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Literature Review

to Support Health Service Planning

for Transgender People

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Contents

Introduction: Purpose of literature review

This literature review has been prepared to inform and support the planning and development of health care services for transgender people. It examines four main topics: estimates of the prevalence of trans people; care needs of trans people; suicidal ideation and attempts amongst trans people; and barriers to competent care. The document concludes with recommendations for topics to address in further literature reviews.

Estimating the size of trans populations

Over the past several decades, estimates of the size of trans populations have significantly increased, and data collection methods have broadened, enabling more reliable estimates to be generated. Early population estimates were limited to the numbers of people coming forward for trans related care to specialist gender clinics; such estimates, by their very nature, grossly underestimated the size of trans populations. The following section focuses on articles and reports released between 2009 and 2012.

In a household probability sample of the population of Massachusetts, 0.5% of the sample disclosed their transgender identity or experience to researchers (Conron, Scott, Stowell, & Landers, 2012). Trans populations may have been under-sampled as the research did not include people who were homeless or had lived in their current residence for less than a month (Conron et al., 2012). This is likely as trans respondents in the household probability survey reported disproportionate rates of poverty, and other research indicates that trans people are over-represented amongst people who are homeless and marginally housed (Conron et al., 2012). The disclosure rate of 0.5% may be low for additional reasons. People who have stigmatized identities may be reluctant to disclose their identities to researchers, and the likelihood of disclosure appears to increase as protections increase and as levels of stigma decrease in society. In the Canadian Community Health Survey, for instance, the number of people disclosing a gay, lesbian or bisexual identity increased substantially between the 2003 and 2005 data collection cycles (Tjepkema, 2008). Significant changes occurred in Canadian society during this period, as same sex marriage was legalized in Ontario and British Columbia in 2003, and was legalized nationwide in 2005 (Canadians for Equal Marriage, n.d.).

Winter and Conway (2011) prepared a review of estimates of the size of trans populations, and included very recent data from studies of university students conducted in Asia as well as North America. These studies found that amongst people assigned female at birth, 2.2% to 2.9% consistently identified as male or wished that they were male (and in the study where 2.9% wished they were male, a further 1.3% perceived their gender as “other”); and that between 0.7% and 0.9% of people assigned male felt that their true gender was female, while an additional 0.4% identified as another gender (Winter & Conway, 2011). This would indicate that up to 3.2% of people assigned female at birth and up to 1.3% of people assigned male at birth may be trans.

Reed, Rhodes, Schofield and Wylie (2009) prepared a report synthesizing research from the UK, Europe, and North America to estimate the number of trans people and proportion of trans people who may seek health care related to transitioning; the report was updated in 2011 with new data indicating that, given indications that gender variance is similar amongst natal males and natal females, that 1% of the population is gender variant and that at some point in their lives, 0.2% of the general population may medically transition (GIRES, 2011). Canadian research has also found that is a fairly equal proportion of people on MtF and FtM spectrum (Bauer et al., 2010). It is important to note that many trans people do not identify as male or female – in all, this was the case for about 20% of trans Ontarians participating in the Trans Pulse survey (Coleman et al., 2011).

Estimates of the number of trans people in BC

Estimates of the number of trans people in each of British Columbia's health authorities have been developed on estimates of the population in BC in 2014, generated from BC Stats (http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationEstimates.aspx). These have been combined with the 0.5% population prevalence of transgender people found by Conron, Scott, Stowell, & Landers (2012), and estimate from GIRES (2011) that 0.2% of the population will transition at some point in their lives. These indicate that there may be over 23,000 trans people in BC, and that over 9,000 people may transition at some point in their lives.

Health authority	**Estimated population in 2014**	**Estimated # of trans* people (at 0.5% prevalence)**	**Estimated # of people who will transition (at 0.2% prevalence)**
Interior	730712	3654	1461
Fraser	1706824	8534	3414
Northern	287729	1439	575
Vancouver Coastal	1146312	5732	2293
Vancouver Island	759725	3799	1519
Province total	**4631302**	**23157**	**9263**

Forms of care needed by trans people

Trans people may seek a range of forms of care related to gender dysphoria - the distress due to incongruence between bodies and gender identities. This distress varies in intensity from person to person. Depending on the person, social transition, and/or legal transition, and/or medical transition may relieve this distress. Forms of care to support a person experiencing gender dysphoria include counselling, voice therapy, electrolysis, and medical transition. The latter can involve taking hormones and accessing one or more forms of surgery; people may desire only hormones, or only one or more surgeries. As previously mentioned, Reed et al. (2009) estimated that 0.2% of the general population may medically transition at some point in their lives.

