



Transition Access Survey 2022

by Dr Trent Grassian



Who are TransActual?

TransActual are a trans led and run advocacy, campaigning and empowerment organisation. We work with and for trans people in the UK to advocate, empower and inform.

We are working to improve:

1. Trans people's experiences of healthcare.
2. Legal recognition & protections for trans people.
3. The representation of trans people and our lives.

We do this by:

- Sharing reliable information about trans people's lives, our needs and our rights.
- Amplifying the voices of trans people so that the world may hear the experiences of a wide range of trans men, trans women and non-binary people.
- Educating people about trans people's lives and the issues we face through our resources, consultancy work, training offer and speaking appearances.
- Empowering trans people and our allies to bring about change for trans people in the UK.

Find out more: www.transactual.org.uk

Contents

Foreword	4
Executive Summary	5
Overview of recommendations	10
Chapter 1: Introduction	11
Chapter 2: A range of identities under the trans umbrella	19
Chapter 3: Accessing transition-related care	24
Chapter 4: “It now just feels right”: the impact of transition-related care	32
Chapter 5: “The NHS finally fixed my body, but broke my psyche”: waiting to access care	46
Chapter 6: Going private	58
Chapter 7: Discussion and recommendations	67
Appendices	71
References	74

Abbreviations

FFS	Facial feminisation surgery
GIC	Gender Identity Clinic
GIDS	Gender Identity Development Services
HRT	Hormone replacement therapy
NHS	National Health Service
WPATH	World Professional Association of Transgender Health

Content note

Please be aware that this report contains themes and anecdotes around transphobia, dysphoria, relationship breakdown, mental ill health, self-harm and suicide. If you're struggling, reach out for support. You'll find details of organisations that can support you at:

www.transactual.org.uk/transorgs

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Foreword

There's much more to trans people's lives than medical transition; however, access (or lack of access) to it can make an enormous difference to the lives of so many of us.

The prevalence of mental health conditions within the trans community is well-documented, but less is said about the impact of dysphoria and waiting times on our personal relationships, work lives and physical health. Our work with those on the waiting list for phalloplasty and metoidioplasty really brought those aspects of people's experiences to the forefront of our minds.

We know from our work with and for the trans community that the crisis around NHS transition related care is worsening. Gender Identity Clinic (GIC) waiting lists are growing, and increasing numbers of people are self-medicating testosterone and oestrogen as a result. The number of requests for us to share people's transition fundraisers has increased at a similar rate to the ever lengthening surgical waiting lists. Fundraisers for facial feminisation surgery (FFS) are common, as this is not available on the NHS.

Whilst GIC waiting times are well documented, information around surgical waiting lists is scarce. Much of the information we do have was gleaned via freedom of information requests or by making estimates based on community knowledge.

We launched the Transition Access Survey 2022 because we wanted to know:

- how long people wait for care and what impact that has on their lives;
- how much people spend on private care and why; and
- what types of care people have accessed and what they feel the impact was.

We'd like to thank everybody that took part in the survey. Thank you for trusting us enough to share your experiences. Some of the experiences documented in this report cannot have been easy to share, and it does not always make for an easy read. However, in this report you'll also find experiences of gender euphoria, joy and freedom. As one person told us, *"it now just feels right"*.

We look forward to a day where everyone can "just feel right" and we call on those with the power to bring about change to act upon this report.

Chay Brown
Director for Healthcare
TransActual



Executive Summary

Reviews of the state of transition-related care in the UK have repeatedly found extreme failings, ever-increasing waiting times, and breaches of the 2010 Equality Act.^{1,2} Recent estimates suggest that waiting times for those having their initial appointments at a Gender Identity Clinic in 2022 now exceed four years, with some clinics averaging even longer.³ The time from initial referral to receiving transition-related care is only continuing to increase and, for many, is likely to exceed a decade.

With little known about the experiences of trans people⁴ in the UK trying to access transition-related care and the impact of being made to wait many years for essential care, TransActual undertook a survey of 1,183 trans people from around the UK. This report provides a summary of our findings.

Respondents came from a wide range of age and ethnic groups, encompassing 33 different gender identities, including 19.7% (228) who identified outside of the traditional gender binary. They also reported a wide range of physical and cognitive disabilities and neurodivergencies. Nearly one in three were autistic (32.5%, 385) and a majority reported having a mental health condition (56.4%, 667).

The high prevalence of a range of disabilities, neurodivergencies, anxiety, and depression are important considerations, particularly given concerns that trans people may have difficulty accessing healthcare services beyond those relating to transition.⁵

In addition to sociodemographic diversity across our sample, responses indicated the wide variation in the types of transition-related services undergone already or desired for the future, including for those who identify across the non-binary spectrum.⁶ While being somewhat less likely than those on the

A note on language

For the sake of analysis, while recognising the wide breadth of gender identities included, we have grouped respondents into three categories: non-binary spectrum (those who identified as non-binary or another gender outside of the masculine or feminine spectrums), feminine spectrum (those who identified as trans feminine, a woman, a trans woman, or similar), and masculine spectrum (those who identified as trans masculine, a man, a trans man, or similar).

masculine or feminine spectrums to have accessed or want to access transition-related procedures, most respondents on the non-binary spectrum wanted to or had undergone surgery (76.7%, 276) or HRT (66.1%, 238).

Across all respondents, 88.4% (1,046) had either accessed HRT or intended to do so in the future. Most respondents (60.4%, 715) had accessed HRT, with 70.7% (331) of those who had not stating they planned to do so in the future.

90.4% of respondents had either undergone or hoped to undergo transition related surgery. While less than one-half of respondents had undertaken transition-related surgery (27.5%, 326), 86.8% of those who had not done so stated that there were surgeries they hoped to access.

Where respondents had undergone or intended to undergo medical procedures related to their transition, a wide range of impacts and potential impacts were cited. Notably, respondents told us how the impacts of transition-related medical procedures could and generally did permeate across all or nearly all elements of daily life.

One transfeminine respondent explained that, after taking hormones, *“for the first time ever I can look forward to the rest of my life”*. Many described procedures as having been lifesaving.

1. Cass, H. (2022). Independent review of gender identity services for children and young people: Interim report. Available at: <https://cass.independent-review.uk/publications/interim-report/>.

2. Women and Equalities Committee. (2016). Transgender Equality: First Report of Session 2015-16. Available at: <https://publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf>.

3. Gender Construction Kit. UK service wait times. Available at: <https://genderkit.org.uk/resources/wait-times/>.

4. The term ‘trans’ is used as an umbrella term throughout this report to include those “whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth”. This includes those who identify outside of the gender binary. For more information, see: <https://www.stonewall.org.uk/what-does-trans-mean>

5. Women and Equalities Committee. (2016); Cass, H. (2022).

6. To reflect the wide range of reported gender identities across respondents, self-reported gender identities have been grouped into three spectrums: masculine, feminine, and non-binary. See Methods section of Chapter 1 for more information.

“It saved my life. It stopped me from [attempting] suicide. If I hadn’t been able to access it I wouldn’t be alive right now”.

transfeminine respondent

“I had serious plans to end my life and was receiving crisis care from CAMHS at the time to prevent suicide. Taking testosterone as a teenager enabled me to engage with life again, to avoid my body changing further and to start to learn to love my body for what it is. 15 years on I am married, starting a family, have a job I love and an active social and community life. Without testosterone not only would I not have that, I think I’d probably be dead”.

transmasculine respondent

Feeling safer leaving the house and reducing instances of harassment or abuse were also common themes across respondents, particularly those on the feminine spectrum. This could include more positive experiences at work, though just 9.0% (71) of respondents agreed that their workplace had supported their medical transition.

However, to receive any transition-related care through the NHS, participants referred in recent years have had to overcome longer and longer waiting times.⁷ With time from referral to receiving hormones or surgery approaching or exceeding a decade, many described not only the agony and severe negative consequences of waiting, but feelings of despair that something they felt they needed so badly *“felt so out of reach”*.

Nearly two in three respondents (65.9%, 779) stated that concerns about waiting times had impacted their decision to begin medical transition, including 84.0% (139) of those referred in 2021 and 90.9% (40) in 2022.

Just 14.8% (77) of those referred to a GIC after 2017 had attended a first appointment. Across all respondents seeking transition-related surgery, average waiting times were over three years (983 days, n=116) after the first GIC appointment, while those for hormones were nearly a year (325 days, n=284). There were many stories of people who had yet to receive a referral for hormones or surgery they had first asked their GP or a GIC for five or ten years before.

Many spoke of how things they had struggled with because of gender dysphoria worsened dramatically while waiting. The most common impacts included decreased mental health and wellbeing, including increased feelings of suicidality, anxiety, and depression.

Nearly all respondents (86.9%, 814) stated that waiting to access hormones had negatively impacted their mental health, while 83.8% (897) said the same of waiting for surgery.

“There’s a particular kind of nervous energy, and anxiety, around waiting for such a hugely transformative and affirming operation, it can’t help but permeate every aspect of your life, it’s an act of will to not simply wobble off your axis”.

response from a woman

“I can’t make long-term plans because I honestly am not sure that I will survive the next however many years before I can access surgery, that is how unbearable it is to wait”.

agender respondent

Most also reported negative consequences for their physical health while waiting for hormones (78.0%, 543) and/or surgery (62.0%, 663). This included the exacerbation of existing medical conditions, as well as the behaviours people reported using to manage gender dysphoria and/or be read as the gender they identified with. Needing to bind one’s chest for a longer period could be particularly dangerous and harmful for respondents.

All these areas could have a negative impact on respondents’ ability and desire to socialise, with 62.3% (667) reporting negative consequences on their personal relationships due to waiting for surgery and 61.1% (572) saying the same for the wait for hormones. As waiting times continue to increase, we are concerned that the negative impacts of waiting many years for transition-related care may only become more common and more severe.

This can have dangerous consequences, including an increasing number of people choosing to self-medicate for HRT. Those who self-medicate often are not able to access a safe and reliable source of hormones and may not have access to blood testing.

The average waiting time for an initial private appointment was just 67 days (n=386), more than 9 times shorter than the average wait through the NHS (and more than 25 times less than current average waiting times), with many reporting that delays from accessing referrals through the NHS contributed to the bulk of their wait to access private care. Surgery waiting times through the NHS (983 days, n=116) were more than three times higher than for private

7. Gender Construction Kit. UK service wait times.

8. See, for instance, Women and Equalities Committee. (2016). Transgender Equality: First Report of Session 2015-16.

surgery (321 days, n=114). Respondents on the masculine spectrum reported the longest NHS waiting times, averaging nearly four years (1,448 days, n=39).

Waiting times were the primary reason that participants were more likely to have accessed hormones (54.0%, 386) or surgery (60.8%, 191) privately than to have done so through the NHS (56.7% / 185 for surgery and 46.0% / 329 for hormones). For those needing laser hair removal or electrolysis, just 20.5% (65) had done so through the NHS, with 90.5% (287) paying for private hair removal.

Even where hair removal procedures could be accessed through the NHS, 79.7% (50) felt that these had not been adequate, the (generally) six sessions provided were often just a small proportion of the number of appointments they actually required. Other procedures, particularly facial feminisation surgery (FFS), were also described as essential but not currently available through the NHS.

One woman told us she “*need[ed] to have FFS for safety reasons*”:

“As I’m visibly a trans woman I’ve been targeted for abuse far too frequently. My right arm & shoulder got injured in an attack by a group of men in 2020 & it’s now the first thing to get injured in other attacks. ... In 12 yrs I’ve had at least one physical attack each year, most year[s] it’s much more than one incident. I now have CPTSD [Complex post-traumatic stress disorder] & agoraphobia which in turn causes depression”.

Across the 504 respondents who indicated they had incurred costs related to their transition, the average estimated cost was £5,573, a figure that is likely to represent only part of what those having to pay out of pocket for transition-related care will end up paying. Those on the feminine spectrum reported even higher average costs of £6,285 (n=263).

“Last week I had to go to a food bank, because we couldn’t afford food to eat. I can’t stop Testosterone, because it’s been phenomenal not just for my mental health, but it’s had positive effects on my physical health too ... but that £90 a month is A LOT when we don’t have much”.

transmasculine respondent

As waiting times continue to grow, more and more of those who are financially able to are likely to turn to private care, further exacerbating the socio-economic inequity between those stuck in a system that has been failing trans people for many years⁸ and those who can pay to get the care they need.

Overview of recommendations

Recommendations for NHS England, NHS Scotland, NHS Wales, and Health and Social Care Northern Ireland:

1. Improve data collection, monitoring, and transparency of waiting times for transition-related care and use this as a basis to create an action plan to resolve long waiting lists.
2. Review the Gender Dysphoria Service Specification to ensure necessary procedures and treatments are publicly available in a timely manner, without unnecessary obstacles.
3. Work with Integrated Care Services to ensure mental health support is easily available to trans people at all stages of social and medical transition.
4. Establish and improve collaboration with the Royal College of GPs to ensure all GPs understand the needs and rights of trans people in the UK.
5. Work with the Royal College of Surgeons to proactively develop the workforce that can offer transition-related surgeries in the UK.

Recommendations for the Royal College of GPs and the Royal College of Surgeons:

6. Ensure that all GPs receive necessary training to be able to support trans people who are socially and/or medically transitioning.
7. Take urgent action to increase the number of surgeons able to offer transition-related surgeries in the UK.



Chapter 1: Introduction

For many trans people,⁹ the ability to access timely and necessary transition-related care can be not only essential, but lifesaving. Research has repeatedly demonstrated the vital importance of medical transition for many who identify within the trans spectrum of identities^{10, 11, 12, 13, 14} and, yet, over the past decade, it has repeatedly been found that *“the NHS is failing in its legal duty under the Equality Act”* to provide necessary and timely healthcare for trans people.

In December 2015, the House of Commons’ Women and Equalities Committee Select Inquiry on Transgender Equality, a cross-party political investigation into trans experiences, rights, and access to services and support in the UK, published its initial report. They wrote:

“The NHS is letting down trans people: it is failing in its legal duty under the Equality Act. Trans people encounter significant problems in using general NHS services, due to the attitude of some clinicians and other staff who lack knowledge and understanding—and in some cases are prejudiced. The NHS is failing to ensure zero tolerance of transphobic behaviour. GPs too often lack understanding and in some cases this leads to appropriate care not being provided. A root-and-branch review must be conducted, completed and published by the NHS”.¹⁶

The report outlined a range of issues in trans people’s abilities to access medical care in the UK, including discrimination in accessing general NHS services, being denied treatment, inappropriate referrals to mental health services (where they should have been referred for trans-related

medical care), and assumptions that health conditions stem from identifying as trans. They found that the absence in universal standards for training and awareness of trans identities and health needs meant that some general practitioners (GPs) were significantly lacking in “*knowledge and understanding*”, describing “*some cases of out-and-out prejudice*”.¹⁷

The report also examined access to trans-specific health services. In the UK, access to transition-related health services is primarily overseen by Gender Dysphoria Clinics (GDCs), which are also known as Gender Identity Clinics (GICs) or Gender Identity Services (GISs). At the time of the survey, there were seven GICs in England, including the Tavistock and Portman Clinic that also supports under 18s through the Gender Identity Development Service (GIDS).

The House of Commons’ Women and Equalities Committee highlighted severe issues with abilities to access clinics and receive necessary care, stating that the NHS’ treatment of trans people was in breach of the 2010 Equality Act. The GICs were described as having formed “*organically*”, with staff members learning by experience and not receiving training specified to the services they offered. Issues included: inequity in ability to access services due to unequal geographic distribution; patients reporting poor experiences and communication; lack of capacity; and extremely long waiting times for initial assessments and gender affirming surgery.

They also explained that GPs serving as ‘gatekeepers’ to access these services can make it even harder for people to receive GIC or GIDS referrals. Nonetheless, at the time referrals had been increasing by 50% or more each

9. The term ‘trans’ is used as an umbrella term in this report to include those “whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth”. This includes those who identify outside of the gender binary. See: <https://www.stonewall.org.uk/what-does-trans-mean>

10. Olson, K. et al. (2016). Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*, 137(3), e20153223.

11. Wiepjes, C. et al. (2018). The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets. *The Journal of Sexual Medicine* 15(4): 582-590.

12. Olson-Kennedy, J., Warus, J., and Okonta, V. (2018). Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults Comparisons of Nonsurgical and Postsurgical Cohort. *JAMA Pediatrics* 172(5): 431-436.

13. Hughto, J.M.W., et al. (2020). Social and Medical Gender Affirmation Experiences Are Inversely Associated with Mental Health Problems in a U.S. Non-Probability Sample of Transgender Adults. *Archives of Sexual Behaviour* 49(7): 2635-2647.

14. Turban, J. et al. (2020). Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation. *Pediatrics* 145(2): e20191725.

15. Women and Equalities Committee. (2016). Transgender Equality: First Report of Session 2015-16. Available at: <https://publications.parliament.uk/pa/cm201516/cmselect/cmwomeq/390/390.pdf>.

16. Women and Equalities Committee. (2016).

17. Ibid, 16.

18. NHS England (2015). Written evidence submitted by NHS England to the Transgender Equality Inquiry. Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/transgender-equality/written/20376.pdf>

year.¹⁸ As a result, waiting lists were continuing to increase, routinely breaching the NHS Constitution's legal obligation to provide an initial consultation within 18 weeks of a referral.¹⁹

The Women and Equalities Select Committee reported waiting times of 12 to 18 months for an initial appointment at the largest clinic (Charing Cross GIC) and waiting times of 2 to 3 years in other clinics.²⁰ In support of these findings, the charity Mermaids shared a survey from parents of 44 children and adolescents, finding that 27% reported wait times of over 18 weeks for a first appointment at GIDS.²¹ Surgery waiting times were also rising, with waiting times for vulvoplasties and vaginoplasties (surgeries designed to create a vulva and vagina) at 22 months and predicted to increase to 42 months by 2017.²²

The report concluded with a range of recommendations, highlighting their concerns around the multiple breaches to the NHS Constitution and the *“apparent lack of any concrete plans to address the lack of specialist clinicians in this field”*.²³ However, despite their having highlighted severe concerns with access to health services for trans people in the UK, including transition-related services, very few steps have yet been taken to address these.

