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The First Australian National Trans Mental Health Study

Summary of Results

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2013

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Copies of this report and other publications arising from this project may be obtained by visiting the study website at transoz.org or by writing to:

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Preface

The health of trans people in Australia is in a state of crisis. While it is true that some trans people are living healthy and happy lives, this is not true for all. The findings detailed in this report show that at least in absolute terms, an alarmingly large number of trans people experience high levels of mental distress (particularly depression and anxiety syndromes) and poor quality of life.

During the period our research team was conducting this study, we became aware of a number of suicides in the trans community. These were not the first such suicides that we knew had occurred. Sadly, neither will they be the last unless urgent action is taken to address the health disparity experienced by this population.

One such suicide took place in the researchers' home city a few weeks after the study began. This suicide is no more or less tragic than any other, but what was significant for us was that this woman had written about what life was like as a young trans person in Western Australia shortly before she died. We think her story is now especially poignant, and we present an extract below. The full article ("*Amber's story*") can be found on page 18 of Red Flag issue 4 (24 July 2013), available online at:

<http://redflag.org.au/article/amber%E2%80%99s-story>

As a young trans person living in Perth, my experience attempting to find housing illustrates the discrimination that transgender people face on a daily basis. I've been rejected from share-houses on the basis that the advert specified they were looking for a female and I don't "fit that criterion". Several times I was rejected on the basis that the house was looking for "real girls".

When I sought their assistance, Youth Futures, Western Australia's TINOCA (Teens In Need Of Crisis Accommodation) service, informed me that it is their policy to house young people with people of the same physical sex ... A different service hung up on me after telling me that they only had spaces for females (evidently I didn't sound female enough).

...

While initially attempting to access services to help me transition, I came across a “youth specialist” who after three sessions informed me that he had only ever met one other person my age who identified as transgender. He then went on to explain that he had convinced this person that it was not in their best interests to transition and that consequently he neither could nor would help me.

In addition to this, my experiences with doctors from whom I’ve sought assistance for other issues made clear the serious lack of suitable health care for trans people. I was admitted to hospital in December last year with an admission document that, I later found out, described me as a “transitioning transvestite”.

I was also told by another doctor that though the staff were aware of my status as a trans person and aware that I identified as female, I would have to constantly remind people and correct them if they misgendered me. This same doctor also asked me whether I planned to have genital surgery, regardless of the fact that this had no relevance to the issue I was hospitalised for.

...

The people who participated in this study shared with us many stories like this. It is clear that experiences like those described above, although extremely tragic, are far from unique.

This report is dedicated to all of the trans people who we have lost to suicide.

We hope that the findings of this report are acted upon with urgency, so that trans people do not continue to die unnecessarily.

List of abbreviations

AFAB	Assigned female at birth
AMAB	Assigned male at birth
ATSI	Aboriginal and/or Torres Strait Islander
BP	Bodily pain (SF-36 summary scale)
DSM	Diagnostic and Statistical Manual of Mental Disorders
FTM	Female to male
GH	General health (SF-36 summary scale)
GLBTI	Gay, lesbian, bisexual, trans, and intersex
GnRH	Gonadotropin-releasing hormone
GP	General practitioner
HILDA	2001 Household Income and Labour Dynamics in Australia survey
ICD	International Classification of Diseases and Related Health Problems
ID	Identifying documents
LGB	Lesbian, gay, and bisexual
LGBTI	Lesbian, gay, bisexual, trans, and intersex
MBS	Medicare Benefits Schedule
MH	Mental health (SF-36 summary scale)
MTF	Male to female
NESB	Non-English speaking background
NHMRC	National Health and Medical Research Council of Australia
NHS	1995 National Health Survey
NITV	National Indigenous Television channel
PBS	Pharmaceutical Benefits Scheme
PDRQ-9	Patient-Doctor Relationship Questionnaire
PF	Physical functioning (SF-36 summary scale)
PHQ	Patient Health Questionnaire
QOL	Quality of life
RE	Role-emotional (SF-36 summary scale)
RP	Role-physical (SF-36 summary scale)
SF	Social functioning (SF-36 summary scale)
SF-36	36-item Short Form Health Survey
TAFE	Technical and Further Education
VT	Vitality (SF-36 summary scale)
WHO	World Health Organisation

Synopsis

This report provides an overview of the findings of The First Australian National Trans Mental Health Study. The study, which ran for 5 months between August and December 2013, was designed to investigate the mental health and well-being of trans people living in Australia. The study was anonymous, Internet-based, and open to anyone who self-identified as trans (or could have been described as such) and was aged 18 years or older. Participants were recruited through social media; through flyers and posters sent to doctors, service providers, and other organisations working with this population; and with snowball sampling. After excluding people who did not fit the inclusion criteria for the study, 946 people took part. Participants included 482 trans women (51.0%), 232 trans men (24.5%), 136 people who were assigned female at birth but now had a non-binary identity (14.4%), and 96 people who were assigned male at birth but now had a non-binary identity (10.1%). The study is the largest study of its kind in Australia, and one of the largest in the world.

The study found that trans people experience very high levels of mental health problems, particularly depression and anxiety syndromes. At the time they completed the questionnaire, 43.7% of the sample were currently experiencing clinically relevant depressive symptoms; 28.8% met the criteria for a current major depressive syndrome; 5.4% for another depressive syndrome; 18.3% for a panic syndrome; and 16.9% for another anxiety syndrome. One in 5 participants (20.9%) reported thoughts of suicidal ideation or self-harm on at least half of the days in the 2 weeks preceding the survey.

Over half of participants (57.2%) had been diagnosed with depression at some point in their lives. Of those diagnosed with depression, 54.2% had been diagnosed in the last 12 months. Roughly 2 out of every 5 participants (39.9%) had been diagnosed with an anxiety disorder at some point, and of these, 62.1% had been diagnosed in the last 12 months.

To place these results in context, trans people appear to be 4 times more likely to have ever been diagnosed with depression than the general population, and approximately 1.5 times more likely to have ever been diagnosed with an anxiety disorder. Of even greater concern, is that the proportion of participants who were *currently* affected by a depression or anxiety syndrome was greater than the *lifetime* prevalence of depression and anxiety disorders in the general population. This finding held after the data were age-standardised to the Australian population.

There was a marked difference in the proportion of people who were currently experiencing clinically relevant depressive symptoms by both hormone use, and surgical status. In those taking hormone therapy the proportion was 39.8%, while in those who were not taking it (but wished to do so), the proportion was 58.4%. Of those who had undergone at least some form of transition-related surgery, the proportion with clinically relevant depressive symptoms was 34.6%. Among those who desired (but had not undergone) surgery, it was 51.3%. This supports previous research that access to hormones and surgery improves quality of life.

In multivariate regression analyses, the factors associated with poor mental health were: sex identity (trans men, and especially trans women, were more likely to have clinically relevant depressive symptoms than non-binary individuals, while non-binary individuals were more likely to have been diagnosed with an anxiety disorder or to currently have an anxiety syndrome); lower educational attainment; being unemployed or unable to work; low income; poor self-rated health; wanting to take hormone therapy; wanting to undergo surgery; difficulty changing identifying documents; not feeling comfortable telling doctors about being trans; and a recent experience of discrimination.

Participants were also asked to describe the factors they thought influenced their mental health; what their experiences accessing healthcare were like; how they felt about changing identifying documents; and experiences of discrimination. The personal stories shared by participants were consistent with the findings of the regression analyses.

Overall, participants reported that obtaining hormone therapy was often a difficult and frustrating experience, but immensely rewarding and affirming once they were able to commence hormone therapy. They reported that it was often very difficult, if not impossible to access some kinds of surgery in Australia, because they were either unable to afford the cost or because the desired surgery was unavailable. Participants reported that changing their identifying documents was often a difficult and frustrating process, and recounted the negative impact that not being able to change these documents had on their life.

Experiences of discrimination and harassment were common. Nearly two thirds of participants (64.8%) reported at least one instance, with experiences ranging from social exclusion to violence and assault. Many participants reported changing their behaviour for fear of being subject to further instances. Participants also reported discrimination when accessing healthcare, and that the healthcare system generally failed to meet their needs. Some participants did report good relationships with medical practitioners, but this was often a matter of luck in finding a supportive doctor and knowing where to go for help.

These findings suggest trans people experience worse mental health than possibly any other community in Australia, and demonstrate an urgent need to address the factors underlying this disparity, such as poor healthcare and discrimination. This report concludes with a series of recommendations that could dramatically improve the quality of life of trans people. They are relatively simple to implement. In particular, key areas for reform include:

- (i) Provision of a multidisciplinary clinic in each state and territory (operating within the public health system), which can provide healthcare for trans people;
- (ii) Health departments must develop clear referral pathways and protocols for trans people, so that trans people and their doctors know the exact steps to follow to achieve a medical transition;
- (iii) Healthcare for trans people should be based on an informed consent model, rather than a “gatekeeping” approach;
- (iv) Trans health must become a part of multidisciplinary health curriculums, including (but not limited to) medicine, nursing, social work, and psychology;
- (v) State and territory governments must develop a simplified and consistent procedure common to all Australian jurisdictions for changing an individual’s legal sex. Medical intervention should not be a prerequisite, and married trans people must not be forced to divorce in order to change their legal sex;
- (vi) Government agencies, service providers, and other organisations should ensure that their staff are adequately trained to work with trans people in a respectful and affirmative manner. They must develop policies to actively prevent discrimination and to make trans people feel welcome when accessing their services;
- (vii) Governments and education providers must develop policies to ensure that educational settings are secure and safe places for trans people of all ages;
- (viii) Mental health services should develop mental health promotion interventions and programs targeting trans people, in consultation with trans people;
- (ix) Suicide-prevention interventions and research must specifically target trans people; and,
- (x) Funding bodies such as the NHMRC should consider making the health and well-being of trans people a research priority area.

These recommendations would go a considerable way toward addressing the health disparity observed between trans people and the general population. Trans people deserve the same quality of life, and deserve to receive the same quality of care as any other Australian. To quote one participant: *“We are not monsters. I do not expect to be treated as one”*.

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1 Introduction

In this chapter, we present an overview of the study and its rationale; a very brief introduction to trans issues; and a summary of the demographic characteristics of the 946 participants in this study.

1.1 About this report

This report should be read as a summary document. While we were conducting this study, we were overwhelmed with the level of support we received, and the number of personal stories that participants chose to share with us. Sadly, we cannot possibly report everything that people shared with us in the detail that we would like. Therefore, in order to properly analyse the stories and information that participants gave us, we plan to release an on-going series of articles that will explore aspects of this study in greater depth.

Because we want this research to have an impact on policy and healthcare, we hope to publish these articles in medical and public health journals. These are the publications that people who interact with trans people on a professional basis (such as healthcare workers) are likely to read. As these are published, we will announce them on the study website (**transoz.org**). Many articles in scientific journals are not readily accessible to the public, but state and territory reference libraries may be able to provide access to these. University libraries usually also have access to these journals.

1.2 Background to the study

Despite the growing visibility of trans people, there has been very little research conducted with this population, especially in Australia. This is important, because mounting evidence suggests that trans people experience worse health than the general population, particularly with regard to mental health. There is an urgent need to understand why this is so, and more importantly, to find out how this can be addressed.

This study builds on previous research conducted in Australia, such as the *Transgender Lifestyles and HIV/AIDS Risk* project¹, the *Western Australian Transgender and Transsexual Health and Well-being Survey*², the *TranZnation study*³, the *Gender Identity Australia* study⁴, and some studies of lesbian, gay, bisexual, trans, and intersex (LGBTI) people, such as the *Private Lives* study⁵ and the *Writing Themselves In* studies⁶⁻⁸.

Although pioneering, a limitation of these studies is their relatively small sample size, and limited exploration of the prevalence of mental health problems and the factors associated with this.

With nearly 1,000 participants, we hope that this study will provide a comprehensive overview of the state of the mental health and well-being of trans people in Australia, and provide the evidence base needed for reform of the healthcare sector and other areas.

Ethical approval for this study was granted by the Curtin University Human Research Ethics Committee.

1.3 Who are trans people?

There are many different ways that people define the term *trans*. Some people feel very strongly about terminology, and prefer some words over others. Some common words that people use include *transsexual*, *transgender*, *androgynous*, and *genderqueer*. Some communities, such as Aboriginal and Torres Strait Islander (ATSI) people, might use culturally-specific terms such as *sistergirl* or *brotherboy*. Sometimes, ATSI people may use words from the Aboriginal language(s) which they speak to describe themselves.

For the purpose of this report, we use the word *trans* to describe a person who experiences an incongruence between the sex assigned to them at birth and the sex they feel they belong to, and/or a person who has a gender expression (e.g., masculine, feminine) that is inconsistent with societal expectations of their sex.

Owing to the many different ways that trans people describe themselves, and the many unique ways that people experience being trans, it is necessary to pick some form of umbrella term. We recognise that some of the participants in our study used a different word to describe themselves (or in some cases, no label at all), but owing to the sheer variety of terminology used, we hope that readers will understand the need to use a single term for the purpose of this report.

However, one danger in using an umbrella term is that it can obscure differences between sub-populations within the trans community. The findings of this study show that there are groups within the trans community who have different legal, medical, and social needs. This should be borne in mind when working with this population, planning policy, and designing interventions to improve the health of trans people.

We also use the words *sex* and *gender* slightly differently to common usage. We use the word *sex* to describe whether someone feels themselves to be male or female (or both, or neither), and we use the word *gender* to describe someone's behaviour (i.e., whether they are masculine, feminine, some mix of the two, or neither).

It is important to recognise that sex and gender are not always aligned. For example, a person who was raised as a girl but feels that they are male and later goes on to live as a man (a trans man), may not always be masculine. Most trans men in this report did describe themselves as masculine, but some may feel uncomfortable with the strict way that men and women are expected to behave^a, and may enjoy activities that would be perceived as feminine. Similarly, a trans woman might feel very strongly female, but have an androgynous gender expression, or might like to do things that are considered masculine.

So, although sex and gender are often used as synonyms, it is important to note that these words are best used to describe different concepts. Accordingly, when we talk about a participant's sex (or *sex identity*) we are talking about whether they described themselves as a man or a woman (or neither). When we talk about gender (or *gender expression*), we are describing behaviour.

It is also important to note that everyone has a sex identity and gender expression, regardless of whether they are trans. Everyone has the right to determine their sex identity for themselves, and to express their gender in their own way, without fear of discrimination.

Everyone is assigned a sex at birth, but some people do not neatly fit into the categories of male and female. Some people are born with reproductive systems or genetic factors that are neither exclusively male nor female. These people are *intersex*. Most intersex people identify strongly as male or female, but some feel they are neither, or a combination of both. Owing to the complexity of the intersex experience, which sometimes includes non-consensual surgery to "fix" the genitals in childhood^b, this study was designed to investigate the experiences of trans people only. (However, it is important to note that some intersex people may identify as trans as well as intersex). Regardless, there is an equal need for research to explore the health and well-being of intersex people.

^a The social expectations for how men and women are expected to behave are known as *gender roles*. It is important to note that gender roles vary across cultures, and have not remained fixed over time. For some people, being expected to fit a rigid gender role is a considerable source of stress.

^b This can be catastrophic if the "wrong" sex is chosen, and sometimes the surgery can result in lasting sexual dysfunction. For more information about intersex issues, see the recent Senate Report into the involuntary sterilisation of intersex people⁹.

A final point to note is that it remains unclear how sex identity and gender expression are formed. We do know that the brain undergoes sexual differentiation *in utero*. We know that people who have complete androgen insensitivity syndrome, a state in which a person has the sex chromosomes of a male (XY) but lacks the ability to respond to testosterone, identify strongly as female except in a handful of very rare cases¹⁰. In situations where the body can respond to some or nearly all testosterone (partial androgen insensitivity syndrome), sex identity is more likely to be male. This suggests that exposure to sex hormones such as testosterone and oestrogen plays at least some role in determining sex identity.

There is mounting evidence to suggest that hormonal and/or genetic factors may influence sex identity and gender expression¹¹⁻²⁰. Unfortunately, being trans is currently considered a mental disorder by both the American Psychiatric Association, who publish the Diagnostic and Statistical Manual of Mental Disorders (DSM)²¹, and the World Health Organisation (WHO), who publish the International Classification of Diseases and Related Health Problems (ICD)²². How this might affect the relationship between doctors and trans people is unknown. However, this classification may change in the next revision of the ICD²³.

It is our position that being trans is not a mental disorder, but probably a variation of sex development. Or, to simplify, a situation in which the brain and the rest of the body develop along different pathways, similar to being intersex, but not affecting the reproductive system.

1.4 Trans people and the LGBTI community

The term *LGBTI* (lesbian, gay, bisexual, trans, intersex) is an acronym for the most common labels that people use to describe either their sexuality, or sex and/or gender.

Trans people, like non-trans people, can be heterosexual, homosexual, bisexual^c, or asexual (experience little or no sexual desire and/or attraction to other people). For analysis purposes, we generally use these well-known terms to describe the sexuality of participants, but it is important to note that participants used a wide range of labels (or no label at all) to describe their sexuality. Participants used such a variety of language to describe their sexuality, that it was necessary to aggregate their responses into these four basic categories in order to analyse the data. We also did not wish to prioritise any particular label over another. The manner in which we aggregated the data should therefore not be interpreted to mean that participants only described themselves using these terms.

^c Some people prefer to use the term *pansexual* or *omnisexual* rather than bisexual.

However, it should be noted that some trans people (and also some intersex people) do not consider themselves to be members of the LGBTI community, or even that such a community exists. Some people feel that the issues that affect trans people (sex and gender) should not be conflated with sexuality. Conversely, others believe that people who are not heterosexual are not conforming to the gender role expected of them, and thus commonality exists between trans people and LGB people. Also, people can be both trans and LGB, and therefore feel part of a broader community on that basis.

It must be remembered though, that discrimination sometimes occurs between groups in the LGBTI community. Trans people have, and continue to experience discrimination from some non-trans LGB people (and occasionally *vice versa*), and there is continuing tension between some members of these respective groups.

Most important of all, it should be noted that trans people have specific social, legal, and medical needs that are not shared with non-trans LGB people. Given that non-trans LGB people vastly outnumber trans people, care should be taken when speaking of the LGBTI community to ensure that trans people are not marginalised, and that the different needs of these diverse groups of people are not assumed to be the same. In particular, care should be taken to ensure that the language often used to describe LGB people is not applied to trans people unless it is appropriate to do so.

For example, the concept of “coming out” operates very differently between non-trans LGB people and trans people. For LGB people, coming out is hopefully an empowering experience, correcting a misconception in the way that others see them. For trans people, “coming out” can be radically disempowering, because people may no longer see them as how they present themselves to the world, but rather as the sex assigned to them at birth. However, for non-binary trans people, coming out may be a necessary and desirable way to articulate their identity as something other than a man or woman.

1.5 What was the aim of the study?

Previous research indicates that trans people appear to experience health disparity compared with the general population. However, most research has been conducted overseas, and the majority of Australian studies feature small numbers of trans people. For example, the TranZnation Study (one of the largest studies of trans people living in Australia and New Zealand) recruited only 253 people³. This means that previous studies may not be

representative. Previous studies might also have sampled people from either high- or low-risk groups, evidenced by high levels of educational attainment in some studies.

Unfortunately it is impractical to conduct a random sample of trans people owing to the relatively small size of this population. The exact size of the trans population is unknown. A 2008 study of New Zealand passport holders found at least 1 in 6,364 people were trans ²⁴. However, not all trans people hold a passport or seek to change it, so this number is probably an underestimate. Others have suggested between 1 in 1,000 and 1 in 2,000 is a more realistic figure, and perhaps as many as 1 in 500 people might be trans ²⁵. A recent study of New Zealand high school students found that 1.2% described themselves as trans ²⁶. Given that trans people are a stigmatised group, many prefer not to disclose their trans status to anyone, or only to some people. This makes recruiting this population difficult.

