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Mental Healthcare Access Indicators for Trans and Non-binary People in Aotearoa/New Zealand

A thesis

submitted in fulfilment

of the requirements for the degree

of

Master of Social Sciences in Psychology

at

The University of Waikato

by

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THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2024

Abstract

Access to mental healthcare (MHC) is one of the social determinants of mental health that underlies the large mental health disparities faced by trans and non-binary people (TNB). TNB people may seek MHC for reasons related specifically to gender-affirming needs or for general mental health needs, which also needs to be affirmative of their gender. The topic of general MHC access has received some research, but there are still gaps regarding examining specific MHC settings and demographic differences. Furthermore, research in Aotearoa/New Zealand is still scarce being composed mainly of the Counting Ourselves survey. This thesis aimed to describe the rates of different MHC access indicators for TNB people in Aotearoa/New Zealand, including utilisation, unmet needs, satisfaction levels, and barriers to access. Subsequently, to examine demographic differences in these indicators across age, gender/sex assigned at birth (SAAB), and ethnicity groups. Demographic differences were hypothesised based on existing inequities. Analyses of data from the Counting Ourselves 2022 study were performed, which employed a cross-sectional methodology. Measures included demographic data, use of different MHC providers, unmet need for MHC, satisfaction with different MHC providers, and general and trans-specific barriers to MHC. In total, 2,631 valid responses were analysed, with almost all participants (99.8%) completing the survey online. All participants lived in Aotearoa/New Zealand, and their ages ranged from 14 to 86, with an average age of 27.1. The most common gender/SAAB groups were non-binary AFAB (43.7%) and transgender women (22.1%), while the most frequent ethnicity groups were European (75.3%) and Māori (13.9%). Results showed that the majority (58.1%) of participants had accessed at least one MHC service in the past year, with private MHC professionals being the most frequently accessed provider. Younger participants and non-binary AFAB were more likely to use MHC services, while service use did not differ significantly by ethnicity. Most participants (59.6%) reported an unmet need for MHC in the past year, with younger participants and non-binary AFAB participants being more likely to report this. Satisfaction with MHC providers was relatively positive, but approximately one-third of participants expressed dissatisfaction. Older participants were more satisfied with MHC,

and transgender women were more satisfied, only in comparison with transgender men. The most frequent barriers to accessing MHC that are shared with the general population were cost (57.4%) and lack of knowledge of services (44.8%). The most frequent trans-specific barriers were fear of professionals lacking understanding of TNB people (50.2%) and fear of pathologisation (48.9%). Participants reporting most trans-specific barriers were more likely to be younger, and non-binary AFAB participants were more likely to report fear of insufficient understanding and fear of misgendering from providers. These findings indicate that younger and AFAB TNB people may face additional barriers to accessing and being satisfied with MHC, suggesting a need for targeted interventions. Overall, ethnicity did not significantly predict MHC access indicators, suggesting that it might not be a strong predictor of these within this population. Nevertheless, ethnicity findings differ from patterns observed in the general population of Aotearoa/New Zealand, calling for more targeted research. The high rates of use of MHC services as well as unmet needs and experienced barriers underscore the importance of addressing barriers and improving MHC accessibility and quality for TNB people. This should include improving MHC providers' education and training, as well as implementing routine procedures to ensure a culturally safe and respectful environment.

Acknowledgements

I extend my deepest appreciation to all the trans and non-binary people who generously participated in the Counting Ourselves survey. Your willingness to share your experiences and trust in the research team made this possible, and your voices have added immense value to the understanding of the healthcare experiences of trans and non-binary people in Aotearoa. I am also thankful to the Royal Society Te Apārangi for providing funding for the Counting Ourselves project. Their support has been instrumental in bringing this research to fruition.

Special gratitude is owed to my primary supervisor, Dr Jaimie Veale, whose unwavering patience, support, and guidance have been very important throughout this academic journey. She not only shared her vast knowledge, experience, and insights but also provided me with access to an exceptional research team. The opportunity to collaborate with trans and non-binary researchers has been incredibly enriching, enhancing my overall experience and understanding.

I am also indebted to my secondary supervisor, Dr Gareth Treharne, for his willingness to offer time and support during the later stages of my thesis writing. His contributions were crucial in ensuring the completion of this work, and I am grateful for his valuable feedback.

I'm also grateful to the members of the Transgender Health Research Team who were involved in the design and execution of the survey. Their collective effort and dedication have laid the foundation for the data presented in this thesis. I am equally appreciative of their willingness to assist and provide guidance whenever I encountered challenges during my research.

To my family, and particularly my parents, Marisol and Juan, I am thankful for their constant emotional and practical support. Your teachings of perseverance, hard work, and determination have been my guiding lights, and I am grateful for your encouragement to pursue both academic and personal aspirations.