Care needs not related to medical transition

It is important to remember that trans people who do not intend to transition may still be in need of trans-related care. In addition to distress arising in relation to gender dysphoria, distress also stems from experiences in society, including the lack of acceptance that trans people often experience (Seidl, 2006), as demonstrated by the high proportion of trans people who have experienced violence, harassment, and discrimination.

Substantial evidence points towards several other areas of need for trans people. Gender-related abuse and discrimination impacts mental health (e.g. PTSD, anxiety and depression), physical health, employment and income, and willingness to seek care (Lombardi, 2010). Other areas of concern include substance use and HIV (Lombardi, 2010).

Exponential growth in numbers of trans people seeking care

Reed et al. (2009) identified that a significant proportion of people who might transition have not yet come forward to do so. Similarly, according to the Trans Pulse survey in Ontario, almost half of the respondents were living full-time in their felt gender, with another 30% living part-time in their felt gender, and 22% not living in their felt gender at all (Coleman et al., 2011). About 25% of trans people in the Trans Pulse survey identified that they had completed transitioning, to whatever extent that was relevant to them. Almost 25% were in process of transitioning, 28% were planning to transition, but had not begun; and 10% were unsure about whether they would transition, while the remaining 13% identified that they did not plan to transition or that the concept of transitioning was not relevant to them (Coleman et al., 2011).

Reed et al. (2009) found that the number of trans people coming forward for care is increasing exponentially, perhaps due to greater public awareness of trans issues, and greater availability of information via the internet, and due to the ability for trans people to make contact with and support one another. Reed et al.'s study was updated in 2011, and indicated that on average since 1998, 11% more people have presented annually for treatment for gender dysphoria, and thus numbers coming forward for treatment were doubling every 6.5 years (GIRES, 2011). Similarly, a clinic serving gender variant children and adolescents in Boston reported exponential growth, with a four-fold increase in the number of patients presenting over an 11 period, spanning 1998 to 2009 (Spack et al., 2012). Most recently, a British clinic serving youth reported a five-fold increase in the number of trans youth referred per year over the course of five years: from 91 youth referred in 2009/10 to 441 youth referred in 2013/15 (Harvey & Smedley, 2015).

Suicidal ideation and attempts

Extremely high rates of suicidal ideation and attempts have been reported for some time in trans populations. It must be noted that suicide attempts are underreported, as people who have died by suicide are not able to report their attempts to researchers (Scanlon, Travers, Coleman, Bauer, & Boyce, 2010). This section reviews suicidal ideation and attempt rates amongst trans people across the lifetime and in past 12 months, correlates with suicidal ideation and attempts, implications for the health care system, and barriers to counselling as suicide prevention.

Suicidal ideation

Recent data from the Trans Pulse project, which conducted a respondent-driven survey with 433 trans Ontarians age 16 and older, found that across the lifespan, 77% of their respondents had seriously considered suicide (Scanlon et al., 2010). Of this 77%, 50% had considered suicide related to being trans, and an additional 27% had considered suicide due to reasons they felt were not related to being trans. This stands in stark contrast with lifetime suicidal ideation rates in the Canadian population at large – in an international study, 11.25% of the Canadian sample had ever seriously considered suicide (Weissman et al., 1999).

A total of 32% of respondents in the Trans Pulse survey had seriously considered suicide in the past year (Scanlon et al., 2010). As with other populations, trans youth are more at risk. In the past twelve months, 47% of the youth age 16-24 and 27% of trans adults had seriously considered suicide (Scanlon et al., 2010). Again, these rates contrast strongly with prevalence rates in the Canadian population, as 3.7% of respondents in the Canadian Community Health Survey reported thinking about suicide in the past 12 months (Government of Canada, Statistics Canada, n.d.).

Suicide attempts: Lifetime

Of the respondents in the Trans Pulse project, 43% of trans Ontarians reported having ever made a suicide attempt. Suicide attempt rates from the Trans Pulse project are similar, though slightly higher, than those found in a US study in which more than 6,000 trans and gender variant people completed an online survey. The US study found that 41% of respondents had attempted suicide at least once in their lifetime (Grant et al., 2011). A study of 515 trans residents of San Francisco found somewhat lower rates of attempted suicide (32%) although almost half (47%) of trans youth in this study had made at least one attempt (Clements-Nolle, Marx, & Katz, 2006).