This study shared this unavoidable limitation with regard to achieving a representative sample of trans people, but by using a wide range of recruitment techniques, we aimed to recruit a much larger sample than previous studies. This means that our findings are much more likely to accurately reflect the health and well-being of trans people.

We designed The First Australian National Trans Mental Health study to gain a national snapshot of the mental health and well-being of trans people living in Australia. We aimed to:

- determine the prevalence of depression and anxiety syndromes;
- determine how many people had been diagnosed with depression and anxiety disorders and were receiving treatment;
- determine whether depression and anxiety syndromes are associated with risky health behaviours such as illicit drug use;
- explore the patient-doctor relationship between trans people and their general practitioners, and health workers generally;
- explore the factors that encourage and discourage trans people from accessing healthcare; and,
- explore the factors that protect and promote mental health in trans people.

We hope that our findings will enable healthcare workers and other relevant bodies to engage effectively with trans people, and to develop interventions and make legislative and policy changes that will improve the mental and physical health of this population.

1.6 How were participants recruited, and who was eligible?

We used a range of non-probability sampling techniques to recruit participants because random sampling methods are not feasible with this population. We used an anonymous, Internet-based questionnaire that was accessible between August 2013 and December 2013 (inclusive). We chose to conduct the study anonymously, because some trans people are *stealth* (i.e., they prefer other people not to know about their trans status, or prefer to only tell some people). We thought that some trans people might choose not to participate in the study if they thought they could be identified, and for this reason did not seek written informed consent from participants. The website explained the purpose of the study to participants, and stated that if they chose to proceed to the questionnaire, then they “consent[ed] voluntarily to be a participant in this study”.

People were eligible to participate if they were aged at least 18 years and self-identified as trans, or had done so in the past (some people no longer consider themselves trans after completing a medical transition). The study website explained to potential participants that we “used the word trans in an inclusive way, and would like to hear from people who use words like transsexual, transgender, sistergirl, brotherboy, androgynous, or genderqueer to describe themselves. All trans people, including those who just describe themselves as men or women are encouraged to participate”.

The study website also explained that the study was “not intended for people who are intersex”. The website noted that there may be some similarities between the experiences of trans and intersex people, and that we thought that “transsexualism and intersex states are likely to both be variations of sex development”. However, the website noted that some intersex people face challenges that trans people do not, such as non-consensual genital surgery in childhood. One questionnaire could not adequately address the experiences of both groups, and our focus was on the experiences of trans people. However, the health and well-being of intersex people is also a neglected area, and there is a need for research to address the specific concerns of the intersex population.

We promoted our study by sending promotional materials (fliers and posters) to approximately 150 doctors (mostly general practitioners, endocrinologists, psychiatrists, and sexual health physicians) and other service providers that we knew worked with this population. Because there are very few clinics for trans people in Australia, people tend to access only a small number of doctors who work in this area and/or have a good

understanding of trans medicine. Knowledge of these doctors is largely spread by word of mouth within the community.

We advertised the study in LGBTI media that we thought trans people might be likely to access, including Blaze, Fuse Magazine, LOTL, Out in Perth, Polare Magazine, Melbourne Community Voice, Q Magazine, Q News, Queensland Pride, SX, and Star Observer. Where LGBTI media was not available in some states and territories, we placed advertisements in local media including Darwin Suns, Launceston Examiner, The Mercury, and Northern Territory Weekly. We also promoted the study through radio interviews.

We made extensive use of social media, and shared the link to the study website on Twitter and Facebook. We posted links to the study website in trans-specific Facebook groups, and groups that we thought trans people might be likely to access. To ensure ATSI people and people from ethnic minority communities who were trans were aware of the study, we also posted links to the study in groups specific to these sub-populations. We followed a similar procedure for sex workers. We also asked people to share the study with their friends using social media, and the website featured Facebook “Like” and “Share” buttons and a Twitter “Tweet” button to make this easy^d. We also posted links to the study on trans-specific support websites, some LGBTI websites, and the Facebook pages of LGBTI and mental-health related organisations.

Numerous service providers, including ACON, headspace, Queensland AIDS Council, Victorian AIDS Council/Gay Men’s Health Centre, and the West Australian AIDS Council helped us to promote the study to people accessing their service.

We also made use of a simple snowball sampling technique. Both study participants and visitors to the website were able to register their e-mail address to receive news about the study if they wished to do so. (People did not need to take part in the study in order to register their e-mail address). Approximately 250 people registered their e-mail address, and we sent an e-mail to these people asking them to tell their trans friends about the study.

Finally, our study was guided by an advisory group comprising individuals from the peak organisations for trans people in Australia, and other interested parties. In addition to reviewing our study materials and this report, the group provided invaluable assistance by promoting the study to their respective communities.

^d The study received 1,455 Facebook “Likes” during the data collection period, and 36 tweets.

1.7 How was mental health and well-being assessed?

This was both a quantitative and qualitative study. We used a number of validated instruments that are widely used in the field to assess mental health and well-being. We chose these particular instruments because population norms were available for Australia. Our findings are therefore directly comparable to the general population, and other groups.

However, it should be noted that at least one of the instruments we used was not ideal to gather data from trans people, because it contained questions with the wording “people of my own sex” and “people of the other sex”²⁷. Although this instrument was suitable for most people who took part in our study, some participants (particularly those who identified as something other than male or female), found these questions difficult to answer. We would have preferred to have used a more appropriate instrument in this instance, but a suitable alternative for the trans population was not available, and we did not have the resources to develop one. This highlights the importance of further research to develop psychometric instruments that are reliable and validated with this population.

Instruments that we used included the Patient Health Questionnaire (a screening and diagnostic tool for depression and anxiety syndromes)²⁸, 36-item Short Form Health Survey (a measure of health status and quality of life)²⁹, Patient-Doctor Relationship Questionnaire³⁰, Body Image Quality of Life Inventory²⁷, and selected items assessing alcohol, tobacco, and illicit drug use from the National Drug Strategy Household Survey³¹. We also included some demographic items, and items assessing whether mental health problems had been previously diagnosed and treated.

We developed a number of qualitative questions to investigate what participants’ experiences of healthcare were like, what they thought their health care needs were, factors that participants felt affected their mental health, and factors that encouraged and discouraged participants from seeking healthcare. We asked participants about their attitudes toward and ability to obtain hormone therapy and surgery, their experiences with changing identifying documents (such as the birth certificate, driver’s license, passport, and educational awards), and whether participants had experienced discrimination and harassment (and if so, how this had affected their life).

Our questionnaire was piloted with members of our advisory group, who ensured that the materials were culturally appropriate. We subsequently revised some questions and text on the study website based on their feedback.

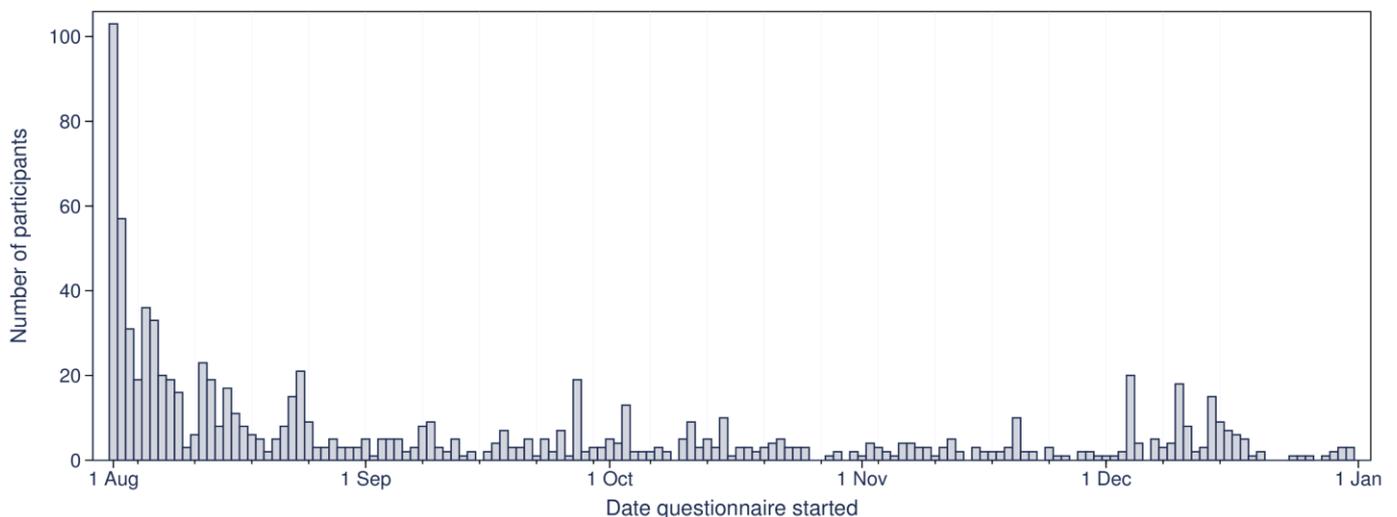
2 Who took part in the study?

This chapter describes who took part in the study and their demographic characteristics. Between August 2013 and December 2013 (inclusive), 1024 surveys were completed. From these, we had to remove 13 that were received from people not living in Australia, 2 from people aged less than 18 years, 6 duplicate surveys, 35 people who did not report the sex they were assigned at birth and how they now identified (a mandatory question), and an additional 22 people who were either not trans, or appeared to have provided malicious responses. This left 946 people in the study.

2.1 Timing and location of responses

As shown in Figure 1, there was an initial surge of responses on the day the survey opened, which corresponded to the initial promotion of the study on social media. Subsequent peaks in August (and to a lesser extent in later months) probably correspond to the time at which adverts for the study appeared in print media. Finally, there was another peak in December, which corresponds with the time at which we sent e-mails to everyone who had registered an e-mail address with us, asking them to please remind their trans friends about the survey.

Figure 1: Frequency of survey responses by date



As shown on the next page in Table 1, the majority of participants came from the states of Victoria and New South Wales. This is expected, given that the majority of the Australian population lives in these two states. However, we appeared to have over-recruited people from Victoria by about 5%, and under-recruited people from New South Wales by about 6%. People from all other states and territories appeared to be appropriately represented. Interestingly, a similar pattern was also observed in the TranZnation study³. This could be due to chance. Alternatively, it is possible that it is harder to recruit people from New South

Wales because there are fewer services there than in Victoria (several participants made comments about the limited number of doctors working with trans people in this state), or because some trans people choose to leave New South Wales for Victoria. This could be because Victoria has a clinic for trans people within the public health system (The Southern Health Gender Dysphoria Clinic)³². This clinic is the main publicly-funded clinic in Australia. Alternatively, perhaps trans people perceive Victoria to be a state in which it is easier to transition and/or a state that is more welcoming to trans people.

Table 1: Proportion of participants recruited by state and territory, and proportion of the general population living in each state and territory

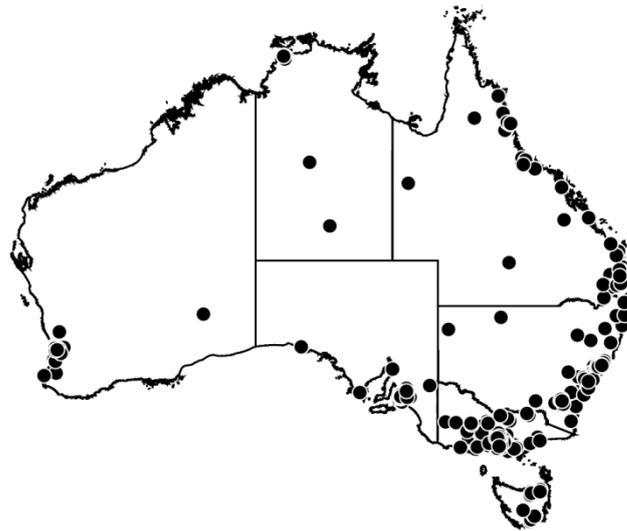
State or territory	This study	Australian population ^e
	n (%)	%
Australian Capital Territory (ACT)	28 (3.0)	1.6
New South Wales (NSW)	242 (25.6)	32.0
Northern Territory (NT)	11 (1.2)	1.0
Queensland (QLD)	175 (18.5)	20.1
South Australia (SA)	91 (9.6)	7.2
Tasmania (TAS)	19 (2.0)	2.2
Victoria (VIC)	282 (29.8)	24.8
Western Australia (WA)	98 (10.4)	10.9

The majority of participants lived in one of the major cities of Australia. Almost all (93.3%, n=883) lived in either a major city or inner regional Australia (as defined by the Australian Bureau of Statistics), while 5.9% (n=56) lived in regional or remote Australia. Seven people did not disclose their postcode, and so we could not determine this.

Using the postcodes provided by participants, we were able to generate a geo-coded map showing the approximate distribution of respondents across Australia (Figure 2). Each black circle represents a postcode where at least one participant lived. Note that the location of the circles may not match the exact location of the participant for privacy reasons, and because postcodes in regional and remote areas can cover a very large area.

^e Based on the estimated resident population of Australia at 30 September 2013³³.

Figure 2: Map of Australia showing the distribution of participants



2.2 Sex and gender of participants

Participants were asked what sex they were assigned at birth; 578 (61.1%) were assigned male and 368 (38.9%) were assigned female. Participants were also asked if they now described themselves as “a man/male”, “a woman/female”, or “other”. Those who answered *other* could write their own description. For analysis purposes, people who described themselves as something other than male or female were classified as *non-binary*. The number and proportion of people in each category is shown in Table 2.

Table 2: Number, proportion, and age of participants by identification

Category	n (%)	Mean age (years)
Assigned female at birth (AFAB) non-binary	136 (14.4)	27.2
Man/male	232 (24.5)	28.2
Woman/female	482 (51.0)	41.6
Assigned male at birth (AMAB) non-binary	96 (10.1)	42.2

Trans women accounted for the majority of the sample, followed by trans men, and AFAB non-binary individuals. Trans women were older than trans men ($p < 0.001$; Mann-Whitney U test). AMAB non-binary participants were also older than AFAB non-binary participants ($p < 0.001$; Mann-Whitney U test).

Participants were also asked what word or words they used to describe their sex and/or gender. There are too many to list in this report (although we intend to report on the diversity of language that trans people used to describe themselves in future analyses). However, some of the more common terms are given below.

Descriptions used by trans men included: *“transgender”, “transsexual”, “trans man”, “transguy”, “dude”, “boy”, “bloke”, “FTM”, “I was born a woman but am now a man”, “male”, “I would only ever describe myself as male, without any other qualifier”, and “man with transsexualism”.*

Examples of terms used by trans women included *“transgender”, “transsexual”, “trans woman”, “trans girl”, “female”, “MTF”, “lady”, “sistergirl”, “straight female born with a defect”, “tomboy, female”, “woman with a trans history”, “big gorgeous tranny”, “transwoman and proud of it”, “a girl with an errant Y chromosome and an annoying penis :P But basically I just describe myself as a woman who grew up as a boy”, and “approximately ninety percent female, seventy percent feminine and zero percent lady”.*

Common words that non-binary people used to describe themselves were *“genderqueer”, “agender”, “bi-gender”, “genderfluid”, “androgynous”, “transmasculine”, “no label”, “combination of male and female”, and “gender non-conforming”.*

Some people used different terminology based on context. For example, one person explained that they described themselves as genderqueer around their queer friends, and that their friends used neutral pronouns (e.g., “they”), but in other contexts such as work, they would describe themselves as female and colleagues would use female pronouns.

In addition to asking participants whether they felt themselves to be a man/male, a woman/female, or something else, we also asked participants to describe how masculine or feminine they felt themselves to be (i.e., their gender expression). Responses are summarised in Table 3.

Table 3: Gender of participants by category of identification

Gender	Category of identification			
	AFAB	Trans	Trans	AMAB
	non-binary	men	women	non-binary
	n (%)	n (%)	n (%)	n (%)
Very masculine	6 (4.4)	51 (22.0)	0 (0)	2 (2.1)
Somewhat masculine	42 (30.9)	121 (52.2)	19 (3.9)	6 (6.3)
Neither masculine nor feminine	26 (19.1)	15 (6.5)	25 (5.2)	11 (11.5)
Both masculine and feminine	52 (38.2)	40 (17.2)	90 (18.7)	48 (50)
Somewhat feminine	7 (5.2)	3 (1.3)	224 (46.5)	23 (24.0)
Very feminine	2 (1.5)	0 (0)	120 (24.9)	6 (6.3)
No answer	1 (0.7)	2 (0.9)	4 (0.8)	0 (0)

As expected, most trans men felt themselves to be at least *very* or *somewhat* masculine, and most trans women described themselves as *very* or *somewhat* feminine. But it is important to note that not everyone’s gender expression matched their sex identity. So, while someone might strongly feel that they are a man or male, they may not necessarily feel particularly masculine. Similarly, one should not expect all trans women to be feminine.

Trans people should not be expected to want to conform to gender roles (just as some non-trans people also feel uncomfortable doing so). Additionally, this highlights the importance of not confusing sex with gender^f.

^f This point is especially pertinent in light of the debate as to whether the diagnostic categories “gender identity disorder of childhood” (ICD-10) and “gender dysphoria in children” (DSM-5) are scientifically defensible. It has been noted that young children diagnosed with these conditions generally do not transition in adulthood (although adolescents who feel this way generally do) and instead simply grow up to be feminine men and masculine women. Some are gay, lesbian, or bisexual.

Some have therefore argued that “gender identity disorder” in children is unlikely to persist into adulthood, and could therefore be “treated”³⁴. (Others go further, and question whether “treatment” could prevent the development of homosexuality³⁵). However, the lack of persistence probably reflects the very poor sensitivity and specificity of the diagnostic categories, and their failure to distinguish between gender expression and sex identity. Young children may not be able to easily articulate the difference, and should not be pathologised if their gender expression is not consistent with the social expectations of their sex.

However, adolescents who seek to transition should be able to receive treatment under an appropriate, non-psychopathologising diagnostic category, which should be located in the ICD rather than the DSM. Such a diagnostic category should not be included in the chapter of mental disorders.

2.3 Other demographic characteristics of participants

Other key demographic characteristics of the sample are shown below and overleaf.

