area which shows that anticipated and enacted stigma lead to an increased risk of poor health and healthcare avoidance, which then leads to an increase in psychological distress, suicidality, and poor physical health in trans populations (Reisner et al. 2016; Seelman et al. 2017).

Participants in this study reported accessing HRT privately or self-medicating in order to improve their mental health and reduce their waiting time for GAHC. A UK study of 74 trans individuals accessing the GIC in 2016 found that 50% of participants had sourced hormones over the internet, 28% with no medical advice (Bouman et al. 2016). Recent studies indicate that HRT is safe and effective for trans individuals (Meyer et al. 2020) and early access to HRT improves quality of life, depression, and anxiety (Rowniak, Bolt, and Sharifi 2019). Having a mixed provision of GAHC in England means that trans individuals who are better off financially are more likely to have safe access to early HRT than those who are less well off, this is likely to increase health disparities within the trans population. This study also found geographical inequality between which trans individuals could access early HRT, supporting previous findings that trans individuals will travel long distances (at financial cost) or even move house to access healthcare providers that are known to be trans-affirming (Bohlmann et al. 2021; Gandy et al. 2021; Heng et al. 2018; Hibbert et al. 2018). Other inequalities with

trans communities which were highlighted by this study include that participants with multiple marginalized identities were more likely to avoid seeking healthcare for mental health difficulties, neurodivergence, and physical disability due to fears of the impact of this on their access to GAHC. This study did not show the additional impact of racial discrimination, likely due to there being a single participant of color in the sample. Previous studies have shown that practitioners are more likely to stereotype trans people of color, and trans people of color report poorer care than white trans individuals, including experiences of racism in healthcare settings (Agénor et al. 2022; Grant et al. 2011; Howard et al. 2019).

When trans participants had experiences that were affirming and were able to access GAHC in a timely manner, they described life-changing improvements in their mental health. Previous research has also shown that having a supportive GP is associated with lower rates of self-harm and suicidal ideation in trans communities (Kattari et al. 2019; Treharne et al. 2022). Early access to HRT, vocal coaching, laser hair removal and fertility preservation were seen as key, and participants favored an informed consent model of care provided by NHS primary care practitioners. Previous research has also argued that the risk of withholding treatment greatly outweighs the risk of providing care through this model (Wylie et al. 2016). The new WPATH Standards of Care Version 8 states that “considering barriers to health care access and the importance of gender-affirming hormone therapy to this population, primary care providers must be able and willing to provide gender-affirming hormone therapy for trans patients” (Coleman et al. 2022; Shires et al. 2017). Previous pilot studies of the informed consent model of care have high patient satisfaction (Ker et al. 2020; Spanos et al. 2021). Normalizing GP prescribing of HRT using an informed consent model of care would mean that trans individuals were able to self-identify as trans rather than having to prove distress and have a psychiatric diagnosis imposed on them. This would reduce the negative mental health impact of the current “medicalized” GAHC model, which has been described by previous studies as “dehumanizing” (Ashley 2019), and therefore likely improve the mental health of the UK trans population.

Participants in this study also described having benefitted from peer and community support and affirmative psychotherapy. Peer support has been previously described as a crucial part of trans care (Wylie et al. 2016) with the trans population relying on peer knowledge to help them navigate the cisgenderism of the GAHC system (Harner 2021; Willis et al. 2020). Peer support can improve mental health experiences, including attenuating suicide risk, and moderating the effects of discrimination and stigma on mental health outcomes (Johnson and Rogers, 2019; Kia et al. 2021). Trans community experts in England recommend that rather than the NHS providing individual trans peer supporters in community mental health teams, there is a need for wider workforce development (Borthwick et al. 2020). This includes mental health services paying for training and support from the trans specialist voluntary organisations to improve their accessibility. Trans specialist voluntary organisations also need to be able to access sustainable long-term funding in order to support the resilience and mental health support skills of their peer support workers (Borthwick et al. 2020). Participants described affirmative experiences with psychotherapists, however, there has not yet been an in-depth examination of what “trans-affirmative psychotherapy” means to trans individuals. Previous research has indicated that a key concern for

trans individuals when accessing mental healthcare is that practitioners will think their mental health difficulties are due to them being trans, without understanding the nuances of their experience (Ellis, Bailey, and McNeil 2015). Research with psychotherapists has highlighted that trans-affirmative therapy means therapy that is person-centered, that therapists should be able to repair the relationship should a microaggression occur, and that therapy should be rooted in theoretical foundations of social justice, intersectionality, feminism, and the nonbinary nature of gender (Banks 2021; Chang et al. 2018).