Lastly, I want to acknowledge my partner, Bev, for his unwavering company, encouragement, and, most importantly, his patience during the most stressful times of this

academic endeavour. I am grateful for his understanding and support, which sustained me throughout this journey.

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Usage of terms

In this thesis, I will use the term *trans and non-binary people* (TNB) to refer to all gender identities falling under the *transgender* umbrella, recognizing that no single term can capture the diversity of transgender people's identities and experiences (Coleman et al., 2022). Transgender is a term used to refer to people whose sex assigned at birth does not correspond with their gender identity, while *cisgende*r refers to people whose sex assigned at birth and gender are the same (Oliphant et al., 2018). The term transgender encompasses a wide spectrum of identities, including those who identify with a binary gender, such as a transgender woman, and those who do not identify exclusively as a man or a woman (*non-binary* people, Oliphant et al., 2018). Some examples of non-binary identities are *gender fluid* (a person whose gender fluctuates through time) and *bigender* (a person who identifies with two genders) (Oliphant et al., 2018). Non-binary people are sometimes included in the transgender umbrella and sometimes categorized separately (Coleman et al., 2022). TNB people may identify with one, multiple, or no gender identity terms.

An additional term used in this thesis is *sex assigned at birth* (SAAB), which generally corresponds to the sex that was assigned to a child at birth, most often based on anatomical characteristics (Oliphant et al., 2018). The acronym AMAB refers to *assigned male at birth*, and AFAB to *assigned female at birth* (Gender Minorities Aotearoa, n.d.).

Introduction

This thesis aimed to explore *mental healthcare (MHC) access indicators* for trans and non-binary (TNB) people in New Zealand, including their unmet need for MHC, their satisfaction with received MHC, and experienced barriers, among other topics. This chapter will first introduce the context and relevance of the topic of research, linking it to health disparities, and the role of healthcare access as a determinant. Subsequently, a narrative review will be presented, covering existing literature on MHC access for TNB people (internationally and in Aotearoa/New Zealand),

and identifying gaps in existing research. Finally, the rationale for the current thesis and the specific research questions will be outlined.

Relevance and context: mental health disparities and determinants of disparities

Health disparities are conceptualised as health outcomes that are not explained by medical reasons and are perpetuated by underlying social and environmental determinants, which put marginalised groups at higher risk of developing these problems (Whitehead & Dahlgren, 2007). Research has shown that TNB people face disproportionately high rates of health problems compared to general population estimates, with the most striking disparities concerning mental health problems, such as depression, anxiety, suicide ideation, and suicide attempts. To list examples of research from diverse international locations, in the US, the Colorado Transgender Health Survey (*N* = 406) found that their sample of TNB participants had a substantially higher rate of current depression (43% vs 7%) and lifetime diagnosis of anxiety problems (52% vs 15%) than general population estimates (Christian et al., 2018). Another large-scale survey conducted in the US (*N* = 47,894) revealed that TNB people were approximately four times as likely to report poor mental health in the past month than cisgender respondents (Fredriksen Goldsen et al., 2022). In Korea, the prevalence of depressive symptoms for TNB participants in a study (*N* = 255) was 9.71 times that of the general population (Lee et al., 2020). The 2013 Australian National Transgender Mental Health Study (*N* = 946) showed that TNB people were four times as likely to have a lifetime diagnosis of depression and 1.5 times as likely to have a lifetime diagnosis of an anxiety disorder (Hyde et al., 2014). In short, TNB people have three to 10 times the risk of presenting different mental health problems than cisgender people, or than the general population.

Suicide-related disparities are even larger and more concerning. The 2011 US National Transgender Discrimination Survey (*N* = 6,450) found that TNB participants were over 20 times as likely to have ever attempted suicide than the general population (41% vs 1.6%). Lee and colleagues (2020) found that suicide ideation rates for TNB participants living in Korea were 19 times higher than those of the general population. A survey in Canada (*N* = 923) revealed that TNB youth were

five times as likely to have presented suicide ideation (65% vs 13%), and to have attempted suicide in the past year (32% vs 7%), than the general youth population (Veale et al., 2017).

In Aotearoa/New Zealand, research has revealed similar disparities. The first wave of the Counting Ourselves survey (*N* = 1,174) found that TNB people were almost nine times as likely to suffer high psychological distress and were 40% less likely to be satisfied with life (51% vs 83%) than the general population (Veale et al., 2019). In addition, participants were approximately three times as likely to be diagnosed with depression and over five times as likely to be diagnosed with an anxiety disorder (Tan, Ellis, et al., 2020). The Youth'19 survey (*N* = 7,668) also found that TNB students across Aotearoa/New Zealand were two times as likely to report depressive symptoms and self-harm behaviour in the past year, and four times as likely to report suicide attempts in the last year, than cisgender peers (Fenaughty et al., 2023).