Table 4: Other demographic characteristics of participants

Variable	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Age (years)					
18-19	92 (9.7)	29 (21.3)	38 (16.4)	20 (4.2)	5 (5.2)
20-29	321 (33.9)	67 (49.3)	111 (47.8)	121 (25.1)	22 (22.9)
30-39	168 (17.8)	25 (18.4)	49 (21.1)	79 (16.4)	15 (15.6)
40-49	140 (14.8)	8 (5.9)	20 (8.6)	96 (19.9)	16 (16.7)
50+	216 (22.8)	6 (4.4)	10 (4.3)	163 (33.8)	37 (38.5)
Missing data	9 (1)	1 (0.7)	4 (1.7)	3 (0.6)	1 (1)
Live in a regional or remote area	56 (5.9)	7 (5.2)	4 (1.7)	39 (8.1)	6 (6.3)
Missing data	7 (0.7)	1 (0.7)	1 (0.4)	3 (0.6)	2 (2.1)
Born overseas	191 (20.2)	24 (17.7)	35 (15.1)	104 (21.6)	28 (29.2)
Missing data	7 (0.7)	1 (0.7)	2 (0.9)	4 (0.8)	0 (0)
Parent(s) born overseas	452 (47.8)	73 (53.7)	115 (49.6)	214 (44.4)	50 (52.1)
Missing data	8 (0.9)	1 (0.7)	1 (0.4)	5 (1.0)	1 (1)
ATSI person	22 (2.3)	5 (3.7)	2 (0.9)	13 (2.7)	2 (2.1)
Missing data	9 (1)	2 (1.5)	3 (1.3)	4 (0.8)	0 (0)
NESB	52 (5.5)	10 (7.4)	16 (6.9)	19 (3.9)	7 (7.3)
Missing data	9 (1)	2 (1.5)	3 (1.3)	4 (0.8)	0 (0)
Education					
Primary school	6 (0.6)	0 (0)	0 (0)	6 (1.2)	0 (0)
Some high school	124 (13.1)	11 (8.1)	24 (10.3)	76 (15.8)	13 (13.5)
Year 12	231 (24.4)	40 (29.4)	72 (31.0)	99 (20.5)	20 (20.8)
TAFE/trade certificate	242 (25.6)	29 (21.3)	62 (26.7)	125 (25.9)	26 (27.1)
University degree	335 (35.4)	54 (39.7)	71 (30.6)	173 (35.9)	37 (38.5)
Missing data	8 (0.9)	2 (1.5)	3 (1.3)	3 (0.6)	0 (0)

Table 4: Other demographic characteristics of participants (continued)

Variable	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Gross annual income					
<\$20,000	427 (45.1)	88 (64.7)	120 (51.7)	185 (38.4)	34 (35.4)
\$20,000 to \$39,999	163 (17.2)	23 (16.9)	32 (13.8)	90 (18.9)	18 (18.8)
\$40,000 to \$59,999	131 (13.9)	8 (5.9)	40 (17.2)	72 (14.9)	11 (11.5)
\$60,000 to \$79,999	91 (9.6)	11 (8.1)	14 (6.0)	54 (11.2)	12 (12.5)
\$80,000 to \$99,999	49 (5.2)	2 (1.5)	10 (4.3)	30 (6.2)	7 (7.3)
≥\$100,000	72 (7.6)	3 (2.2)	11 (4.7)	46 (9.5)	12 (12.5)
Missing data	13 (1.4)	1 (0.7)	5 (2.2)	5 (1.0)	2 (2.1)
Employment status					
Employed	487 (51.5)	63 (46.3)	120 (51.7)	249 (51.7)	55 (57.3)
Unemployed	120 (12.7)	12 (8.8)	27 (11.6)	72 (14.9)	9 (9.4)
Unemployed student	165 (17.4)	28 (28.7)	59 (25.4)	52 (10.8)	15 (15.6)
Unable to work	112 (11.8)	20 (14.7)	21 (9.1)	63 (13.1)	8 (8.3)
Other	55 (5.8)	2 (1.5)	2 (0.9)	42 (8.7)	9 (9.4)
Missing data	7 (0.7)	0 (0)	3 (1.3)	4 (0.8)	0 (0)
Living alone	215 (22.7)	18 (13.2)	25 (10.8)	154 (32.0)	18 (18.8)
Missing data	5 (0.5)	0 (0)	2 (0.9)	3 (0.6)	0 (0)
Single	458 (48.4)	50 (36.8)	109 (47.0)	262 (54.4)	37 (38.5)
Missing data	48 (5.1)	8 (5.9)	11 (4.7)	20 (4.2)	9 (9.4)
Health Care Card	509 (53.8)	79 (58.1)	130 (56.0)	251 (52.1)	49 (51.0)
Missing data	8 (0.9)	0 (0)	4 (1.7)	4 (0.8)	0 (0)
Health insurance	412 (43.6)	60 (44.1)	118 (50.9)	196 (40.7)	38 (39.6)
Missing data	9 (1)	2 (1.5)	2 (0.9)	3 (0.6)	2 (2.1)

It is notable that 62.4% of the sample reported a gross annual income below \$40,000. After excluding unemployed students, 55.9% of the sample earned less than \$40,000 per year. (The mean Australian income in 2013 was \$58,000)³⁶. Also notable is the high proportion of participants possessing a Health Care Card, and the high proportion of trans women who were single or lived alone. This may have implications for social support and well-being.

3 Mental health

This chapter details the mental health of participants, as measured by the Patient Health Questionnaire (PHQ), 36-item Short Form Health Survey (SF-36), and self-report. The PHQ is a screening tool for depression and anxiety syndromes, while the SF-36 provides a general measure of health status and quality of life. These instruments gave us a measure of the health status of participants at the time they took the questionnaire. We also asked participants if they had ever been diagnosed with depression by a doctor, and in the last 12 months. Similar questions asked about an “anxiety disorder”. These latter questions gave us a lifetime and 12-month history of depression and anxiety diagnoses in participants.

3.1 Current prevalence of depression and anxiety syndromes

The PHQ was completed by 827 participants, and the results are shown in Table 5. Proportions are calculated without removing missing responses, because we did not want to overestimate the proportion of people with mental health problems. Therefore, the proportions quoted below may underestimate the true prevalence.

Table 5: Prevalence of depressive and anxiety syndromes, by identification

Mental health status	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Clinically relevant depressive symptoms	413 (43.7)	60 (44.1)	101 (43.5)	218 (45.2)	34 (35.4)
Major depressive syndrome	272 (28.8)	43 (31.6)	69 (29.7)	138 (28.6)	22 (22.9)
Other depressive syndrome	51 (5.4)	6 (4.4)	5 (2.2)	35 (7.3)	5 (5.2)
Panic syndrome	173 (18.3)	36 (26.5)	42 (18.1)	82 (17.0)	13 (13.5)
Other anxiety syndrome	160 (16.9)	32 (23.5)	49 (21.1)	72 (14.9)	7 (7.3)

Significant differences between groups were observed for all mental health syndromes ($p < 0.05$; Chi-square test).

To investigate whether mental health differed by age, we calculated the prevalence of mental health syndromes by age group. These are shown in Table 6.

Table 6: Prevalence of depressive and anxiety syndromes, by age

Mental health status	Age group (years)				
	18-19	20-29	30-39	40-49	50+
	(n=92) n (%)	(n=321) n (%)	(n=168) n (%)	(n=140) n (%)	(n=216) n (%)
Clinically relevant depressive symptoms	56 (60.9)	155 (48.3)	68 (40.5)	65 (46.4)	66 (30.6)
Major depressive syndrome	40 (43.5)	97 (30.2)	47 (28.0)	43 (30.7)	42 (19.4)
Other depressive syndrome	5 (5.4)	21 (6.5)	6 (3.6)	8 (5.7)	11 (5.1)
Panic syndrome	25 (27.2)	68 (21.2)	28 (16.7)	33 (23.6)	18 (8.3)
Other anxiety syndrome	20 (21.7)	65 (20.3)	30 (17.9)	21 (15.0)	22 (10.2)

Proportions were significantly different by age ($p < 0.05$; Chi-square test), with the exception of other depressive syndrome by age ($p = 0.425$; Chi-square test). The proportion of people who met the criteria for a mental health syndrome was lower with older age. Nonetheless, proportions remained high in all age groups.

To enable an accurate comparison between trans men, trans women, and non-binary participants (all of whom had different age distributions), and also to facilitate comparisons with the general population, we age-standardised these data using the direct method. Our reference population was the estimated resident population of Australia at 30 June 2013 as determined by the Australian Bureau of Statistics⁹. Age-standardised prevalence data for any depressive syndrome and the anxiety syndromes are shown in Table 7.

⁹ We used the estimated Australian population at 30 June 2013 for all age standardisation, unless otherwise stated. For illicit substance use (chapter 9), we age-standardised our data using the population described in the 2010 National Drug Strategy Household Survey report³¹. The 2010 report is based on the estimated resident population of Australia at 30 June 2010.

Table 7: Age-standardised prevalence of depressive and anxiety syndromes, by identification

Mental health status	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	%	%	%	%	%
Any depressive syndrome	31.0	41.0	30.5	34.3	26.7
Panic syndrome	15.6	10.2	23.2	16.0	12.8
Other anxiety syndrome	14.7	31.9	16.8	14.4	6.1

Because we used a screening tool (the PHQ) to investigate mental health, we cannot be sure that participants who met the criteria for a mental health syndrome actually had the corresponding disorder. Clinical interviews would be necessary to establish this. For example, someone who met the criteria for a depressive syndrome may actually have been affected by bereavement, and therefore generally would not be considered to have depression. However, this seems an unlikely explanation for the very high prevalence of mental health syndromes observed. It is probable that many of the people who met the criteria for an anxiety syndrome or a depressive syndrome were actually affected by an anxiety disorder or depression.

To place these results in context, the lifetime and 12-month prevalence of mental disorders in the general population in 2007 were as follows: depressive episode (11.6% and 4.1%); dysthymia (1.9% and 1.3%); panic disorder (5.2% and 2.6%); and any anxiety disorder (26.3% and 14.4%)³⁷. In comparison, the proportion of participants in this study who were *currently* affected by a mental health syndrome was markedly higher.

3.2 Lifetime and 12-month prevalence of depression and anxiety disorders

To gauge the lifetime and 12-month prevalence of diagnosed depression and anxiety disorders, we asked participants whether they had been diagnosed with “depression” or an “anxiety disorder” by a doctor. We also asked participants whether they were currently receiving treatment for these conditions.

Lifetime prevalence of diagnosed depression and anxiety disorders is shown in Table 8, stratified by current identification, and by age.

Table 8: Self-reported history of depression and anxiety, by identification and by age

Mental health status	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Ever diagnosed with depression	541 (57.2)	74 (54.4)	144 (62.1)	284 (58.9)	39 (40.6)
Ever diagnosed with an anxiety disorder	377 (39.9)	67 (49.3)	95 (41.0)	186 (38.6)	29 (30.2)
	Age group (years)				
	18-19	20-29	30-39	40-49	50+
	(n=92) n (%)	(n=321) n (%)	(n=168) n (%)	(n=140) n (%)	(n=216) n (%)
Ever diagnosed with depression	40 (43.5)	204 (63.6)	103 (61.3)	82 (58.6)	108 (50.0)
Ever diagnosed with an anxiety disorder	30 (32.6)	150 (46.7)	64 (38.1)	59 (42.1)	70 (32.4)

Of the 57.2% of participants who had ever been diagnosed with depression, 54.2% (n=293) were diagnosed in the last 12 months, and 44.2% (n=239) were currently being treated for depression. Of the 39.9% of participants who had been diagnosed with an anxiety disorder, 62.1% (n=234) had been diagnosed in the last 12 months, and 47.8% (n=180) were receiving treatment. We did not ask participants what form of treatment they were receiving for their mental health problems.

To compare self-reported history of a diagnosis of a mental disorder in our sample with the general population (and between sub-groups), we age-standardised our data (Table 9).

Table 9: Age-standardised history of depression and anxiety, by identification

Mental health status	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	%	%	%	%	%
Ever diagnosed with depression	55.9	74.7	59.0	57.9	39.7
Ever diagnosed with an anxiety disorder	37.9	56.5	39.9	37.6	28.9

Based on the previously quoted prevalence data for the general population, it appears that trans people are 4 times more likely to have ever been diagnosed with depression than the general population, and approximately 1.5 times more likely to have ever been diagnosed with an anxiety disorder. Also concerning is the high proportion of participants who reported suicidal ideation or thoughts of self harm. As part of the PHQ, participants were asked whether they had “thoughts that you would be better off dead or of hurting yourself in some way” in the last two weeks. Responses to this question are shown in Table 10 below.

Table 10: Suicidal ideation or thoughts of self-harm, by identification

Response	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Not at all	440 (46.5)	62 (45.6)	106 (45.7)	224 (46.5)	48 (50.0)
Several days	189 (20.0)	20 (14.7)	45 (19.4)	104 (21.6)	20 (20.8)
More than half the days	85 (9.0)	10 (7.4)	22 (9.5)	50 (10.4)	3 (3.1)
Nearly every day	113 (12.0)	21 (15.4)	27 (11.6)	59 (12.2)	6 (6.3)
No answer	119 (12.6)	23 (16.9)	32 (13.8)	45 (9.3)	19 (19.8)

One fifth (20.9%) of participants reported suicidal ideation or thoughts of self-harm on at least half of the days in the last 2 weeks. In 2007, the 12-month prevalence of suicidal ideation (excluding self-harm) in the general population was 2.3%³⁷. We did not ask participants directly about suicide, or whether they had previously attempted suicide. However, coupled with the high prevalence of mental health syndromes observed in the sample, and the extremely high proportion of participants who had ever been diagnosed with depression (57.2%), our results strongly suggest that trans people living in Australia are a high-risk group for suicide. This is borne out by longitudinal studies of this population. In a recent study of 1,331 trans people from The Netherlands who were followed for at least 18 years, suicide was a leading cause of death. The authors of that study reported that trans women were 5.7 times more likely to die from suicide than expected, while trans men were 2.2 times more likely to die from suicide³⁸.

Given that the prevalence of mental health problems in our study was similar between trans men and trans women, it is unclear why this discrepancy should exist. It may be that trans women have fewer sources of support to draw upon. As we noted in chapter 2, trans women were more likely to live alone and to be single. Alternatively, it may be because the effects of puberty on the skeleton are generally more obvious and much harder, if not impossible, to reverse for trans women. Some trans women find it very difficult to blend^h with other women because of the powerful effects of testosterone on bone structure. These may be particularly obvious with regard to facial features. Some trans women opt for facial feminisation surgery to address this, but the cost typically runs into tens of thousands of dollars. Given the low incomes reported by participants, this surgery is simply out of reach for many. Being unable to blend may pose a constant source of dysphoria, expose trans women to discrimination, and may affect others' perception of their attractiveness and desirability as a partner, further negatively affecting body image and self-esteem. An additional factor to consider is the use of hormones. Sex hormones have effects on nearly all organ systems of the body, including the brain. Oestrogen generally has anti-depressant propertiesⁱ, although some people can experience negative effects on mood. Some trans women also take progestogens, such as the anti-androgenic progestin cyproterone acetate (which acts to stop the production of testosterone, and also to prevent testosterone from binding to testosterone receptors). However, some progestogens, and cyproterone acetate

^h The term *passing* or *to pass* is also sometimes used to describe being accepted by others as the sex with which a person identifies. Some have argued that the term is pejorative and suggestive of deception. We have therefore opted to use the more neutral term *blend* instead.

ⁱ Oestradiol, the most potent naturally occurring oestrogen in humans, acts as a weak monoamine oxidase inhibitor, and prevents the breakdown of neurotransmitters such as serotonin and noradrenaline³⁹.

in particular, are known to cause depression in some individuals ⁴⁰. Testosterone can also have both positive and negative effects on mood, both directly and after conversion to oestrogen in the body, but generally has a mood-elevating effect ⁴¹. Very high doses of testosterone can cause mania in susceptible individuals ⁴².

3.3 Mental health status by hormone use and surgery

Generally, most trans people who take hormone therapy or undergo surgery report that it has a strongly beneficial effect on mood and well-being ⁴³⁻⁴⁵. In this study, we found that the desire to take hormone therapy and/or being on hormone therapy was significantly associated with mood, as was surgery. In the following table (Table 11) we present associations between hormone therapy and clinically relevant depressive symptoms.

Table 11: Clinically relevant depressive symptoms by use of hormone therapy

Clinically relevant depressive symptoms	Use of hormone therapy					
	Never taken and unsure or unwanted	Never taken but would like to	No longer taking - unsure or unwanted	No longer taking but would like to	Taking hormone therapy	Missing data
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
No	56 (45.5)	55 (27.9)	12 (48.0)	11 (35.5)	280 (49.5)	0 (0)
Yes	46 (37.4)	115 (58.4)	12 (48.0)	15 (48.4)	225 (39.8)	0 (0)
Missing data	21 (17.1)	27 (13.7)	1 (4.0)	5 (16.1)	61 (10.8)	4 (100)

We observed a marked and statically significant difference between categories ($p < 0.001$; Chi-square test). The proportion of people with clinically relevant depressive symptoms was lowest in those currently taking hormone therapy (39.8%) and in those who were not taking it, but either did not desire it, or were unsure if they wanted it (37.4%). In contrast, those with the highest proportion of clinically relevant depressive symptoms were participants who had not taken hormone therapy, but wanted to (58.4%). A similar picture emerged with regard to surgery, as shown in Table 12 overleaf. People who had undergone at least some surgery were much less likely to have clinically relevant depressive symptoms ($p < 0.001$; Chi-square test). Although these results are cross-sectional (meaning that we cannot infer causality), our results are supportive of previous research showing that mental health improves when trans people are given access to hormone therapy or surgery ⁴³⁻⁴⁷.

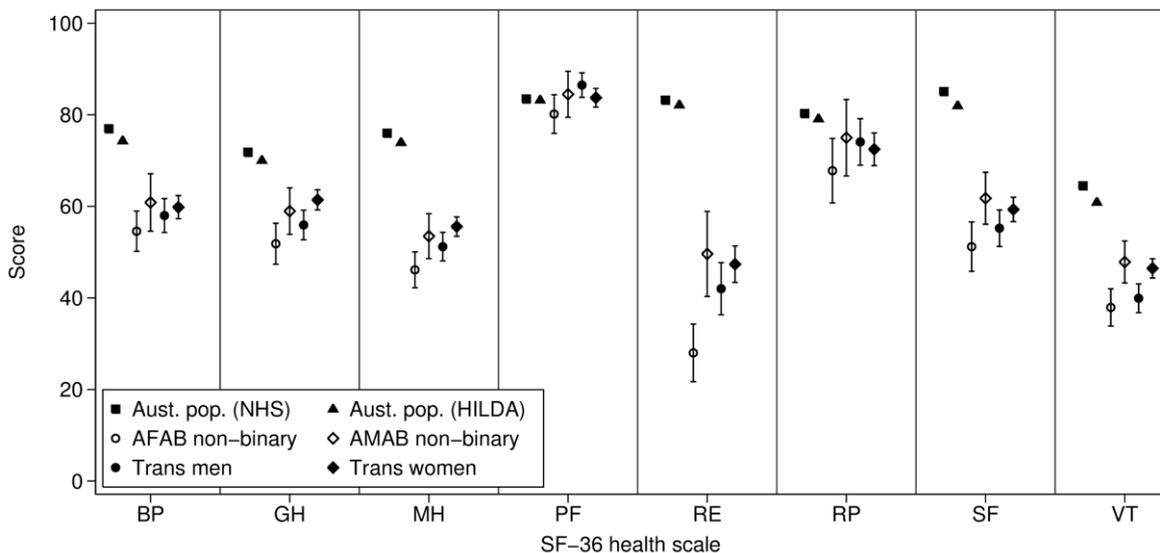
Table 12: Clinically relevant depressive symptoms by surgical status

Clinically relevant depressive symptoms	Surgical status			
	Don't want n (%)	Would like n (%)	Have had n (%)	Missing data n (%)
No	82 (45.3)	184 (37.6)	148 (56.3)	0 (0)
Yes	71 (39.2)	251 (51.3)	91 (34.6)	0 (0)
Missing data	28 (15.5)	54 (11.0)	24 (9.1)	13 (100)

3.4 Quality of life

In addition to determining the prevalence of depressive and anxiety syndromes, we also measured participants' general health status and quality of life with the SF-36. This instrument measures a series of physical and mental health domains, which we compared against data from two recent studies of the general population. This is depicted in Figure 3 below.

Figure 3: Quality of life in study participants and in the general population



Notes: Higher scores indicate better quality of life. BP=bodily pain; GH=general health; MH=mental health; PF=physical functioning; RE=role-emotional; RP=role-physical; SF=social functioning; VT=vitality. NHS=1995 National Health Survey⁴⁸; HILDA=2001 Household Income and Labour Dynamics in Australia survey⁴⁹. The 95% confidence intervals are not shown for the reference populations because they are sufficiently small to overlap the data points.

Participants experienced demonstrably worse quality of life in almost all domains (particularly those associated with mental health) than the general population. The SF-36 also has two summary scores for physical and mental well-being: the Physical Component Summary (PCS) score, and the Mental Component Summary (MCS) score. Scores range from 0 to 100, and are standardised to have a mean of 50 and a standard deviation of 10. The mean PCS score for participants in this study was 51.2 ± 10.7 , while the mean MCS score was 33.7 ± 14.9 .

This indicates that the physical health of participants was similar to the general population, but mental health and well-being were not. It also strongly suggests that the poor quality of life we observed in participants is not due to poor physical health, but rather to poor mental health.