Strengths and limitations

A key strength of this study is that it was co-produced with the trans community. Rich data were generated from open-ended questions, which allowed the research team to gain insight into the experiences of the trans community of accessing GAHC from a wide variety of providers including NHS and non-NHS options. This study also provided trans participants with the opportunity to voice their opinions on what they would like GAHC to look like for them to be heard, through the dissemination and publication of the research findings. Collecting data from individuals who lived across Sussex, rather than urban centers only, allowed for the views of people in rural areas to also be collected and included.

This study's findings are generated from a small and self-selecting sample. This study only used qualitative methodology, and the findings may have been strengthened by an additional quantitative analysis of the mental health issues experienced by the sample for example by inclusion of a survey measuring symptoms of depression, anxiety, and other common mental illness. The majority of participants were white and trans feminine and as such, the diversity of experiences of people of color, trans masculine people and nonbinary people may not have been adequately captured. A longer time period for recruitment may have allowed further purposive sampling of under-represented groups. The fact that the community researcher was known by many participants to have a combined role as both researcher, trans community member and worker at a trans support charity, means that their involvement may have introduced participant bias and influenced some participants' responses. However, their involvement may also have increased participant trust in the process. In order to navigate this issue, close personal contacts and those receiving individual professional support from the community researcher were not included, and where possible the least known interviewer for each participant was chosen.

Implications for future research and practice

In the short term, whilst the mixed provision of GAHC continues, it is vital that trans people receive good mental health support and trans-led community support, in order to help prevent suicide, depression, anxiety and social isolation of trans individuals on the GIC waiting list. Funding should be provided to local support organisations run by and led by the trans community, to allow them to provide support such as online and in-person psychosocial groups and peer support. However, the demand for statutory mental health support is also high. NHS mental health services should be willing to receive training from trans support organisations and to provide trans-affirmative counselling to individuals whilst they wait, rather than expecting them to receive

counselling only after accessing the GIC. Best placed to triage the mental health needs of trans individuals are GPs and other primary care providers, but in order to do so they must be openly trans-affirming and clear that accessing mental health support will not damage an individual's attempts to access GAHC.

In the medium- to long-term, the mixed provision of NHS and non-NHS GAHC should be streamlined into a more inclusive pathway that is free at the point of use for all trans individuals. This needs to be done in such a way that individuals in rural areas, those on low incomes, and those with multiple marginalized identities can all access support equally. Primary care providers throughout England should be able to support access to hormones, vocal coaching, laser hair removal and fertility preservation. Specialists that can provide gender-affirming surgeries, specialist endocrinology and mental health input, should be available at local regional hubs. All providers, be they primary care or specialist, should use an informed consent model of care. In practice, this would include the system-wide removal of pathologizing labels such as the “gender dysphoria” diagnosis. Individuals should be able to access GAHC once they have come out to their healthcare provider as trans and understood the risks and benefits of interventions. There should not be a need for psychological evaluation, pressure to conform to cis-normative assumptions about gender identity and expression, or to have proven they are “trans enough” by having reached arbitrarily set social transition milestones. All new providers should be informed, led, and routinely evaluated by the trans community. This should not be limited to individual trans peer supporters being placed within the current healthcare systems but by paid collaboration with trans specialist community sector organisations. Trans peer workers need to be adequately supported to support community members who have complex needs and to be able to easily facilitate access to crisis intervention services.

Further research should focus on the specific needs of the trans populations who also have multiple marginalized identities, such as those who are neurodivergent, and/or disabled, and/or people of color. More in-depth trans perspectives on what “trans affirmative psychotherapy” looks like in practice in a UK context should be sought. Additional quantitative research on the prevalence of and contributing factors to mental illness in the trans community in England would be beneficial, as the largest and most cited survey by McNeil et al. (2012) was published over ten years ago. Such research would also benefit from examining protective factors which improve resilience, community connectedness, and pride in the trans community. There is also a lack of research comparing the experience of accessing GAHC in different UK nations and between different geographic locations in England.