Health disparities are caused by a wide range of social determinants; some examples are lower access to employment, lower access to education opportunities (World Health Organization [WHO], n.d.), as well as gender minority stress and internalised stigma, in the case of TNB people (Tan, Treharne, et al., 2020). An additional determinant of health is access to healthcare that is of good quality and affordable (WHO, n.d.). The accessibility of a healthcare service refers to the degree of fit between the healthcare service's characteristics and the client's characteristics, including the healthcare service's approachability, affordability, and availability of resources (Levesque et al., 2013). To understand and address mental health disparities for TNB people, then, it is relevant to study this population's use of mental healthcare and the barriers to access it.

Literature review: Mental healthcare access for TNB people

Differentiating mental healthcare for gender-affirming needs and for other needs

Mental healthcare (MHC) is a broad area of care that involves different healthcare disciplines and professionals. The term is defined by the American Psychological Association as a "category of health care service and delivery provided by several fields involved in psychological assessment and intervention (psychology, psychiatry, neurology, social work, etc.)" (APA, n.d., para.

1). This care may take place in different settings; in Aotearoa/ New Zealand, mental health and addiction services are grouped and defined as "primary and secondary services (…) that are provided through primary care organisations (such as general practices), non-governmental organisations or district health boards (DHBs)[1] in hospital inpatient, outpatient, forensic or community care settings" (Government Inquiry into Mental Health and Addiction, 2018, p. 23).

MHC has traditionally focused on the evaluation and treatment of mental illness, as mental health has been traditionally conceptualised as the absence of mental health problems (Bohlmeijer & Westerhof, 2021). However, more recent models such as positive psychology have proposed to expand the scope of mental healthcare, by highlighting the importance of mental *wellbeing* for mental health, instead of the mere absence of mental illness (Bohlmeijer & Westerhof, 2021). The WHO emphasises the importance of this aspect by defining mental health as "a state of mental wellbeing that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (2022, para. 1). Therefore, MHC also includes services aimed at promoting positive affect, enhancing positive functioning, and fostering supportive social relationships.

Gender-affirming healthcare refers to the specific area of healthcare provided to TNB people which supports them to "identify and facilitate gender healthcare goals" (Oliphant et al., 2018, p. 4). In this area, the role of MHC would include psychological services to support gender identity exploration, psychological evaluations to assess readiness for gender transition (where required), and services to accompany the different forms of transition. A common misconception when discussing MHC for TNB people is that this care is always related to their gender identity or gender-affirming needs specifically. Benson (2013) conducted in-depth interviews with seven American transgender participants who had sought mental healthcare, finding that many of them wished to challenge the idea that TNB people seek mental healthcare for reasons only related to their gender

[1] DHBs have been disbanded as of 2022 and replaced by Te Whatu Ora, an agency that has taken over the planning and commissioning of services of the 20 former DHBs (Te Whatu Ora, n.d.).

identity. Other frequent reasons included emotional challenges that are shared with cisgender people, and to improve their quality of life, in addition to dealing with social stressors associated with their gender identity.

Research has indeed revealed that TNB people frequently seek MHC for multiple reasons that are not related to gender-affirming care. In the US, some studies have found that TNB participants most commonly seek MHC for reasons not directly related to their gender identity, with some of the most common being depression (20%), anxiety (19%), and relationship problems (19% [Shipherd et al., 2010; McCullough et al., 2017]). Hunt (2014) conducted a small-scale survey (*N* = 74) in the UK finding that some of the most frequent reasons for participants to seek counselling outside gender identity exploration were depression (52%), self-esteem and self-worth (40%), and anxiety (37%). Participants in Benson's study (2013) also emphasised that mental health problems they experienced are often related to the negative psychological effects of having to conceal their gender identity, internalised stigma, and experiences of transphobia (Benson, 2013), all examples of gender minority stressors associated to striking mental health disparities (Tan, Treharne, et al., 2020).

Scope of this review

Building upon the previous discussion, it is beneficial to avoid conflating MHC for TNB people in the context of gender-affirming care with MHC in the context of general mental health needs. Multiple articles on MHC for TNB people do not differentiate the specific MHC context their participants are addressing, or whether the reported experiences involve a blend of both contexts. For example, Riggs and colleagues (2014) conducted an online survey to examine (among other topics) the experiences of TNB people living in Australia with psychiatrists, but they did not distinguish whether these psychiatrists were accessed for mental health assessments to receive gender-affirming care, for other mental health reasons, or both. Other articles that lack this distinction include Bartholomew et al. (2019), Elder (2016), Goldberg et al. (2019), Fitzpatrick (2023), Hall and DeLaney (2021), Kattari et al. (2017), Klein et al. (2020), Lehavot et al. (2017), McCann

(2015), McCullough et al. (2017)., Mizock and Lundquist (2016), Moallef et al. (2022), Sperber et al. (2005), She et al. (2022), and Simeonov et al. (2015). On the other hand, some articles do specify the reasons for which their participants sought MHC, but presented combined findings for both contexts. For instance, Hunt (2014) researched barriers to MHC outside gender identity clinics, indicating that some of their TNB participants still accessed MHC for gender identity issues, others for general psychological concerns, and some for both. Subsequently, they proceeded to report combined barriers related to both contexts (e.g., cost of service and counsellor's knowledge of TNB people). Other studies with combined results include Benson (2013), Bess and Stabb (2009), De Vries et al. (2023), and Haliday and Caltabiano (2020).