3.5 Factors associated with mental health problems and quality of life

To investigate the factors that were associated with mental health problems and quality of life, we performed a series of binary logistic regression analyses (for dichotomous outcomes such as ever being diagnosed with depression), and linear regression (for quality of life).

We entered participants' demographic characteristics into these models, along with factors such as body mass index, self-rated health^j, use of (or desire for) hormone therapy, surgical status, whether participants had changed any identifying documents (ID), whether they told doctors about being trans, whether they had a GP, their relationship with their GP (measured with the Patient-Doctor Relationship Questionnaire), whether they had experienced discrimination relating to being trans, and use of alcohol, tobacco, and illicit drugs.

After adjustment, we found the following factors were associated with poor mental health and/or poor quality of life in regression analyses: sex identity (trans men, and especially trans women, were more likely to have clinically relevant depressive symptoms than non-binary individuals, while non-binary individuals were more likely to have been diagnosed with an anxiety disorder or to currently have an anxiety syndrome); lower educational attainment; being unemployed or unable to work; low income; poor self-rated health; wanting to take hormone therapy; wanting to undergo surgery; difficulty changing ID; not feeling comfortable telling doctors about being trans; and a recent experience of discrimination. People who were younger had worse mental health than participants who were older.

^j Self-rated health was not included in the models assessing quality of life with the SF-36 MCS, because self-rated health is a component of this scale.

3.6 Participants' thoughts about their mental health

We asked participants to describe the things that they thought affected their mental health in a good way, the things that affected their mental health in a bad way, and what participants did to look after their mental health. Some comments that illustrate the major themes that emerged are shown below.

3.6.1 Factors that positively affected mental health

"feeling 'man enough' feeling accepted spending time with those I care most"

"being treated as male, being with my girlfriend, being fit and muscular, having time to relax"

"Being able to be a woman and interact with people in a no[r]mal female way"

"Having the freedom to be myself around my friends family and the public"

"Being accepted as female means everything to me. Also having a lot of love and support from friends goes a long way. I also have a wonderful GP ... who is always there to help me with any medical problems"

"Transitioning fixed a lot for me, I retained some social anxiety but nothing like what I suffered in the past"

"Transition has completely changed my mental health. I no longer suffer depression, anxiety is rare, and it's been more than a year since I have felt suicidal. I consider myself entirely recovered. What's more, the change was rapid"

"Knowing that I am now the person I should have been. The bright colours I now see because every day is precious"

Participants reported that feeling accepted by others, and being able to express their sex identity and/or gender expression freely had a positive effect on mental health. Participants who wished to transition, and had done so, noted that transitioning made an enormous difference to their mental health. Prior to transitioning, some participants suffered from depression, anxiety and suicidal ideation. Transitioning "completely changed" this, because they now felt that they were living as "the person I [always] should have been".

"Good sleep, healthy food, being at home, talking with friends, reading, writing"

"friends, motorcycle riding, exercise, feeling useful, seeing health care workers I connect with"

"Exercise and company and good diet"

"Good attitude, support of friends and family"

"Supportive friends and family, regular counselling sessions, self affirming behaviour, truthful portrayals of people like me or experiences I share socially and in the media"

"Positive reinforcement, caring for my pets, being with my family, being at home by myself, singing, being with good, safe friends for short bursts. Sunshine"

Participants noted the supportive role that friends and family could play in their lives. For some, friends and family provided praise, love, and acceptance. However, not everyone was fortunate to have supportive friends and family. Resources such as *Families Like Mine*⁵⁰ may be able to help friends and family understand the life experiences and challenges that trans people face, and help friends and family accept and support them. It is also important to note that many of the factors that participants thought positively affected their mental health are the same that would be expected for the general population, such as “feeling useful”, and keeping socially active. This suggests that mental health promotion programs such as *Act-Belong-Commit*⁵¹ could either actively target trans people, or similar programs could be developed for this population.

“Just being understood and love[d] for who I am”

“people being nice to me. it’s very easy to read how people feel about you from their faces as much as what they say”

“Acceptance by friends and family. General normal conversation when talking to friends. Being pronounced [correctly] or called my prefer[red] name”

“Feeling that I am supported by the people around me. Being reassured that things will get better”

“Being with my boyfriend. And being away from my parents as they ar[e]n’t supportive at all”

“Personal achievements. Affirmation from others that I am a good, helpful & honest person. Contact with people who through actual experience, understand my trans identification”

“singing, being with people, helping people, exercise, achieving goals, travel, reading, taking photographs, good regular meals, focusing on today”

“Seeing friends (or other people) who I feel I can connect to, seeing myself look good”

A key theme was participants’ need for acceptance. Participants also needed reassurance that “things will get better”. This stresses the need for better resources and information for both trans people and their friends and families. Information and/or educational materials that include personal stories and factual information about transitioning throughout the life cycle need to be developed and disseminated in appropriate formats. Materials should be in simple English and also available in multilingual formats. It must be remembered, however, that the trans population is not homogenous and materials need to be respectful of these differences. (For example, the needs of non-binary trans people are likely to differ in some respects from those of trans men and trans women). Participants also expressed a need to have people that they “can connect to”. This stresses the importance of services that organisations such as Twenty10⁵² and the Freedom Centre⁵³ provide. However, more services are required. Given the high prevalence of mental health problems in all age groups (Table 6) services are needed for people of all ages.

3.6.2 Factors that negatively affected mental health

“being verbally abused by people on the street if I get read. And secluding myself away makes me more depressed”

“general societal attitudes towards trans people, and negative interactions with people”

“I think a lifetime of accumulated stress about trans stuff has left me permanently damaged. Even though life is much better post-transition, the damage has been done”

“Job opportunities, feelings that my life has been wasted, feelings of lost opportunities, loneliness”

“Feeling stuck in a situation I have no control over - especially concerning money and job. And also body dysphoria - not relating to what I see in the mirror, at all. Actually hating my body to the point of never swimming in public etc or doing activities I would do if my body was different”

“Not being able to progress my transition (at the moment it is the facial hair that is getting me down and the lack of money for electrolysis)”

“Lack of access to some desired surgeries. The lack of understanding of the average person. The things that can never be ‘corrected’ by either of those things”

Factors that had negative effects on participants’ mental health included discrimination and harassment, and also for many, a strong sense of dysphoria that they were unable to address because surgery and/or other procedures were unavailable or unaffordable. For those who seek a medical transition, the cost can run into tens of thousands of dollars and make take several years to complete. This may lead to a sensation of their life being on hold, or that years of their life are “wasted” while they wait for transition to be complete. For some people, transition may never be complete, either because the changes they desire are not possible or unattainable. This stresses the importance of providing easy and affordable access to hormone therapy, surgery, and other interventions such as speech therapy and hair removal, through both public and private health systems.

“Looking on my facebook at all the friends I will probably lose. Also wondering how the community in general will react when I start going out as a woman”

“Having to be female at work. Worrying about the social ramifications of ‘coming out’ at work”

“Interacting with people who are transphobic, biphobic, and belittle me for having depression and anxiety”

“Dealing with medical professionals. Even my current GP who I like and respect a lot, he still makes me very anxious because I have such a bad history with doctors. I also don’t like large crowds, or feeling trapped”

Transitioning participants who were yet to live in their new role expressed fear about how others would react. To some extent, this could perhaps be reduced through workplace education, such as that offered by the *Opening Closets* program⁵⁴. It also reinforces the need for the development and wide dissemination of educational materials and information. Such materials should target multiple audiences, such as the general public, employers, families, and health workers. Some participants reported a “bad history with doctors”, suggesting an urgent need to improve attitudes and knowledge among the medical profession. Changes to the medical curriculum are necessary so that doctors understand how to care for trans people, and can do so in an appropriate and respectful manner.

“stress, financial insecurity, relationship difficulties, issues with family/friends etc not understanding my identity, etc”

“Being isolated, without community or friends. Not enough sleep. Being around people who aren’t my mob”

“Violence, abuse, discrimination, hard to find a relationship. Sometimes it’s difficult as so many transpeople around me suffer from poor mental health”

“Not being valued, being mocked or humiliated, being disrespected, not being accepted”

“insults discrimination comments made not feeling ‘man enough’”

“Work-related stress, family-related stress”

Discrimination and harassment during interactions with others was a recurring theme. In addition to educational materials and workplace training, this suggests a need to strengthen anti-discrimination protections for this population.

“Winter. Poor self image, especially body image. Loneliness. Frustration. Feelings of disapproval or rejection”

“When people use the wrong pronouns or ask inappropriate questions”

“Anything that is associated with revealing my transsexual history. It’s awful and makes me absolutely miserable. I really hate it and always feel completely full of shame”

“Having to face being transsexual - i live in stealth and being forced to reveal my past upsets me”

People must not be forced to disclose their trans history or be placed in a situation where they have to constantly educate people about what it means to be trans. Although there are occasions where respectful questions might be appropriate, trans people should not bear the burden of having to repeatedly educate others. Trans people should never be asked “inappropriate questions” such as whether or not they have undergone surgery. Educational materials could be helpful here, explaining respectful ways of interacting and communicating with trans people.

These comments also reveal some of the problems that are associated with living “stealth”. Although being stealth is a perfectly valid choice, the fear of discovery is likely an ongoing source of stress for many trans people. In an ideal world, a person disclosing that they are trans should not matter. “Coming out” could potentially be empowering. However, it is more likely that “coming out” results in trans people being treated as the sex assigned to them at birth, negating who they are and their lived experience. However, for non-binary people, coming out may be necessary to articulate their non-binary status. It is likely that the experience of coming out differs markedly for sub-populations within the trans community.

3.6.3 Things participants do to look after their mental health

“cycling, rock climbing, yoga, chin ups, play video games, relax with my girlfriend, always present as male, take time at the end of the day to wind down and watch telly with my girlfriend”

“Go to the gym regularly. Ensure that I get regular ‘me’/down time Invest time in my relationship Make sure I enjoy my work, and the place I’m living Spend time with my dog”

“Yoga, medication, study, volunteering, socialising. Looking after my partner and our two dogs. Reading”

“Meditate, mindfulness, follow the dharma.. Listen to Ajahn Brahm.. Music..”

“reading. going to church”

“I place great store in my faith. It keeps me grounded and connected with life”

Participants engaged in a range of activities to look after their mental health, including those of an athletic, leisure, self-care, and spiritual nature. Several participants reported that they spent time with, and cared for animals. This suggests that interventions modelled on the *Act-Belong-Commit*⁵¹ program could work with this population, and should be a research priority.

“Exercise, share any problems with someone I can trust”

“I’ve stopped watching the news. I walk a lot. I spend time with family and friends”

“fresh air, exercise, pleasant social activities - book club, lectures, meeting friends, occasional contact with trans support groups”

“look after my cat, take my medication, try to reach out to and socialise with friends”

“I try not to let the ignorant parasites get me down, I am glad that I am not fake like they are. I spend time with my boyfriend and my two friends on the weekend and keep in touch with other friends on facebook”

“Keep a positive outlook and avoid people who are idiots and dickheads”

“I eat very particular foods, and I try to meditate or at least reflect on my life and goals each day. I also try to be nice to others, because I find then they are nice back”

Participants' comments reinforce the importance of having supportive friends, partners, and family with whom they can talk and share problems. They also note the importance of maintaining and building social relationships, trying to develop a "positive outlook", and avoiding perceived negative influences on mental health (insofar as this is possible).

"I regularly see a psychiatrist and physiologist plus I am taking medication to offset the effects of my mood disorder"

"Sometimes when I feel really awful I just sleep for a few days or until I'm ready to go back outside"

"Not much, I'm not very good at looking after my own mental health"

"Have a good cry and try to pull myself together. Generally it has worked, but I know that one day it won't. Then I will probably call it quits"

Several participants reported that they saw mental health professionals and/or took medication to help with mental health problems. However, some participants may have difficulty locating trans-friendly mental health professionals. There is a need for either centralised clinics in each state and territory specialising in trans health which can refer people to appropriate practitioners, and/or for trans people to be able to easily access a directory of health professionals who are trained to work with this population. This stresses the need to improve health curriculums. Participants should not need to seek out a trans-friendly doctor or psychologist. All health workers should be trans-friendly.

Some participants noted that they weren't good at looking after their mental health. The final comment by the participant in the above block of quotes (and similar comments by others) is very worrying, and reflects the disproportionate suicide risk in this population³⁸. There is an urgent need to address this disparity, and to reach out to people who feel they are "not very good at looking after my own mental health". Further research should investigate how this especially vulnerable group can be assisted.

4 Hormone use

This chapter explores participants' attitudes toward, and use of hormone therapy. As shown in Table 13, there was a marked contrast between use and desire for hormone therapy by category of identification ($p < 0.001$; Chi-square test). Non-binary participants were less likely to desire or to be taking hormone therapy than trans men and trans women. (More than two thirds of trans men and women were currently taking hormone therapy). Although the attitudes of participants toward hormone therapy may change over time, this strongly suggests that there are clear differences between sub-populations in the trans community, and that members of these sub-populations desire different transition pathways.

Table 13: Desire for, and use of hormones, by identification

Response	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Never taken and don't want or are unsure	123 (13.0)	73 (53.7)	3 (1.3)	7 (1.5)	40 (41.7)
Never taken, but would like to	197 (20.8)	31 (22.8)	61 (26.3)	81 (16.8)	24 (25.0)
Not currently taking and don't want or are unsure	25 (2.6)	7 (5.2)	1 (0.4)	11 (2.3)	6 (6.3)
Not currently taking, but would like to	31 (3.3)	5 (3.7)	2 (0.9)	19 (3.9)	5 (5.2)
Currently taking hormone therapy	566 (59.8)	20 (14.7)	163 (70.3)	362 (75.1)	21 (21.9)
No answer	4 (0.4)	0 (0.0)	2 (0.9)	2 (0.4)	0 (0.0)

4.1 Factors preventing participants from using hormone therapy

Participants who were not currently using hormone therapy were asked if there were any factors that prevented them from taking it. Some comments that illustrate the different themes that emerged are shown overleaf.

“I’d like to be a parent and I’m not sure if I could live with being sterile”

“Long-term health concerns about taking testosterone. There really haven’t been any studies and there are no long term research papers on the affects of someone taking testosterone”

“Had a small heart attack and was taken off oral estrogen and put on a gel, kind of got fed up with it so haven’t used it for a while. Probably linked to feelings about the heart, and other things which cause stress at the moment so have given up”

“I got depression after being on T”

As noted in Table 13, nearly a quarter of participants who were not currently taking hormone therapy wished to do so. However, the actual and perceived negative experiences of some participants, together with the limited knowledge regarding the long-term effects of hormone therapy present a challenging situation for some. In particular, what does it mean for participants who need hormone therapy for their mental health and well-being, but are unable to take it due to physical or mental health problems? Additionally, there is a need for the long-term effects of hormone therapy to be studied, and the results made available and accessible in appropriate educational materials for the trans population.

“Fear of social stigma (especially as a non-binary trans person who would be taking hormones, rather than as a trans man), Having to come out, Being trans on official records”

“I don’t want feminine features, but I don’t want masculine features either. There’s no hormone therapy that can give that without other medical issues”

“Too old and too late but if I could go back 40 years and have the knowledge of such [a] thing, life would have been much different”

Some non-binary participants expressed reservations about hormone therapy, in that either it could not provide them with the body that they desire, or that they fear that doctors and other people will not understand their identities because they do not fit a typical transsexual narrative. The final comment about being “too old and too late” reinforces the need for educational materials to be easily accessible so trans people (especially young trans people) know what options are available to them, and can pursue a medical transition if they wish.

“Scared of what others would think”

“My job prospects. I can’t imagine being able to get a job after transitioning since the industry I work in is pretty intimate and everyone would know. They would just think that was way too much baggage”

“Fear of family’s reactions, worried that it’s not the right path”

“My partner would possibly have too much difficulty coping with the changes that would occur”

The legitimate concerns that many trans people have about how others will react to them beginning a medical transition reinforces the need for educational materials for friends and family, and also workplace education and anti-discrimination measures. For some people with partners, these concerns may be insurmountable, because their partner may have “difficulty coping”. Depending on their sexuality, some partners may find that their sexual attraction to their trans partner lessens. Some partners may not know how to cope with what may be either a perceived or real change in their sexuality, and how others may react to this.

“Money, not knowing a doctor I would be comfortable with”

“Just getting it prescribed from doctor”

“Yea my location I live in a small aboriginal community”

“Finding out how to start, since I have pretty limited knowledge and don’t feel comfortable talking about it with any of the GPs I’ve had contact with, as well as possible associated costs”

“Not sure how to go about getting hormone therapy, Due to lack of education about such things, unknown as to whether there is a professional that specializes in gender identity within my area. Lack of information”

All doctors (and especially general practitioners, since they are usually the first point of contact with the medical system), need to be educated about trans health while they are studying medicine. Upon graduation, continuing professional development programs as well as workplace training may be useful and/or necessary. Clear referral pathways and protocols must be developed. Trans people should not have to face the burden of finding a trans-friendly doctor, and all doctors should have some knowledge of trans health.

“Having to wait nearly a whole year just to see the one damn psych in this state that focuses on transgender issues. Without his say I cannot legally start HRT. At least that’s what the doctor said. Perhaps I was lied to”

“the insanely traumatic ignorant hoops of gate keepers you have to jump through to access hormones. having to convince a psychiatrist who has no understanding or consideration of gender diverse people to let me take hormones is totally degrading”

“IT SHOULDN’T TAKE A YEAR OF GATEKEEPING TO GET IT. Gatekeeping killed my friend - her psych didn’t let her have them for over a year. It should be available at request from a GP”

People who want to begin a medical transition generally first have to see a psychiatrist or psychologist. Mental health professionals can help people to understand what is involved in transition, and provide support during what may be a stressful journey. However, participants criticised the “gatekeeping” role that some are perceived to play. This suggests that an informed consent model may be more appropriate⁵⁵. Participants’ comments also suggest an urgent need for more doctors to work in this area to reduce waiting times.

4.2 Other comments about hormone therapy

Participants were also asked if there were any other comments they wanted to make about hormone therapy. Typical responses are shown below.

“Best thing I have ever done in my life. I went through puberty wishing there was a pill that would make me a girl so I wouldn’t be a boy and now I have found it. Best ever....Life saving”

“Having taken Hormones for [the] last 7 months has made me feel happier and so much more at ease with myself”

“I would be lost without it”

“It makes the person in the mirror look like the person within”

Not every trans person desires a medical transition, but for those who do, hormones can be “life saving”. Hormone therapy has radically improved the lives of some participants, particularly with regard to mental health. All forms of hormone therapy must be easily accessible and included in Australia’s Pharmaceutical Benefits Scheme (PBS). This would ensure that participants do not face large out-of-pocket expenses. Both Medicare and private health insurance schemes must recognise that hormone therapy is an essential medical need for many trans people.

“It’s expensive. Additionally, had I know[n] such a thing was possible I’d have dearly wanted to go on puberty blockers when younger, but that information plain wasn’t available to me at the time”

“I use injectable hormones and have to get them overseas because it’s not available here. It’s also cheaper and more effective and I don’t waste my time and money going to doctors that ar[e]n’t qu[a]lified in treating Trans people”

“There are so many gatekeepers, none of which have a lived trans experience, most of them are super patronizing and some just outright transphobic”

Given the low incomes reported by participants, the cost of hormone therapy is an issue requiring urgent attention. Some products, such as GnRH analogues and the anti-androgen cyproterone acetate, may be prohibitively expensive. This is of particular concern for trans adolescents, who may require access to these drugs. Addressing this issue would require changes to the PBS so that such products are authorised for the treatment of trans people. Participants also reiterated that it is sometimes difficult to find information about hormones and their effects, difficult to find doctors who have the knowledge to prescribe and monitor hormone therapy, and difficult to find doctors who are accepting of trans people and prepared to adopt a more flexible approach to transition (such as the use of an informed consent model).