In the seven intervening years since the publication of the Committee's report, there has been a near absence of research into the experiences and challenges of trans people accessing health services in the UK. In 2021, the London Assembly Health Committee's report on trans healthcare in London found that *“there is a dearth of NHS data on TGD [trans and gender-diverse] people, and that this has significant impacts both individually and at a population level. Without this data, it is difficult for the NHS to provide patient-centred care and offer the most appropriate treatments to TGD patients”*.²⁴

Existing data includes TransActual's Trans Lives Survey 2021, which found

19. The Women and Equalities Committee. (2016).

20. Reed, T. (2015). Written evidence submitted by GIRES to the Transgender Equality Inquiry. Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/transgender-equality/written/19292.pdf>

21. Mermaids (2015). Written evidence submitted by Mermaids to the Transgender Equality Inquiry. Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/transgender-equality/written/19540.pdf>

22. Women and Equalities Committee. (8 September 2015). Oral evidence: Transgender Equality Inquiry, HC 390. Available at: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidence-document/women-and-equalities-committee/transgender-equality/oral/21345.pdf>

23. Women and Equalities Committee. (2016), 45.

24. London Assembly Health Committee. (2021). Trans health matters: improving access to healthcare for trans and gender-diverse Londoners. Available at: https://www.london.gov.uk/sites/default/files/health_committee_-_report_-_trans_health_matters.pdf

that 29% of respondents had been refused care because they were trans and 45% reported that their GP did not have a good understanding of the needs of trans people.²⁵ In addition, 70% of respondents indicated that they had been impacted by transphobia when accessing GP services. Similarly, a 2018 survey from the charity Stonewall found that 32% of trans people reported unequal treatment by healthcare staff.²⁶

TransActual's report also found issues with accessing trans-specific medical care, with 54% (327) stating that the available services through the NHS were 'not at all adequate', while just 2% (7) stated that they were 'completely adequate'.²⁷ More than one-half of respondents (52%, 362) said that the lack of access to trans-specific healthcare had impacted them 'very much'.

Evidence also suggests that waiting times have continued to rise since the Women and Equalities Select Committee's inquiry. In 2022, those attending a first appointment in England have been waiting an average of four years from referral.²⁸ After the initial waiting and attending initial appointments, wait times to receive hormone replacement therapy (HRT) can average up to 41 months at the Northern Region GIC in Newcastle-upon-Tyne.

In August 2022, the Laurels, a GIC in the South West of England, reported that they were seeing people who had been referred more than six years before.²⁹ At the same time, the Northern Region GIC reported seeing patients for initial appointments who had been referred 54 months previously, with people waiting 44 months for a second assessment (66 months from their initial referral).³⁰ With the number of referrals continuing to go up and the new pilot services only able to slightly ease the pressure on the longer established clinics, those being referred in 2022 are likely to wait even longer.

As was originally highlighted in the Women and Equalities Committee's 2016 report,³¹ issues have also been exacerbated by the lack of specialist providers offering trans-specific services. For instance, the NHS contract for the team providing phalloplasty and metoidioplasty procedures (surgeries designed to create a penis) ended in March 2020, with a new provider only being confirmed in September 2021.³²

25. TransActual. (2021). Trans lives survey 2021: Enduring the UK's hostile environment. Available at: <https://www.transactual.org.uk/trans-lives-21>

26. Stonewall. (2018). LGBT in Britain: Health Report. Available at: https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf

27. TransActual. (2021).

28. Gender Construction Kit. UK service wait times.

29. NHS. Waiting Times. Available at: <https://www.dpt.nhs.uk/our-services/gender-identity/waiting-times>.

30. NHS Cumbria, Northumberland, Tyne and Wear. Frequently asked questions. Available at: <https://www.cntw.nhs.uk/services/northern-region-gender-dysphoria-service-specialist-service-walkergate-park/additional-information/faq>

31. The Women and Equalities Committee. (2016).

After a hiatus of 21 months, surgeries were resumed in December 2021. A response to a Freedom of Information Request at that time found that 1,944 individuals were waiting to receive these procedures, with just 30 procedures having been conducted in the 71 days since they had re-commenced. NHS England announced plans to commission two new surgical teams for phalloplasty and metoidioplasty, but at the time of writing, these teams have yet to begin work. Even when the three teams can begin surgery, there is a high likelihood that some people will have to wait over 4 years for surgery.

Assessing the range of reported waiting times, it is evident that, if significant steps are not taken to address capacity issues, many will have to wait over a decade from the point of referral until they can begin to access transition-related services. This is particularly concerning, given the range of research demonstrating the significant and lifesaving impacts transition-related care can provide.

Previous research has found that the ability to access medical transition can eliminate marked differences in trans teenagers' mental health in comparison to same-age peers, while reducing suicidality.^{33, 34} Evidence also suggests similar improvements for adults, with access to transition-related services reducing suicidal ideation and improving both mental health and quality of life, while potentially returning trans people's mental health difficulties to levels consistent with averages across the general population.^{35, 36}

Delays to accessing transition-related care can have other consequences. For instance, impediments to accessing a bilateral mastectomy (a procedure to remove chest tissue and conduct a chest reconstruction) can necessitate prolonged chest binding. This can lead to back and chest pain, overheating, shortness of breath, dermatological issues, scarring, and rib fractures, particularly amongst individuals with larger chests.^{37, 38}

Not being able to receive HRT in a timely manner can also lead more people to self-medicate and self-administer hormones. The absence of the necessary

32. TransActual. What's happening with NHS phalloplasty and metoidioplasty? Available at: <https://www.transactual.org.uk/nhs-phallo-meta>

33. Olson, K. et al. (2016).

34. Turban J et al. (2020).

35. See, for instance, Dhejne, C. et al. (2016). Mental health and gender dysphoria: A review of the literature. *International Review of Psychiatry* 28(1), 44-57.

36. Also, White Hughto, J.M. and Reisner, S.L. (2016). A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals. *Transgender Health*, 1(1), 21-31.

37. Peitzmeier, S., et al. (2017). 'Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study'. *Culture, Health & Sexuality* 19(1), 64-75.

38. Jarrett, B.A. et al. (2018). 'Chest Binding and Care Seeking Among Transmasculine Adults: A Cross-Sectional Study'. *Transgender Health* 3(1), 170-178.

monitoring can present significant medical risks. Additional risks can emerge when hormones are not administered safely or with a secure understanding of dosage and potential side-effects.³⁹

There are some steps that are currently being undertaken by NHS England that could lead to improvements, although it is not yet clear what impact they may have. Four national pilots have been set up in England to trial new approaches to offering transition-related care, each in partnership with a different type of medical service or organisation:

- **Cheshire and Merseyside Adult Gender Identity Collaborative** (CMAGIC), founded in partnership with providers, commissioners, commissions, and service users;⁴⁰
- **Indigo Gender Service** in Greater Manchester, founded in partnership with gtd healthcare (a non-profit primary and urgent care service) and LGBT foundation (a national charity offering services and advice);⁴¹
- **The Nottingham Centre for Transgender Health**, led by nurses and general practitioners (GPs) who will be receiving specific training in trans healthcare;⁴² and
- **TransPlus** in London, founded in partnership with 56 Dean Street (a sexual health and HIV clinic).⁴³

These are in addition to the seven adult GICs in England, four adult and one under 18 GIC in Scotland, one adult and one under 18 GIC in Northern Ireland, and the Welsh Gender Service (which operates on a different model to the English, Scottish and Northern Irish gender clinics), .

The Scottish Government are currently reviewing the provision of transition related care for people in Scotland, having established the National Gender Identity Healthcare Reference Group early in 2022.

37. Peitzmeier, S., et al. (2017). 'Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study'. *Culture, Health & Sexuality* 19(1), 64-75.

38. Jarrett, B.A. et al. (2018). 'Chest Binding and Care Seeking Among Transmasculine Adults: A Cross-Sectional Study'. *Transgender Health* 3(1), 170-178.

39. Metastasio, A. et al. (2018). 'Transitioning Bodies. The Case of Self-Prescribing Sexual Hormones in Gender Affirmation in Individuals Attending Psychiatric Services'. *Brain Sciences* 8(5): 88.

40. Cheshire and Merseyside Adult Gender Identity Collaborative. Who we are. Available at: <https://www.merseycare.nhs.uk/our-services/liverpool/sexual-health/cmagic-cheshire-and-merseyside-adult-gender-identity-collaborative>

41. Indigo Gender Service. What is Indigo? Available at: <https://indigogenderservice.uk>

42. Nottinghamshire Healthcare. East of England Gender Service. Available at: <https://www.nottinghamshirehealthcare.nhs.uk/east-of-england-gender-service>

43. TransPlus. Welcome. Available at: <https://www.wearetransplus.co.uk>

44. Anderson, J and Rhoden, P. A. (28 July 2022). "NHS to close Tavistock child gender identity clinic". BBC News. Available at: <https://www.bbc.co.uk/news/uk-62335665>

45. Cass, H. (2022). Independent review of gender identity services for children and young people: Interim report. Available at: <https://cass.independent-review.uk/publications/interim-report>

In July 2022, the NHS stated that they would be shutting down GIDS, England and Wales' only service for trans people under 18 years of age, and replacing it with a number of regional centres, beginning with two pilot clinics.⁴⁴ This decision came after the publication of the 2022 interim report from the Cass Review – an NHS England-commissioned independent review of gender identity services for children and young people that was published in 2022.⁴⁵ The review found that increasing referrals had led to longer and longer waiting times and, ultimately, that a single service could not meet the needs of all young people across the country. They also found inconsistencies in abilities to access referrals, with many GPs not being aware of GIDS. As a result, the Clinic is planned to be replaced with regional services. It is crucial that these new services follow international best practice to ensure that provision improves, not worsens.

While the steps taken by NHS England and the Scottish Government have the potential to lead to some reductions in waiting times and improved care for those who identify as or are unsure if they identify as trans, it is evident that, at present, there are significant gaps and failings in the provision of transition-related services for trans people in the UK. With waiting times to access transition-related services approaching or exceeding ten years, it is also clear that significantly more is likely to need to be done to address the severely inadequate services currently available.⁴⁶

In addition, there is a clear gap in the literature into understanding the experiences of those seeking transition-related care in the UK. To improve services, it is essential that we have a better understanding of the experiences of NHS service users accessing transition-related care. This includes the types of services desired, the barriers in accessing these, and, particularly given the excessive waiting times, the impact that being made to wait for years can have on trans people.

In 2022 TransActual undertook a key piece of research to better understand the needs and experiences of trans people accessing transition-related services in the UK, including the key barriers they have faced. This report provides a summary of our findings.

Methods

An online survey was hosted for UK-based trans people who are 18 years or over, seeking to understand the types of transition-related medical procedures or treatments they had accessed and/or wanted to access and the impact that

46. This includes projected waiting times for phalloplasty and metoidioplasty surgeries, as well as the total waiting times for referral to accessing hormones and then surgery (see Gender Construction Kit).

47. TransActual. (2021).

having these procedures or treatments had on their lives. Questions also related to whether procedures had been accessed privately, through the NHS, or a combination (e.g., a bridging prescription for hormones) and any associated costs and waiting times. Some sociodemographic data was also gathered, consistent with Trans Actual's 2021 survey,⁴⁷ for the purposes of identifying trends in transition-related access. Respondents were asked about their age, religion, gender identity, sexual orientation, ethnicity, any disabilities or mental health challenges, and whether they identify as intersex.

The survey was hosted through the online platform Typeform and was open from 2 March through 22 May 2021. The survey was shared through Trans Actual's newsletter and social media channels. It was also sent to trans and LGBTQ+ organisations, local trans community groups, and shared in trans specific Facebook groups. As initial monitoring of collection data revealed a lack of representation of those over 35, Black people, and people of South Asian heritage, efforts were made to specifically target these individuals through the content and images used in posts, as well as seeking support from groups that serve these communities specifically.

Ethics and limitations

Due to the convenience sampling strategy, the sample discussed herein is unlikely to be fully representative of the range of experiences and identities of trans people in the UK. In particular, the use of an online survey is likely to have contributed to the disproportionate representation of those 35 and under.

The wide range of gender identities and sexualities (see Appendices) also encompassed within this group are also difficult to accurately portray. For the sake of analysis, we have grouped respondents into three gender categories, in recognition of the spectrum of identities exhibited across those who identify as trans.

As such, those who self-identified as trans feminine, a woman, a trans woman, or similar were grouped under the feminine spectrum. Similarly, those who identified as trans masculine, a man, a trans man, or similar were grouped under the masculine spectrum. Finally, those who identified as non-binary or another gender outside of the masculine or feminine spectrums (e.g., agender, genderqueer, genderfluid, or bi-gender) were grouped under the non-binary spectrum.

We have also subdivided respondents into four sexuality groups: straight / heterosexual / heteroromantic; gay / lesbian, queer / other sexual orientations (including bisexual, pansexual, etc.); and those who were as yet unsure of their sexual or romantic identity.

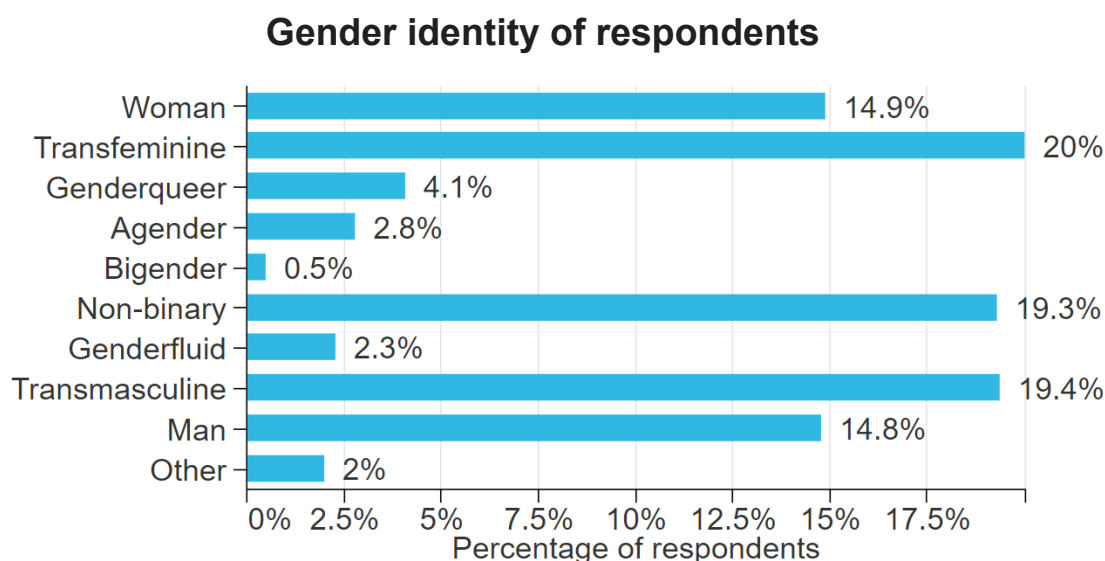


Chapter 2: A range of identities under the trans umbrella

Across survey respondents, we can see the large diversity of identities and experiences that exist across those who identify as trans. Respondents came from every age and ethnic group. While most identified as atheist or agnostic, those from eleven other religious affiliations were also included.

Gender identity

Respondents self-identified with a large range of different genders, encompassing 33 different gender identities, with the most common being transfeminine (20.5%, 237), transmasculine (19.8%, 229), and non-binary (19.7%, 228). A further 14.9% (176) identified as a woman and 14.8% (175) as a man.



Nearly one-third of respondents identified as a gender outside of the masculine and feminine spectrums, with 30.4% identifying on the non-binary spectrum (360). Slightly more respondents identified on the feminine spectrum (35.3%, 418) than those on the masculine spectrum (34.2%, 405).

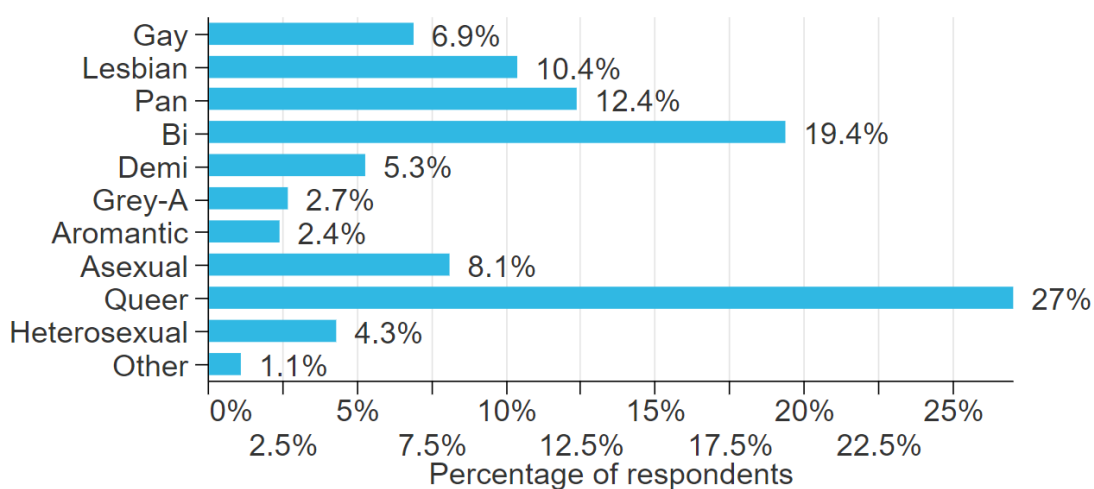
Participants were similarly likely to indicate that they were intersex (1.6%, 19) as the general population,⁴⁸ with 20.4% (241) stating that they did not know if they were intersex and 78.0% (923) stating that they were not.