Several factors may contribute to authors not making these distinctions or finding it challenging or unnecessary to do so. Authors may not aim to study specific MHC settings, participants might have utilized MHC concurrently for both gender identity-related and other reasons (or non-concurrently, reporting on both), or the topics of interest / findings may indeed be relevant or applicable to both settings.

In light of the focus on general MHC for TNB people in this research, I have excluded literature and findings exclusively related to MHC in gender-affirming care, such as transition support, gender identity counselling, and hormone access assessments. However, due to the explained reasons (characteristics of existing literature and the topic's nature), some findings may still be pertinent to MHC for gender-affirming needs, specifically those from the aforementioned articles. Keeping this in consideration, throughout the remainder of this thesis I will use the term *general MHC* or simply *MHC* to encompass all MHC services that are unrelated to gender-affirming care.

Concerning the search strategy for this review, the following databases were searched: APA Psyc Articles, JSTOR, ProQuest Social Sciences, PubMed Central, SAGE Journals, ScienceDirect Scopus, and Wiley Online Library. The terms used to find articles were "trans", "transgender", "non-binary", "gender fluid", and "gender expansive" to refer to TNB people. The terms "mental health",

"mental healthcare", "counselling", and "therapy" were used to search for articles on MHC experiences. I will not report on the number of articles returned by each search as this is a narrative review of relevant literature. The results from the selected articles were then organised into different topics of interest, including MHC use, satisfaction with services, unmet need for MHC, and barriers to accessing MHC.

Rates of use of MHC

Studies have reported varying rates of MHC use by TNB people for purposes outside of gender-affirming care. Ellis and colleagues (2015) found that 66% of TNB participants taking a national online UK survey had ever used mental health services for reasons excluding gender reassignment support (*N* = 621). In the US, Shipherd and colleagues (2010) found that 37% of TNB volunteers in their study had sought mental healthcare not related to gender identity counselling in the past year (*N* = 130). The lower rate of use reported in this study might be related to the shorter timeframe they measured MHC use for (one year vs "ever"). Lombardi (2007) analysed data from questionnaires administered to 90 TNB participants in the US who had ever had a problem with substance use, finding that 63% had ever accessed substance use treatment (and 72% had accessed a self-help group).

There appears to be scarce data on rates of general MHC utilization among TNB people, with some studies using smaller sample sizes and/or set in very specific settings. Nevertheless, available data suggests that the majority of TNB people access general MHC at least once in their lives. As explained previously, TNB people commonly seek MHC for general emotional and relationship concerns, with some of them related to the negative experiences faced due to being TNB (Benson, 2013; Hunt, 2014; Shipherd et al., 2010).

Literature gaps on rates of use. There is growing research on the MHC utilisation pattern and rates of unmet need for TNB people, however, some limitations of these studies remain present. There is a significant gap regarding the specific types of MHC services utilised by TNB people. Aside from some studies focusing on specific MHC settings, no studies were found that explored what are

the rates of use for specific MHC providers, such as private providers, public health services, inpatient services, community organisations, etc. This research is crucial for obtaining a comprehensive understanding of the most frequently utilised healthcare providers by TNB people, identifying underutilised providers, and discerning the underlying factors contributing to these patterns, including barriers experienced with each provider type. Such insights can contribute to addressing the unmet MHC needs within the TNB community, pinpointing specific service gaps, and enhancing the overall quality of MHC services.

Regarding the relationship between demographic characteristics and MHC rates of use, this review found no articles analysing demographic differences (such as gender, age, or ethnicity groups) in MHC use. This remains s an important area to be studied. Alongside measuring rates of use, it is relevant to also explore the satisfaction that TNB people report with the services used.

Satisfaction with MHC

Rates of satisfaction. Panchal and colleagues (2021) conducted a systematic review of 35 articles on MHC for TNB clients, including satisfaction with MHC among the topics of interest. They found five articles that touched on satisfaction with general MHC (or on both general MHC and MHC for gender-affirming needs). Their review concluded that studies reported varying degrees of satisfaction from TNB participants with MHC received. One of these was Hunt's (2014) survey in the UK, which found that under 50% of participants were very or extremely satisfied with counselling services, while 33% reported being slightly or not at all satisfied (*N* = 74). Hunt also reported that only 47% of participants reported their counsellor was always or usually able to help them in working through their presenting problems, while 29% reported this rarely or never happened. Contrastingly, in Canada Simeonov and colleagues (2015) found that the great majority (88%) of TNB survey participants were satisfied or very satisfied with MHC received in the past year.