CONCLUSION

This research has provided an important insight into trans individuals' experiences of accessing GAHC in England. The inequity and mixed provision of these services, particularly the long and unknown waiting times and subsequent reliance on self-medication and private healthcare, systemic geographical and class disparities in access to care, and experiences of and anticipated discrimination, contribute to trans minority stress and therefore have a substantial negative impact on the mental health of trans individuals. Mental distress described by participants included depression, anxiety,

suicidal thoughts, and chronic stress-related physical illness. The way that trans individuals access GAHC in England must change to prevent ongoing harm to this population. Participants were vocal in advocating for early access through primary care services to HRT, voice coaching, laser hair removal, and fertility preservation following the principles of self-identification and informed consent. Trans-affirmative psychotherapy and online and in-person trans-led peer support and community advocacy were also identified as important to support self-affirmation and reduce mental distress.

REFERENCES

- Agénor, Madina, Sophia R. Geffen, Dougie Zubizarreta, Raquel Jones, Shane Giraldo, Allison McGuirk, Mateo Caballero, and Allegra R. Gordon. “Experiences of and Resistance to Multiple Discrimination in Health Care Settings Among Trans-masculine People of Color”. *BMC Health Services Research* 22 (1). <https://doi.org/10.1186/s12913-022-07729-5>.
- Ashley, Florence. 2019. “Gatekeeping Hormone Replacement Therapy for Transgender Patients is Dehumanising.” *Journal of Medical Ethics* 45: 480–82. <https://doi.org/10.1136/medethics-2018-105293>.
- Bachmann, Chaka L., and Becca Gooch. 2018. *LGBT in Britain: Health Report*. London: Stonewall. https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf.
- Baker, Carl, and Esme Kirk-Wade. 2023. *Mental Health Statistics: Prevalence, Services and Funding in England*. London: House of Commons Library. <https://researchbriefings.files.parliament.uk/documents/SNO6988/SNO6988.pdf>.
- Banks, Jordyn. 2021. “Psychotherapists’ Approaches to Transgender Affirmative Psychotherapy”. MA diss. University of Western Ontario. <https://ir.lib.uwo.ca/cgi/viewcontent.cgi?article=10293&context=etd>.
- Bohlmann, Michele. L., Alex J. Dolan, Nat. C. Jones, and Brian. D. Knox. 2021. “Negative Healthcare Experiences, Healthcare-Seeking Behavior, and Mental Health in Tampa Bay Area Transgender and Gender-Nonconforming Individuals.” *Southern Medical Journal* 114 (6): 361–67. <https://doi.org/10.14423/SMJ.000000000001260>.
- Borthwick, Jess, Lara Jaffey, and Juliet Snell. 2020. *Exploration of Peer Support Models to Support LGBTQ+ People with Their Mental Health*. London: Centre for Mental Health. https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMentalHealth_PeerSupport_LGBTQ.pdf.
- Bouman, Walter. P., Laurence Claes, Ellen Marshall, Gill T. Pinner, Julia Longworth, Victoria Maddox, Gemma Witcomb, Susana Jimenez-Murcia, Fernando Fernandez-Aranda, and Jon Arcelus. 2016. “Sociodemographic Variables, Clinical Features, and the Role of Preassessment Cross-Sex Hormones in Older Trans People.” *Journal of Sexual Medicine* 13 (4): 711–9. <https://doi.org/10.1016/j.jsxm.2016.01.009>.
- Brooks, Virginia R. 1981. *Minority Stress and Lesbian Women*. Lexington, MA: Lexington Books.
- Chang, Sand C., Anneliese A. Singh, and lore m. dickey. 2018. *A Clinician’s Guide to*