Sexual or romantic orientation

Our research also supports previous findings that a majority of trans and/or non-binary people do not identify as straight,⁴⁹ with less than one in ten identifying as heterosexual. The most common sexualities were queer (44.7%, 522), bisexual (32.2%, 376), and pansexual (20.6%, 241), with participants being able to select more than one sexual or romantic orientation.

After grouping sexual and romantic orientations, those who identified as straight / heterosexual / heteroromantic comprised 5.7% (66) of the sample, those who identified as gay or lesbian 12.7% (148), those who identified as queer or another orientation 81.4% (951), and those who were unsure of their orientation 0.3% (4). A total of 22 sexual or romantic orientation identities were indicated by respondents.

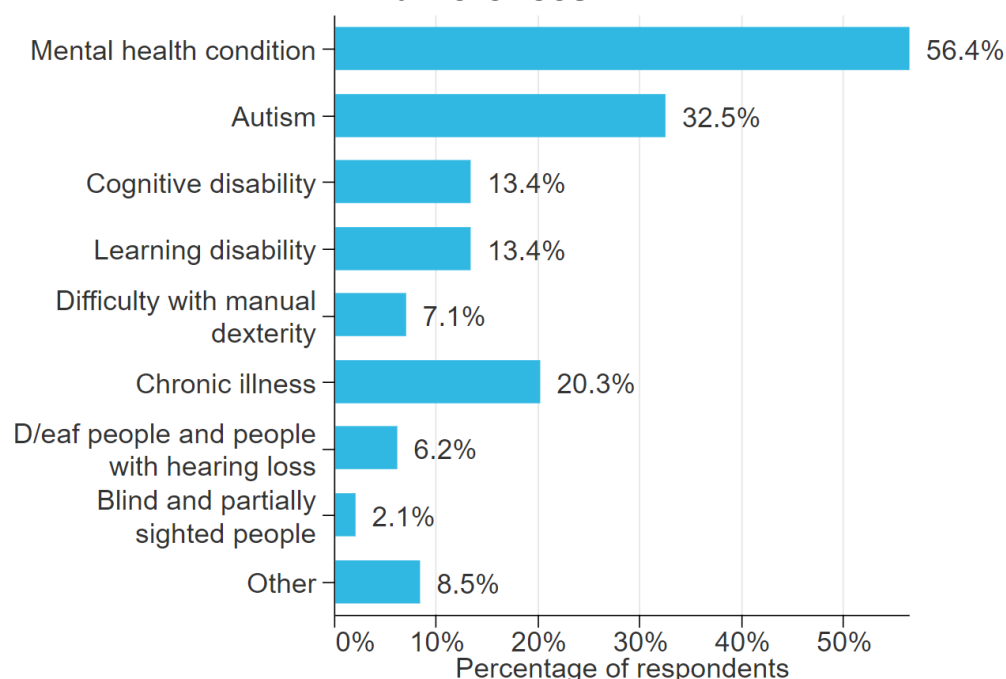
Romantic or sexual orientations of respondents



Dis/ability, neurodivergence and mental health

Most respondents (72.5%, 858) indicated that they were disabled, were neurodivergent, or had a mental health condition (which they may or may not have considered to be a disability). The most common disability or neurodivergence was a mental health condition (56.4%, 667), followed by autism (32.5%, 385), chronic illness (20.3%, 240), learning disabilities (13.4%, 158), and mobility difficulties (12.0%, 142). Excluding mental health conditions,

Prevalence of disability, neurodivergence chronic illness and sensory differences



54.6% (646) of respondents indicated that they had a disability and/or were neurodivergent.

Ethnicity

While there was an overrepresentation of white respondents (91.0%, 1075) compared to the general population of the UK (78.4%),⁵⁰ respondents came from a wide range of ethnic backgrounds, including those who identified as: mixed race (4.6%, 54), Asian / British Asian (2.0%, 23), Black / Black British (1.0%, 12), Latinx (0.6%, 7), Arab (0.3%, 4), Roma (0.1%, 1), and other ethnic groups (0.5%, 6).⁵¹

Religion

While a range of religions were included within the sample, most (57.3%, 652) identified as atheist or having no religion. This was followed by those who were Agnostic (13.7%, 156), those who were Christian (9.7%, 11), those who were Pagan (6.8%, 77), and those who identified as spiritual (6.8%, 77). A total of 22 religions were represented across the research sample.

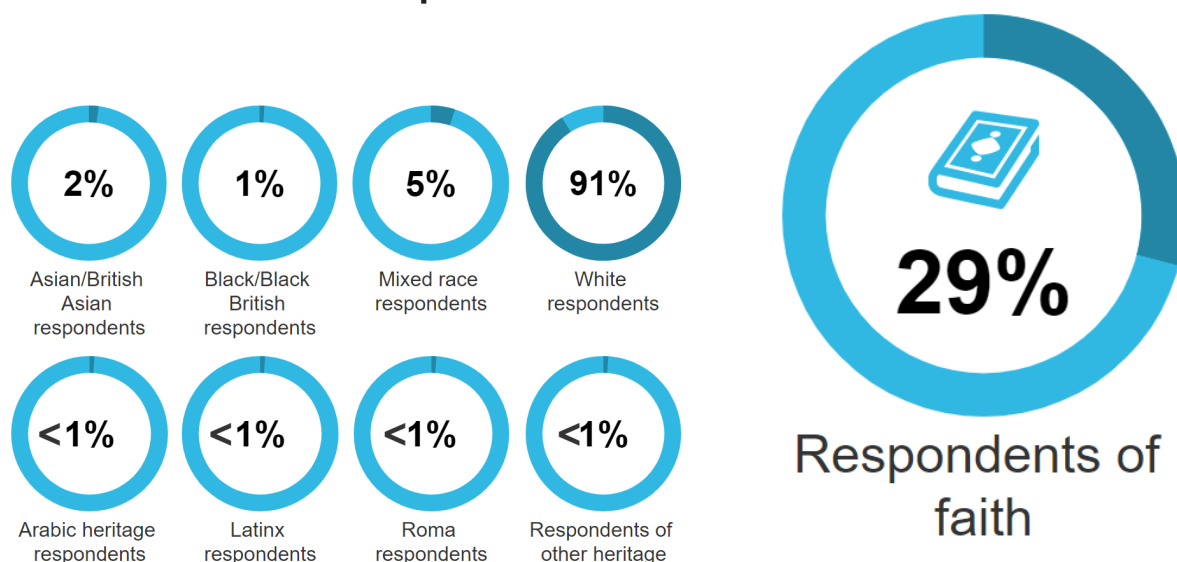
48. Fausto-Sterling., A. (2000). *Sexing the Body: Gender Politics and the Construction of Sexuality*. New York: Basic Books.

49. e.g., Bauer, G.R. et al. (2013). Sexual Health of Trans Men Who Are Gay, Bisexual, or Who Have Sex with Men: Results from Ontario, Canada. *International Journal of Transgenderism* 14(2), 66-74.

50. Office for National Statistics. (2019). Population estimates by ethnic group and religion, England and Wales: 2019. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/populationestimatesbyethnicgroupandreligionenglandandwales/2019>.

51. See Appendix 3 for a more detailed breakdown of respondents' ethnic groups.

Ethnicities of respondents



Age

Respondents were most likely to be between 18 and 35 years old (68.5%, 809), with the youngest groups being the most well-represented and the oldest the least represented. For instance, while 37.6% of respondents were 18 to 25 (444) and 30.9% were between 26 and 35 (30.9%), just 0.2% (2) were 75 and over.

There were some notable distinctions between the identities of older and younger respondents. Those 45 and under were more likely to identify on the non-binary spectrum, with 34.9% (335) doing so, compared to 12.4% (27) of those 46 and older. They were also less likely to identify as heterosexual / heteroromantic (4.7% / 45, compared to 9.7% / 21 for those 46 and over) and more likely to identify as queer / other (84.6% / 805, compared to 67.6% / 146). These findings are in line with previous research.⁵²

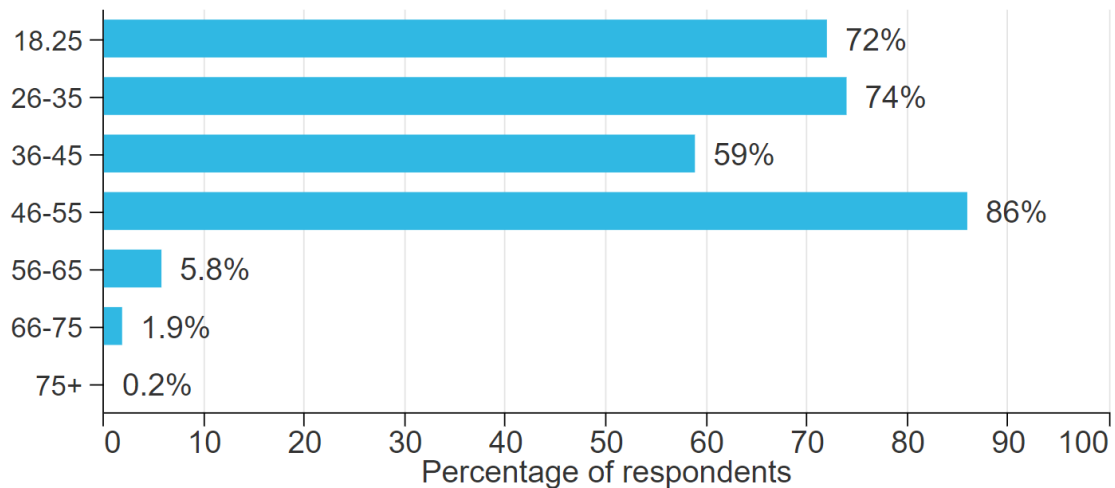
With a lack of comparative data on the UK population, it is unclear to what degree the overrepresentation of younger groups may be due to sample bias. It may be a combination of factors, including increased awareness and normalisation of trans identities in younger individuals, particularly through the widespread use of the internet and social media, and/or the greater comfort with filling out web-based surveys in younger populations.

Conclusion

When considering the transition-related medical needs of trans people in the UK, it is vital to understand and recognise the enormous diversity across this group.

Despite the overrepresentation of those under 36, respondents came from all

Respondent age



age groups. They also included people from a wide range of ethnic and religious backgrounds, those who identified as intersex, and people with a wide range of physical and cognitive disabilities and neurodivergencies. Nearly one in three respondents were autistic and most respondents reported mental ill health.

The high prevalence of a range of neurodivergence, as well as a range of disabilities, anxiety, and depression are important considerations in relation to concerns that trans people may have difficulty accessing care unrelated to their gender identity.⁵³



52. e.g., Government Equalities Office. (2019) National LGBT Survey: Summary report. Available at: <https://www.gov.uk/government/publications/national-lgbt-survey-summary-report/national-lgbt-survey-summary-report>

53. Women and Equalities Committee. (2016); Cass, H. (2022).

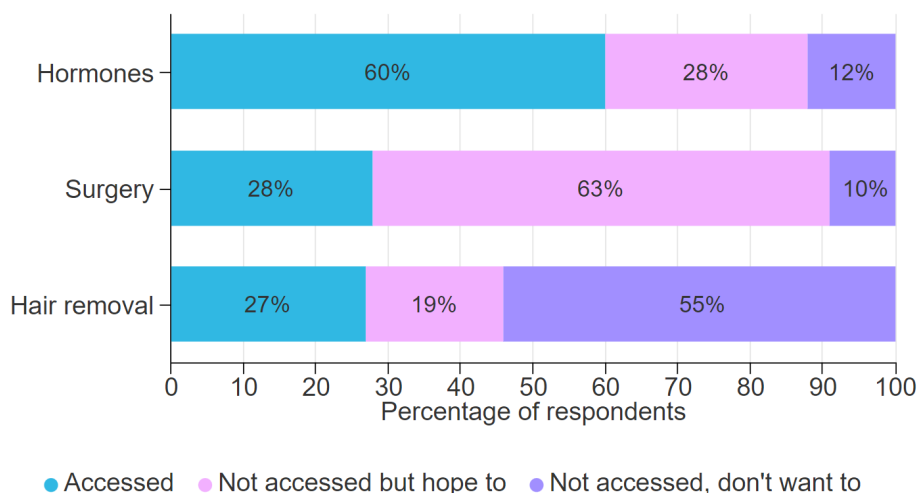


Chapter 3: Accessing transition-related care

Respondents had accessed and sought to access a range of services in relation to their transition, many of which they had or hoped to undertake through the NHS. Less than 5% of respondents had been referred to GIDS, the service for children and young people. Respondents were more likely to have accessed or wanted to access HRT than surgery, though some sought surgery who did not want HRT.

Laser hair removal or electrolysis was also a common feature of transition-related services sought by respondents. Though primarily desired by those on the feminine spectrum, some on the non-binary spectrum and a few on the masculine spectrum (who sought donor site hair removal) had sought this as well.

Proportion of respondents having undergone or planning to undergo medical transition



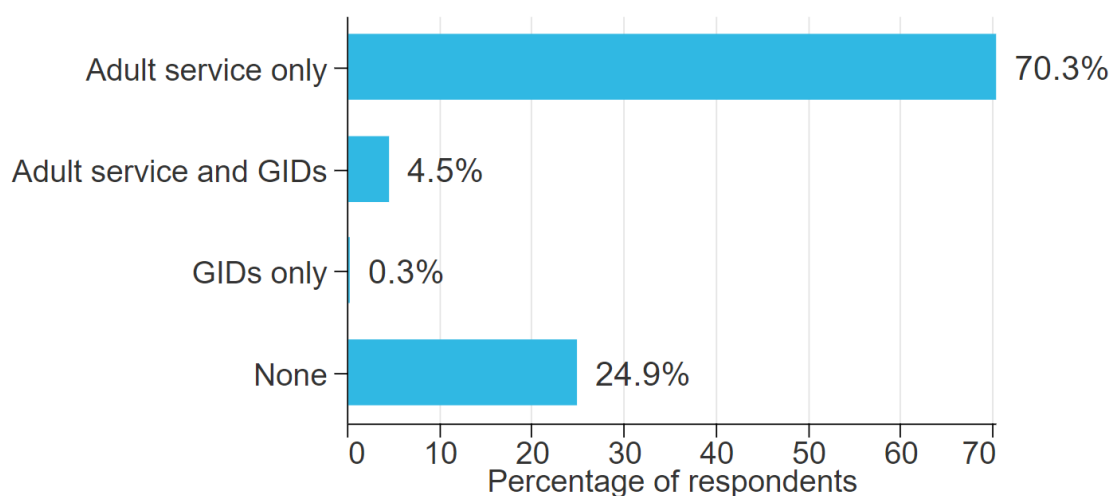
Referrals to GIDS and/or a GIC

Very few respondents – less than one in twenty – had been referred through GIDS, the NHS service for children and young people. Specifically, 0.3% (4) of respondents had been referred only to GIDS, while 4.5% (53) had been referred to both GIDS and an adult GIC. While 70.3% (831) had been referred to an adult GIC only, 24.9% (295) had not received any referral.

The majority of those who had been referred to GIDS had been referred in 2016 or earlier (63.8%, 37), with just 5.2% (3) having been referred in 2020 or later. Most who had received GIDS referrals identified on the masculine spectrum (64.9%, 37), with 21.1% (12) on the non-binary spectrum and just 14.0% (8) on the feminine spectrum.

Those who had been initially referred through GIDS before being transferred to an adult GIC reported a range of experiences with this process. Some reported a simple and relatively straightforward process, potentially one that led to a reduction in waiting times compared to those who were being referred directly to the GIC.

Prevalence of referral to gender identity services



“My experience was good on the child service side. The specialists were clear about the wait times and called the different GICs up in front of me so we could find out the different waiting lists and choose the shortest one. I ended up waiting for about 9-10 months to transfer from child services to GIC and stayed in the child services until the month I turned 18 even though the referral had gone through”.

agender respondent

One non-binary respondent stated:

“I was transferred to the adult services at 17, I had a wait of just under a year until I was seen by the adult services. This was half the time of the wait for the adult services, so I felt incredibly lucky”.

For others, however, the experience was less positive. Some reported that long waiting times at GIDS (see Chapter 5 for more on waiting times) meant that they were never seen by the clinic, and then being transferred to the adult GIC when they turned 18 without their even being aware this had happened.