These previous studies on satisfaction with MHC both involved relatively small sample sizes of approximately 70 participants, limiting their generalisability. Two of the additional articles cited by Panchal and colleagues (2021) focused instead on satisfaction with MHC through large public

healthcare organisations. One of these was Ellis and colleagues' (2015) survey, which revealed that the satisfaction of TNB participants with MHC provided by the UK National Health Service seemed to be varied, as 63% of participants reported being satisfied/very satisfied with those services, whereas 34% were dissatisfied/very dissatisfied (*n* = 396). The second study was Lehavot and colleagues' (2017) survey, which found, similarly, that 69% of TNB US veteran participants reported being satisfied with MHC received through the US Veteran Administration care, while 31% were dissatisfied (*N* = 298). A contextual consideration of the latter study is that the US Armed Forces has banned TNB people from joining under their identified gender for most of its history, with this ban being in place when the data for this study was collected (2014) (Readler et al., 2017). This might contribute to dissatisfaction rates through greater identity concealment and discrimination experiences within the specific context (Veteran Administration care).

Differences by demographic group for rates of satisfaction. Panchal and colleagues (2021) identified some associations established by previous research between satisfaction with MHC and other variables**,** including demographic factors. Regarding differences by age groups, clients who are in their middle adulthood seem to report the greatest rates of satisfaction compared to other age groups. In the study that recruited TNB participants who had used the Veterans Administration Care in the US (Lehavot et al., 2017), the youngest (18-34 years old) and oldest (over 60 years old) participants were significantly more likely to report dissatisfaction with MHC, however, this was not significant after adjusting for other variables (such as gender, ethnicity, and relationship status). Studies with the general population have also found that younger participants are less satisfied with MHC services (e.g. Blenkiron & Hammill, 2003).

Lehavot and colleagues (2017) also found satisfaction with MHC to be significantly different across ethnicity groups, with 30% of white participants, and 38% of non-white participants, being dissatisfied with MHC. Nevertheless, ethnicity was not a significant correlate for dissatisfaction with MHC after controlling for other demographic variables through a regression analysis. Concerning gender differences, transgender men in the study were more likely to be dissatisfied with MHC

received than transgender women (56% vs 26%). After conducting a multiple regression that adjusted for several variables, gender was still a significant correlate for dissatisfaction with care, as transgender men were over three times as likely to be dissatisfied with care than transgender women (Lehavot et al., 2017). This study did not include non-binary as a possible categorisation for gender groups.

Literature gaps for satisfaction with services. Some insightful research exists in regard to satisfaction with MHC services for TNB people. The remaining limitations include studies using small sample sizes (which might explain varying results) or being set, again, in specific settings (e.g., the US veteran healthcare system). Large national surveys can facilitate making wider generalisations. In addition, there is a lack of research on satisfaction specifically with residential MHC settings, which can pose a different set of challenges to outpatient ones.

Regarding differences in satisfaction with MHC by demographic groups among TNB people, likewise, only one article was found (Lehavot et al., 2017), which found significant differences across gender groups. This article only included two ethnicity groups and did not allow for participants to identify as non-binary. The latter could be explained by research with non-binary genders emerging only more recently.

Unmet need, delayed care and difficulty accessing MHC

Unmet need refers to the difference between the degree to which a population needs services and having received those services (Bryant et al., 2009). Considerable percentages of unmet need for MHC have been reported by previous research with TNB people. It is important to point out, once again, that the studies measuring unmet need did not make a distinction between general and gender-affirming MHC, which could inflate these results beyond general MHC. In the US, Shipherd and colleagues (2010) found that 52% of their TNB sample had a current need for mental health treatment but had not used services during the past year. Similarly, Simeonov et al. (2015) reported that 54% of TNB participants in their community survey based in Canada (*N* = 71) indicated that they had required MHC in the past year but had not received it.

Other studies have focused on particular groups among TNB people. Lehavot and colleagues (2017) surveyed veteran TNB participants from the US (*N* = 298), finding that 36% of them had delayed mental healthcare in the past 12 months.. This is alarming considering this population might experience high rates of mental health problems due to war-related experiences. She and colleagues (2021) explored this question focusing specifically on transgender women sex workers in China. The authors conducted a survey with 199 participants, finding that, out of a subsample of 55% that reported a need for MHC in the past year, the vast majority (85%) had not accessed it. Furthermore, out of a subsample of 63% of the transgender women sex workers who presented probable depression, anxiety, or suicidal ideation in the past year, 90% had not received MHC (She et al., 2022). As explained by the authors, this finding may be related to the increased intersecting stigma experienced by this population due to their gender identity and their occupation.