- Gender-Affirming Care: Working with Transgender and Gender Nonconforming Clients*. Oakland, CA: Context Press.
- Coleman, Eli., Asa E. Radix, Walter P. Bouman, George R. Brown, Annelou L. C. de Vries, Madeline B. Deutsch, Randi Ettner et al. 2022. "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8." *International Journal of Transgender Health* 23 (sup1): S1–S259. <https://doi.org/10.1080/26895269.2022.2100644>.
- DeJonckheere, Melissa, and Lisa M. Vaughn. 2019. "Semistructured Interviewing in Primary Care Research: A Balance of Relationship and Rigour." *Family Medicine and Community Health* 7: e000057. <http://dx.doi.org/10.1136/fmch2018-000057>.
- Ellis, Sonja J., Louis Bailey, and Jay McNeil. 2015. "Trans People's Experiences of Mental Health and Gender Identity Services: A UK Study." *Journal of Gay and Lesbian Mental Health* 19 (1): 4–20. <https://doi.org/10.1080/19359705.2014.960990>
- Gandy, Megan. E., Kacie M. Kidd, James Weiss, Judith Leitch, and Xavier Hersom. 2021. "Trans* Forming Access and Care in Rural Areas: A Community-Engaged Approach." *International Journal of Environmental Research and Public Health* 18 (23): 127000. <https://doi.org/10.3390/ijerph182312700>.
- Gender Identity Clinic. 2022. "Waiting Times." *National Health Service*, May 2022. <https://gic.nhs.uk/appointments/waiting-times/>.
- General Medical Council. n.d. "Trans Healthcare." <https://www.gmc-uk.org/ethical-guidance/ethical-hub/trans-healthcare>.
- Grant, Jaime M, Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. 2011. *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force. https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf.
- Harner, Vern. 2021. "Trans Intracommunity Support & Knowledge Sharing in the United States & Canada: A Scoping Literature Review". *Health & Social Care in the Community* 29 (6): 1715–28. <https://doi.org/10.1111/hsc.13276>.
- Harrison, Nicola, Lisa Jacobs, and Adrian Parke. 2020. "Understanding the Lived Experiences of Transitioning Adults with Gender Dysphoria in the United Kingdom: An Interpretative Phenomenological Analysis." *Journal of LGBT Issues in Counselling* 14 (1): 38–55. <https://doi.org/10.1080/15538605.2020.1711292>.
- Hendricks, Michael L., and Rylan Testa. 2012. "A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model." *Professional Psychology: Research and Practice* 43 (5): 460–7. <https://doi.org/https://doi.org/10.1037/a0029597>.
- Heng, Audrey, Clare Heal, Jennifer Banks, and Robyn Preston. 2018. "Transgender Peoples' Experiences and Perspectives about General Healthcare: A Systematic Review." *International Journal of Transgenderism* 19 (4): 359–78. <https://doi.org/10.1080/15532739.2018.1502711>.
- Hibbert, Matthew, Aedan Wolton, Whitney Crenna-Jennings, Loren Benton, Peter Kirwan, Irina Lut, Sandra Okala et al. 2018. "Experiences of Stigma and Discrimination in Social and Healthcare Settings Among Trans People Living with HIV in the UK." *AIDS Care* 30 (7): 836–43. <https://doi.org/10.1080/09540121.201>

8.1436687.