“I never got to attend any appointments. They never contacted me to tell me that I had been changed from the childrens to adult gic”.

transmasculine respondent

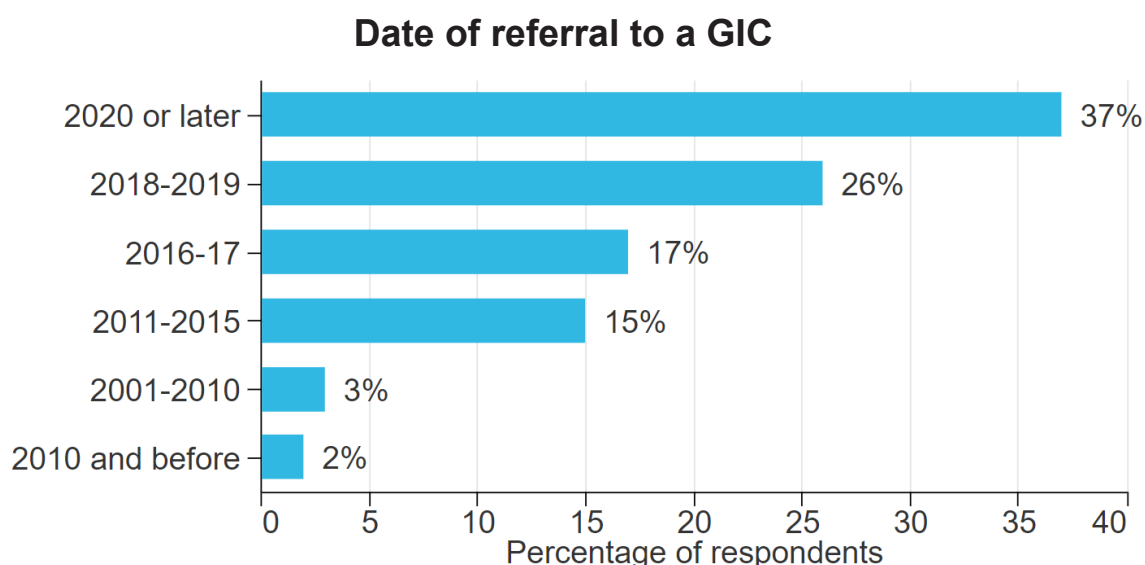
“I haven’t had any appointments with either services and I have been waiting for three years. It was incredibly messy when they transferred me from child to adult services (I was 17 when I was referred so not much time) and I have yet to be spoken to by anyone at charring cross”.

transmasculine respondent

“I aged out of the system before I even reached the top of the waiting list”.

transmasculine respondent

Some also described issues with GIDS not being willing to transfer them on to an adult GIC. For instance, one non-binary respondent stated: *“I was not [transferred] as GIDS refused to refer me to their adult counterpart. My GP sent a [referral] to the adult clinic”.*

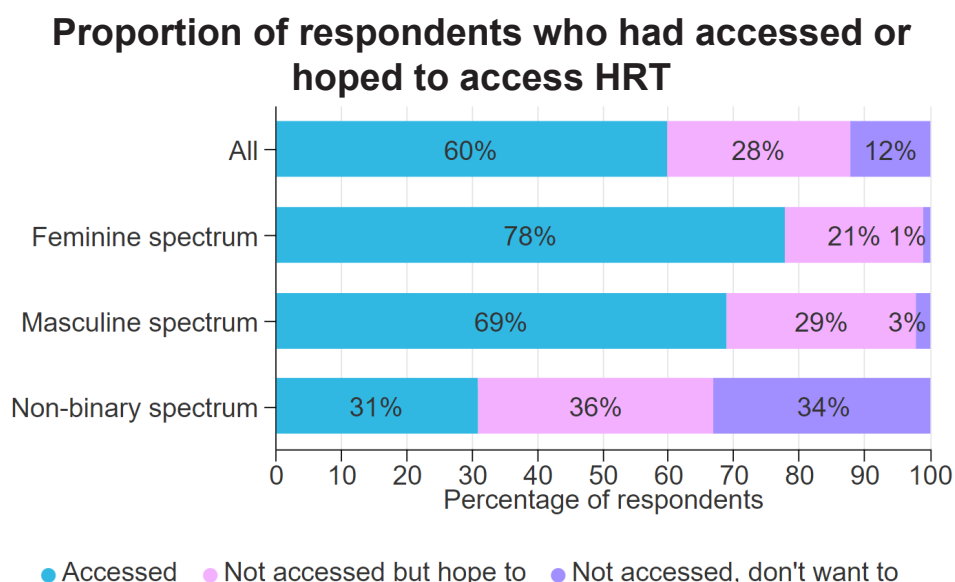


Across all respondents, most referrals to a GIC had occurred after 2012, with almost one-half being after 2018. While just 1.8% (15) had been referred before 2000, in total slightly over one in five (20.3%, 125) had been referred prior to 2016.

Just over one-third of respondents (37.1%, 308) had been referred in 2020 or later, while just over one-quarter (25.9%, 215) had been referred in 2018 or 2019. Most respondents (58.7%, 486) were yet to have their first appointment (see Chapter 5 for more on appointments and waiting times).

Hormone replacement therapy

The most common type of transition-related care sought by respondents was HRT, with 60.4% (715) stating that they had accessed HRT as part of their medical transition. Of the 39.6% (468) who had not taken hormones, most (70.7%, 331) planned to do so in the future and most (66.8%, 221) were on a waiting list. Thus, across all respondents 88.4% (1,046) had either accessed HRT or intended to do so in the future.



Those on the feminine spectrum were the most likely to have accessed hormones (78.2%, 327), followed by those on the masculine spectrum (68.6%, 278). Despite being the least likely to do so, nearly one in three non-binary respondents still reported that they had accessed hormones (30.6%, 110).

Of those who had not accessed hormones, most (70.7%, 331) hoped to undergo HRT in the future. Feminine respondents were the most likely to report intending to access hormone therapy (95.6%, 87), followed by masculine individuals (91.3%, 116). A slight majority of non-binary respondents reported intending to access HRT in the future (51.2%, 128).

Thus, across all respondents, **88.4% (1,046) had either taken hormones or planned to do so in the future**, including: 99.0% (414) of feminine individuals, 97.3% (394) of masculine individuals, and 66.1% (238) of non-binary respondents.

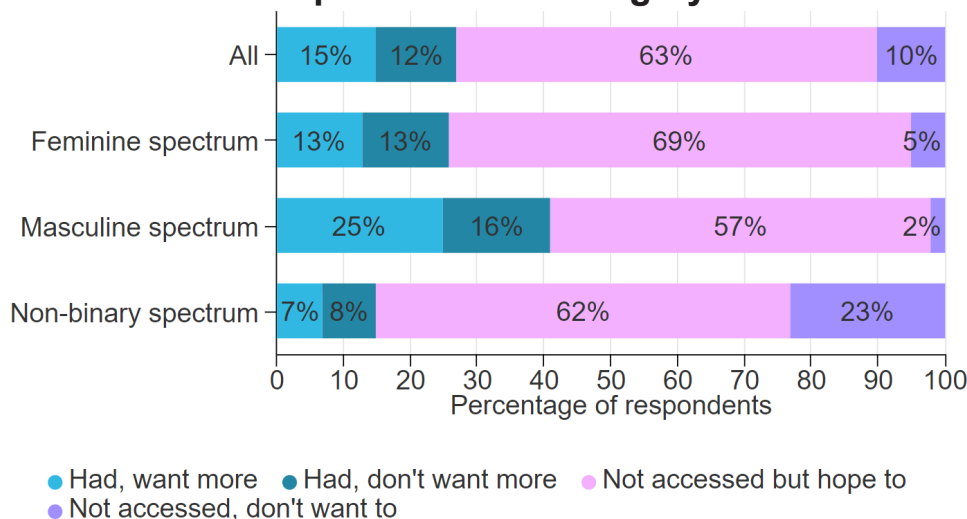
Surgery

A small proportion of those who had not accessed HRT had nonetheless undergone transition-related surgery (4.7%, 22), suggesting that while most trans individuals may choose to access hormones before surgery, this is not always the case.

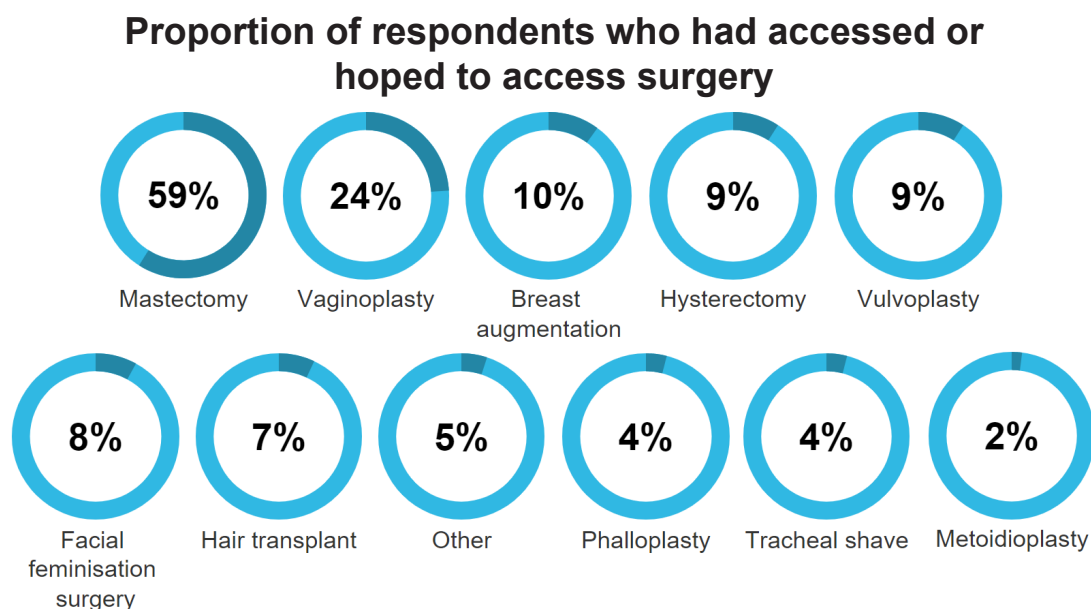
In addition, while most respondents had accessed HRT, most respondents had not accessed surgery as part of their medical transition. Across respondents, 27.5% (326) had undertaken surgery related to their trans identity, 56.1% of these individuals (183) stated that they also wanted to access future transition-related surgeries. Most people who had never had surgery (86.8%, 744) indicated that there were transition related surgeries they hoped to access. Thus, **90.4% of respondents (1,070) had either undergone or hoped to undergo surgery**.

Those on the masculine spectrum were the most likely to report having had surgery (50.0%, 166) and, for those who had yet to have surgery, the most likely to report hoping to do so in the future (97.1%, 232). In total, 98.3% (398) of masculine respondents had either had or planned to have transition-related surgery, though most (59.3%, 232) had not yet undergone any surgery. Of those who had undergone surgery already, 62.1% (103) hoped to access additional surgeries in the future.

Proportion of respondents who had accessed or hoped to access surgery



The most common surgery for masculine respondents to have had was a mastectomy (93.4% of those who had undergone surgery, 156), with other surgeries being much less commonly accessed, including: a hysterectomy (13.9%, 23), phalloplasty (6.6%, 11), and metoidioplasty (4.2%, 7). The same order of prevalence emerged for anticipated future surgeries: a mastectomy (54.0%, 215), hysterectomy (42.7%, 170), phalloplasty (25.1%, 100), and metoidioplasty (23.6%, 94).



While one-half of masculine individuals reported having undergone surgery as part of medical transition, just over one-quarter of those on the feminine spectrum reported the same (25.8%, 108). However, of those who had yet to have surgery, 92.9% (288) hoped to do so in the future. In total, 95.2% (396) had either undergone or hoped to undergo surgery, though most (78.3%, 310) had yet to undergo any surgeries. A slight majority of those who had already had surgery (50.9%, 55) wished to access additional surgeries in the future.

Of those who had undergone surgery, most had received a vaginoplasty (64.8%, 70). Other surgeries included: a breast augmentation (25.0%, 27), vulvoplasty (6.2%, 26), facial feminisation surgery (a.k.a. FFS, 23.1%, 25), hair transplant (20.4%, 22), and tracheal shave (11.1%, 12). FFS was the most popular planned surgery (67.6%, 232), followed by a vaginoplasty (65.6%, 225), vulvoplasty (33.2%, 114), tracheal shave, and hair transplant (19.8%, 68).

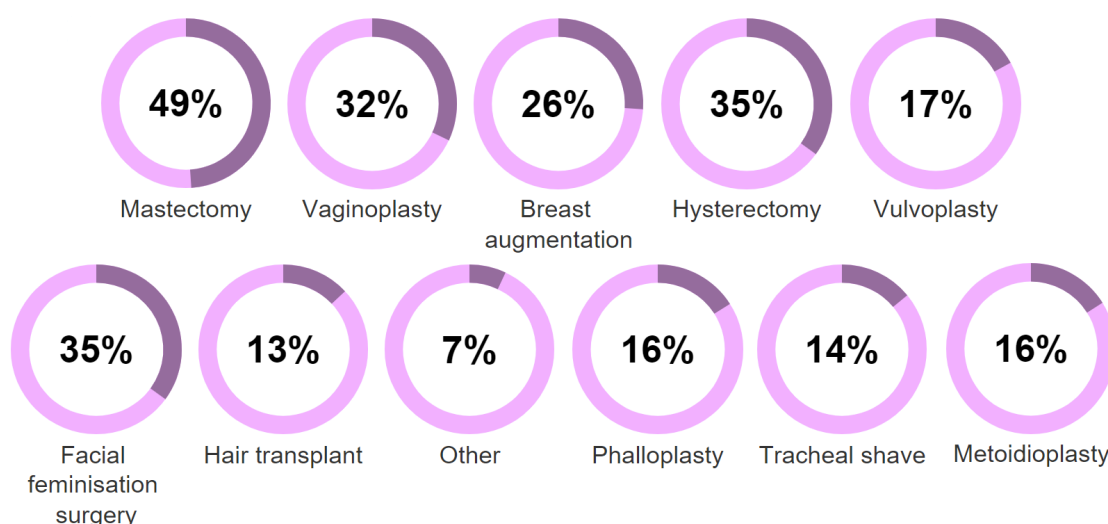
Those on the non-binary spectrum were the least likely to report having undergone surgery (14.4%, 52) or, for those who had surgery, to want to have future surgeries (48.1%, 25). However, of those who had yet to have surgery, most (72.7%, 224) hoped to access surgery in the future. In total, more than three in four had either had or wanted to have surgery (76.7%, 276).

As with masculine individuals, the surgery most commonly reported for non-binary respondents was a mastectomy (10.3%, 37), with 66.5% (149) of those hoping to access surgery in the future intending to have a mastectomy. Non-binary respondents were unlikely to have undergone other surgeries, though many hoped to have a hysterectomy (40.6%, 91) and some a breast augmentation (17.4%, 39). Other responses included a metoidioplasty (9.4%, 21), a hair transplant (8.9%, 20), a phalloplasty (8.5%, 19), other surgeries outside of those listed in the standard survey responses (8.9%, 20), a tracheal shave (6.3%, 140), a vaginoplasty (5.8%, 13), or a vulvoplasty (3.6%, 8).

Other surgeries that respondents hoped to access (7.3%, 54) included body feminisation or contouring, *“bottom surgery”*, breast reduction, buccal fat removal, buttock augmentation, chest contouring / masculinisation / revision, endometrial ablation, face lift or masculinisation, fat transfer, hip filler, hip reduction, orchidectomy, rhinoplasty, salpingectomy, scrotoplasty or scrotoplasty revision, testicular repair, *“top surgery”*, vocal deepening, and/or vocal feminisation surgery.⁵⁴

The most common reason that desired surgeries had yet to be accessed was due to respondents not being able to access it privately (76.7%, 584), which could be the case for those on multi-year waiting lists as well as for those wanting surgeries not available on the NHS (25.8%, 196). Some had gone through the long process of trying to access surgery through the NHS, only to have their referral refused. **The most common reason for a referral being refused was due to respondents’ body mass index (BMI)**, which was the case for 4.2% (32) of respondents. Other refusals had been due to mental (2.1%, 16) or physical health (1.2%, 9).

Prevalence of types of anticipated future surgeries



Electrolysis or laser hair removal

Just over one in four respondents (26.8%, 317) had undergone electrolysis or laser hair removal as part of their medical transition, most of whom (98.6%, 284) were on the feminine spectrum. Across all respondents, of those who had not done so, 25.5% (221) hoped to do so in the future.

Respondents on the feminine spectrum were extremely likely to have either undergone hair removal (67.9%, 284) or to hope to do so in the future (30.1%, 126), with just 1.9% (8) stating that they had not and had no intention to undergo hair removal. Laser hair removal or electrolysis had generally been used to remove facial hair (88.9%, 248), with 6.5% (18) having had body hair removal and 4.7% (13) accessing hair removal in preparation for surgery.

Most non-binary individuals had not accessed and did not plan to access hair removal (72.2%, 260), though 8.3% (30) had undergone hair removal and 19.4% (70) planned to do so. As with feminine individuals, this was generally to remove facial hair (86.7%, 26), with some having removed body hair (6.7%, 2) and some accessing hair removal in preparation for surgery (6.7%, 2).

A minority of people on the masculine spectrum had accessed (0.7%, 3) or planned to access (8.3%, 30) hair removal procedures as part of their medical transition. Where indicated, this was done in preparation for surgery (2 respondents); for instance, to prepare a donor site before a phalloplasty.

Conclusion

In addition to sociodemographic diversity across our research sample of trans individuals, responses indicated the wide variation in the types of transition-related services people had accessed or wanted to access in the future. In particular, responses demonstrated the vast range of medical procedures that can be undertaken across a wide range of gender identities as part of a trans person's medical transition.

However, these options are severely limited by challenges with accessing necessary services through the NHS (including that FFS is not available under the NHS), waiting lists of 5 or more years, and – given both of these barriers – financial barriers to accessing private care.

54. Some respondents may have been unsure of the medical name of the surgical procedures they had undertaken, as evidenced by those who stated they had undergone 'top' or 'bottom' surgery.



Chapter 4: “It now just feels right” the impact of transition-related care

Where respondents had undergone or intended to undergo medical procedures related to their transition, a wide range of impacts and potential impacts were cited. What came through most strongly from respondents was how the impacts of transition-related medical procedures could and generally did permeate across all or nearly all elements of daily life.

Positive improvements were far-reaching and covered nearly every aspect of daily life, from going to the bathroom to showering or getting dressed in the morning, to going to work, making friends and forming romantic relationships, feeling safe leaving the house, no longer having to fear harassment or assault, and being able to and enjoying being physically intimate.

Many respondents spoke of being able to look forward to the future for the first time and/or overcoming lifelong struggles with depression or anxiety. They told us about no longer wanting to end their own life and being able to stop self-harming. Struggles with eating disorders and/or drug or alcohol addiction were also discussed, as were the experiences of those who had severe social anxiety and struggled to form meaningful (or any) relationships.

Severe pain and health issues related to chest binding made it impossible for many respondents to be able to socialise or leave the house for anything other than work. Respondents described overcoming lifelong “*aches and pains*”, stabilising high blood pressure, and curing chronic insomnia after undergoing surgery and/or accessing HRT.