Differences by demographic groups for unmet need. Some research has explored how rates of unmet MHC need differ among different demographic groups within TNB people, finding that younger TNB people and transgender men experience more difficulties in this regard (Lehavot et al., 2017; Moallef et al., 2022). In their study in the US, Lehavot and colleagues (2017), found that younger TNB veterans were more likely to delay accessing MHC, with participants who were 65 years and above being 70% less likely to have delayed MHC in the past year than those who were in the 18-34 years old cohort. Nevertheless, this relationship did not remain significant after controlling for several other demographic variables (gender, ethnicity, relationship status, income, etc.). Younger people experiencing higher rates of unmet MHC need has also been reported in studies with the general population (e.g., Lopes et al., 2016).

Concerning ethnicity, Lehavot and colleagues (2017) found no significant differences in delaying MHC between white and non-white participants. Regarding gender differences, the authors found that transgender men were significantly more likely to delay accessing MHC than transgender women (56% vs 26%); nevertheless, this difference did not remain significant after conducting a regression controlling for the other demographic variables. A study in Thailand (*N* = 603) reported

that transgender men were the most likely to find it difficult to access MHC (Moallef et al., 2022). However, this difference was relatively small and was not tested for statistical significance, with 16% of transgender men, 15% of transgender women, and 14% of non-binary persons reporting they would find it difficult to access MHC if they needed it.

Literature gaps on unmet need. The existing research on unmet need for MHC in TNB people reveals several gaps. In the same line as research on rates of utilisation, existing research on unmet need did not specify whether the unmet need was for general MHC or gender-affirming MHC, which makes it difficult to make conclusions about unmet need for general MHC specifically. Research regarding demographic differences in rates of unmet need was only comprised of two studies, with emerging evidence indicating that age and gender are significant correlates.

Barriers to accessing MHC

Several studies have revealed that TNB people face significant barriers to accessing MHC. Snow and colleagues (2019) conducted a systematic review on the topic, excluding articles which focused exclusively on *gender identity counselling,* to focus on general MHC. Their review included eight studies based in the UK, the US, and Ireland. They organised their findings thematically into three main barriers: personal concerns, incompetent practitioners, and affordability (Snow et al., 2019). The following section utilises their proposed thematic structure to update and complement their findings, by integrating two more recent literature reviews and additional recent articles.

Personal concerns and anticipation of negative experiences. The first major barrier identified by Snow and colleagues (2019) was the personal concerns of TNB clients, which prevented them from seeking care. It is important to note that these concerns are usually based on previous negative experiences and are consistent with commonly reported negative experiences in research (described in the following sections), meaning that these concerns are substantiated rather than emerging from TNB individuals in an isolated manner (which the word “personal” might imply).

TNB clients' anticipation of negative experiences has been related to a fear of being pathologised and a fear of being mistreated. For example, the UK study by Ellis and colleagues

(2015) found that the most frequent worry reported by participants was that their gender identity would be pathologised by being perceived as a symptom, or a cause, of their mental health issues. Lehavot and colleagues (2017) found that 25% of their TNB participants (US veterans) had delayed MHC in the last year due to fear of discrimination or fear of disrespect from practitioners, being the second most common reason for delaying care (after affordability). In their study with transgender women in China, She et al. (2022) found that unwillingness to disclose gender identity was significantly and inversely associated with MHC utilisation and intention of utilisation. In addition, a high percentage of participants indicated that confidentiality concerns, fear of discrimination, and fear of mistreatment were barriers to using MHC in the present (55.6%, 54.8%, and 33.3% respectively for the subsample with probable mental health problems; 51.4%, 51.4%, and 29.4% for the subsample with a perceived MHC need; She et al., 2022). In Ireland, De Vries and colleagues (2023) conducted an online survey (*N* = 279) finding that some participants shared experiences of avoiding seeking MHC after negative experiences with providers.

A different area of personal concerns identified by Snow and colleagues (2019) was objection to common therapeutic practices. Shipherd and colleagues (2010) found that, out of a subsample of TNB participants who reported mental health concerns but had not sought care in the past year (*n* = 68), 21% did not want to discuss their personal life, 21% did not want to be prescribed medication, and 18% did not like to speak in groups, which might also reflect concerns associated to disclosing their gender identity. Anticipated negative experiences not only can impact care-seeking behaviours, but also engagement with the care received. In a study undertaken by Lyons and colleagues (2015) in Canada, 14 TNB participants who had accessed residential substance use treatment were interviewed. These participants expressed a fear of being stigmatised or judged by other residents in the residential facility, as well as perceiving that they were a “disturbance” to them (p.4), which subsequently limited their engagement in treatment.