- Hill, Alistair, and Ruth. Condon. 2015. *Brighton & Hove Trans Needs Assessment 2015*. Brighton and Hove: Brighton and Hove City Council. <https://www.bhconnect-ed.org.uk/sites/bhconnected/files/Brighton%20%26%20Hove%20Trans%20Needs%20Assessment%202015.pdf>.
- Holland, Daisy., Luka White, Marija Pantelic and Carrie Llewellyn. 2023. "The Experiences of Transgender and Nonbinary Adults in Primary Care: A Systematic Review." Unpublished manuscript.
- Howard, Susanna D., Kevin L. Lee, Aviva G. Nathan, Hannah C. Wenger, Marshall H. Chin, and Scott. C. Cook. 2019. "Healthcare Experiences of Transgender People of Color." *Journal of General Internal Medicine* 34 (10): 2068–74. <https://doi.org/10.1007/s11606-019-05179-0>.
- Johnson, Austin. H., and Rogers A. Baker. 2020. "We're the Normal Ones Here': Community Involvement, Peer Support, and Transgender Mental Health." *Sociological Inquiry* 90 (2): 271–92. <https://doi.org/10.1111/soin.12347>.
- Kattari, Shanna K, Matthew Bakko, Hillary K Hecht and Leonardo Kattari. 2019. "Correlations Between Healthcare Provider Interactions and Mental Health Among Transgender and Nonbinary Adults". *SSM Population Health* 10: 100525. <https://doi.org/10.1016/j.ssmph.2019.100525>.
- Ker, Alex, Gloria Fraser, Antonia Lyons, Cathy Stephenson, and Theresa Fleming. 2020. "Providing Gender-Affirming Hormone Therapy Through Primary Care: Service Users." *Journal of Primary Health Care* 12 (1): 72–8. <https://doi.org/10.1071/HCI9040>.
- Kia, Hannah, Kinnon R. MacKinnon, Alex Abramovich, and Sarah Bonato. 2021. "Peer Support as a Protective Factor Against Suicide in Trans Populations: A Scoping Review." *Social Science & Medicine* 279: 114026. <https://doi.org/10.1016/j.socscimed.2021.114026>.
- Jones, Bethany A., Walter Pierre Bouman, Emma Haycraft, and Jon Arcelus. 2019. "Mental Health and Quality of Life in Non-binary Transgender Adults: A Case-Control Study." *International Journal of Transgenderism* 20 (2–3): 251–62. <https://doi.org/10.1080/15532739.2019.1630346>.
- Malterud, Kirsti, Volkert Dirk Siersma, and Ann Dorrit Guassora. 2016. "Sample Size in Qualitative Interview Studies." *Qualitative Health Research* 26 (13): 1753–60. <https://doi.org/10.1177/1049732315617444>.
- McNeil, Jay, Louis Bailey, Sonja Ellis, James Morton, and Maeve Regan. 2012. *Trans Mental Health Study 2012*. Edinburgh: The Scottish Transgender Alliance. https://www.scottishtrans.org/wp-content/uploads/2013/03/trans_mh_study.pdf.
- Mepham, Nick, Walter P. Bouman, Jon Arcelus, Mark Hayter, and Kevan R. Wylie. 2014. "People with Gender Dysphoria Who Self-Prescribe Cross-Sex Hormones: Prevalence, Sources, and Side Effects Knowledge." *The Journal of Sexual Medicine* 11 (12): 2995–3001. <https://doi.org/https://doi.org/10.1111/jsm.12691>.
- Meyer, Gesine, Moritz Mayer, Antonia Mondorf, Anna K. Flugel, Eva Herrmann, and Joerg Bojunga. 2020. "Safety and Rapid Efficacy of Guideline-Based Gender-Affirming Hormone Therapy: An Analysis of 388 Individuals Diagnosed with Gender Dysphoria." *European Journal of Endocrinology* 182 (2): 149–56. <https://doi.org/10.1530/EJE-19-0463>.