Impacts were commonly described as nothing short of life changing, often representing feelings of ‘gender euphoria’ in the process of reducing or overcoming often debilitating gender dysphoria:

“I feel so much better about myself now. It feels like everything works as it should. The biggest changes were mentally where it now just feels right”.

response from a woman

“My mental health and general wellbeing have sky rocketed. ... My [relationships] with everyone from platonic friends, family, lovers have been so much easier. Everything in my life feels less strained. I feel calmer and happier”.

response from a woman

“Vastly reduced my physical dysphoria, vastly increased my physical euphoria. Which has in turn greatly improved my mental health. Accessing hormones has allowed me to become my true authentic self”.

transmasculine person

“I [couldn’t] leave my house without binding my chest and I was having pain and health problems from binding for over 8 years. ... I couldn’t have waited much longer. I finally feel able to live my life”.

response from a man

“I have ... gone from barely able to speak to being able to present in front of groups. I feel changes throughout my body have made me grow more at ease with my body than before, even if I haven’t been able to achieve everything I would like to”.

non-binary person

Mental health

Mental health was one of the most prominent themes across all areas of impact, including planned and past hormone therapy, hair removal, and surgery. Many respondents spoke of how chronic or lifelong struggles with mental health – including depression, anxiety, and/or feelings of suicidality – were greatly relieved or even eliminated through aspects of their medical transition. Discussing taking hormones, a transmasculine person stated:

“It has completely changed my life. My lifelong chronic depressions and anxiety disappeared”.

Improved mental health could have a range of knock-on effects, including improved ability to socialise, greater feelings of comfort in one's own body and in daily life, and a greater sense of stability. One transmasculine respondent explained: *"I have suffered with depression and anxiety since puberty and hrt has improved my mental health so much, I feel more able to socialise and am a lot more comfortable in my skin"*.

For many respondents, mental health was at the heart of much of the actual or anticipated impacts of medical procedures related to their transition, as one man explained when discussing his mastectomy:

"Top surgery has saved my life, it hasn't been long since I got the surgery - but I already can feel my life getting better, I look after myself and my body much more and want to keep myself health[y]. I'm less angry and frustrated about myself and about how I feel, I can focus on issues that affect me away from my transitioning and dysphoria".

Many described feeling less worried about how they would be perceived and treated in public. One transfeminine person described how the removal of facial hair had *"reduced dysphoria and depression, less anxiety about how I will be perceived - better able to go out into the world and get on with my day to day"*.

A transfeminine respondent who had accessed hormones and hair removal, and was hoping to undergo a vaginoplasty and breast augmentation in the future, explained that she wanted future surgeries *"to feel complete, I still feel half done"*. Similarly, a man who had received a mastectomy and taken hormones but was waiting to complete a partial phalloplasty procedure explained, *"I'm not 'finished' until it's done"*.

Many described medical transition as life saving. When discussing the impact of taking hormones, a man explained that taking hormones had *"utterly changed [his] life"*:

"I had serious plans to end my life and was receiving crisis care from CAMHS at the time to prevent suicide. Taking testosterone as a teenager enabled me to engage with life again, to avoid my body changing further and to start to learn to love my body for what it is. 15 years on I am married, starting a family, have a job I love and an active social and community life. Without testosterone not only would I not have that, I think I'd probably be dead".

Similar impacts were also described by many accessing surgeries. When describing the impact of her vaginoplasty, one woman said: *“I no longer want to kill myself every time I see my genitals... I don’t think it’s exaggerating to say that my surgeon gave me my life back”*. When discussing his mastectomy, a man said: *“I can look at my chest without feeling suicidal”*.

Physical health

The overarching theme of improvements to mental health aligned closely with what many respondents described as generally feeling better in their body, both physically and emotionally. Physical health improvements could be linked to: (a) being better able to care for oneself due to an improved mental state and ability to go places without fear of abuse; (b) a reduction or elimination in self-harming triggered by feelings of gender dysphoria; and (c) the ability to stop activities that could potentially be physically harmful but helped individuals be perceived as the correct gender, particularly chest binding.

Respondents described a range of physical disabilities and issues, with many describing how accessing hormones, hair removal, and/or surgery had significantly improved or eliminated these challenges. For instance, one transfeminine respondent stated that, after accessing hormones

“my blood pressure dropped to a level where I now don’t need medication. I’m no longer on antidepressants. I can sleep again and for the first time ever I can look forward to the rest of my life”.

Some respondents described chronic self-harm and repeated suicide attempts, often in conjunction with physically harmful coping mechanisms, such as smoking, over- or under-eating, or self-injury. One woman explained: *“When I started hormone therapy I felt so much more relaxed ... and the acts of self-harm I engaged in faded away. I even stopped smoking”*.

A transmasculine respondent described his challenges with undereating:

“Starting Testosterone therapy literally saved my life. When I started self medicating my eating disorder had become so severe I was below a size 0, and being prescribed [sic] high calorie drinks from the Doctor, who said I would need to be hospitalised if I didn’t put on weight. I was also severely suicidal, and it wasn’t looking like I had much time left in this world. Both my eating disorder and suicidal thoughts completely vanished after I began transitioning”.

Transmasculine and many non-binary respondents commonly discussed the physical toll of prolonged chest binding, which could make it difficult to socialise or engage in physical activities. A transmasculine respondent stated: *“Binding every day for extended periods of time is painful and has resulted in bruised ribs on several occasions. I am limited in what sports I can do due to wearing my binder”*.

Respondents described needing to bind for prolonged periods due to working hours, practices that can lead to back and chest pain, overheating, shortness of breath, dermatological issues, scarring, and rib fractures, particularly amongst individuals with larger chests.⁵⁵ One non-binary respondent stated: *“I have hurt my chest from years of binding”*. A man explained that, following mastectomy surgery: *“I no longer have back and shoulder pain and do not have to damage my rib cage from binding”*.

Being “authentically me”

Decreased anxiety, depression, suicidality, and physical challenges could have a wide range of positive effects for respondents. Many described the day-to-day improvements in their quality of life, feeling more relaxed and comfortable now that they were, as some explained, *“at home in my body”*.

Describing the impacts of hormone therapy, one woman stated:

“My body is becoming more and more mine and the near constant dysphoria and disassociation [that] dominated my life are subsiding. I finally feel I can love myself and confidence instead of constant anxiety. HRT has helped to improve my quality of life immensely”.

Thus, for many respondents, the impacts went far beyond improvements in one area (i.e., physical or mental health) and could, instead, permeate all or nearly all aspects of daily life. This could also contribute to a more positive outlook on daily life and the future, with a man explaining that accessing hormones meant he was now *“excited about the future”*.

One man described the impacts of his mastectomy as including how *“it made it practically and emotionally so much easier to exercise, dance, swim, have sex, hug, wear clothes, sit at a desk for a full work/study day, and be outside the house for more than a few hours at a time”*. He went on to explain how, by not needing to wear a binder after accessing a mastectomy, his social life *“drastically improved”*, while he was able to *“feel much safer in public”*, having previously experienced *“harassment and violence”*.

Similarly, a genderqueer respondent described the transformative impact of taking hormones on their life:

“It has honestly been life changing, in the best way possible. Before HRT I was depressed all the time and I couldn’t imagine a future with me in it. Since starting HRT, I have been successful in my career, been in a wonderful, healthy long-term relationship, bought a house, and my partner and I are currently trying to adopt to start a family. Without HRT enabling me to live my authentic life, I wouldn’t have been able to do any of these things”.

A non-binary trans woman described the daily trauma they experienced before having FFS:

“Before I got FFS every single day was a struggle for me. It was difficult to impossible to find work, it was hard to make friends, it was difficult to even just leave the house because of how people treated and interacted with me. I learnt very quickly how vulnerable I was and I still live with the mental and physical scars left from that”.

Confidence, self-esteem, and social anxiety

Increased confidence and self-esteem were one of the most frequently cited benefits of accessing transition-related medical care. This included both feeling more comfortable in one’s own body and self and decreasing concerns of being misgendered, harassed, or assaulted by others. This could mean being able to *“do activities that I [never] would have done before”* (transmasculine respondent) and feeling *“more confident in social settings”* (non-binary respondent).

Not having to worry or worrying less about how one would be perceived in public could have enormous impacts on respondents’ abilities to form meaningful relationships, including improving relationships with colleagues and acquaintances and in the ability to form and sustain romantic relationships. For instance, describing the impact of taking hormones, a transmasculine person stated: *“all other relationships (friends, sexual and romantic partners and professional/academic relationships) improved greatly from not being withdrawn from reality anymore”.*

One transmasculine respondent described *“not talk[ing] at all in public for fear of ‘outing’ myself”* and how, by taking hormones, he is able to be *“more outgoing ... improv[ing] my relationships with my friends and partner”.*

A transfeminine respondent explained that having a vaginoplasty meant that she could be *“100% comfortable being intimate with a partner”*, such that she *“was actually able to sustain a relationship”*. A woman described the procedure as having *“dramatically improved my sex life”*.

Some described prolonged struggles with social anxiety, sometimes leading to a near total or complete absence of friendships or romantic relationships. A transmasculine person described having had *“enormous social anxiety due to constantly being mis[gendered]”*, such that he would *“avoid social situations if at all possible”*.

For some, this meant feeling that they could not have romantic relationships and/or be physically intimate comfortably or, in some cases, at all, until they had undergone certain transition-related procedures. For instance, when explaining why he would like to have a phalloplasty, one man explained: *“Because [I] would like to have sex and I cannot bear another person seeing my body as it is now”*.

“My workplace is openly transphobic”: Transitioning at work

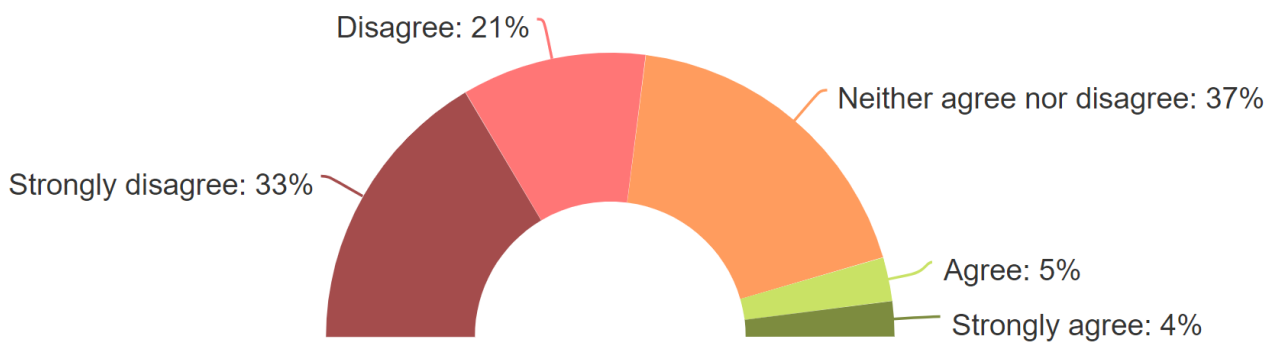
In addition to changes and impacts on social lives and abilities to form positive, supportive relationships, respondents described a range of challenges with colleagues at their workplace when going through transition-related procedures.

Nearly three in four respondents (72.5%, 794) stated that they had been employed for at least some of the period when they were undergoing medical transition. They were over six times more likely to disagree with the statement ‘My workplace has been supportive of my medical transition’ than they were to agree with it. Specifically, 54.2% (427) strongly disagreed (33.4%, 263) or disagreed (20.8%, 164) with the statement, while 9.0% (71) strongly agreed (3.7%, 29) or agreed (5.3%, 42).

Some groups were more likely to report supportive work environments than others. Feminine individuals were more likely to disagree with the statement that their workplace had been supportive, with 64.0% (201) disagreeing or strongly disagreeing, in comparison to 40.1% (71) of those on the non-binary spectrum and 52.4% (153) of those on the masculine spectrum.

Though there were smaller sample sizes, respondents in older age groups were also most likely to disagree with the statement on workplace support, potentially due to having medically transitioned further in the past, because of the nature of the work, or due to their colleagues being less aware of trans identities and rights. For instance, 58.4% (39) of those 56 to 65 disagreed that

Respondents' agreement that their workplace had supported their medical transition



their workplace had been supportive, in comparison to 47.8% (120) of those aged between 18 and 25 years old.

While most respondents did not agree that their workplace had been supportive, some spoke of current or former employers in unwaveringly positive terms. For instance, an agender respondent said: *"The support was genuine. They wanted the best for me"*. One man said that his employers "couldn't have been better", specifying that they had *"updated my name and title [and] had a meeting with my colleagues and management to tell everyone and discussed the need for support and discretion"*.

Some who were or had been in supportive work environments described themselves as *"lucky"*. One transmasculine respondent explained: *"My manager is very supportive and I am lucky to be able to speak about what I'm going through in the future and time off that I will need"*. Similarly, another respondent, who identified as a woman and agender, described themselves as *"lucky to work for a supportive organisation that wants to be led by my needs"*.

For those who had been in multiple jobs during their medical transition, it was common to describe mixed experiences. One transmasculine person described his last workplace as *"terrible"* and having *"tried to refuse me days off to visit the doctors"*. However, he described his new workplace as *"amazing"*.

Another transmasculine respondent described how changing jobs had helped him move from a setting where he experienced daily transphobic interactions with colleagues to one where he feels supported:

“My old work place ... was supportive enough when I first came out and requested to use a new name and start HRT. However, the staff individually [sic] were ‘casually transphobic’ on a daily basis. My current work place ... were incredibly supportive of me having top surgery, giving me all the time I needed to recover and being supportive with my return to work”.

Some described having left jobs that they felt had been unsupportive, potentially even going through periods of unemployment or where they were struggling to find a job where they could feel safe and comfortable. An agender person explained: *“[I] started hormones just after quitting a job after they hassled me out for being trans. then [I] was unemployed for two years, and then [I] got a new job ... and they’ve been nothing but wonderful, accepting, and accommodating”.*

Others, particularly those who described always being read as trans and/or not as the gender they identify as, told of struggling to find employment, feeling forced out of multiple jobs, taking retirement earlier than they would have otherwise, and repeated experiences of discrimination and/or harassment. This included several respondents describing working for employers who had trans-inclusive policies or who followed mandated anti-discrimination procedures, but were still unsupportive or even openly discriminatory. One transfeminine respondent stated:

“I took early retirement this year ... entirely as a consequence of 4 years of trans antagonistic behaviour, marginalisation, and overt transphobia from colleagues. [My employer] just wanted me to work elsewhere, and downplayed the seriousness of the effect on my mental health to the extent that I went on long term sick and was seen by the NHS as a high suicide risk. They had all the policies of course”.



Some described experiences in direct contravention of UK anti-discrimination laws. This included a non-binary respondent who said a Senior Manager had outed them when they were having surgery. They explained that after they had complained, the Senior Manager *“was supported”*, while they were not.

Another non-binary respondent stated that a failure to adhere to current law had led a trans colleague to file a lawsuit against their shared employer. They explained that, while their team and direct managers *“are incredibly supportive and inclusive”*, the organisation’s own anti-trans beliefs helped to promote and maintain institutional transphobia that *“goes unchallenged and unchanged”*.

One woman described an experience where she felt her employer had attempted to terminate her employment as a direct result of her accessing transition-related care:

“The company tried to make me redundant a month before surgery after I had been there [almost 20] years. They took legal advice and changed their mind at the last minute. They have replaced me since I have been on sick leave longer than the anticipated 3 months due to surgical complications”.

Other common negative experiences included being misgendered and colleagues routinely using incorrect names and/or pronouns. A transmasculine respondent, who stated that his current job was *“massively supportive”*, described his previous employer as *“extremely unsupportive”*, where *“managers intentionally used the wrong pronouns and names round me”*.

A non-binary respondent described both jobs they had been at during their medical transition as *“awkward”*. They told us that while their employers had *“wanted to be non-transphobic”*, a lack of training and awareness meant that they were misgendered and treated *“like a problem”*. They explained:

“I wasn’t confident enough to stand up for myself or ask for what I needed, and I didn’t know what my rights were as an employee”.

Even where colleagues were supportive, those in customer-facing roles could struggle with routinely being referred to by the wrong pronouns. On some occasions, this was counter-balanced by employers being supportive, such as with one man: *“I get misgendered quite a lot by customers and some coworkers but HR have been really helpful and haven’t had any issues with me having documents with different names or anything like that”*.

However, for some, routinely being misgendered made it too difficult to stay in their roles. A transmasculine respondent explained:

“My coworkers were relatively supportive but I worked in customer service and regularly got misgendered by customers, which I found so distressing that I had to leave that job”.

Many respondents raised issues or positive experiences with how employers had handled issues with colleagues and/or customers / clients. For instance, a transfeminine person stated: *“My manager and colleagues have been very supportive and some of them have made me feel truly accepted. I had one incident where someone was transphobic, but this was handled really well and I was fully supported by management”.*

While a transmasculine respondent also described a positive outcome, where the person who had been harassing them ultimately left the role, they explained that, initially, when a complaint was made about the situation *“nothing was done”*. Specifically, *“a member of the team refused to work with me, call[ed] me an ‘it’ and said that he would ‘come out as a toaster tomorrow’ he would stare [sic] at me and make me feel uncomfortable”*. The team member only quit after a manager *“went to the top”* after there was no response to the initial complaint.

Many respondents also described challenges with being able to attend appointments during work hours and in receiving sick pay while recovering from transition-related surgeries. A trans man said that co-workers *“had difficulty accepting my medical transition”* and described how his workplace deemed his transition-related surgery as a cosmetic, elective procedure and therefore one that was not covered by sick leave. Thus, while recovering he *“had to fight to be paid”*. Another man, however, explained that his employer had *“a policy in place which means that transition related sickness does not count towards sickness records”*.

Some who were able to be read as the gender they identify with described choosing to remain ‘stealth’ and not reveal their trans identity at work, often because of past experiences or concerns of harassment or discrimination. A woman explained how employers at previous roles during her *“early transition”* had been *“unsupportive”*, which led her to keep her trans identity *“hidden”*.