Practitioner lack of competence and cultural safety. The second and most recurrent barrier that emerged from Snow and colleagues' review (2019) was the lack of competence from MHC

practitioners to work with TNB clients, including providers that are unknowledgeable, unnuanced, and/or unsupportive. More recent conceptualizations have opted for utilising the wider concept of *cultural safety*, rather than competence, in healthcare settings. This concept has been traditionally applied to ethnicity, but it is also applicable to work with TNB people. Cultural safety refers to the provider being aware of power relations inherent to the relationship between themselves and the client, as well as being aware of their own culture and biases, and how these contribute to health inequities for marginalised cultural groups (Curtis et al., 2019). This concept goes beyond the provider becoming educated on the patient's culture, and instead being critical about their own assumptions, prejudices, and their impact on healthcare barriers experienced by patients. The three sub-themes explained in the following section can be conceptualised as expressions of culturally unsafe practices from MHC providers, as they involve providers not being reflective about how their beliefs and practices are causing harm to TNB clients.

Unknowledgeable and inexperienced practitioners. The first sub-theme identified by Snow and colleagues (2019) was unknowledgeable providers. In a more recent review of negative aspects of negative aspects of MHC experienced by TNB people (which included 19 additional articles) Panchal and colleagues (2021) also found that the most frequent theme in literature was lack of provider knowledge and experience. Insufficient foundational knowledge about TNB people among providers has been associated with a lack of basic understanding of gender diversity and social stressors faced by TNB clients. For example, in several studies in Ireland, the UK and the US, lack of transgender knowledge among practitioners was associated with disinformation about transgender people, a limited or narrow understanding of gender identity (e.g., assuming there is a right way to express one's gender, or perceiving gender in a binary way), and a conflation of gender identity with sexual orientation (Benson, 2013; De Vries et al., 2023; Ellis et al., 2015; Mizock & Lundquist, 2016). In the study conducted by McCullough et al. (2017), based in the US, the majority of TNB participants reported experiences of practitioners lacking basic knowledge around social and political aspects of their identity, such as their lack of legal protection against hate crimes, or the exposure to

harassment and discrimination, which led to them feeling disrespected and feeling distrust towards these providers. Participants in focus groups conducted by Sperber and colleagues (2005) in the US (*N* = 34) perceived that lack of knowledgeability partly emerged from providers lacking previous experience working with TNB clients. Due to the lack of foundational knowledge, providers sometimes learn about TNB people directly from TNB clients, which was reported by participants in Benson's study (2013). In a different cultural setting (China) She and colleagues (2021) found that lack of access to qualified doctors was also a frequent barrier reported by TNB participants (33.3% of those with a probable mental health problem, and 37.6% of those reporting a MHC need), although they did not specify the meaning of "qualified" in this case.

Lack of foundational TNB knowledge and training can result in MHC practitioners not adjusting their procedures and interventions to fit TNB patients' particular needs, and not being sensitive to their gender identity. For example, Duffy and colleagues (2016) applied an online questionnaire to 84 TNB people (the majority of them living in the US) who had accessed eating disorder treatments, finding that 15% of participants reported that therapists tried to apply traditional models of body positivity to them, which was perceived as invalidating and inappropriate, as issues of body image for TNB people may be related to gender identity rather than an expression of pathology. This might be related to marginalised populations being historically over-diagnosed with mental health issues due to biases and lack of cultural competence, which was also the case for psychosis diagnosis among TNB people in the mid-20th century (Barr et al., 2021).

The cited literature shows that gaps in knowledge from MHC practitioners are usually filled with assumptions based on cis-normative beliefs held by them, which aggravates the barriers experienced by TNB clients and demonstrates a lack of cultural safety.

There is very scarce research analysing MHC providers' perceptions about their training in TNB people, but recent research in the US suggests that training may be increasing (Obasi et al., 2023), as the majority (83%) of MHC professionals surveyed by the authors had received some form of specific training to work with TNB people (*N* = 142). Nevertheless, the training source, type, and

length varied widely, suggesting that the quality/content of training also varied, calling for more regulation and standardised training across providers.

Provider's unnuanced focus on gender. Snow and colleagues (2019) identified as a second sub-theme MHC providers' lack of nuance when discussing gender. In their review, Panchal and colleagues (2021) also identified over or under-focus on gender as a prominent barrier.

Mizock and Lundquist (2016) interviewed 45 American TNB individuals of various genders who frequently reported that practitioners focused too much on their gender during therapy, even when they wanted to discuss other topics, an issue they termed *gender inflation*. On the other hand, some participants reported experiences of therapists avoiding discussing gender altogether, which authors interpreted to be associated with the therapist's lack of training on transgender issues, and the resulting discomfort. As an illustration of this, a participant in the study conducted by Hall and DeLaney (2021) in the US, commented "Any time I wanted to talk about something … [my MHC provider] changed the subject to my transition like I was some kind of science experiment" (p. 1290).

Practitioners being unnuanced can also be expressed in expecting all TNB people to be the same (*gender generalizing*, Mizock & Lundquist, 2016). This issue is especially problematic when the practitioner is not sensitive to the intersections of a patient's multiple identities (e.g., ethnic and gender identities), which was a negative theme reported by participants in McCullough and colleagues' (2017) interviews with TNB people in the US.