Suicide attempts: Past year

Amongst respondents in the Trans Pulse survey, 10% of the respondents had made at least one suicide attempt in the past year (Scanlon et al., 2010). Trans youth were disproportionately represented amongst this group, with 19% of respondents age 16-24, and 7% of adults age 25 and older, having attempting suicide in the past year (Scanlon et al., 2010).

Suicide attempts: Comparisons with national and international studies

It is important to bear in mind that trans people's rates of suicide attempts, both across the and in the past 12 months are extraordinarily high, especially in comparison to prevalence rates found in the Canadian population and in international studies focusing on the population at large. Canadian population estimates fall within the range of estimates found in international studies. An international study found that in the general population, lifetime suicide attempt rates ranged from 0.7% to 5.9%, with the rate from the Canadian sample being reported as 3.82% (Weissman et al., 1999). Prevalence of past-year suicide attempts varied from 0.5% to 1% internationally (Fairweather-Schmidt & Anstey, 2012). This would indicate that lifetime suicide attempt rates

for trans Canadians are over 11 times higher than the general population, while past-year suicide attempt rates for Canadian trans people are 10-20 times higher than the ranges found in the general population in international studies, and are 20-40 times higher for trans youth.

The following table provides a breakdown of suicide attempt rates across geographically-based health authorities in BC.

Health authority	Estimated population in 2014	Estimated # of trans* people (at 0.5% prevalence)	Est. # of trans people making at least one suicide attempt in their lifetime (a 43% attempt rate)	Est. # of trans people who made at least one suicide attempt in the past year (a 10% attempt rate)
Interior	730712	3654	1571	365
Fraser	1706824	8534	3670	853
Northern	287729	1439	619	144
Vancouver Coastal	1146312	5732	2465	573
Vancouver Island	759725	3799	1633	380
Province total	**4631302**	**23157**	**9957**	**2316**

Correlates with suicidal ideation and attempts

From the perspective of service provision, a very important finding of the Trans Pulse project was that the people most at risk of past-year suicide attempts were people who were planning but had not begun a medical transition, followed by people who were in the process of medically transitioning (Bauer, K, Pyne, Scanlon, & Travers, 2012). People who by their own description had completed transition had the lowest rates of suicide attempts (Bauer et al., 2012).

In addition, the Trans Pulse project found that trans people who have experienced physical or sexual assault related to their gender identity or expression were four times more likely to have attempted suicide in the past year (Scanlon et al., 2010). Similarly, reports of an online survey of over 6,000 trans people found that lifetime suicide attempt rates were associated with either trans-specific discrimination or other forms of marginalization or inequity. In this study, 51% of people who had been bullied or harassed in school had attempted suicide; had lost a job due to anti-trans bias or discrimination (55% suicide attempt rate), or had a low household income (Scanlon et al., 2010). Clements-Nolle et al. (2006) also found correlations between suicide attempts and trans-specific prejudice and forced sex, as well as depressive symptoms and substance abuse.

Suicide: Implications for the health care system

In the general population, most—but not all—suicide deaths are preventable (Joshi, Damstrom-Albach, Ross, & Hummel, 2009). Targeted primary prevention initiatives are important in reducing both preventable deaths, and using scarce health care resources most effectively (Bennett, Vaslef, Shapiro, Brooks, & Scarborough, 2009). According to the Public Health

Agency of Canada, intentional self-inflicted injuries are among the top 10 leading causes of hospitalizations in Canada for youth between the ages of 15 and 24 (Public Health Agency of Canada, n.d.). This age grouping also corresponds with the highest past-year suicide attempt rates for trans people, with 19% of trans youth ages 16-24 reporting at least one past year suicide attempt, and 47% having seriously contemplated suicide in the past 12 months (Scanlon et al., 2010). Intentional self-inflicted injuries, including suicide attempts, account for 9.14% of injury-related hospital discharges in Canada (Public Health Agency of Canada, n.d.). In the US, an analysis of National Trauma Bank data compared hospital patients presenting for unintentional injuries, injuries stemming from assaults and self-inflicted injuries (Bennett et al., 2009). This analysis found that hospital patients presenting for self-inflicted injuries had significantly higher mortality rates, and their care required longer hospital stays, including longer stays in intensive care units and more days on a ventilator (Bennett et al., 2009).