- Meyer, Ilan H. 2003. "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence." *Psychological Bulletin* 129 (5): 674–97. <https://doi.org/10.1037/0033-2909.129.5.674>.
- NHS. 2019. "Guide to NHS Waiting Times in England." <https://www.nhs.uk/nhs-services/hospitals/guide-to-nhs-waiting-times-in-england/>.
- NHS England. 2019. *Service Specification: Gender Identity Services for Adults (Non-Surgical Interventions)*. Service Specification No. 1719. Leeds: NHS England. <https://www.england.nhs.uk/wp-content/uploads/2019/07/service-specification-gender-dysphoria-services-non-surgical-june-2019.pdf>.
- Royal College of General Practitioners. 2019. "Transgender Care." <https://www.rcgp.org.uk/representing-you/policy-areas/transgender-care>.
- Royal College of Psychiatrists. 2018. *Supporting Transgender and Gender-Diverse People*. PSo2/18. London: Royal College of Psychiatrists. https://www.rcpsych.ac.uk/pdf/PSo2_18.pdf.
- Reisner, Sari L., Jaclyn M. White Hughto, Kristi E. Gamarel, Alex S. Keuroghlian, Lauren Mizock, and John E. Pachankis. 2016. "Discriminatory Experiences Associated with Posttraumatic Stress Disorder Symptoms Among Transgender Adults." *Journal of Counselling Psychology* 63 (5): 509–19. <https://doi.org/10.1037/cou0000143>.
- Ritchie, Jane, and Liz Spencer. 1994. "Qualitative Data Analysis for Applied Policy Research". In *Analyzing Qualitative Data*, edited by Alan Bryman and Robert Burgess, 173–94. London: Routledge
- Rowniak, Stefan, Lindsay B. Bolt, and Claire Sharifi. 2019. "Effect of Cross-Sex Hormones on the Quality of Life, Depression and Anxiety of Transgender Individuals: A Quantitative Systematic Review." *JBI Database of Systematic Reviews and Implementation Reports* 17 (9): 1826–54. <https://doi.org/10.11124/JBISRIR-2017-003869>.
- Schulz, Sarah L. 2018. "The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria." *Journal of Humanistic Psychology* 58 (1): 72–92. <https://doi.org/10.1177/0022167817745217>.
- Seelman, Kristie L., Matthew J. P. Colon-Diaz, Rebecca H. LeCroix, Marik Xavier-Brier, and Leonardo Kattari. 2017. "Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults." *Transgender Health* 2 (1): 17–28. <https://doi.org/10.1089/trgh.2016.0024>.
- Shires, Deirdre A, Daphna Stroumsa, Kim D Jaffee, and Michael R Woodford. 2017. "Primary Care Providers' Willingness to Continue Gender-Affirming Hormone Therapy for Transgender Patients." *Family Practice* 35 (5): 576–81. <https://doi.org/10.1093/fampra/cmz119>.
- Spanos, Cassandra, Julian A. Grace, Shalem Y. Leemaqz, Adam Brownhill, Pauline Cundill, Peter Locke, Peggy Wong, Jeffrey D. Zajac, and Ada S. Cheung. 2021. "The Informed Consent Model of Care for Accessing Gender-Affirming Hormone Therapy Is Associated with High Patient Satisfaction." *Journal of Sexual Medicine* 18 (1): 201–08. <https://doi.org/10.1016/j.jsxm.2020.10.020>.
- Sussex CCG. 2021. *Service Specifications: Management of Transgender, Non-binary and Intersex Adult Patients in Primary Care*. Service Specification Schedule 2. <https://>

www.westsussexccg.nhs.uk/wp-content/uploads/sites/4/2021/09/2.6.1-Tackling-Health-Inequalities-in-the-Trans-Community.pdf.

- Treharne, Gareth, J., Rona Carroll, Kyle K. H. Tan, and Jaimie. F. Veale. 2022. "Supportive Interactions with Primary Care Doctors are Associated with Better Mental Health Among Transgender People: Results of a Nationwide Survey in Aotearoa/New Zealand." *Family Practice* 39 (5): 834–42. <https://doi.org/10.1093/fampra/cmaco05>.
- Willis, Paul, Christine Dobbs, Elizabeth Evans, Michele Raithby, and Jenny-Anne Bishop. 2020. "Reluctant Educators and Self-Advocates: Older Trans Adults' Experiences of Health-Care Services and Practitioners in Seeking Gender-Affirming Services." *Health Expectations* 23 (5): 1231–40. <https://doi.org/10.1111/hex.13104>.
- Wright, Talen, Emily J. Nicholls, Alison J. Rodger, Fiona M. Burns, Peter Weatherburn, Roger Pebody, Leanne McCabe, Aedan Wolton, Mitzy Gafos, and T. Charles Witzel. 2021. "Accessing and Utilising Gender-Affirming Healthcare in England and Wales: Trans and Non-Binary People's Accounts of Navigating Gender Identity Clinics." *BMC Health Services Research* 21 (1): 609. <https://doi.org/10.1186/s12913-021-06661-4>.
- Wylie, Kevan, Gail Knudson, Sharful I. Khan, Mireille Bonierbale, Suporn Watanyusakul, and Stefan Baral. 2016. "Serving Transgender People: Clinical Care Considerations and Service Delivery Models in Transgender Health." *Lancet* 388 (10042): 401–11. [https://doi.org/10.1016/S0140-6736\(16\)00682-6](https://doi.org/10.1016/S0140-6736(16)00682-6).

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