5 Surgery

This chapter examines participants' attitudes toward, and uptake of transition-related surgery. We hypothesised that desire for, and access to surgery might affect mental health. Similar to the pattern observed with regard to hormone therapy, there was a marked difference in desire for surgery between sub-populations in the trans community. As shown in Table 14, more than half of AFAB non-binary individuals desired or had undergone chest reconstruction, but genital surgery and hysterectomy were only desired by a minority.

Table 14: Attitudes toward surgery among AFAB non-binary participants

Surgery	Attitude					
	Have had	Would like	Not sure if wanted	Don't want	N/A	Missing data
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Chest reconstruction	9 (6.6)	67 (49.3)	28 (20.6)	29 (21.3)	1 (0.7)	2 (1.5)
Metaoidioplasty	0 (0.0)	10 (7.4)	37 (27.2)	83 (61.0)	4 (2.9)	2 (1.5)
Phalloplasty	0 (0.0)	7 (5.2)	31 (22.8)	93 (68.4)	3 (2.2)	2 (1.5)
Hysterectomy	1 (0.7)	29 (21.3)	43 (31.6)	59 (43.4)	2 (1.5)	2 (1.5)

In contrast, trans men were more likely to desire or have undergone chest reconstruction, and were also more likely to desire genital surgery and/or hysterectomy.

Table 15: Attitudes toward surgery among trans men

Surgery	Attitude					
	Have had	Would like	Not sure if wanted	Don't want	N/A	Missing data
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Chest reconstruction	86 (37.1)	132 (56.9)	4 (1.7)	3 (1.3)	0 (0.0)	7 (3.0)
Metaoidioplasty	3 (1.3)	66 (28.5)	89 (38.4)	58 (25.0)	9 (3.9)	7 (3.0)
Phalloplasty	4 (1.7)	53 (22.8)	84 (36.2)	73 (31.5)	11 (4.7)	7 (3.0)
Hysterectomy	34 (14.7)	103 (44.4)	57 (24.6)	29 (12.5)	2 (0.9)	7 (3.0)

However, it is important to note that not all men desired this kind of surgery. This could be

because some see procedures such as hysterectomy as unnecessary (having no effect on their outward appearance); because of issues such as cost and/or availability (trans men generally have to travel overseas for phalloplasty and the procedure costs tens of thousands of dollars); or because some surgeries (particularly phalloplasty) are complex procedures which can fail and/or cause lasting sexual dysfunction. The result may be unsatisfactory for some men, and many already feel “man enough” and that surgery is unnecessary ⁵⁶.

Table 16: Attitudes toward surgery among trans women

Surgery	Attitude					
	Have had	Would like	Not sure if wanted	Don't want	N/A	Missing data
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Breast enlargement	60 (12.5)	160 (33.2)	120 (24.9)	115 (23.9)	17 (3.5)	10 (2.1)
Facial feminisation	49 (10.2)	209 (43.4)	83 (17.2)	110 (22.8)	21 (4.4)	10 (2.1)
Orchidectomy	106 (22.0)	198 (41.1)	70 (14.5)	64 (13.3)	34 (7.1)	10 (2.1)
Vaginoplasty	117 (24.3)	240 (49.8)	72 (14.9)	31 (6.4)	12 (2.5)	10 (2.1)

In contrast to men, trans women were more likely to desire or have undergone genital surgery (Table 16). This may reflect the relatively lower cost, lower rate of complications, and better cosmetic result for this type of surgery. However, relatively few women had undergone the procedure, which may be attributable to cost (typically \$20,000 - \$30,000), and the necessity to travel overseas to find a surgeon skilled in performing this surgery.

Table 17: Attitudes toward surgery among AMAB non-binary participants

Surgery	Attitude					
	Have had	Would like	Not sure if wanted	Don't want	N/A	Missing data
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Breast enlargement	1 (1.0)	30 (31.3)	21 (21.9)	37 (38.5)	2 (2.1)	5 (5.2)
Facial feminisation	4 (4.2)	30 (31.3)	18 (18.8)	36 (37.5)	3 (3.1)	5 (5.2)
Orchidectomy	3 (3.1)	17 (17.7)	23 (24.0)	48 (50.0)	0 (0.0)	5 (5.2)
Vaginoplasty	0 (0.0)	21 (21.9)	22 (22.9)	46 (47.9)	2 (2.1)	5 (5.2)

Like their AFAB non-binary counterparts, AMAB non-binary participants were less likely to have undergone or to desire genital surgery (Table 17). However, they were more likely to desire genital surgery than AFAB non-binary participants, and their desire for genital surgery was similar to trans men, although lower than trans women.

These findings highlight the importance of recognising the existence of sub-populations within the trans community, and their different medical needs. They also stress that it is unrealistic to insist that surgical intervention should be required for a legal change of sex. Surgical intervention may be unwanted, unnecessary, unaffordable, or otherwise unavailable. Some individuals may also have health problems that are barriers to surgery.

5.1 Factors that led participants to have surgery overseas

Overall, 27.8% of participants (n=263) had undergone surgery. Of these, 35.0% (n=92) had a procedure performed overseas. This proportion rose to 50.3% for trans women. The corresponding proportion for trans men was 13.2%. Knowing that participants often travel overseas for surgery, we asked participants why they made this choice.

"I had gender reassignment surgery in Thailand because the surgeons there are better AND cheaper than surgeons in Australia"

"The surgeons overseas are better for some things, I had FFS done in Chicago. Also I went to Thailand for BA so I could see if I liked the doctor enough to choose him for SRS"

"Because they didn't offer all the surgeries I wanted in Australia - I wanted forehead reconstruction"

"Lack of experience with Australian surgeons compared to the U.S. I wanted the best I could find for specific procedures"

"No surgeon available in Perth, superior technique and lower cost in Thailand"

"Surgery in Thailand did not require the consent of Australian medical authorities"

"The costs were prohibitive, the doctors were inexperienced and did not perform the best SRS possible. They also have strange requirements that made little to no sense"

Trans people may need to undergo a variety of surgical procedures. However, many of these procedures (such as facial feminisation surgery or phalloplasty) may be unavailable in Australia, or may not be fully covered by Medicare or private health insurance schemes. Additionally, since many trans people understandably want to see a surgeon likely to provide the best possible surgical outcome, these factors often necessitate overseas travel to surgeons who perform many of these procedures on a near-daily basis. Trans people may still choose to travel overseas to visit their surgeon of choice, but people should not be forced to leave Australia in order to meet their health needs. What of people who cannot

afford to travel overseas? There is an urgent need for health departments across the country to address this issue. Ideally, each state and territory should have a hospital-based trans health clinic, where trans people can at the very least access some of the less complex surgeries such as chest reconstruction and orchidectomy. It may be necessary for one central clinic in Australia to specialise in more complex surgical procedures, such as vaginoplasty, phalloplasty, and facial feminisation surgery. Adequate financial resources must be directed to such clinics to ensure that waiting times are kept to a minimum.

5.2 Factors associated with participants not having surgery

Given the large proportion of participants who desired surgery, but had not yet undergone a surgical procedure, it is important to understand the factors that might prevent participants from having surgery. Comments that illustrate participants' responses are shown below.

“Fear of complications and bad health”

“My family would oppose it and I would be ostracised by them; also there are so many hoops and procedures to be gone through before a surgeon will perform the required surgery”

“Cost and the additional burdens of combating these costs as a lone young person with no family support was and still is an issue. These are several surgeries costing in total tens of thousands of dollars and this is simply to get an average looking body”

“There are the usual financial and gatekeeping restraints. In particular, it looks like I will be forced into sex work as the only way to fund this”

“The cost, money, don't want to have to see a therapist for 2 years prior to surgery as I know I'm a male and I shouldn't need to prove it to anybody”

“The cost of surgery is unaffordable and the medical system which won't offer us the kind of surgery options here in Australia. Can't even get a hysterectomy!!!!”

“Money is a large factor in not having surgery. Another big factor is a fear of surgical complications and possible loss of sensation during sex if I choose to have a vaginoplasty”

“It took me 2 years of 2x psychiatrists referrals to get approval for mastectomy, and money and Australian access to surgeons has prevented me from having meta or any lower genital surgery. My full/radical hysto was performed early in my transition as an emergency procedure as I had cysts on my ovaries and was in a great deal of pain (exasperated by starting testosterone). It also took me years to save enough money for the surgeries I have had”

Key factors preventing those who wanted surgery from obtaining it, were cost, lack of availability, and “gatekeeping”. Given that the cost of some surgeries can run into tens of thousands of dollars, many surgeries are simply out of reach, particularly for young people. As noted previously, Medicare and private health insurance schemes must regard trans-related surgery as essential medical treatment, rather than cosmetic. Tax rebates must also apply, as they would for any other essential medical procedure. It is particularly worrying that some participants might be “forced into sex work” to fund their healthcare.

“I managed to save enough money myself to have chest reconstruction by a local well respected surgeon who personally I’m happy with my results... I would have loved to have been able to have a full hysto including removal of ovaries but neither are covered by Medicare”

“If lower surgery outcomes were better, and if surgery was available in Australia I might consider it more seriously. I would only have hysterectomy/oophrectomy surgery if medically necessary (or if required as part of having full lower surgery)”

“Current surgical outcomes (i.e. success rate, limitations of what medical science can currently achieve) are making me hold off on getting any bottom surgery for the time being”

“Metaoidioplasty and phalloplasty is not available in Australia, and the expense is too great to go overseas (it would probably be too expensive if it was available in Australia as well)”

“There is nowhere in Australia to have phalloplasty performed. I’ve heard rumours about a new doctor in Melbourne but it’s very hard to get real information about that. The surgery I am looking into is only performed in Europe (\$AU40,000) and America (\$US56,000). I have been saving for years for this surgery. I’m 31 now and still about \$20,000 away from the FIRST of three or four procedures. ... In Australia, there is no such recognition [as a legitimate medical condition] and no insurance company will cover these procedures, as they are not deemed ‘medically necessary’”

Some participants were able to undergo some kinds of surgery in Australia and were happy with the results. However, overwhelmingly participants reported that many of the surgeries they wanted were either not available in Australia, or they were concerned about the state of the art. This stresses this importance of surgery not merely being available, but hospitals offering the very latest surgical techniques and aftercare. For some of the more advanced procedures, such as vaginoplasty and phalloplasty, it might be necessary for Australian surgeons to visit some of the “expert” surgeons elsewhere in the world to receive training. Some participants felt that certain surgeries were not “medically necessary” for them (which currently may present a barrier to a legal change of sex), while others wanted such surgeries, but were either denied them, or could only obtain them for “legitimate” reasons, such as having cystic ovaries. This highlights the fact that at least some doctors do not seem to regard trans-related surgery as a legitimate medical need.

“I have an excellent and healthy sexual life with my ‘original plumbing’, and I am not emotionally or psychologically impacted by not having male genitalia. I think if I was younger, in my late teens or early twenties I might want to have phalloplasty. However, my sense from research and other transguy’s experiences is, that the operation is very expensive, there are many surgeries, for what in the end is ostensibly a skin-covered dildo with no sexual sensation”

Not everyone desired genital surgery. Some were happy with their “original plumbing”. Educational materials, which include personal narratives and factual information about all transition-related surgical procedures, need to be developed and made accessible in formats appropriate to the trans population, so that they can make evidence-based informed decisions.

6 Changing identifying documents

It is common for trans people to want to change their name and sex on important legal documents, such as the passport and birth certificate. This is often essential to being accepted as one's preferred sex. Not being able to change identifying documents can result in discrimination, difficulty accessing services (including medical care), and an on-going source of distress. However, the situation may be more complex for some individuals (particularly those with non-binary identities) who choose not to pursue a medical transition. Participants' attitudes to changing identifying documents are shown in Table 18 below.

Table 18: Attitudes toward changing identifying documents, by identification

Response	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Not tried, and don't want to or are unsure	107 (11.3)	35 (25.7)	3 (1.3)	28 (5.8)	41 (42.7)
Not tried, but would like to	293 (31.0)	58 (42.7)	67 (28.9)	131 (27.2)	37 (38.5)
Tried, but could not	35 (3.7)	9 (6.6)	3 (1.3)	21 (4.4)	2 (2.1)
Tried, and changed some	285 (30.1)	20 (14.7)	101 (43.5)	154 (32.0)	10 (10.4)
Tried, and changed all documents	200 (21.1)	11 (8.1)	51 (22.0)	137 (28.4)	1 (1.0)
No answer	26 (2.8)	3 (2.2)	7 (3.0)	11 (2.3)	5 (5.2)

The low proportion of those who tried to change their documentation but could not, together with the qualitative data in the following section, suggests that many trans people do not attempt to change their documentation because they know they will be unsuccessful. In many states and territories, it is a requirement for trans people who are currently married to divorce before the birth certificate can be changed. Understandably, many do not wish to do so, and should not be forced to. Additionally, some form of surgical intervention is generally required, but this may not be possible for people to obtain (even if desired). Individuals who

were born overseas may find it difficult, if not impossible to change certain documents, while non-binary individuals may wish to change documents such as the birth certificate, but wish to be recognised as something other than male or female (which is generally not possible).

6.1 Impact of not being able to change identifying documents

Being forced to live with identifying documents that do not match one's sense of self and outward appearance can have a profound negative effect on mental health and well-being. It may also place trans people in danger of discrimination or violence. Some comments that illustrate the impact of not being able to change identifying documents are shown below.

"It's a nasty, alienating bureaucratic process that costs a lot of money and seems never ending"

"I fear going anywhere that identification may be needed, and I still get called by my legal name at doctors and other such appointments which has been very distressing"

"Travelling on a passport that didn't match my gender presentation saw me incarcerated on claims of a false passport. Not having this document reflect my appearance was traumatic and impacted my right to privacy as I had to come out at work as a consequence"

"what do you think. I hate the drivers license, I have it facing backwards in my purse so I can't see the picture or the name. same with all the other cards"

"Even though I think I am pretty robust - I must admit it does impact me and for a period of time it can make me feel angry, sad, frustrated. It creates administrative difficulties that can get in the way - impact me financially or else make me fear being outed"

"As an FtM trans person, having female on a birth certificate and driver's licence is very awkward. Employment, health care, centrelink, housing and anything requiring identity documents are all very stressful. It basically means you have to 'out' yourself as trans at every turn"

"Still being identified as male with centrelink (due to not having reassignment surgery) and identified with female by my university creates headaches a few times a year when I have my payments suspended until I can prove my enrolment. The idea of being legally male for the foreseeable future scares and upsets me"

Being unable to change their identifying documents had a profound negative effect on participants' mental health and well-being, and created many unnecessary and stressful difficulties for them. Furthermore, changing identifying documents is not the simple process it should be, because different rules operate at the Commonwealth level (e.g., changing the sex marker on passports and the Medicare record), and at the state and territory level (e.g., changing the birth certificate or driver's license). People who were born overseas may face additional barriers. Generally, changing one's legal sex at the Commonwealth level does not require surgery, as mandated by the Australian Government Guidelines on the Recognition of Sex and Gender⁵⁷. However, almost all state and territory jurisdictions require at least some medical intervention to have taken place. Complex and costly surgical procedures such as vaginoplasty may be required.

There is an urgent need for reform of state and territory legislation so that a legal change of sex becomes a simple administrative matter, and does not require medical intervention. The Australian Government Guidelines on the Recognition of Sex and Gender could be used as a model for such legislation. However, even at the Commonwealth level, problems remain. The Australian Government Guidelines on the Recognition of Sex and Gender are gradually being adopted by Commonwealth departments, but do not need to be implemented until 2016. This must be accelerated. Furthermore, the entire process of changing one's legal sex must be simplified. Ideally, trans people should be able to make a single application with one authority. All other agencies should be notified on their behalf automatically.

"Yes, it causes great distress not being able to change the gender marker (you must have vaginoplasty, which I can't afford and likely will never be able to afford) ..."

"The inability to change my gender marker on my birth certificate without having sterilised myself (hysto) is very demeaning. When having a hysto is not a medical necessity, why should I be required to go through this surgery when I've been able to change all of my other documentation (i.e. drivers licence, passport, Medicare etc.) to read 'Male'?"

"The marriage act makes it unlawful to change my primary birth marker, without a divorce"

"Had a problem with Medicare who did change my sex to male but then wanted my permission to change back to female so they could process my claim for ovaries removed. They said their system would not allow the claim to go through because males can't have the procedure done. I would not allow them to change my sex and said they had to change their system. It was processed in the end but I did not allow [them] to change to my sex and it took some time"

"... Documentation can often be changed but is purposely delayed, for example changing my sex to 'male' wherever I can (ie medicare) will mean I have to pay more for 'female' surgeries - in my case I was not ready (financially and otherwise) for top surgery for years, so have been keeping my documentation 'female'. It is also weird documentation-wise to get papsmears etc. as a 'male'. There are many different government agencies that have differing levels of what is required to change sex, and being [a] different sex to different agencies can create problems and is very confusing for everyone. There are also issues such as PBS benefits changing depending on your sex"

Given the experiences of participants in this study, it is unrealistic to insist that medical intervention be a prerequisite for a legal change of sex, because there is no one-size-fits-all approach. Furthermore, participants found it "demeaning" to have to sterilise themselves in order to receive legal recognition. Trans people who are married are also often prevented from changing their legal sex. It is grossly unfair to force married trans people to choose between legal recognition and remaining married. Further problems arise when certain hormone therapies or medical procedures are only subsidised on the PBS or the Medicare Benefits Schedule (MBS) for people of a specific sex. Even after surgical intervention, trans people may still retain some of their original reproductive organs. (For example, the prostate is generally not removed during vaginoplasty). Thorough reform of the PBS and MBS is required so that no medical intervention that trans people might require is dependent on the Medicare sex marker.

“Not at all, I present as who I want to be, police and anyone who requires ID are polite and understanding”

“There is no legal recognition for my status as a non-binary individual, and I am instead treated medically, legally and socially as female. I do not identify as female or male”

“The fact that the only options for documentation is to be either male or female is frustrating. I feel greatly invalidated, and this has fuelled my depression”

“It’s even more difficult to change your documents if you were born in another country, and the cost is astronomical as well. It basically just feels like the government wants to take a giant shit on you anytime you want to do anything if you’re trans. Like at least let me do this. because I’m not ever going to be able to afford surgery or anything”*

Not all participants reported that being unable to change their identifying documents created problems for them. However, the majority of participants felt otherwise. It is also important not to overlook the experiences of people with non-binary identities. People who identify as something other than male or female must have the option to identify themselves this way on Commonwealth, and state and territory records and identifying documents. This could be achieved by having an “X” option as with passports, or the ability to have one’s sex recorded as “indeterminate” (or similar) on the birth certificate. Clearly, though, there is an urgent need to reform what trans people experience as a “nasty, alienating bureaucratic process”.

6.2 Participants’ thoughts on changing identifying documents

We asked participants if they had any other comments to make about changing identifying documents. Overwhelmingly, participants thought that the process should be simplified and the requirements much easier to meet.

“I think it would be good if the law could be changed. So instead of needing surgery to record a change of sex, if a doctor and a psychiatrist could sign off on it that would be fantastic and make life so much easier”

“Name changes are simple enough, though expensive with no allowance for necessity. You cannot use the cheaper name change upgrade for passports that people can use when marrying. The sex marker requires surgery and letters and things that are not possible or wanted for many people”

“It is essential for trans people to have the option to change their documentation, to get on with their lives”

In summary, there are at least two key areas requiring urgent action: (i) the implementation of the Australian Government Guidelines on the Recognition of Sex and Gender; and, (ii) for state and territory authorities to simplify the process required for a legal change of sex. Medical intervention must not be a prerequisite, and upon a successful change of sex, the relevant state or territory authority should notify all state, territory, and Commonwealth government departments on the applicant’s behalf.