One man explained how the way his boss and colleagues spoke about trans people and identity prevented him from feeling comfortable telling them he was trans:

“I was stealth at my work ... and was constantly worried that my boss or a coworker would realise that I wore binders, or that they would see my packer if they walked in on me on the loo (since the stall door was broken). When I had time off for top surgery, I just refused to say anything at all about what procedure I was having. I have heard my boss & others at work use transphobic slurs ... it was enough to make me feel I was right to have remained stealth”.

Others, instead, described delaying undergoing medical transition or continuing to present as a gender that matched their birth sex for fear of how their workplaces would react. For instance, one woman stated:

“My workplace is transphobic. I’m unable to present as my gender as it’s likely I’ll be fired or forced to leave. If I lose my job I’ll be unable to fund my HRT”.

Part-way through: “I feel incomplete”

A minority of people explained that the completion of some – but not all – of the medical procedures they hoped to access could be challenging for their mental health. They explained that the anticipation could be extremely difficult, particularly when NHS waiting times can be many years, leading to a worsening of mental health as individuals were left in a state of ‘limbo’.

One transmasculine respondent who was on hormones and had undergone a mastectomy, vaginoplasty, and partial phalloplasty, explained: *“Each step I felt better but dysphoria kicked in more also. Being half way through feels horrible”.*

A transmasculine person described how, despite being on hormones, he still suffered from *“dysphoria related depression”* as he waited to have a mastectomy. He described having felt *“stuck in limbo, unable to move forward with my life”* and how he finally could after having had surgery.

Similarly, a man who was on hormones stated that, until he has the surgeries he knew to be necessary to alleviate his dysphoria – a mastectomy and a phalloplasty, *“I can’t move on with my life. I will feel incomplete and my gender dysphoria will never be under control”*. A transfeminine respondent also described herself as *“feel[ing] incomplete”*, describing how, while waiting to have a vaginoplasty, she *“feel[s] awful”* when she sees her genitals.

For some respondents, certain procedures were more important than others for relieving their feelings of gender dysphoria and improving their mental health, while some continued to struggle until all of the procedures they

needed had been completed. As a result, certain elements of their transition had no or less of an impact on improving their mental health.

For instance, one non-binary trans woman described how, while accessing a vaginoplasty through the NHS had not improved their mental health, paying privately for FFS (a procedure not currently available through the NHS) had:

“[FFS] altered how I and the world see and interact with myself and helped me feel more comfortable and less threatened or vulnerable in my daily life while also helping my mental health towards myself. GRS [gender reassignment surgery] helped me feel more comfortable with my body and calmed my mind but had little to no impact on my social life. While I’m happy with myself and all my surgeries I feel like if the FFS had been available on the NHS, I would have chosen that over the GRS because of the massive huge positive impact that had and still has on my life”.

Similarly, a transfeminine respondent stated:

“My life’s made worse every time I go outside and am seen by strangers who take one look at my face and my overall body shape and conclude that I’m ‘actually’ a guy wearing women’s clothing. That the NHS will cover the cost of inverting my genitalia (a part of my body no one but my spouse and I will ever see), but claims FFS is ‘unnecessary’ (despite the fact that every single person I will ever meet will look at my face and use it to inform their expectations of my gender) demonstrates yet again that the NHS does not actually care about the wellbeing or safety of trans people”.

Conclusion

Across responses, it is evident that a wide range of positive impacts can arise for trans individuals accessing medical transition. These can range from shifts in how one perceives oneself or is perceived by the world to overcoming lifelong struggles with mental ill health and/or suicidality, with many referring to the effects of procedures as *“lifesaving”*.

Medical transition, in many cases, helped to improve physical health by eliminating the need to engage in activities that may be physically harmful and by alleviating symptoms stemming from mental ill health. It also empowered many individuals to feel able to better care for themselves.

The physical changes associated with accessing hormones, surgeries, and/or hair removal often also helped respondents feel more comfortable and

confident being social and in building supportive romantic and non-romantic relationships. Many people also described feeling safer and more confident when leaving the house and/or going to work, with reductions in or the elimination of experiences of harassment and violence.

However, these changes did not generally come without difficulties. Most participants who were employed during their transition did not feel supported, with just 9.0% (71) agreeing that their workplace had been or would be supportive. Colleagues using incorrect names or pronouns were frequently reported, as were difficulties with accessing sick leave when recovering from surgery or when needing to attend other medical appointments.

Some respondents also reported certain procedures as being less helpful in overcoming feelings of gender dysphoria than others, with a number mentioning how procedures not covered by the NHS would or did have a substantial positive impact on their daily life. For instance, several respondents discussed how being able to access FFS had been would be more impactful than surgeries available through the NHS (i.e. vulvoplasty and vaginoplasty).

Others described difficulties with feeling “*halfway done*” in their transition and how the anticipation after accessing some, but not all, medical procedures they needed could enhance some feelings of dysphoria. This was particularly exacerbated by increasingly long NHS waiting times, which can mean waiting many years from being first referred to a gender clinic until being able to access hormones and/or surgeries.





Chapter 5: “The NHS finally fixed my body, but broke my psyche”: waiting to access care

While it is clear that respondents felt strongly that transition-related care had or would have substantially positive improvements in their life, there are a range of barriers that can inhibit their ability to access it. Many procedures and treatments that participants described as essential (especially FFS) are not currently available through the NHS. Being able to obtain hormones, surgery, or hair removal through the NHS can also be incredibly challenging, given the incredibly long waiting lists.

Nearly all respondents referred to challenges related to increasing waiting times, which have only continued to rise year on year.⁵⁶ With time from referral to receiving hormones or surgery approaching or exceeding a decade, many described not only the agony and severe negative consequences of waiting, but feelings of despair that something they felt they needed so badly “*felt so out of reach*”.

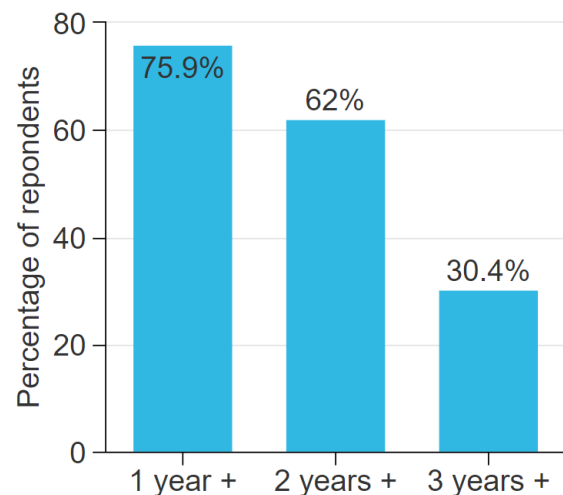
NHS referral waiting times

Most respondents (58.7%, 486) who had been referred to the GIC had yet to have their first appointment. Of those who were referred to the GIC after 2017, just 14.8% (77) had already had an initial appointment, meaning that 85.2% (444) of those referred in 2018 or later had yet to receive any support through the clinic. **Fewer than one in ten who had been referred after 2018 (9.1%, 37) had attended a first appointment.**

56. Gender Construction Kit. UK service wait times. Available at: <https://genderkit.org.uk/resources/wait-times>.

The average waiting time to attend a first appointment at the GIC was over 1 and 2/3 years (613 days, n=345). Most (66.1%, 226) had waited for over one year, with over one-third (36.0%, 123) having waited more than two years. Nearly one in six had waited for more than three years (14.0%, 48). While few referred after 2017 had yet to attend an appointment, those who had (n=79) had an average waiting time of more than two years (755 days). Of these, 75.9% (60) had waited one year or more, 62.0% (49) two years or more, and 30.4% (24) three years or more.

GIC waiting times for respondents referred after 2017



The average waiting time for the smaller number of respondents who had been referred to the GIC through GIDS and attended a first appointment (n=55) was slightly shorter, averaging 566 days or just over 1.5 years. Of these, 43.6% (24) had waited for more than one year for their first appointment, 30.9% (17) had waited more than two years, and 18.2% (1) had waited for more than three years. Two respondents had yet to have an initial appointment. For those referred after 2017 (n=11), the average wait was more than two years (800 days).

Black People and People of Colour (BPOC) reported longer average waiting times for first appointments to a GIC or GIDS. While white respondents reported an average wait of 588 days at the GIC (n=320), BPOC reported an average wait of 641 days (n=23). Waiting times for a first appointment at GIDS were 70% longer for BPOC (774 days, n=6) than they were for white respondents (541 days, n=49).

Waiting times to access hormones

For those who planned to, but had not yet accessed hormones (28.0%, 331), two-thirds (66.8%, 221) stated that they were currently waiting to do so. Average waiting times varied dramatically depending on the routes taken to access hormones, with those going through the NHS (284 respondents) waiting an average of 325 days after their first appointment with a GIC. This compares to 170 days for those who accessed hormones through a bridging prescription⁵⁷ (82) and 113 days for those who had done so through a private prescription (386).

57. Bridging prescriptions are temporary prescriptions of HRT that can be issued by a GP to a patient waiting to be seen by a GIC.

Average number of days between a first appointment and prescription for HRT



Waiting times for those with disabilities, neurodivergencies, and/or mental ill health were 25% longer, averaging 225 days (n=407), than they were for other respondents (average 180 days, n=200).

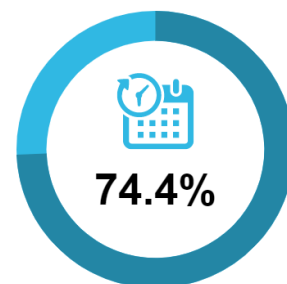
The average waiting time for a first appointment for those who had accessed hormones privately (386) was 67 days. This is more than nine times less than the average waiting time through the NHS for an initial appointment and does not include the additional months or years of waiting before hormones could be prescribed. Just 1.6% (6) of those accessing hormones privately stated that they had waited for more than a year.

Waiting times to access surgery

For those intending to have future surgeries (64.3%, 761), 20.9% (159) indicated that they were currently on a waiting list to do so, with an additional 53.5% (407) still waiting for their initial referral through the GIC. Thus, 74.4% of those planning to access surgery (566) were on a waiting list.

Across all respondents, the average waiting time from referral for surgery to accessing surgery was just over one and two-thirds years or 611 days (285). However, surgery waiting times through the NHS were more than three times higher than those for private surgery. While waiting times for private surgery averaged less than one year at 321 days (114), those for NHS surgery averaged nearly three years – 983 days (116).

Proportion of respondents who want surgery and are on a waiting list

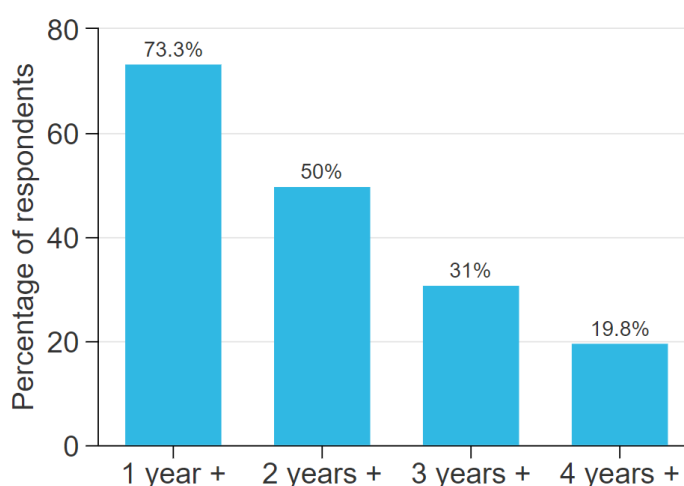


It is also important to recognise that the average waiting time is likely to be an underestimate.

Firstly, many who had decided (and were financially able) to access surgery privately were also those who had already been waiting many years through the NHS. Thus, average NHS waiting times would likely have been longer had the average time private patients had initially spent waiting for NHS surgery also been included.

In addition, if such a high proportion had not decided to pay for private surgery, average waiting times would be even not account for the long, often multi-year, delays experienced by many in accessing a referral to a GIC, nor do they include the often multi-year waits for appointments.

Waiting times between surgery referral and surgery for respondents who had accessed surgery on the NHS



Nearly three in four respondents who had undergone surgery through the NHS had waited over a year from their referral date (73.3%, 85), with one half waiting over two years (50.0%, 58), 31.0% (46) over three years, and 19.8% (23) over four years.

It was not uncommon for respondents to describe waiting more than five years from first requesting surgery until their surgery date. For instance, one man explained that, despite having stated he wanted a mastectomy at his first GIC appointment in 2017, he could not actually be referred until his second appointment, four years later.

An androgynous respondent described waiting years for their initial surgery referral, which, they were told year after year would come after their next annual appointment:

“I was told I’d been referred for surgery six months after starting HRT. ... I was told in every appointment ... that, after that appointment, that that same referral could be sent. ... It took years for them to SEND the referral after saying they would. I spent more years waiting to be contacted by the surgeon ... I was promised surgery in 2015. Not just the referral, but that the surgery would happen before 2016. I still haven’t had it”.

After waiting seven months to have three private surgeries conducted on the same day, a transfeminine respondent explained that she had been waiting years for the referral for a vaginoplasty through the NHS. After initially waiting 19 months to speak to a doctor for the referral, she was then told she would have to wait another 12 months to speak to a second doctor before receiving a surgery referral. She explained that, after this more than 2.5 year wait, *“I will be on a [surgery] waiting list which can be up to a year long. In total the whole process will end up taking 3 and a half years”*.

Respondents on the masculine spectrum reported the longest waiting times, averaging nearly four years (1,448 days, 39) for those who had gone through the NHS, compared to just over two years for those on the feminine (747 days, 20) and non-binary (748 days, 57) spectrums.

This was particularly evident for those who had undergone a full or partial phalloplasty or metoidioplasty, with many stating that they had already been on waiting lists for three to five years without yet having a surgery date.

One man explained that he had already been waiting 4 years from his referral date for his phalloplasty, without yet receiving a surgery date or timeline on when he may have the first stage of this (usually 3-stage) procedure:

“The worst part was getting a letter saying that the only surgeons performing phalloplasty had lost their NHS contract. The letter had no information about when I could expect this to change ... Now, a new contract has been awarded, but they are (understandably) working through those patients who were caught between stages first - I have had to make peace with the fact it could be years before I am seen”

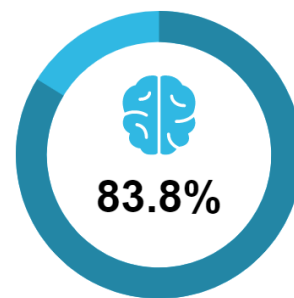
The impact of waiting

As discussed in the previous chapter, respondents reported a range of negative impacts stemming from the often multi-year waits for transition-related medical procedures. This included 86.9% (814) of respondents who had accessed hormones and 83.8% (897) who had accessed surgery indicating that waiting had negatively impacted their mental health.

Similarly, 83.8% (897) agreed that waiting to access surgery had negatively impacted their mental health. Just 4.5% (42) stated that waiting for hormones had not negatively impacted their mental health, while only 3.4% (37) said the same about surgery waiting times.

In open responses about the impact of waiting times, references to mental health, anxiety, and/or depression were frequent. This could be in relation to the anticipated positive changes, as well as those who felt their life was on hold. In describing the impact of her wait for surgery, one woman stated:

“There’s a particular kind of nervous energy, and anxiety, around waiting for such a hugely transformative and affirming operation, it can’t help but permeate every aspect of your life, it’s an act of will to not simply wobble off your axis”.



reported negative mental health impacts of waiting for surgery

The anticipation of such a transformative experience, combined with the uncertainty of when appointments would be made and/or when a person would finally make it off a long waiting list, could lead or contribute to extreme anxiety, depression, or suicidality. For those with existing mental health diagnoses, the wait could feel unbearable. A man described having “*a severe mental health crisis*” while waiting to access hormones. He said that during this time he “*was unable to work, cut off communication in person with people, and even stopped going to uni for a while*”.

Multi-year waiting times were often described as the cause of poor mental health or suicidality. One man described the severe impact of receiving a letter stating that the NHS surgeons had lost their contract after already having waited years for the first stage of his phalloplasty.

“At first, I didn’t realise how much it had impacted my mental health, until about 3 months later when I suddenly felt I couldn’t cope. I accessed counselling through [a local LGBTQ+ organisation] which helped me to realise that I was grieving for the body I had been ready to receive, which suddenly felt so out of reach”.

A woman explained how waiting over a decade from when she had first requested a GIC referral from her doctor, with the hope of accessing a vaginoplasty and vulvoplasty, had taken her from being in “*good mental health with no depression*” to being so severely suicidal that the surgeons decided to further delay her surgery:

“I asked my GP for a GIC referral in 2005/6 but this request for referral was repeatedly refused/ignored. ... I had started this process in good mental health with no depression, but a realisation that I needed to transition to retain my mental health. But facing delay after delay after delay, year after year, suicidality developed and became more and more frequent ... 2 months before scheduled surgery date (summer 2018), I was suddenly refused surgery BECAUSE the delays had made me suicidal. ... I was now completely dysfunctional and in a state of suicidal despair almost every waking moment. I only survived because a transgender charity ... intervened with the GIC on my behalf to get me scheduled for surgery again. [sic] I finally received my surgery in Dec 2018 ... I’m no longer suicidal - the surgery fixed that completely and immediately, I was finally able to be myself - but nonetheless ‘broken’ in many ways by what this process did to me - unable to trust, unable to enjoy life. The NHS finally fixed my body, but broke my psyche”.

Not knowing when appointments or surgeries might be scheduled could enhance feelings of being “*in limbo*”, with respondents describing struggling or worrying about making plans. Some also described frustrations with doctors asking them to wait an additional year before being put on waiting lists and/or accessing hormones or surgeries, particularly after having generally already waited lengthy periods for appointments or referrals.

One man explained:

“Waiting for hormone therapy to start was the hardest part of transition. The GIC insisted on a one year wait since they had started seeing me, even though I had known I was trans for over ten years at that point and wanted nothing more than to be visibly male and stop being misgendered all the time. There was no point in being made to wait so long, and knowing that the HRT was so close and yet so far was also damaging to mental health and caused a lot of anxiety”.