Understanding where people present for health care following a suicide attempt or self-injury may assist in prioritizing education and training for health care providers on both the provision of respectful and competent care for trans people, and prevention of further suicide attempts. Emergency departments may be a key site for training in providing trans competent care as well as in secondary prevention of suicide attempts, as people who present to emergency departments for self-inflicted injuries, whether minor or life-threatening in nature, are more likely to return to emergency departments than other patient populations, including people who have asthma (Colman et al., 2004). In addition to emergency departments, depending on the severity of self-inflicted injuries and the risk of further suicide attempts, people may require inpatient psychiatric care, care for physical injuries in in-patient hospital units such as general medical, general surgery, trauma and orthopedics, and intensive care (Bennett et al., 2009; Corso, Mercy, Simon, Finkelstein, & Miller, 2007; Sinclair, Gray, Rivero-Arias, Saunders, & Hawton, 2011). Following hospital discharge, care requirements may include outpatient psychiatric care, outpatient consultations in hospital units, group home or nursing home care and care in residential rehabilitation facilities (Bennett et al., 2009; Corso et al., 2007; Sinclair et al., 2011).

The BC Suicide Prevention, Intervention and Postvention initiative identified that for populations that are vulnerable or are at high risk of suicide attempts, best practices include supporting positive cultural identity, cognitive behavioural therapy, dialectic behavioural therapy, and problem-solving therapy (Joshi et al., 2009). Some promising practices for vulnerable populations included providing education for communities, families and gatekeepers; providing early screening and identification, advancing peer and youth support, addressing stigma, and providing treatment for substance use (Joshi et al., 2009).

For trans people, access to competent counselling may be effective in preventing suicide deaths as well as significant self-inflicted injuries. Spack et al. (2012) noted that gender dysphoric children and youth who are not supported through counselling are more likely to experience behavioural and emotional problems as well as psychiatric diagnoses; trans youth who do not have access to counselling are more likely to engage in problematic substance use, suicidal ideation and suicide attempts. Given both Bauer et al.'s (2012) findings regarding the links between transition status and suicide attempt rates, and Spack et al.'s findings, this would imply that a suicide prevention strategy for trans populations would include reducing barriers to

transition and to increase psychosocial support for people who are considering transition or in the process of transitioning.

Barriers to counselling as suicide prevention

Two significant barriers exist for trans people to access counselling: financial barriers, and counsellor competency in working with trans populations. Trans people's incomes are significantly lower than the general population—the Trans Pulse study found that 50% of trans people in Ontario had a personal annual income of under $15,000 per year, another 21% had incomes under $30,000, and only 14% had incomes over $50,000 (Bauer et al., 2010). Similar high rates of poverty for trans people have been found in the US, where, for instance, in a large sample of trans people, respondents were almost four times as likely to report a household income of under $10,000 than the general population (Grant et al., 2011). As well, trans people are significantly more likely to be unemployed than the general population, resulting in less access to counselling through employee assistance programs. In Ontario, only 37% of respondents to the Trans Pulse survey were employed full time, 15% worked part-time, 25% were students and 20% were unemployed or on a disability pension, while 3% were retired (Bauer et al., 2011). In the US, the likelihood of being unemployed was on average two times higher for trans people, however trans people of colour experienced a much higher burden of unemployment, with rates being up to four times the average unemployment rate (Grant et al., 2011).

In addition to financial barriers, trans people experience barriers in finding mental health professionals who are knowledgeable and competent in working with transgender people. Experiences in health care, including barriers to competent care, are discussed in the following section.

Experiences in health care

Experiences and fear of maltreatment and breaches of confidentiality, reluctance to disclose trans status, and needing to teach health care providers about trans care have been reported in a number of studies (Grant et al., 2011; Heinz & MacFarlane, 2013; Pitts, Couch, Croy, Mitchell, & Mulcare, 2009). In a US study in which over 6,000 trans people participated in an on-line survey, 19% of respondents had been refused medical care due to being trans; trans people who are racialized were refused care at even higher rates (Grant et al., 2011). Over a quarter of respondents had experienced harassment in health care settings, while 2% had experienced violence in physicians' offices (Grant et al., 2011). Furthermore, 50% of respondents had had to teach their medical providers about transgender care (Grant et al., 2011). Fear of discrimination and maltreatment resulted in 28% of this sample postponing or avoiding seeking needed medical care when they were sick or injured; 33% delayed or did not seek preventative health care (Grant et al., 2011).