7 Discrimination

Discrimination and harassment is a daily reality for many trans people. This chapter explores participants' experiences of discrimination and harassment, and how they responded and tried to remain safe. As shown in Table 19, almost two thirds of the sample had experienced discrimination or harassment at some point in their life. Almost half experienced this in the last 12 months.

Table 19: Experiences of discrimination and harassment, by identification

Response	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
Never experienced	296 (31.3)	44 (32.4)	75 (32.3)	143 (29.7)	34 (35.4)
Experienced, but not in the last 12 months	152 (16.1)	13 (9.6)	39 (16.8)	84 (17.4)	16 (16.7)
Experienced in the last 12 months	461 (48.7)	72 (52.9)	107 (46.1)	241 (50.0)	41 (42.7)
No answer	37 (3.9)	7 (5.2)	11 (4.7)	14 (2.9)	5 (5.2)

Of the 613 people who experienced discrimination or harassment (64.8% of participants), an alarming 76.3% (n=468) reported that they had changed their activities or behaviour to avoid further experiences.

7.1 Experiences of discrimination and harassment

We asked participants to describe the discrimination and harassment that they had experienced. Below are some examples of participants' comments.

"I'm a non-binary gender and people tend to disregard that and assume we're just playing around. Like this is a game. It's not"

"Just small things like people whispering behind my back and strange looks all the time"

"General condescension, being treated as strange or other, being told I'm faking it, being told I should get over it, being told that I'm mentally ill"

“Nobody knew how to approach someone in my situation so they opted to just not talk to me at all. It was isolating. When I didn’t pass I would get verbally abused/harassed daily by strangers on the street”

“Isolation due to being invisible in society both within the gay and lesbian community and heterosexual communities. Loss of social connection due to assumptions that I’m male”

“violence, verbal harassment, as a volunteer in so-called GLBTI orgs, especially the mess called [media organisation in Victoria]. From [telephone counselling service] (as both volunteer and client) many years ago”

Participants detailed the multiple ways discrimination and harassment play out in their lives, which often result in social isolation. It is important to note that discrimination occurred in a variety of contexts, including within the LGBTI community. Discrimination could perhaps be mitigated to some extent by education. As previously noted, this could take the form of workplace education and resources for family and friends. School sex education curriculums should also discuss trans issues in a positive and inclusive manner. Education campaigns for the general public, such as the *Stop. Think. Respect.* campaign⁵⁸ may also be effective at reducing stigma and increasing understanding.

“I started falling for a girl, and I thought before things got too serious I should tell her about my medical history, so I wouldn’t one day be quietly nodding along while she complained of reproductive pains, seeking some sense of sisterhood where there is none. She used to be really excited to talk to me. I never hear from her anymore”

Establishing and maintaining relationships can be daunting for trans people, particularly those who are “stealth”. Trans people face the dilemma of disclosing their trans status early to appear “honest”, before a potential partner has got to know them well, or to wait until they have built rapport with a potential partner only to face the possibility of being accused of “deception” and possibly violence. Trans people who are not stealth may still face similar problems, and may not be seen as desirable partners. At the other extreme, trans people are sometimes fetishised, which may increase the chances of finding a partner at the cost of their identities being disrespected.

“doctors not wanting to treat me”

“I’m having a hard time acquiring paid work because of my ‘trans status’. While I can’t prove it, as soon as a potential employer finds out I’m trans the interview ends suddenly. They find out because they ask for proof of my right to work and see the female marker on my birth certificate”

“Forced to resign my job, verbally abused and belittled in front of co workers, stalked, threatened, hate mail”

“Tafe teacher using transphobic language in class for ‘laughs’ even tho she knew about me. other students in the class followed up with more ‘jokes’”

“Been openly called numerous names (e.g. ‘ladyboy’, ‘shemale’, ‘tranny’), been asked if i was male or female, unwelcome stares and whispers in the past. Was labelled ‘gay’ and ‘queen’ in school. Other forms include racist remarks from transgender folk, General harassment from men ranging from car honks, solicitation and unwelcome advances”

“Worst was being fired [the] day after I announced my intention to transition. Have had people try and kick me out of bathrooms, sports teams. Have been excluded from social situations. And if I ever have to hear another tranny joke.... Only choice is either to out yourself or smile nod and condone it. Makes me sick”

Participants reported discrimination in a wide range of settings, including healthcare, their workplace, and educational institutions. They reported being the focus of hurtful comments and “jokes” from their peers and teachers. Participants had difficulty securing employment, and some reported losing their job after announcing their intention to transition, or during the transition process. Some participants resigned from work because their peers made life unbearable for them.

Some participants also reported experiencing racism from other trans people. In this regard, it is important to note that the trans community is not necessarily a welcoming and inclusive place for all. Apart from interventions to address racism (and other forms of discrimination) within the trans community, research on the intersection of race, sex, and gender expression should be made a priority area.

Can discrimination and harassment be eradicated or at least minimized through education? Hopefully, it can. As mentioned previously, campaigns such as *Stop. Think. Respect.*⁵⁸, workplace education, inclusion of trans people in school education curriculums, and enforcement of the new protections included in the Sex Discrimination Act 1984 (Cth) which came into force on 1 August 2013, may help to mitigate this.

“I was chased along the Yarra River by a bunch of youths throwing stones. Also general refusal to provide services, people laughing and pointing at you or talking about you behind your back socially”

“As a child I was bullied for being effeminate, by peers and siblings. Parents would not allow me to express myself”

“Being called a poofter; was bashed once because they thought I belonged in a mental institution”

“Assaulted at a tram stop. A man asked man or woman? I answered does it matter. he said ‘I hate you’ and hit me”

The Australian Institute of Criminology should collect information about, and report on hate crimes against trans people. Legislation to outlaw vilification of people based on their trans status should be considered.

7.2 Changing behaviour to avoid discrimination

Participants who had experienced discrimination or harassment often went to great lengths to avoid future experiences. Comments illustrating their coping strategies are shown below.

“I feel obliged to make myself seem inconspicuous when I am by myself in public if I am presenting a more feminine exterior so as to divert attention from myself to avoid any discrimination and/or harassment”

“Not getting undressed completely and undressing partially in the corner of gym locker rooms to avoid revealing my genitals and chest scars. Avoid using urinals, and always shut stalls to urinate, limit the amount of chest (scar) exposure, keep shirt on and rarely wear singlets in summer, have grown facial hair at times to help in being publicly identified as male (even though I hate facial hair and would much rather be clean shaven), had to make up stories of a male childhood when asked to avoid any suspicion of having grown up female”

“Constantly maintaining awareness of people out on the streets, changing sides of the road when I see large groups of young drunk guys, groups of us going out of our ways to make sure that everyone makes it ok to a car or train station, staying over at people’s houses or taking taxis rather than risking public transport on football nights”

“I do not venture to straight clubs. I rarely go out into public nightlife. I move quickly through public, and am hyper vigilant of anything I consider dangerous”

“Keep social life to a minimum. in other words go home lock myself up throw away the key”

“Stopped playing sport, ceased going to usual venue. Left a job”

“I’ve dropped out of uni and TAFE because of bullying and because neither administrations cared. I’ve pretty much given up on tertiary education”

“Not dating and being afraid to seek out a romantic partner ...”

“I have avoided people from before my transition, moved interstate to be anonymous and start a new life, avoided changing rooms and sports, changed doctors, lied about my past, not let new acquaintances get close to me... it affects every facet of my life. I constantly feel on edge about someone outing me and I worry what would happen if someone exposed me”

“public toilets is the worst. every fight i’ve been in has been after i use a public toilet so i now avoid using them”

“As a general rule, I live what is known as ‘stealth’ - namely, I don’t make it known, and actively avoid telling people, that I’m not just a normal guy. Things like, if I’m asked why I only took two subjects during the semester in which I had chest reconstructive surgery, I have a consistent story about an injury sustained during working on a [workplace environment], which is something I do often. This has been the case ever since I started transitioning. I used to lie and say I was younger than I am, pre-testosterone, because I was lucky enough to be able to pass as a younger guy. When binding my chest, I was called on it once, and immediately responded that it was a back brace ...”

Participants reported numerous ways that they protect themselves from discrimination and harassment. All likely have a negative effect on mental health even if they “work” to some degree. For example, being stealth protects individuals’ privacy (and is a perfectly valid choice), but the fear of discovery may be an ongoing source of stress and a self-imposed prison of sorts. The provision of a unisex option for toilets in public places, workplaces, and schools, may help trans people avoid potentially dangerous confrontations with others.

8 Accessing healthcare

This chapter explores participants' relationship with general practitioners (GPs) and health workers generally. As shown in Table 20, over 80% of trans men and women had a GP, but only approximately two-thirds of non-binary participants did. This may be because many non-binary participants do not seek a medical transition (having a regular and supportive GP is generally essential to the transition process), or because they fear that GPs will not understand what it means to have a non-binary identity. However, finding a supportive GP may be equally difficult for trans men and women, as participants' comments in the following sections illustrate.

Table 20: Participants who had a general practitioner, by identification

Response	Category of identification				
	Entire sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	n (%)	n (%)	n (%)	n (%)	n (%)
No	106 (11.2)	26 (19.1)	16 (6.9)	45 (9.3)	19 (19.8)
Yes	736 (77.8)	90 (66.2)	187 (80.6)	397 (82.4)	62 (64.6)
No answer	104 (11.0)	20 (14.7)	29 (12.5)	40 (8.3)	15 (15.6)

Of those who had GP, 82.3% (n=606) had told their GP that they were trans. We also asked participants who had a GP about their relationship with that doctor, using the Patient-Doctor Relationship Questionnaire (PDRQ-9). Only 51.2% (n=377) met the criteria for a good relationship with their GP.

8.1 Reasons for not having a GP

Participants who did not have a GP were asked why this was the case. Responses that illustrate the themes that emerged are shown below.

“Because I generally am dissatisfied with how I’m treated”

“because you don’t get treated well. ... because they don’t know how to treat you. no knowledge”

“The GPs where I live do not generally provide bulk-billed services”

“I live in a remote community where there is no GP. I do have a Transgender friendly clinic that I attend when I am able to and I am in Melbourne - usually about twice a year”

While the majority of participants had a GP, and some reported a good relationship with that person, this was not universal. Some participants expressed dissatisfaction with how they were treated, and that their doctor lacked the knowledge to provide adequate healthcare. This appears to support other research. In a recent survey conducted in the U.S., half of trans people reported that they had to educate their doctor about their healthcare needs⁵⁹.

Participants also reported difficulty locating a GP, especially in rural and remote areas of Australia. This problem is likely acute for ATSI people living in remote communities. There are likely to be few health professionals who specialise in trans health in regional and remote Australia. Those that do may attract a large caseload of trans people, and could become overwhelmed, resulting in them choosing to leave this area of medicine. This stresses the importance of all GPs having some knowledge of trans health – at the very least they must be aware of appropriate referral pathways. Telemedicine may also be an option for people living in rural and remote areas. Doctors working in the major cities of Australia who are able to offer telemedicine must consider providing this service.

Cost was another barrier reported by participants. Given the low incomes reported by participants, having access to doctors who bulk bill is essential.

8.2 Disclosing being trans to healthcare workers

We asked participants about their experiences of healthcare generally, and how they felt about disclosing being trans to health workers. Only one-fifth (20.4%, n=193) always disclosed, 25.0% (n=236) sometimes disclosed, 33.8% (n=320) disclosed only if they had to, and 12.2% (n=115) never disclosed. The remaining 82 participants did not answer this question.

Although it is not always necessary for a doctor to know that a patient is trans, there may be times when not knowing could result in the patient receiving sub-optimal care. For example, a trans man who looks unambiguously male is unlikely to be offered routine reproductive health checks, such as a Pap smear. It is also concerning that participants felt that they could not be open with healthcare workers. This may be due to a fear of discrimination, privacy and safety concerns, a way to manage the burden of having to educate healthcare workers, and/or not wishing to draw attention to this aspect of their lives.

To further explore this issue, we asked how participants felt about telling people that they were trans when accessing healthcare. Typical responses are shown overleaf.

“Being ‘post-op’ I don’t feel the need to I’d rather not ‘out’ myself”

“My policy is to confirm my status if asked, otherwise I do not mention. I see myself as female, not someone pretending to be female”

“I get uncomfortable as most health care workers seem unsure how to deal with a trans patient”

“Frustrated. Embarrassed. Nervous”

“Very nervous because I often have to educate the health professional, whether they think they need it or not”

“Mostly unsafe. I’m never sure who I can trust. Although so far everyone I’ve told has been very professional about it, some people have had bad experiences with refusal of care or being outed (or worse), which scares me. I feel like not enough doctors are educated in transgender issues, and most of the ones I have talked to have been going with their gut feelings and some vague knowledge”

“Concerned about my privacy, concerned that they will start screwing up with pronouns, concerned they will see me as less of a man, concerned they will think I have a mental health problem, concerned that my friends and classmates will find out somehow (I’m a medical student at present)”

“I’m not really worried because I go to a trans friendly doctor, but I have had a bad experience at the start of my transition with a very judgmental doctor”

“I prefer not to but when it comes to health care I understand it may sometimes be necessary and when pressed will not hide or lie about it even if it isn’t relevant to the situation at hand”

“Pretty cautious. On one hand I know they should treat me impartially and provide good care regardless, but snarky comments, and body language can do a lot to show disapproval”

“I am proud of being trans, and I love talking about it”

Only a minority of participants (20.4%) always told health workers that they were trans. Many participants were clearly uncertain how disclosure would be received, and reported feelings of fear, frustration, embarrassment, and nervousness. Many felt unsafe and lacked trust in doctors, worrying about whether the doctor would be judgemental and whether being trans would be treated as confidential information. Some who were stealth saw no reason to disclose at all. While being stealth is a valid choice, if the doctor is unaware of their patient’s trans status, they may not provide optimal care and may miss opportunities for disease prevention. (e.g., offering a Pap smear to trans men, or a prostate check to trans women).

Given that many participants reported experiences of poor treatment by doctors, fear of disclosure is understandable. Although trans people should not be forced to disclose, medical services must create a welcoming environment so that trans people know that disclosure will be received positively if they choose to do so. This could be achieved by displaying trans-friendly materials and resources such as posters and fliers, and brochures about trans health.

All staff working in healthcare settings (including support staff), must be educated about trans health, to improve the likelihood that trans people will feel comfortable that they can be

open about being trans (if they wish to do so). Information and educational materials that include personal stories and factual information about what it means to be trans are needed for healthcare workers. These materials must be disseminated in appropriate formats to everyone working in the healthcare sector to increase their knowledge and skills, and acquire a trans-positive attitude. Several guidelines have already been developed for this purpose, and could easily be adapted for use in the Australian setting⁶⁰⁻⁶³.

8.3 Factors affecting disclosure to healthcare workers

We expected that participants would be reluctant to disclose their trans status. We therefore asked about the factors that encouraged and discouraged participants to do this.

8.3.1 Factors that encourage disclosure

Below are some comments that are representative of the factors that encouraged disclosure.

“Nothing ! Don’t see the point”

“When I’m in an environment that seems positive I might tell them. And when I’m forced to say what medications I’m taking”

“It is kinda obvious, especially with health care. Not really something I can hide”

“When the procedure is of a nature that the information about my history would be relevant to diagnosis or treatment”

“If they seem positive towards me and seem understanding and friendly”

“Alluding to my non-binary status and judging their response to be positive”

“If I know that they have knowledge regarding transgender people”

“Well that they have GLBTI posters or info in the reception area. Although I went to a local community health centre that had all that once and ended up making a complaint about a GPs conduct - He said ‘I was depressed because I was too muscly and masculine’...!/ What tha?”

“When clinics specifically advertise themselves as trans-friendly, or when a friend recommends someone”

“Just makes me feel good as I hid this for 47 years off my life only person who ever knew was myself”

Participants generally disclosed only when they felt it was relevant to the medical issue that they were being treated for, or if they thought that health workers seemed “understanding and friendly”. A visibly trans-friendly environment can encourage openness. As noted previously, the prominent display of trans-friendly materials and resources could encourage this. But organisations must do more than simply state that they are trans-friendly. A trained workforce is essential to ensure that medical care is genuinely trans-friendly. Health workers must also clearly know the difference between populations that comprise the LGBTI community, and not assume that the needs of LGB people are the same as trans or intersex

people. Resources such as *Is Your T Written in Disappearing Ink?*⁶⁴ can help providers ensure that the “T” in LGBTI is not a token gesture, and make their service truly inclusive.

8.3.2 Factors that discourage disclosure

Below are some comments typical of the factors that discouraged disclosure.

“It’s always humiliating to admit to physical aspects of the other sex”

“Nothing, except it is outing myself”

“I still feel shame, fear and embarrassment”

“Fear that they won’t adequately help me due to the fact I’m trans, or limited medical knowledge of trans issues and medicine”

“Confidentiality breaches/people overhearing Reactions can be worrying”

“The fact that the few times I have had to, they completely disregard what I have told them or have no idea what I am on about and require me to spell it out slowly for them. I go to the doctors because I’m sick, not to teach the ignorant”

“Past negative experiences”

“Always feel slightly more trepidation telling males that I am trans”

“lack of visible diversity / inclusivity statements”

“if the[y] have voiced conservative or offensive views about sex or gender, they are apathetic or don’t care about me in general”

Factors that discouraged trans people from disclosing included fear of negative reactions, healthcare workers’ lack of knowledge regarding trans health, an unwelcoming environment (lacking “diversity / inclusivity statements”), and the desire not to “out” themselves. Non-disclosure is a perfectly valid choice, but in some cases could indicate a degree of internalised transphobia, as indicated by comments about “shame ... and embarrassment” about being trans. This stresses the importance of improving awareness and acceptance of trans people by the general population in all spheres of life. Although being trans can be a challenging and difficult experience for many, encompassing not just the struggle of self-acceptance and the decision to transition, but also a long and costly process of medical intervention, mental health promotion programs may possibly help to alleviate distress. A priority for mental health research should be to examine how greater self-esteem and self-worth can be fostered in trans people.

8.4 Experiences of accessing healthcare

We asked participants what accessing healthcare as a trans person was like. Some comments that illustrate the themes that emerged are shown below.

“Avoid it when possible. Don’t have the knowledge about how to seek it as well”

“Great in terms of general health care. Pretty close to terrible as far as trans specific health care is concerned”

“Good and bad. Some healthcare providers have been surprisingly understanding and helpful, others have outright denied me even an appointment due to being trans”

“I have had good and bad experiences with accessing healthcare. The worst experience was when doctors at a local hospital refused to treat me after I disclosed to them that I was trans and had a sexual reassignment surgery. I had developed complications post-operatively after my first mastectomy and approached numerous hospitals about it and none of them would treat me, I had to fly back to Sydney so my surgeon could treat me. But other than that, there are a number of trans friendly and trans experienced healthcare professionals in my city that I utilise and feel there is good access to a variety of them”

“I have had no major issues, I found good doctors and stuck with them, I’ve only really had uncomfortable experiences when I had to use other doctors [at] short notice. In fact I have been very happy with the fact that I found doctors/surgeons happy to work with me outside the current psychiatric pathologising system”

“Very occasionally you find a good practitioner. They are like gold. Most however are useless and know nothing but won’t admit the limits of their knowledge. Some are rude. Others just unprofessional. Some are inappropriately sexual”

Participants reported mixed experiences. Positive experiences were associated with the medical health professional being knowledgeable about trans health and having a trans-positive attitude. Poor experiences arose from lack of knowledge, negative attitudes, and experiences of discrimination.

Trans people’s experiences of accessing healthcare appear to be very much contingent upon the attitudes and knowledge of the medical health professional. Trans people should not have to search for “good practitioner[s]” who are “like gold”. Trans health must become part of the medical curriculum, professional development programs, and workplace training. Clear referral pathways are also urgently needed, so people are not left wondering “how to seek” trans healthcare.