Many respondents described an exacerbation of symptoms related to mental ill health stemming from feelings of gender dysphoria. This included feelings of social anxiety, self-harming, desires and attempts to end one's life, and struggles with eating disorders. Unhealthy relationships with food were frequently discussed. A woman stated that, while waiting for hormones,

“every part of myself made me self conscious, this affected my mental health which then impacted my physical health as it affected my relationship with food as well as leading me to self-harm when I felt super distressed”.

One man explained how, while waiting for a mastectomy,

“My chest dysphoria was debilitating. I struggled with eating disorders and never wanted people to look at me. Having to wait for something I needed so badly was terrible for my mental health. It felt like the wait would never end and I'd have to be miserable forever”.

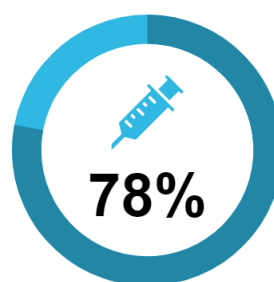
Most respondents also indicated that waiting times had negatively impacted their physical health, including 78.0% (543) of those who had accessed hormones and 62.0% (663) of those who had accessed surgery. Some described a worsening of existing physical health conditions due to increased anxiety while waiting. For instance, a transmasculine respondent explained how the negative impacts on his mental health of waiting for hormones had led to a worsening of his epilepsy.

Behaviours to manage gender dysphoria could also contribute to physical ill health. One man stated how his desire to avoid using the bathroom means, *“I tend to be dehydrated a lot to avoid seeing my genitals”.*

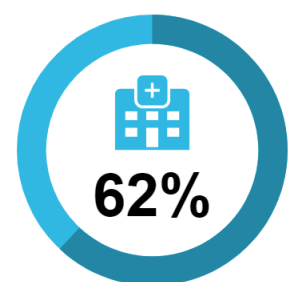
Those on the masculine spectrum were the most likely to indicate that waiting for surgery had negatively impacted their physical health, with 75.9% (302) agreeing with this statement, compared to 57.3% (158) on the non-binary spectrum and 51.3% (203) on the feminine spectrum.

The impact of prolonged chest binding on one's physical health and, subsequently, ability to socialise and overall mental health, was a common theme:

Impact of waiting on physical health



Waiting to access HRT negatively impacted my physical health



Waiting to access surgery negatively impacted my physical health

“Having a large chest means that every time I leave the house I’m binding, and that extends to if I’m staying at a friend’s accommodation. The pain I am in from binding for over 24 hours is really bad, to the point I cannot lie on my sides, but my dysphoria is so bad I don’t leave my house without it. As well I would be scared to leave the house without binding due to potential hate crimes or being potentially perceived as a woman. So, not having top surgery is ruining my physical health and that makes me not enjoy seeing friends as much and acts as a deterrent to spend time with people often, thus affecting my mental health”.

transmasculine respondent

“[S]ome days I could not leave my bedroom, or see anyone. ... In the summer I often stay in my room or house as wearing so many layers is very upsetting in the heat. I bind for longer than I am supposed to daily; I am not able to leave my bedroom without a binder on and this has caused physical damage to my skin, ribs and lungs”.

response from a man

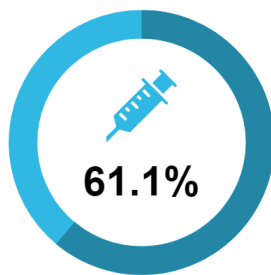
“I’m in constant discomfort/pain due to binding. I’m delaying my wedding because I don’t want to have to bind on my wedding day. I’ve missed out on social events because of binding pain”.

genderqueer respondent

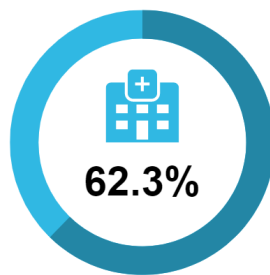
Negative impacts on one’s ability to socialise and form or maintain relationships were commonly described, with 62.3% (667) of respondents stating that waiting for surgery had negatively impacted their personal relationships and 61.1% (572) stating the same of waiting for hormones. Masculine respondents were particularly likely to report negative impacts on relationships while waiting for hormones (68.2%, 168) or surgery (68.6%, 276).



Impact of waiting on relationships

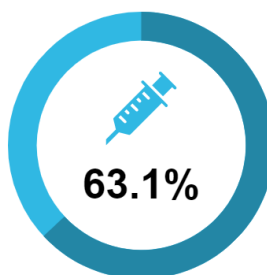


Waiting to access HRT negatively impacted my personal relationships

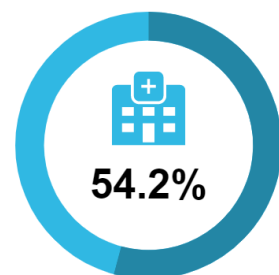


Waiting to access surgery negatively impacted my personal relationships

Impact of waiting on work life



Waiting to access HRT negatively impacted my work life



Waiting to access surgery negatively impacted my work life

Respondents commonly described how their own struggles with mental health and/or low confidence could make it difficult or, for some, impossible to form relationships. This could mean that some only wanted to have romantic relationships and/or physical intimacy after they had undergone necessary transition-related procedures. For instance, a transfeminine respondent said:

“I tend to avoid and not form relationships with people because I cannot imagine feeling connected with people when I can’t feel connected to myself”.

Waiting for care was also commonly described as negatively impacting respondents’ work life, with 63.1% (936) stating that this was the case while waiting for hormones and 54.2% (580) while waiting for surgery.

Those on the masculine spectrum (72.6%, 267) were much more likely than those on the non-binary (57.7%, 97) or feminine (56.8%, 227) spectrums to report negative impacts on their work life of waiting for hormones.

They were also more likely to report negative impacts of waiting for surgery (66.6% / 265, compared to 47.5% / 131 for non-binary respondents and 46.5% / 184 for feminine respondents).

This included, for some, having to work fewer hours because of their need to bind, a challenge that could also make it more difficult to save enough money to access the surgery sooner by paying for private care. For instance, one transmasculine person explained: *“Because of binding I can no longer work long hours as a bartender”.*

Given the many challenges and negative impacts associated with multi-year waits, some stated that they chose to delay or not undergo medical transition, despite feeling that this was necessary for their own wellbeing. One woman explained how she did not openly identify as trans for fear of how she would be treated while waiting multiple years to access hormones:

“The long waiting times convinced me to go back into the closet rather than try to transition for many years, the thought of trying to transition without HRT or the approval of the medical establishment, which most people in the UK mistakenly consider the bare minimum to be a valid trans person was horrifying to me. I couldn’t face coming out, waiting many years to see a specialist and then potentially a longer wait for HRT all while people treated me as a ‘fake’ trans person”.

Conclusion

It is evident from our respondents that years of waiting could – and generally did – have a range of severe and negative impacts. These can include the exacerbation of mental ill health or feelings of suicidality or, for those without a prior history of mental ill health, new and often severe symptoms.

“I feel powerless to make other decisions about my life, since I’m waiting for this ‘one’ thing that will give me confidence in my body and no longer cause me constant anguish. I can’t make long-term plans because I honestly am not sure that I will survive the next however many years before I can access surgery, that is how unbearable it is to wait”.

agender respondent

Particularly for those who feel the need to bind their chests, waiting could have irreversible impacts on their physical health. It can also greatly limit people’s ability to form meaningful and/or romantic relationships, be intimate with another person, and feel safe leaving their house or while at work. A bigender respondent stated:

“My life feels in limbo and has done so for two years, which makes managing my mental illnesses and disabilities harder. I am constantly misgendered which grates on me the longer it goes on. I struggle to date as [I] feel terrible about my looks, which leaves me with little confidence”.

As waiting times continue to increase and surpass five or even ten years, it is concerning that negative impacts may become even more common and severe. This can also have dangerous consequences, as more may decide to self-medicate and might do so unsafely.

“It really impacted my mental health having to wait, I have bipolar disorder and the anxiety and stress made my mood more unstable ... and made me suicidal ... I had zero confidence, I couldn’t speak to people on phones as my voice was high and people would always misgender me or would mean I have to out myself. My eating disorder was really bad due to anxiety, stress, the hate of my body and dysphoria ... I would have bad urges to harm myself...I put off going to college or getting a job because I didn’t pass and was too scared of having everyone know I’m trans. It stopped me wanting to go in any relationship. It stopped me going out and doing activities I really wanted to do. I thought I’d be dead before I’d access hormones through the NHS which is why I self medicated and then went private. Hormones saved my life and turned it around in a major positive way”.

response from a man

The incredibly high barriers to accessing transition-related care through the NHS may increasingly make accessing these procedures through the public health system seem close to impossible.

As waiting times continue to grow, more and more of those who are financially able to are likely to turn to private care to overcome the many challenges with being referred and to wait exponentially less time.

These trends will only further socio-economic inequity, between those stuck in a system that has been failing trans people for many years and those who can pay to get the care they need.





Chapter 6: Going private

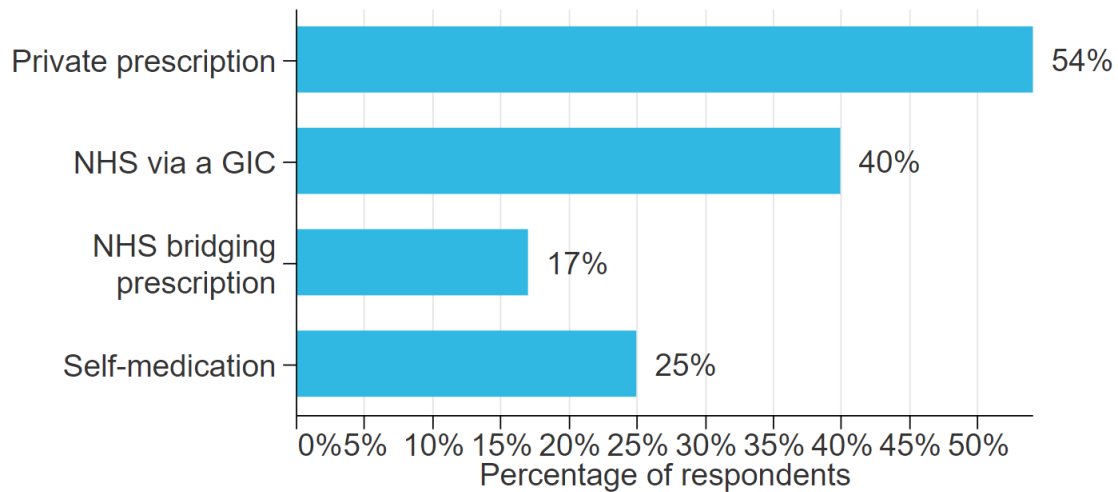
The burden of lengthy delays, combined with the often complicated and multi-step approval processes, led many respondents to feel that they had no choice but to pay for private transition-related services. Some cited transition-related procedures – particularly FFS – that felt necessary to them but were not covered by the NHS. Others cited concerns that they would be found to be “*not trans enough*”, going through all the approval stages and waiting years, only to be rejected for the referrals they needed to access care. As one non-binary respondent explained:

“The waiting list for NHS GICs was up to 5 years, I couldn’t wait that long and keep myself alive whilst battling the dysphoria that greatly contributed to my depression and anxiety. Also, the NHS was unlikely to provide treatment for me as a non-binary person as I wasn’t ‘trans enough’, whereas with a private provider this wasn’t an issue and they accepted me without having to put up any kind of a fight”.

Private access to hormones

The most common type of private transition-related care was receiving a prescription for HRT. Respondents were more likely to have accessed hormones through a private provider than to not have. Specifically, **54.0% (386) of respondents had used a private prescription to access hormones,**

Mechanism for accessing HRT



while 46.0% (329) had not. Just under four in ten (39.7%, 284) stated that they had accessed hormones through the GIC, while 16.8% (120) had used a bridging prescription through their GP.⁵⁸

It is particularly concerning to see that **one-quarter indicated that they had accessed HRT by self-medicating** (25.0%, 179), buying and using unprescribed and unregulated hormone medication over the internet. Not having access to any professional guidance or oversight can be incredibly dangerous for those turning to self-medicating.⁵⁹

Those on the feminine spectrum were the most likely to have accessed hormones through a private prescription, with 55.7% (182) having done so, compared to 54.8% (153) of those on the masculine spectrum and 46.4% (51) of those on the non-binary spectrum. They were also the most likely to have self-medicated, with more than a third having done so (37.3%, 122), compared to 23.6% (26) of non-binary and 11.1% (31) of masculine respondents.

The majority of those who accessed hormones outside of the NHS stated that this was due to the GIC's multi-year waiting times. When asked why they had chosen to access hormones privately, 69.2% (267) specifically referred to waiting times.

“It would take me ‘ideally’ five years at my local GIC to prescribe me hormones. Five years is a long long time to wait. Especially when your mental state depends on the treatment. I needed the HRT. In more ways than I can easily describe here”.

response from a man

58. Some respondents indicated multiple sources for acquiring hormones (e.g. originally self-medicating, before receiving a private prescription).

59. Metastasio, A. et al. (2018).

“NHS waitlists are absolutely, soul-crushingly ridiculous. I was first referred to the London GIC (aka Tavistock & Portman), which is currently taking apparently 52+ months for the first appointment alone, followed by 18+ months for the second to potentially begin HRT. That’s about 6 YEARS to begin HRT. How on Earth is that reasonable or ethical?”

transfeminine respondent

“I felt like my life was on hold while waiting for HRT. I decided to go private so I could get on with life and stop holding back”.

non-binary respondent

Many described frustrations with knowing there were steps they could take to easily and quickly access HRT, describing feeling like their lives were “on hold” or that life was “passing me by” as they waited to access hormones. When describing why she had accessed hormones privately, one transfeminine respondent explained: “I’m not waiting 5-10 years for something readily available in all UK pharmacies”.

Private access to surgery

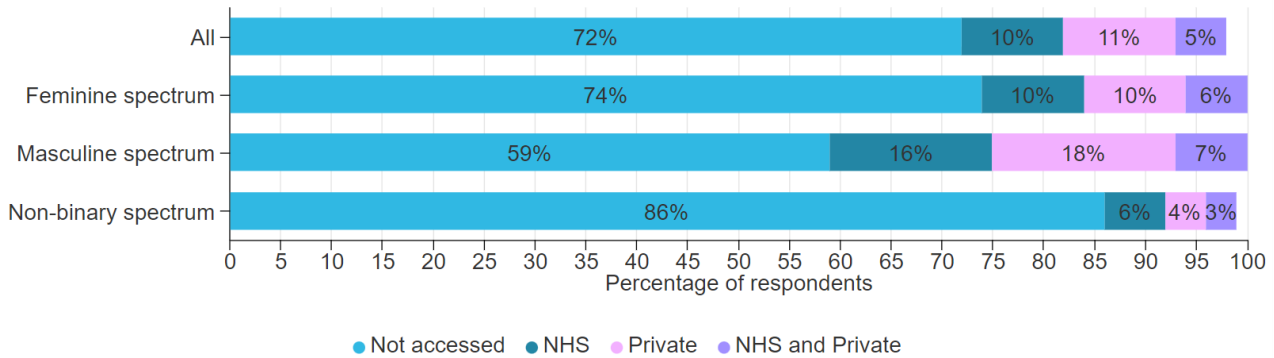
As with hormones, **respondents were more likely to have accessed surgery privately (58.6%, 191) than to have gone through the NHS (56.7%, 185).** Of those who had undergone transition-related surgery, 39.2% (123) had exclusively gone through the NHS, 41.1% (129) had exclusively gone privately, and 19.8% (62) had undergone surgeries both privately and through the NHS. A few described being able to access surgery through private insurance, often obtained through work.

Those on the non-binary spectrum were the least likely to have accessed surgery privately, with those on the feminine spectrum being the most likely. While 44.4% (20) of non-binary individuals had exclusively gone through the NHS, 38.4% (63) of those on the masculine spectrum and 38.1% (40) on the feminine spectrum had done so.

Feminine (61.9%, 65) and masculine respondents (61.6%, 101) were similarly likely to have undergone surgery privately, though masculine respondents were more likely to have only undergone surgery privately (44.5%, compared to 39.1% of feminine and 33.3% of non-binary respondents).

Waiting times were the most common reason for choosing to go private and were mentioned by 57.2% (107) of respondents. Many who could afford private surgery felt that the negative impacts of waiting to go through the multi-year NHS referral process before being placed on a waiting list that could also be one or more years had become or would be unbearable.

Routes for accessing surgery



It was not uncommon for respondents to describe waiting two to five years before they felt they could not wait any longer. For instance, one transmasculine respondent described “*waiting 4 years and 10 months*” before he had “*decided to go forward with private surgery*”. One man described just how much quicker private surgery had been, compared to his experience trying to access surgery through the NHS:

“Privately I was referred, seen, pre assessment, month waiting list then had surgery.. all within 3 months!! Nhs still waiting after a decade to even talk about a referral”.

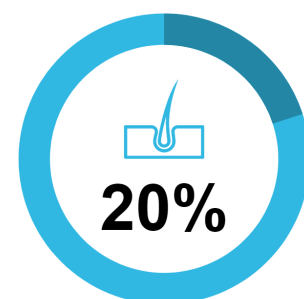
A transmasculine respondent stated that, while he had initially asked for a referral for a mastectomy in May 2017, he was only given an initial appointment nineteen months later. His decision to pay for the surgery privately meant that, “*I had my private surgery in November 2018, within weeks of being referred by the private doctor*”.

Private access to hair removal

While waiting times were also a frequent feature amongst those accessing either laser hair removal or electrolysis, the main motivator for most was the lack of coverage for hair removal through the NHS.

Of those who had undergone hair removal, just 20.5% (65) had done so through the NHS, with 90.5% (287) having done so privately.