In Ontario, the Trans Pulse project found that 52% of trans Ontarians who had presented to an emergency department in their felt gender had had negative experiences such as hurtful or insulting language, or being told the provider did not know enough to provide care. Many trans Ontarians (54%) reported having to provide "some" or "a lot" of education about trans issues to

their providers in the emergency department (Bauer, Scheim, Deutsch, & Massarella, 2014). Overall, 21% of trans Ontarians reported ever avoiding the emergency department when emergency care was needed specifically because of concerns relating to accessing ED care as a trans person (Bauer, Scheim, Deutsch, & Massarella, 2014). Similar concerns surfaced in a needs assessment study conducted on Vancouver Island: although a lower proportion (23%) of trans Islanders experienced poor care in emergency departments, close to half of the Island sample (46%) reported needing to educate providers in the emergency department (Heinz, 2011).

Data from the Vancouver Island needs assessment also indicated that trans people experience barriers to competent primary care. Amongst respondents who have a regular physician, half (52%) reported that they had not experienced any negative behaviour from their physician (Heinz & MacFarlane, 2013). Education, however, was an issue: 30% of their physicians disclosed to their patients that they did not know enough about trans-related care to provide them with care, and only 37% of trans people did not need educate their doctor about trans issues, while 24% provided "a little" education, 26% providing "some" education, and 13% providing "a lot" of education for their doctor (Heinz, 2011). Patients in this sample also experienced hurtful experiences or denial of care from their family physicians, including refusals to see patients because they were trans, refusal to examine body parts, use of hurtful or insulting language, denial of the patient's gender identity, and belittling or ridiculing trans patients (Heinz, 2011).

Health care providers' education needs

Training may be needed to increase providers' competence and knowledge of trans specific health care. Unfortunately, it is not surprising that trans people often need to teach their health providers about transgender care. On average, only 7 hours of time is spent in Canadian and US medical schools on content related to lesbian, gay, bi and trans (LGBT) populations; the majority of this time is during pre-clinical training, and a significantly higher proportion of Canadian schools reported not including any LGBT content at all (Obedin-Maliver et al., 2011). Of 16 LGBT-related topics assessed in a survey, gender identity was the third most common content addressed, however only 34.8% of medical schools reported teaching about sex reassignment surgery, and transitioning was the topic area least taught, with only 30.3% of schools including any content on transitioning in their curriculum (Obedin-Maliver et al., 2011).

In an analysis of qualitative interviews with thirteen Ontario physicians, Snelgrove, Jasudavisius, Rowe, Head, & Bauer (2012) identified five themes in the barriers physicians experience in providing quality care for trans people. These include: accessing resources; medical knowledge deficits; ethics of transition related care; diagnosis versus pathologizing identities; and health system determinants. Issues related to accessing resources included the identification of, availability of, and quality of referral networks and information sources regarding trans care. In particular, identifying "trans friendly" colleagues for referral outside of a physician's scope of practice was a particular challenge. Health system determinants included gender-segregated inpatient beds and wards; challenges in ordering tests for patients who are considered ineligible due to their gender; and inadequate cultural competence and policies in health care organizations (Snelgrove, Jasudavisius, Rowe, Head, & Bauer (2012).

Ensuring that health care is, at a minimum, respectful of trans people is *not* likely to require extensive training of health care providers. In a qualitative study of trans people in Australia and New Zealand, respondents described their best experiences in the health system. Qualities valued amongst health practitioners included empathy, compassion, a non-judgemental attitude, and respect for patients' gender identities (Pitts et al., 2009). Respect was demonstrated through the use of the patient's chosen name and preferred pronoun, and efforts to change medical records to reflect the patient's gender identity (Pitts et al., 2009). In addition to basic respect and compassion, patients greatly appreciated health care providers who had knowledge and experience in working with trans people, and who had an understanding of the challenges trans people face in health care settings.

Areas to explore in future literature reviews:

Additional areas for literature reviews regarding service provision for trans people include:

- Education needs of nurses, social workers, and other allied health providers
- Supports for partners, families, and parents of trans people
- Issues and barriers for people living outside of urban centres
- Impacts of access or barriers to surgical care
- The prevalence of violence against trans people and associated care needs (e.g. counselling, care in emergency departments, agencies that provide support for survivors of sexualized violence)
- Depression, anxiety, and post traumatic stress disorder
- Problematic substance use
- Diversity within trans communities: issues across the lifespan, issues for trans people with disabilities and chronic conditions– including HIV; and trans people who are Aboriginal, racialized, and/ or are refugees or immigrants.

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