“Typically good, the larger the organisation the more likelihood they would have dealt with other trans people before so I try to stick to large practices or go on recommendations”

“Fairly good, I don’t get many doctors that would be discriminatory very often but there is definitely some out there”

“Pretty good. A few surprised looks, but usually accepting. I changed GP a few years ago, the previous one was ok but not overwhelmingly interested. My current GP is great. She even asked me to explain what trans life is all about”

Some participants reported mostly positive experiences with doctors, but this was sometimes a matter of luck and/or knowing where to go. Trans friends were often a valuable source of knowledge, but trans people should not have to rely upon the knowledge of their friends and peers in order to locate qualified health practitioners.

8.5 Factors influencing the decision to access healthcare

Given that trans people experience high levels of discrimination, including in the healthcare setting, we wanted to understand the factors that might influence the decision to access healthcare. The following sections explore the factors that encouraged and discouraged participants from accessing healthcare.

8.5.1 Factors that encourage healthcare access

“The need to access hormones, surgery and keep good health during transition/life”

“Explicitly stating on their website or promotional material that they are trans experienced or trans friendly. When the healthcare professionals have a reputation for being friendly and professional, open communication and genuine interest health. When it’s affordable and they bulk bill”

“Health care facilities and providers who are up to date, that is, are at least vaguely aware/open to transsexual people and issues”

“A doctor / staff that use the right pronouns. Would be a massive improvement, if they have no idea what to use then they should ask”

“if someone in the community recommends a service”

“I access health care only if I need it, and for annual blood tests”

“When I am so ill I have no other option”

Although some trans people accessed healthcare only if they felt they needed it and/or for transition-related purposes, other factors were important in encouraging trans people to access healthcare. These included explicit statements that the service was trans-friendly, doctors and staff who were knowledgeable about trans health (or were willing to learn more in respectful ways, such as appropriate questions about which pronouns people preferred),

and recommendations from friends and peers. However, some participants' negative experiences of healthcare and/or fear of discrimination resulted in some accessing it only when they had "no other option". This reflects an urgent need to improve health services for this population.

8.5.2 Factors that discourage healthcare access

"Nothing really"

"An absence of bulk billing and competent psychiatrists in my area (Newcastle, NSW)"

"The lack of specialists in Australia who deal with trans-specific health services. The lack of financial cover for trans-specific health services from Medicare and private health funds"

"Being discriminated against is my biggest fear when accessing health care, because it has happened in the past, and I believe it will happen again"

"Doctors make me nervous and in the past I have felt they didn't respect my ability to make adequate choices for myself"

"The risk of having a 'gatekeeping' doctor"

"People that abuse their power to give health care by not giving it because of their beliefs. The lack of long term knowledge understanding of trans health and bodies"

"Pap smears, it means I have to show my genitals to a stranger, I hate my female genitals"

For some, there were no barriers to healthcare, but participants who lived in major cities with access to a wide variety of doctors and specialists were more likely to feel this way. Others who lived in smaller cities reported difficulty finding competent doctors, especially specialists. Discrimination, "gatekeeping", and general lack of knowledge of trans health were the most common factors discouraging people from accessing healthcare. Financial barriers, such as lack of Medicare and private health insurance coverage, and difficulty finding doctors who were prepared to bulk bill, were also common. Finally, some participants were discouraged from accessing healthcare if it meant revealing parts of their body that were a source of dysphoria for them. Addressing this latter issue may prove difficult. Doctors who are knowledgeable about trans health, and who can provide a welcoming environment and reassurance to their patients may help, but this may not be sufficient to overcome the intense dysphoria felt by some people. There is a need for research to investigate whether it is possible for the dysphoria experienced by this latter group to be minimised in the healthcare setting, and how important preventive health checks such as Pap smears can be performed while causing minimum distress.

8.6 Participants' perceptions of their healthcare needs

Finally, we wanted to understand what participants thought their healthcare needs were, and also if these needs were being met. In this section, we present the key aspects of healthcare that participants felt were specifically needed by trans people.

"I need hormone treatment to be prescribed so that I don't have to pay exorbitant black market internet prices. I need a proper hormone regime that is monitored and adjusted as required. I need acceptance"

"Need ongoing access to testosterone prescriptions, need regular monitoring (blood work) of my hormone levels and other areas that can be affected by testosterone (e.g. liver function tests). Need a GP experienced in administering testosterone. Knowledgeable of trans surgeries, understands the effects they can have on my body both physiologically and psychologically, and has a good referral database of trans friendly health professionals"

"Regular endocrinologist visits, regular psychologist visits, regular GP appointments. Consultations with surgeons and other specialists. Medications (e.g. testosterone) 3-weekly nurse visits for assistance in injecting testosterone"

"Speech therapy, counselling, electrolysis, endocrinology, psychiatrist, and specialist surgeons"

"The main issue that I have as a trans person that I may not have otherwise is the need for regular psychological care to work toward feeling comfortable with myself and manage the sometimes distressing reaction[s] of those around me"

"I would be more comfortable in my skin if I was able to fund the rest of my surgeries"

"To be always treated like a woman even though I have a penis"

"support and respect and understanding"

Participants' needs included: affordable access to hormone therapy and surgery; ongoing monitoring of the effects of hormone therapy; doctors with comprehensive knowledge of trans health (including both physical and psychological aspects); easy access to specialist services, such as endocrinology, psychiatry, psychology, surgery, and speech therapy; easy access to other (but nonetheless vital) services such as hair removal; and above all, "respect and understanding".

Many services must currently be accessed privately, particularly speech therapy and hair removal. The latter is unlikely to be covered by health insurance schemes, and will be considered a cosmetic procedure for tax purposes (despite genital hair removal being required for some surgical procedures, and facial hair removal being essential for some trans women to blend and to reduce dysphoria). Hair removal, particularly electrolysis, may take several years and cost tens of thousands of dollars. At the least, a tax rebate should apply to such procedures, and ideally they should be covered by Medicare. Health systems require urgent reform so that surgery and hormone therapy are fully covered by Medicare.

Although specialist care is required by many, much of the work currently performed by specialists could be performed by GPs or nurses with training in trans health (such as administering testosterone injections). If GPs were adequately trained in trans health, the cost to people requiring a medical transition could be substantially reduced.

Psychological care was also reported to be an important need for some participants. Although some participants were very critical of psychiatrists and/or psychologists who followed a “gatekeeping” model, appropriate psychiatric and/or psychological care is vital for some. However, mental health professionals must adopt non-psychopathologising models of treatment and be perceived to work with, and support trans people, rather than an obstacle to surmount.

8.7 Fulfilment of participants' healthcare needs

We asked participants if they thought that their healthcare needs were being met. Below are some comments that illustrate participants' thoughts:

“No, there is a systematic lack of care for trans people at all levels of the health system”

“Absolutely not. Trans people have to navigate the health care system more or less alone. Everywhere trans people turn to for medical treatment and advocacy, we're met with under-funded, under-staffed, under-educated and old-fashioned gatekeeper healthcare workers. Both government-run and not-for-profit organisations lack the resources to deal with the volume and diversity of trans people that require their services, and private clinics are only accessible if you have the money to do so ...”

“No. Although hormone therapy from my experience has been affordable for the most part surgery is not affordable for a lot of people including myself and this slows down the process immensely”

“I'd say no: it's actually quite difficult to find doctors or mental health professionals who know anything about transitioning within my state, especially if you aren't a member of the understandably insular trans community already”

“no, I have waited 6 months+ just to see a psych, all the trans people I know are my age and I don't know anyone personally who can advise me on anything about any form of transition”*

“No. My GP is supportive, but reproductive specialists such as gynaecologists continue to treat me as female, encouraging me to use hormones such as the contraceptive pill to 'normalise' my hormone levels and refusing to perform a hysterectomy”

“Mostly. It's hard though because there is not a lot of help where I am and I have to travel to places like Sydney to see my specialist”

“Sometimes yes, largely no. That is to say yes amongst clinics that care and not at all amongst regular GPs and staff”

“yes and no - I know that I have good healthcare providers I can turn to but sometimes the info just isn't out there - what is my cervical cancer risk? As I am in a relationship with a bio guy, what is my pregnancy risk? If you do blood tests for my hormones levels, what should my idea[!] hormone levels look like?”

“I receive good hormone support from a specialist and regular consultations with my GP. These visits are quite expensive and I suspect that any trans person without above-average income might well have difficulty receiving adequate health care”

“Only because I have a great doctor”

Overwhelmingly, participants reported that their health needs were not being met. Participants often felt “alone” on their journey, and that both government and non-government organisations were either inadequate or underfunded, and overwhelmed by the demand for services. The cost of transition was a recurring theme. Given the low incomes reported by participants, how many trans people in Australia are prevented from commencing or completing a medical transition due to the inability to afford it?

Lack of knowledge by doctors was a recurring theme. However, participants need not only doctors who can provide hormone therapy, surgery, and/or appropriate referrals, but also more specialised information. For example, what hormone levels are appropriate for people receiving hormone therapy, and information about their specific sexual health needs. This is particularly relevant for trans people who are in relationships with people of the same sex (for example a trans man who is in a relationship with a gay or bisexual non-trans man). Some doctors may assume that trans people will be heterosexual, and may either be uncomfortable with other types of relationships, or simply lack the knowledge to answer questions such as “what is my pregnancy risk?”.

“Yes. I have a wonderful GP”

“Yes, though I feel that most of the blood work results could be handled by a GP if the right training were offered broadly. This would help reduce cost incurred by needing to see a specialist”

“For a female yes but not as a genderqueer or gender questioning person”

Some participants reported that their healthcare needs were met, but often only because they had “a wonderful GP”. This stresses the importance of all GPs having at least some knowledge of trans health, and the need for trans-specific content in medical curriculums. Much of trans healthcare is not complex. If participants could access more services from GPs (rather than specialists) costs could be markedly reduced.

Some participants with non-binary identities reported that their health needs were only partially met. Medical training for health professionals must be inclusive of all trans people. Some people do not desire a medical transition, or desire only a partial transition. Education about trans health must stress that not everyone fits a typical transsexual narrative.

8.8 A vision of trans healthcare for the future

Participants were asked to describe what they would like healthcare for trans people to look like in the future. Below are some responses that illustrate what participants wanted to see, and how they wanted to be treated:

“Non judgement and treat[ed] with respect”

“FRIENDLY! I don’t need people who are politically correct, or have all the answers, or to have specialists who just deal with trans folk. I just need friendly open honest practitioners who are prepared to educate themselves a little”

“Unbiased and equal to that of services for non trans people”

“I would like to see a trans person treated with respect, compassion and understanding. We are not monsters. I do not expect to be treated as one. ...”

Participants’ comments demonstrate that trans people want to be treated like any other patient: with “respect, compassion and understanding”. As previously noted, negative societal attitudes towards trans people could hopefully be minimized through education campaigns such as *Stop. Think. Respect*⁵⁸. All healthcare staff need access to information and educational materials about trans people and their health needs, and must work toward making their services friendly and accessible to trans people. Guidelines on how this can be achieved have been developed⁶⁰⁻⁶³.

“more lead by the patient, and a focus on informed consent for access to medications and surgical procedures”

“... I guess more education of health professionals wouldn’t hurt. Better funding for surgery would have helped. My life stagnated for a decade with depression while I tried to sort out the financial side of being trans”

“Access to all surgery via medicare”

“I would like to see an ‘informed choice’ model of treatment, particularly considering I can get tattoos, dermal implants, etc without proving my sanity, but I can’t have my breasts removed... it seems a bit ridiculous to me”

“Surgery and hormones and related health needs covered by Medicare. Education in schools. Support offered”

“Perhaps a more combined care with all specialists in the one centre to make the journey much more accessible”

“My GP who practiced in the UK summed it up. In the UK if a person presents to their GP saying they are trans they have a process to follow that lays out every step of transition, where to access services and what happens next. In Australia no such process exists and patients and doctors have to fumble their way through”

“Mandatory training component in medical/nursing courses, and workplace training for new and existing health care professionals to prepare doctors/nurses etc for the possibility of treating trans patients across all health streams. If there is thorough training given alongside the rest of their study content, it would make the treatment of trans people less of an enigma, and provide a more

standardised knowledge base. If every health care provider was queer-friendly and had a basic understanding of the needs of trans and other non-conforming patients, it would be much easier and less stressful seeking access to health care”

“Early childhood education is a big issue as most trans [people] have no materials when they are young to help themselves understand what they are going through. This is the single most important reform that could be done”

“early and easy access to hormones before/during puberty”

“More open discussion about non-binary and bisexual/pansexual identities”

“For no one to even bat an eye-lid at the word trans”

In summary, participants wanted to see trans healthcare become more patient-led, with a move away from “gatekeeping” models toward an informed consent approach⁵⁵. They wanted to see all aspects of trans health covered by Medicare, including (but not limited to) hormone therapy and surgery. This change alone would considerably reduce the financial burden faced by trans people and would almost certainly have a positive flow-on effect with regard to mental health. Participants thought that specialised clinics for trans people where they can access all of the services they require, would “make the journey much more accessible”. However, historically, some trans clinics have been regarded as inflexible and paternalistic^{65,66}. That mistake must not be repeated or perpetuated. Representatives from the trans community must have a governance role in such clinics (e.g., sitting on the board of management). At the very least, clear referral pathways and protocols must be developed for each state and territory (and made easily available) so that trans people know where to go for help, and what can be expected at each stage of their journey (and when).

Education for both the general public and healthcare workers is essential. Education is effective. In a study of second-year medical students, Safer and Pearce⁶⁷ reported that introduction of trans-specific content to the medical curriculum resulted in a 67% drop in discomfort in providing care to trans people. The proportion of students who felt unwilling to treat trans patients dropped from 15-18% to 3%⁶⁷. However, education must reflect the needs of all sub-populations within the trans community, and include education about the lived experience and needs of non-binary trans people, as well as trans men and women.

Young people need better access to information about their options for pursuing a medical transition, and exploring sex and gender expression generally. Adolescents must have access to puberty-blocking drugs to prevent the development of irreversible sexual characteristics, and hormone therapy (i.e., testosterone or oestrogen) should be offered where appropriate. Finally, participants wanted to see societal attitudes to trans people change, and for “no one to even bat an eye-lid at the word trans”.

9 Illicit drug use

This chapter investigates the use of illicit drugs by participants in the last 12 months, and the factors associated with their use. These data are age-standardised to allow comparisons between sub-populations in the study, and also the general population. Data for the general population are drawn from the 2010 National Drug Strategy Household Survey³¹.

Table 21: Age-standardised prevalence of illicit drug use in the last 12 months, by identification

Substance	Category of identification					
	Australian population	Entire trans sample	AFAB non-binary	Trans Men	Trans women	AMAB non-binary
	%	%	%	%	%	%
Cannabis	10.1	25.5	30.0	40.3	24.0	18.9
Ecstasy	3.1	6.7	17.2	10.0	4.7	7.3
Meth/amphetamine	2.2	7.6	15.2	9.4	7.3	5.7
Cocaine	2.3	4.0	3.0	10.4	2.5	4.8
Any illicit drug^k	14.7	28.5	36.8	42.0	26.4	21.2

Participants were approximately twice as likely to have used an illicit drug than the general population in the last 12 months. These differences were statistically significant (95% confidence intervals not shown). Trans men and AFAB non-binary individuals were more likely than trans women and AMAB non-binary individuals to use cannabis, ecstasy, and methamphetamine. Trans men were more likely to use cocaine than any other group. Although the marked discrepancy between the general population and this study is concerning, and suggests that urgent action is required to address illicit drug use by all trans people, health promotion efforts may need to focus more on trans men and AFAB non-binary individuals in particular. These individuals may be at greatest risk of drug-related harm.

To investigate the factors that were associated with drug use, we performed multivariate binary logistic regression analyses. Being unable to work (but not unemployment) was associated with increased risk, as was being heterosexual or bisexual (but not homosexual),

^k Although not shown in the table due to the relatively low proportion of people reporting the use of these substances, we also asked participants if they had used hallucinogens, heroin, ketamine, or GHB. We included these substances when calculating the proportion of people who had used any illicit drug.

having a normal body mass index, and always telling doctors about being trans. Older age was associated with reduced risk, as was having health insurance.

One explanation for the association between drug use and being heterosexual or bisexual may be the stress associated with belonging to a minority group. Although heterosexual trans people have a sexuality that is in accordance with the majority of the population, in reality their sexuality may not be accepted and they may face increased difficulty finding a partner. Trans women in particular may find it hard to find a heterosexual male partner. Heterosexual men are unlikely to consider trans women desirable sexual partners (or may be ashamed to admit that they experience sexual attraction to them), because they may assume that being attracted to a trans woman makes them gay. There have been several incidents where trans women have been attacked or even murdered when a potential partner has discovered that they are trans^{68,69}. Trans women may find themselves in a particularly difficult situation in this regard. If they do not blend well, they are a more visible target for discrimination, but perhaps less likely to attract heterosexual men who are unaware of their trans status (and therefore are less likely to be assaulted by such a person). On the other hand, if they blend “too well”, they may attract men who will react violently when they discover that they have been “deceived”⁶⁸. Heterosexual trans men may also face problems attracting a heterosexual female partner who will accept them as a man, particularly if the trans man has not undergone genital surgery.

One might expect bisexual people to fare better attracting a partner, but bisexual people may face not only the problems described above if they seek a heterosexual partner, but also biphobia from members of the gay and lesbian community. Bisexual people have been shown to have worse mental health and a greater risk for suicide than homosexual people⁷⁰. It is likely that the homophobia that they can experience from heterosexual people, combined with biphobia that they often experience from homosexual people, leaves bisexual people with a sense of not belonging to any community. This is likely further compounded by the lived experience of being trans, transphobia, and associated difficulties.

10 Aboriginal and Torres Strait Islander people

Of the people who took part in this study, 22 (2.3%) described themselves as an Aboriginal and/or Torres Strait Islander (ATSI) person. We therefore had insufficient numbers to investigate the issues affecting this population from a quantitative perspective. However, we explored some of these issues in discussions with members of the advisory group who were either ATSI people, or who worked closely with ATSI communities. The stories that they shared with us indicate that trans ATSI people (sistergirls and brotherboys) are a population that is at high risk of discrimination, violence, and poor mental health.

Sistergirls and brotherboys face a number of problems not shared by non-indigenous trans people. In part, this is due to the intersection of their race, sex identity, and gender expression. For example, ATSI people may find it harder to mix with the mainstream trans community (and therefore find support), because they may experience racism from non-indigenous trans people. Those who come from very traditional backgrounds may also find it especially challenging to access and/or be accepted by mainstream trans support groups and services. They may also face rejection from their ATSI peers, because being a sistergirl or brotherboy may be seen as violating traditional Aboriginal laws and/or customs in some communities. For example, if a sistergirl has gone through men's business, they may be subject to tribal punishment if they transition, because it is against the law for a woman to know men's business. A sistergirl in this situation is also unlikely to be allowed to do women's business, and therefore cannot participate fully as a woman in her culture.

In some communities, sistergirls may be forced to go through men's business, because their elders may think that it will change them and make them want to be a man. However, some ATSI communities are more supportive of sistergirls and brotherboys than others. Some family members are understanding and will prevent them from having to go through men's or women's business. Advocacy work by trans people has also seen some improvements for this population, such as the acceptance of sistergirls at the Alice Springs Women's Shelter.

However, life for a sistergirl or brotherboy is difficult in many ATSI communities. Some health services refuse to acknowledge their identity, and treat sistergirls as male. Like non-indigenous people, sistergirls and brotherboys often face rejection by their families, and sistergirls and brotherboys who live in remote communities are unlikely to be able to access trans-related healthcare at their local health clinic. Sistergirls and brotherboys may have to travel far from their communities to bigger cities such as Darwin. They not only face the cost of accessing healthcare, but also travel and accommodation expenses.