Many described having only a few (generally six or eight) hair removal sessions covered by the NHS, which was described as only a small percentage of what was required. **Only one in five who had gone through the NHS stated that what was covered had been sufficient (20.3%, 13).**



who had accessed NHS hair removal said it had been sufficient

One woman described her experience:

“The NHS offered 8 treatments for facial hair removal. This was less than half the number of treatments it took to remove my facial hair almost completely (I still get a few hairs). I also had body hair which was not covered by the NHS but was very dark thick and needed to be removed. I had to access this privately at great expense (several thousand pounds)”.

Others had been refused access to any NHS-funded hair removal (14.6%, 32). Of these, most stated this was because the hair removal they needed was not funded by the NHS (59.4%, 19), with some stating that it was deemed not clinically necessary for surgery (21.9%, 7). One woman explained that, because she had not been able to access hair removal prior to having a vaginoplasty and vulvoplasty, this meant that she now had hair growth in her vagina. Similarly, a transmasculine respondent explained that, because hair removal was not covered for his phalloplasty donor site (due to not being deemed clinically necessary), he would have to save enough money to do this privately.

Paying for care

While accessing private care was commonly described as providing a range of benefits – most notably dramatically shorter waiting times and fewer barriers for approval, particularly for those on the non-binary spectrum, transition-related procedures are generally extremely costly. Across the 504 respondents who indicated they had incurred costs related to their transition, the average estimated cost was £5,573.

However, when considering these figures, it is important to note that this average is likely to be an underestimate of actual costs for five key reasons. First, while these estimates include those reported for hair removal, surgery, and/or HRT, there are other transition-related expenses not accounted for. These could include after-care dressings following surgery, chest binders for those waiting for a mastectomy, or needing to privately pay for physiotherapy or other services following surgery or because of chest binding for many years while waiting for surgery.

Travel and accommodation costs can also be high, particularly as many procedures are only offered in one or two locations across the UK. For instance, phalloplasty and metoidioplasty surgeries are only offered in London, while vaginoplasties are only available in London or Brighton.

Secondly, many respondents who had multiple expenses were unable to

provide estimates, while those who had fewer costs were more readily able to approximate their total expenses as a result. For instance, when reporting her total costs for hair removal, one woman responded: *“Thousands, over a 19 year period (approx 15 laser sessions + 200 hrs or so of electrolysis)”*.

Thirdly, some had to travel internationally to access more affordable surgeries, additional costs that many did not include in their estimated totals. For those who were self-employed, this could include lost income. One respondent even described having to move internationally to afford surgery through health insurance, at a cost of approximately £20,000, which they reported was less than half the cost of self-funding private surgery in the UK.

Fourthly, many respondents reported costs that occurred one, two, or even three decades before completing the survey, with real costs therefore being much higher in current terms. For instance, one respondent described paying £5,000 in 1992 for multiple surgeries, which, accounting for inflation, amounts to nearly £10,000 today.⁶⁰

Finally, these totals come from a snapshot in time, with many respondents only partially through all transition-related procedures they will eventually undertake. This includes many reporting having to undergo revisions or further stages in multi-stage procedures. One non-binary respondent explained that, while they had already spent £4,000 on hair removal services, they still had *“[t]housands more to go”*.

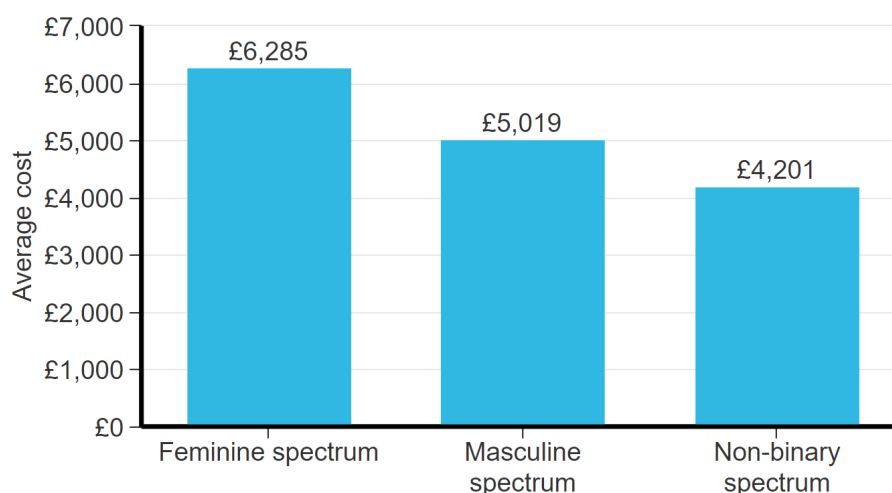
Thus, the approximated average total of £5,573 is likely to represent only part of what those having to pay out of pocket for transition-related care will end up paying.

A majority of respondents who had incurred expenses reported total costs of £1,000 or more (72.8%, 367), with 56.8% (286) reporting total costs of £2,000 or more. More than one in ten (12.7%, 64) estimated they had spent more than £10,000, with the highest costs coming from having to fund surgery and/or hair removal. Those on the feminine spectrum had the highest average expenditure, at £6,285 (263), with those on the masculine spectrum averaging £5,019 (176), and those on the non-binary spectrum £4,201 (65).

Accessing HRT was the most common cost incurred by respondents and, on average, cost less than surgery or hair removal. Nonetheless, the average estimated expense for those who had personally paid to acquire hormones

60. Bank of England. Inflation Calculator. Available at: <https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator>

Average total estimated cost for those who reported expenses for transition related care



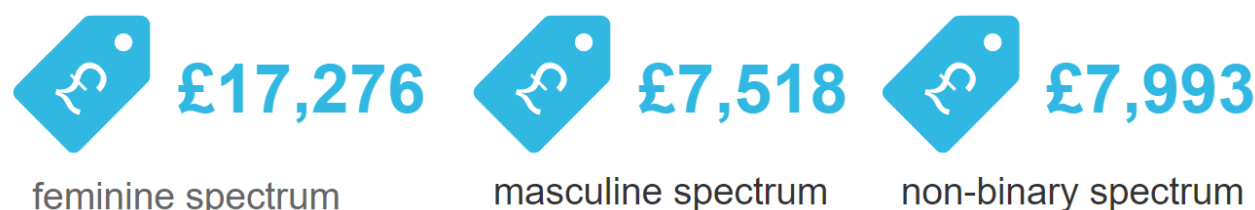
was still over £1,000, at £1,302 (326). Just under one-half (47.9%, 166) spent £1,000 or more, with more than one in five (20.6%, 67) having spent £2,000 or more.

However, for those on fixed incomes, expenses that may seem small may still be incredibly difficult to afford. One transmasculine respondent described how the added expense of accessing hormones privately meant that he could no longer afford the food needed to survive:

“Last week I had to go to a food bank, because we couldn’t afford food to eat. I can’t stop Testosterone, because it’s been phenomenal not just for my mental health, but it’s had positive effects on my physical health too ... but that £90 a month is A LOT when we don’t have much money”.

The ability to transition from a private prescription to receiving hormones through the NHS was a key factor in total costs for accessing hormones. Some had to pay for hormones for a short time, while they waited for their GIC referral or for hormones referrals to be completed. However, some reported having to wait ten years or more, all while paying privately for hormones – either self-medicating or through a private doctor.

Average spend on surgical procedures



“Waiting has forced me to self medicate, and this causes me considerable anxiety for a number of reasons. It also costs a lot of money which I [can’t] really afford, or which would be better spent improving my life in other ways”.

transfeminine respondent

“As I am self medicating the costs are mounting up as buying from the black market is expensive and with a GP who has refused any assistance has also meant I am having to pay for private blood tests to monitor my levels and these are not cheap so overall most of my income is going to pay for hormones and blood test”.

transfeminine respondent

Respondents on the feminine spectrum had the highest average hormone expenditure of £1,465 (149), with those on the non-binary (£1,167, 45) and masculine (£1,164, 132) spectrums having similar average costs. They also had the highest average cost for surgery, at £17,276 (62), compared to £7,993 (23) for non-binary respondents and £7,518 (99) for masculine respondents.

Across all respondents, average estimated surgery expenditure was just over £10,000, at £10,831 (184), while respondents who had privately paid for hair removal reported average costs of £2,112 (206). Most who had paid for hair removal were on the feminine spectrum (91.8%, 189). However, 7.8% (23) were on the non-binary spectrum and one respondent was on the masculine spectrum, who needed hair removal for a phalloplasty donor site.

Average spend on different aspects of medical transition



Conclusion

While nearly one-half of respondents reported costs associated with transition-related care, it is important to note that, for many, these added expenses are simply not affordable. Many spoke of needing procedures but having no conceivable means to pay for them. This included a transfeminine person who was told fully removing her facial hair would cost more than £10,000 who said, *“I just don’t have this kind of cash”*. Instead, she is waiting several years in the hopes that a GIC will fund a small part of this.

This also includes a woman who described “need[ing] to have FFS for safety reasons”, a procedure not currently covered by the NHS:

“As I’m visibly a trans woman I’ve been targeted for abuse far too frequently. My right arm & shoulder got injured in an attack by a group of men in 2020 & it’s now the first thing to get injured in other attacks. ... In 12 yrs I’ve had at least one physical attack each year, most year[s] it’s much more than one incident. I now have CPTSD [Complex post-traumatic stress disorder] & agoraphobia which in turn causes depression”.

Many described considering or making incredibly difficult decisions for the sake of accessing the care they needed. One transfeminine respondent explained that, in order to afford her FFS and a hair transplant she had not only spent all of her life savings, but taken out a loan of £12,000, which she is still paying off.

Another transfeminine person stated:

“Most of my life’s life savings have gone. My hobby equipment sold to pay for my transition”.





Chapter 7: Discussion and recommendations

In the UK, there has historically been a lack of data and understanding of trans people's experiences accessing transition-related care. While existing data has raised concerns about waiting times, this report is the first piece of research to look not only at the scale of the problem but its potential impacts.

Across our 1,183 respondents, it is evident that transition-related care is, for many, essential and lifesaving.

Our research supported earlier findings that trans people are waiting many years for referrals and first appointments, before then waiting even longer to

access HRT and/or surgery. Not only is this in breach of the NHS Constitution, it is also likely leading to significantly higher costs for the NHS. With GIC patients needing regular monitoring and appointments until they have completed all desired medical procedures and treatments, the NHS will inevitably experience increased costs due to the number of appointments during these long waits.

Our research has also shown how years of waiting can have incredibly debilitating consequences on individuals' mental and physical health, in addition to their social and working lives. This also leads to further costs to the NHS. With referrals increasing year on year, it is inevitable that more people will be left waiting for even longer. This will further exacerbate the impact of socioeconomic disadvantage on trans people, with those who can pay able to access private care quickly and those who cannot left waiting for years.

It is our hope that Government, the NHS, and those overseeing the education and training of health providers (including the Royal College of GPs and the Royal College of Surgeons) will use this report to improve the services available to trans people in the UK. While long waiting times and unnecessary barriers have repeatedly been found in previous reports, this is the first time that we have been able to examine the experiences of such a large number of trans people seeking the care they need.

Across our survey, we heard from people who had to choose between being able to buy essentials and accessing the hormones they needed, of people having to go to food banks because they could not afford food and hormones, people feeling unable to make plans as they had no idea when they may be booked in for surgery, and people feeling let down and “*broken*” after years of waiting.

We heard from many who felt that years of waiting and the need to overcome numerous barriers to accessing the care they needed were having debilitating consequences on their wellbeing and day-to-day life. We heard from far too many people who had engaged in self-harming or who had considered or attempted to take their own lives. The people we did not hear from is those who may have succeeded in doing so.

Action is not only urgently needed to improve the situation and save lives, but with referrals increasing each year, action is urgently needed to prevent the situation from continuing to worsen.

Recommendations for NHS England, NHS Scotland, NHS Wales, and Health and Social Care Northern Ireland

1. Improve data collection, monitoring, and transparency of waiting times for transition-related care and use this as a basis to create an action plan to resolve long waiting lists.

While there are some sources of data on waiting lists (e.g., through individual GIC websites and the Gender Construction Kit), these are not sufficient to assess the full picture of waiting times across patient service pathways. Transparent tracking and monitoring systems would not only enable a better understanding of the problem, it would better enable those waiting to make informed decisions and plans. This data could then be used as a basis for a clear, time-bound action plan to reduce waiting lists.

2. Review the Gender Dysphoria Service Specification to ensure necessary procedures and treatments are publicly available in a timely manner, without unnecessary obstacles.

Many respondents felt frustrated that there was no route for them to receive all necessary procedures through the NHS. A review of the existing transition-related care offer is essential and needs to include the voices and experiences of those using these services. We recommend the inclusion of facial feminisation surgery and sufficient hair removal (including donor site hair removal). Ensuring that surgical referrals can be accessed based on one signature can also help reduce the burden on the NHS and reduce barriers to accessing necessary care, and is in line with WPATH's revised Standards of Care. Where changes to the availability and offer of care are made, these need to be communicated in a timely and transparent manner.

3. Work with Integrated Care Services to ensure mental health support is easily available to trans people at all stages of social and medical transition.

While research has shown that the ability to socially and physically transition can have a range of positive impacts on individuals, long waits to access care were incredibly damaging to respondents' mental health. Many respondents also struggled with discrimination at work and in their communities, particularly during medical transition. It is essential that support is available for trans people who need it. This should be co-designed with the input of trans people accessing services and should use existing examples of good practice demonstrated by LGBTQ+ organisations (e.g. Spectra and CliniQ).

4. Establish and improve collaboration with the Royal College of GPs to ensure all GPs understand the needs and rights of trans people in the UK.

Respondents described a range of challenges in receiving support and referrals through GP surgeries, with many GPs not being aware of existing service offers. Particularly given long waiting lists, it is essential that trans people are able to access HRT bridging prescriptions through their GPs. A move to a primary care based, informed consent model of care across all of the UK (similar to those seen in the USA, Canada, and the Netherlands) would greatly improve access to necessary care.

5. Work with the Royal College of Surgeons to proactively develop the workforce that can offer transition-related surgeries in the UK.

While first raised as a key issue in 2015 by the Women and Equalities Committee, it is not evident what (if any) actions have been taken to increase the number of surgeons able to offer transition-related procedures. The ongoing issues with the availability of phalloplasty and metoidioplasty surgeries present a clear example of how a lack of surgeons able to offer these procedures is significantly hindering the health service's ability to improve the availability (and timeliness) of care.

Recommendation for the Royal College of GPs

6. Ensure that all GPs receive necessary training to be able to support trans people who are socially and/or medically transitioning.

GPs in the UK need to be aware of the rights and needs of trans people, including what services are available through the NHS and how people can access them. This includes training and ability to offer HRT bridging prescriptions and supporting trans people to access mental health support, when needed. GPs should not be causing further delays to trans people's ability to access care and it is essential that there are clear avenues to monitor and address discriminatory practices by GPs.

Recommendation for the Royal College of surgeons

7. Take urgent action to increase the number of surgeons able to offer transition-related surgeries in the UK.

A review of the existing number of surgeons able to offer transition-related care is urgently needed. This should include an assessment of the number of people on surgery waiting lists, the number of surgeons likely to be needed in the future to reduce waiting lists in line with NHS guidelines, and a clear action plan of how this will be achieved.

Appendices

Appendix 1: Gender identities

For respondents who indicated that they identified as a gender outside of those provided, 23 other identity categories were included:

- Androgyne
- Butch lesbian
- Demigender
- Feminine Non-binary
- I don't have a gender
- Neutrois (gender neutral)
- Non binary trans woman
- Non-binary Man
- Non-binary Trans Man
- Other
- Part agender trans woman
- Trans Woman
- Trans but use term transexual
- Trans woman
- Trans-non-binary
- TransMan
- Transgender
- Transmasculine non-binary
- Trigender
- Woman/Agender
- man, non-binary, genderfluid
- non-existent
- woman with a transexual history

Appendix 2: Sexual and/or romantic orientations

For those who identified outside of the sexual and romantic orientation categories provided, 14 other orientations were provided, in addition to five respondents who stated they were not sure how they identified:

- Panromantic bi
- Sapphic
- Aceflux
- Demiromantic
- Demisexual
- Dyke
- Homosexual
- I am bi, but I don't like putting it on forms because that makes it sound like I like men. I date women and non-binary people.
- I don't know.
- I don't really know right now.
- No idea
- OCRomantic (OCSexual)
- Other
- questioning
- S
- Straight
- Unknown
- Unsure, changed since transitioning. I was Bicurious and now I'm unsure if I'm asexual or pansexual with low desire for sex

Appendix 3: Detailed breakdown of ethnicities

Two questions were used to assess ethnic identity, with the second including a more detailed breakdown. Responses were as follows.

Ashkenazi (Jewish)	0.09%
Bangladeshi	0.18%
Black African	0.18%
Black Caribbean and South Asian	0.09%
Black Caribbean	0.53%
Canadian	0.09%
Chinese	0.62%
English & Scottish	0.09%
Greek, Irish and English	0.09%
I do not use these labels	0.09%
Indian	0.53%
Jewish	0.09%
Jewish (White)	0.09%
Melanesian Indigenous	0.09%
Mixed Black heritage	0.27%
Mixed White heritage	10.83%
Pakistani	0.53%
Predominantly white/Asian/Caribbean mix	0.09%
Romanian	0.09%
South Asian and White	0.09%
South Asian, Turkish, Arab, Welsh	0.09%
Traveller	0.27%
Whit passing second generation White	0.09%
White	0.09%
White British	0.44%
White Cornish	0.09%
White English	61.19%
White English/Irish	0.09%
White European	6.04%
White Finnish	0.09%
White Irish	2.75%
White Jewish	0.09%
White Scottish	7.73%
White Welsh	3.02%
White and Black African	0.36%
White and Black Caribbean	1.42%
White and East Asian	0.09%
White and Indian Caribbean	0.09%
White and South Asian	0.62%
White and South East Asian	0.53%
White, African, Asian	0.09%

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