Sistergirls and brotherboys living in remote communities may find it especially difficult to connect with others in their situation. The sense of isolation may be compounded by rejection from their peers. Like non-indigenous trans women, sistergirls may also face violence from male partners, and may be victimised by abusive or controlling partners. Some sistergirls may feel pressured to “settle for less”, since having a male partner reinforces their sense of being a woman, and also because sistergirls (like non-indigenous heterosexual trans women) often have difficulty finding partners who will accept them.

Therefore, in addition to the recommendations we make in the following chapter, we think it important to make some recommendations specific to trans ATSI people.

There is a need for greater awareness and understanding of sistergirls and brotherboys among the wider ATSI community. This could be achieved by featuring their stories on the SBS television programme *Living Black*, and/or programming on the National Indigenous Television channel (NITV). Schools could also consider inviting a sistergirl or brotherboy to speak to students.

Both Aboriginal and non-Aboriginal health services must do more to meet the health needs of sistergirls and brotherboys. This must include not only providing access to hormone therapy, but also working to improve the mental health of sistergirls and brotherboys.

Resources developed for and about trans people should include trans ATSI people. The *beyondblue* Families Like Mine resource⁵⁰ is a good example of how this can be achieved.

There is a need for research specifically addressing the health and well-being of sistergirls and brotherboys. However, such research will probably have to be qualitative in nature and will require fieldwork. Researchers must bear in mind that some sistergirls and brotherboys (particularly those from remote communities) may not speak English as a first language and/or have limited English skills. Researchers must be aware of the cultural sensitivities required when working with ATSI people, and with sistergirls and brotherboys in particular. Sistergirls and brotherboys should be involved at all stages of the research and help guide it.

Finally, there is a need for greater funding for programs and organisations that work with sistergirls and brotherboys, and for those led by ATSI people in particular.

11 Summary and recommendations

The findings of this study demonstrate that a substantial proportion of trans people experience alarmingly high rates of mental health problems. Participants also reported difficulty accessing basic healthcare that the majority of the general population take for granted, and numerous legal and administrative difficulties which result in social exclusion and distress. Equally alarming is the high proportion of trans people who reported experiencing discrimination and harassment as a result of being trans. Owing to the high risk of suicide in this population, these issues must be addressed with urgency.

We therefore propose the following recommendations¹:

Health	
Recommendation	Notes
1. Healthcare for trans people should be based on an informed consent model, rather than a “gatekeeping” approach.	<p>For a review of the informed consent model, see Deutsch (2012)⁵⁵. Rates of regret with this system appear to be <1%.</p> <p>This does not preclude the involvement of mental health professionals in the healthcare of trans people. Some people may require ongoing mental health support. However, mental health professionals must work with trans people in a supportive role. Their role should be to assist and support, and to determine whether trans people have the capacity to provide informed consent.</p>
2. Each state and territory should establish a multidisciplinary clinic within the public health system to provide the health care that trans people need. This would include (but not be limited to), hormone therapy, mental health care, and surgery. Owing to population size, it may be	Given the low incomes noted in this study, and the medical necessity of healthcare for trans people, the public health system must provide specialised services for this population. However, trans people who would prefer to be treated privately must retain the option to do so. Mental health

¹ Note that the order in which recommendations appear does not necessarily reflect their priority.

<p>necessary for only one or two centres in Australia to specialise in certain surgeries, such as vaginoplasty or phalloplasty.</p>	<p>professionals should have a team role in multidisciplinary clinics, but not lead them. Historically, clinics for trans people have been perceived by many as inflexible and paternalistic^{65,66}. Trans people should have a governance role in such clinics.</p>
<p>3. Health departments must develop clear referral pathways and protocols for trans people. This information must be made available to trans people, and to all health professionals working in the relevant state or territory, so that they know where to refer a trans person if they are unable to provide the necessary care themselves.</p>	<p>Protocols should clearly specify what services are available to trans people (e.g., hormone therapy, surgery, and speech therapy); what, if any requirements apply; and a timeline for service provision so that trans people know when they can typically expect to receive these services. These materials should use flow-charts and simple English and be available in multilingual formats.</p>
<p>4. Medical intervention for trans people must be flexible with regard to the individual's preferences, and personal circumstances.</p>	<p>Clinicians should not assume that all trans people wish to follow the same transition pathway. Clinicians must recognise that the degree of intervention required differs from person to person. Individuals may also re-prioritise certain medical interventions during the transition process. Together with appropriate medical guidance, trans people must be allowed to set their own pace for a medical transition.</p>
<p>5. Medical assessments and referrals between service providers and doctors must take place in a timely manner.</p>	<p>It is important to realise that many trans people have considered transitioning for many years, but were prevented by their personal circumstances. However, the final decision to embark on a medical transition is often made with some urgency. Delays in the referral and medical assessment process may be very frustrating, result in distress, and harm the patient-doctor relationship.</p>

<p>6. Both the public health system and private health insurance schemes must recognise that surgery for trans people is an essential, rather than cosmetic medical procedure.</p>	<p>Medicare and tax rebates should apply to all trans-related medical procedures. The Australian Taxation Office must recognise that certain “cosmetic” procedures such as facial feminisation surgery are vital for the mental health of some trans people. Surgery should never be denied on the grounds that there is no need to remove “healthy” tissue. (e.g., hysterectomy).</p>
<p>7. Trans health must become a part of multidisciplinary health curriculums, including (but not limited to), medicine, nursing, social work, and psychology. Education must take an affirmative and respectful approach to trans health.</p>	<p>Trans people should not be forced to seek treatment for all medical problems they experience at a trans-specific, or known “trans-friendly” clinic. Trans people should be able to access any medical service and expect to be treated equitably.</p>
<p>8. Mental health services should develop programs specific to trans people.</p>	<p>Programs and interventions for trans people must be developed in partnership with trans people from inception to evaluation. Programs must target all sub-populations within the trans community.</p>
<p>9. Suicide-prevention interventions and research must specifically target trans people.</p>	
<p>10. Healthcare providers (such as hospitals and general practitioners) must create a welcoming environment for trans people, and develop specific anti-discrimination policies and protocols to ensure they adequately meet the health needs of this population.</p>	<p>Healthcare providers should ensure that their policies and protocols are widely known to staff and people accessing the service. For example, the provider could prominently display a statement such as “this organisation welcomes people of any sex identity or gender expression” on promotional materials, posters, or their website. Existing guidelines for working with trans people could be used as a template ⁶⁰⁻⁶³.</p>
<p>11. Where possible, the Pharmaceutical Benefits Scheme (PBS) should be reformed so that all necessary forms of hormone therapy (e.g., GnRH analogues) are available to trans people.</p>	<p>This may require the manufacturers of some hormonal products to conduct clinical trials with trans people, before requesting that their product be listed on the PBS for that indication.</p>

Identifying documents

Recommendation	Notes
<p>12. State and territory governments must develop a simplified and consistent procedure common to all Australian jurisdictions for changing an individual's legal sex. Medical intervention should not be a prerequisite. Married individuals must not be required to divorce.</p>	<p>The Australian Government Guidelines on the Recognition of Sex and Gender⁵⁷ could be used as a model, in which a registered medical practitioner or registered psychologist can provide a letter stating the applicant "has had, or is receiving, appropriate clinical treatment". A template is available from the Guidelines website. The Australian Capital Territory has recently adopted legislation based on this approach.</p>
<p>13. State and territory authorities responsible for noting a legal change of sex should become integrated within the existing system for registering births, deaths, and marriages. Their role should simply be to determine whether the applicant has provided sufficient information to meet the simplified criteria outlined in these recommendations.</p>	<p>An appearance before a judicial board may be a stressful and potentially humiliating experience. Trans people must never be placed in the position where they have to prove that they "really are" a man or woman (or neither). A change of legal sex should be a simple administrative matter.</p>
<p>14. When an individual has changed their legal sex in one state or territory, other state and territory governments should automatically recognise this change.</p>	<p>At present, an individual can change their legal sex in one state or territory, but this may not be recognised by another.</p>
<p>15. Where an individual born overseas has changed their legal sex in that jurisdiction, the relevant Australian state or territory authority should automatically recognise their new legal status.</p>	<p>Some states offer a <i>recognised details certificate</i>, but the requirements for a legal change of sex in that state still apply (e.g., surgical intervention). These certificates are therefore not useful for people born overseas who have changed their legal sex in a jurisdiction that does not require surgery to have taken place (e.g., the United Kingdom).</p>

<p>16. Like some intersex people, not all trans people feel that they are exclusively male or female. Trans people should have the option to identify themselves as something other than male or female on both Commonwealth, and state and territory records and identifying documents.</p>	<p>This could be achieved by having an “X” option as with passports, or the ability to have one’s sex recorded as “indeterminate” (or similar) on the birth certificate. Other options may be required, and will require consultation with non-binary individuals.</p>
<p>17. State and territory authorities responsible for noting a legal change of sex should clearly state the process and required evidence on websites and in published materials.</p>	<p>Published guidelines for some jurisdictions are vague in nature. Trans people should not have to guess whether or not they meet the requirements for a legal change of sex.</p>
<p>18. The authority responsible for noting a change of legal sex at the state or territory level should change all identifying information for trans people in that jurisdiction, and also notify relevant Commonwealth agencies.</p>	<p>At present trans people are required to contact a myriad of state/territory and Commonwealth departments and agencies (e.g., licensing authorities, hospital records, Australian Electoral Commission, Centrelink). This process should be centralised so that the individual only has to make one application, and then all relevant agencies are notified automatically.</p>
<p>19. Government departments and agencies should work to implement the Australian Government Guidelines on the Recognition of Sex and Gender⁵⁷ as quickly as practicable.</p>	<p>The guidelines took effect on 1 July 2013 and make it easier for trans people to change records and identifying documents associated with the Commonwealth government, because surgery and hormone therapy are no longer required to change the sex marker on official records. However, the guidelines do not have to be implemented until 1 July 2016.</p>
<p>20. Electronic health records should provide a voluntary option for trans people to identify themselves if they wish to.</p>	<p>Trans people must never be forced to disclose this information, and must also have the option to remove their trans history from electronic health records if they wish to do so.</p>

Research

Recommendation	Notes
21. Funding bodies should consider making the health and well-being of trans people a research priority area.	Government funding bodies such as the National Health and Medical Research Council, and Australian Research Council should take a leadership role in this area.
22. All research conducted with trans people should be informed by an advisory group comprising trans people from a wide range of social and cultural backgrounds.	Advisory groups should reflect the diversity of the trans community, and not comprise people from similar backgrounds.
23. When trans people are included in research conducted with LGBTI populations, the data for trans people must be analysed separately from LGB people.	Trans people have different needs than non-trans LGB people. LGB people also outnumber trans people. When research data is aggregated, the needs of trans people may go unrecognised. For example, a survey of LGBTI people might find that marriage is a priority issue, whereas if the data were analysed separately, access to healthcare might rank as the most important issue for trans people.
24. Longitudinal studies are needed to determine the safety and effectiveness of hormone therapy in trans people.	
25. The Australian Institute of Criminology and relevant agencies should collect and report on hate crimes against trans people.	This data should not be aggregated with hate crimes against LGB people.

General

Recommendation	Notes
<p>26. Government agencies, service providers, hospitals, and other organisations should ensure that their staff are adequately trained to work with trans people in respectful and affirming ways. In particular, staff should be aware of the privacy needs of this group.</p>	<p>Staff should be mindful that some trans people may not have changed all their identifying documents. Staff should discretely ask for, and use the preferred name and pronoun of their clients.</p> <p>Staff should take special care not to “out” trans people by referring to trans people by their old name or pronouns in front of other staff or people accessing the service. An individual’s trans status should be treated as confidential medical information.</p>
<p>27. All agencies, government departments, and service providers who interact with trans people must allow trans people to define themselves using the language that they choose. Trans people should never be forced to identify themselves as trans.</p>	<p>Trans people may use a variety of language to describe themselves, and some people no longer consider themselves trans after completing a medical transition.</p>
<p>28. Data collected by government agencies should provide a voluntary option for trans people to identify themselves if they wish to do so. Trans people must never be required to identify themselves as such to government agencies.</p>	<p>Existing population-based data collections (such as the Census) could then be used for research purposes, and may enable research into the needs of trans people to be more representative.</p>
<p>29. Agencies and organisations working with trans people must not make assumptions about the sexuality of trans people.</p>	<p>Trans people, like non-trans people, may be heterosexual, homosexual, bisexual, or asexual.</p>
<p>30. Education providers must develop clear and inclusive policies for trans students which accommodate their needs in a way that is consistent with their sex identity. Policies must address structural issues</p>	<p>For example, students should be allowed to use a toilet consistent with their sex identity, rather than being forced to use a toilet for people with disabilities. Policies regarding uniform codes and participation</p>

<p>such as bullying and harassment.</p>	<p>in sport should be similar. Teachers require education about trans issues at the university level, and also via workplace training and professional development courses.</p>
<p>31. Where exemptions apply to anti-discrimination legislation with respect to trans people, those exemptions should be removed.</p>	<p>If being trans is a variation of sex development, and necessitates medical treatment for many people, it should be regarded as a legitimate medical condition. Therefore, exemptions on the grounds of religious belief should not apply.</p>
<p>32. The Commonwealth government should consider funding a national body (similar to the National LGBTI Health Alliance), with the terms of reference being to eliminate the health disparity observed in this study.</p>	
<p>33. Organisations that cater for LGBTI people must ensure they include all sub-populations within this umbrella grouping, and provide services appropriate to the individual needs of each sub-population.</p>	<p>To be truly “trans-friendly” an organisation must do more than state that it caters for LGBTI people. Too often, the needs of trans people are overlooked or assumed to be the same as lesbian and gay people.</p>
<p>34. Organisations providing supported accommodation and/or shelter to trans people seeking refuge from homelessness or domestic violence must review their policies to ensure they align with the new anti-discrimination guidelines.</p>	<p>Trans people must be housed in accommodation appropriate to their sex identity.</p>
<p>35. Trans prisoners must be placed in a facility which is the most safe and appropriate for their sex identity.</p>	<p>The degree of medical intervention undertaken should not determine where trans prisoners are housed. Prisoners must be able to receive trans-related medical care, such as hormone therapy and surgery.</p>

Miscellaneous

Recommendation	Notes
<p>36. Australian representatives participating in the ICD-11 revision process must advocate strongly for the declassification of transsexualism as a mental disorder.</p>	<p>A diagnostic classification such as transsexualism must be retained elsewhere in the ICD so that people can continue to access health services in both public and private health systems. However, the classification should reflect that transsexualism is likely a variation of sex development, not a mental disorder.</p> <p>Classification as a mental disorder results in a negative perception of trans people, and causes problems such as the inability of adolescents to access hormone therapy without the consent of the Family Court of Australia (which can be a costly and stressful process).</p>
<p>37. Australian members of the American Psychiatric Association must advocate for the removal of Gender Dysphoria (and related diagnostic categories) from the DSM.</p>	<p>Once transsexualism has been reclassified in the ICD, no justification remains for the retention of these diagnostic categories. Absence of a diagnostic category in the DSM will not affect delivery of mental healthcare to trans people. For example, trans people suffering psychological distress could be diagnosed with an adjustment disorder.</p>
<p>38. There is a need to develop validated psychometric instruments to assess health, well-being, and body image in this population.</p>	<p>Some well-known instruments are suitable for use with trans people, but others (particularly those that assume people will locate themselves within a binary model of sex and/or gender) may be less useful.</p>

12 The final word

At the end of the survey, we asked participants if there was anything else that they would like to tell us. Nearly 400 participants left a response. As we noted in the introduction, participants shared far more information with us than we can possibly include in this report. Accordingly, we plan to release an on-going series of articles to further explore the health and well-being of trans people in Australia. However, we think it is appropriate to conclude this report with some of the final comments left by participants.

“Thanks for doing this study and for letting me contribute in some small way. It’s nice to know someone out there is looking into this because it needs looking into”

“Thanks for directing some attention to trans mental health! You made my day :)”

“Thank you for conducting this survey - there is still much more research (and social change) needed to respond to the issues which affect the lives of trans people”

“please tell medical professionals to be kind to their transgender patients. I had a suicide plan ready just before I was put in touch with [doctor’s name] in Cairns, the doctor who prescribed me hormones and helped me so much - he saved my life. And he did it by being kind and respectful”

“I would be dead if not for having transitioned, I experience exquisite joy most days now for being who I am. Thanks”

“For me starting HRT was the best antidepressant I have ever had I am so happy and proud of being a Tranny”

“Love being who I am now and love to get out there and educate the general public on trans people and their needs. We are not axe murderers just members of the public”

“I’m a human being and I deserve adequate healthcare, a right to marry and a right to live peacefully in my community without fear of vilification, bullying or attack”

“trans people have the worst mental health and are at the largest risk of violence and suicide. please do anything you can to make trans people safer and have a better quality of life. thank you for doing this survey”

“I wish there was more help for depressed trans people, I know there are trans groups but they don’t receive enough funding to be so readily available. I’m lucky I live in the city and I still receive little help, I can’t imagine what others in rural areas struggle with”

“My life is miserable, and I know it’s even worse for a lot of people. I hope that this survey brings well-needed change. I want to be able to survive myself”

“Although the rainbow is pretty, having to choose a colour sucks”

“I believe that other trans (sistergirls) need attention in other Aboriginal communities because they need more help than the ones that are already open in life about it. They need to know that there is help for all this and that there is support for everything they need in life because in remote communities we can’t access them because we are limited to what can be done because acceptance hasn’t been fully recognised yet for us so hoping that all this will change everything for all of us in life”

“When I was 19-22 I went through massive drug addiction due to the violence and discrimination I experienced. I am now a 36 year old trans lady whom is [an] empowered individual whom is active in the trans community advocating for social change. I however suffered from depression, anxiety and drug dependency due to the violence and discrimination I experienced in life. Up until I moved to [town in the Northern Territory] four years ago I would say that I faced discrimination or abuse on a daily basis. I now work with indigenous communities in remote Australia. I see the sistergirl/brotherboy community in urgent need of support in terms of advocacy, mental health support and community education. They suffer from discrimination due to their gender, sexuality and race. Some health services refuse to acknowledge their existence. Some communities do not believe they exist though they are there, or they want to change them. It is very hard for them, harder than for even most trans people. Something needs to be done for them, though people either aren’t listening, feel it’s too complicated to help or don’t know how to help. They are forgotten!”

“I think it is terrific this survey is happening :-). Thank you! I think generally it would be terrific if there was less pathologising of trans people and more deconstructing and dissolving of gender in our society as a whole. i.e. There needs to be a lot more deeper meaningful discussion in the media and in public forums about ways we can dissolve the traditional gender divide rather than the sensationalist reporting of those who fully transition as if that is the only way. This kind of reporting will not do anything to break down the gender divide, it only reinforces it. We need more people to be talking about the in-betweeners that truly combine both genders or who identify with another gender/s not usually associated with their body type. Those that do not go on hormones or have surgery and why they do not. More discussion around this is needed. Hopefully then society will begin to dissolve the boundaries that restrict our potential as humans to be ourselves in which ever way we feel suits us at any given time. It’s happening, but very slowly at the moment”

“I want people, both health professionals and the general public, to know that being trans does not automatically equate to hating your body. When I tell non-queer people I want top surgery they often respond with ‘But your breasts are beautiful’ and ‘Why do you hate your chest?’ and ‘But you’re gorgeous the way you are!’. I know, I never said I hated any part of my body. I just wish to have surgery to align my body with how I feel on the inside. Just as someone who wants breast implants doesn’t hate their breasts, or someone who wants children doesn’t hate their life not being a parent, or someone who wants to travel doesn’t necessarily hate their home, trans* people don’t necessarily hate their bodies. This doesn’t mean that they don’t want gender related surgery. But it does mean that while they are waiting for the surgery for whatever reason, they can still go about life as perfectly functioning individuals, as long as they are aware that at some point in the future they will be able to alter their bodies to reflect how they feel on the inside. I just want people to know this, it is neither the rule nor the exception, but one possibility that does not make someone any less trans*”*

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Notes