Unsupportiveness and enacted stigma. Regarding unsupportiveness as the final sub-theme of lack of competence described by Snow and colleagues (2019), this refers to mistreating, transphobic and/or invalidating attitudes or behaviours from MHC practitioners. This theme was similar to one of the *health prevention* themes identified in a more recent review by White and Fontenot (2019, who reviewed seven articles from the US and Canada), which was *enacted stigma*, referring to experiences of rejection or insensitivity, and denial of services. In the same line, Panchal and colleagues (2021), identified discriminatory care, pathologization, invalidation of gender identity, and lack of empathy as negative aspects of MHC in their review.

Unsupportiveness can be manifested in multiple forms, and it can be present in the early stages of healthcare access, such as in initial intake forms or providers' digital platforms (Parent & Tebbe, 2022). In a study where 224 TNB participants in the US evaluated mock websites of MHC providers, website disaffirmation (e.g., lack of trans-inclusive language and forms) was significantly associated with a lower likelihood for participants to want to access that provider (Parent & Tebbe, 2022). This is a substantial barrier, considering that, even among provider websites which advertise they work with TNB clients, a great proportion do not use trans-inclusive language (43.2%), do not ask questions about pronouns (94%), and do not offer the possibility to fill a different name to their legal name (81.9%) in their intake forms, as reported by Holt et al. (2019). Australian TNB participants who were interviewed by Halliday and Caltabiano (2020) reported that paper intake forms provided with binary gender options were unhelpful and made them feel excluded.

Regarding interaction with MHC providers, enacted stigma can be expressed in multiple forms, such as verbal expressions of invalidation, intrusive questions, insults and non-verbal gestures. Fitzpatrick (2023) interviewed 43 TNB participants, with some of them reporting MHC providers denying the existence of TNB people and pressing them to conform to traditional gender roles. Other participants of the same study reported providers asking them inappropriate questions about their gender identity. Bess and Stabb (2009) interviewed seven TNB people in the US who reported different verbal expressions of hostility from MHC providers as negative experiences. In Ireland, McCann (2015) conducted interviews with four TNB participants, with a participant sharing an experience of insulting language used by MHC providers, including words such as “freak” and “perverted”. Also in Ireland, some participants in the research by De Vries et al. (2023) perceived their providers were biased against them. Lombardi (2007), found that, out of a group of participants who had accessed MHC in the US (*n* = 57), 20.4% had ever been verbally abused by service staff. Participants in the study undertaken by McCullough and colleagues (2017) shared experiences of microaggressions, referring to more subtle non-verbal gestures, such as discomfort expressed through facial expressions. Abuse experienced by TNB can lead to a low sense of acceptance of their

identities in the MHC settings, which is illustrated in only 44% of participants in Hunt's (2014) study in the UK reported feeling extremely or very accepted by their counsellor.

Unsupportiveness can also be expressed by providers misgendering or using incorrect names when referring to their TNB clients. Participants who were interviewed by McCullough and colleagues (2017) reported experiences of providers using incorrect gender pronouns as an additional invalidating behaviour. This concern was also reported by TNB adolescents staying in a psychiatric unit who were interviewed by Acosta and colleagues (2019). Participants also reported that their legal name being in their medical records made it challenging for staff to use their correct name (Acosta et al., 2019). Research in general healthcare settings has also raised this as a barrier, with some TNB people emphasising that providers should routinely ask for patients' pronouns (M.E. Eisenberg et al., 2020).

Inpatient MHC settings pose additional unsupportiveness barriers for TNB clients, including discrimination experienced by other service users, and harmful residential practices. Lyons and colleagues (2015) researched TNB people's experiences with substance use programmes in Canada, reporting experiences of harassment by other programme residents (including experiences of offensive language, rejection, and sexual assault), resulting in some participants feeling isolated and abandoning the programme earlier. Lombardi (2007), found that, out of a group of participants who had attended drug or alcohol treatment programmes in the US (*N* = 57), 39.6% had been verbally abused and 11.8% had been physically abused by other clients. Additional discriminatory experiences in Lombardi's study included staff requiring participants to sleep or shower in rooms matching their sex assigned at birth (60%), not being allowed to talk about trans issues (33.3%) and being required to wear clothing matching their sex assigned at birth (25.5%).

An additional closely linked form of enacted stigma revealed are pathologising attitudes, with practitioners treating TNB clients' gender identity as a mental health disorder, or as the source of their mental health problems, which can contribute to participants' negative self-perception (Mizock & Lundquist, 2016). Goldberg and colleagues (2019) conducted an online survey answered

by 506 TNB tertiary students (most of them living in the US), who shared experiences of their MHC providers concluding that their gender was the root cause for their mental health issues. Some of them commented this might be related to the idea that it was “inevitable” for someone trans to be depressed or sad. A participant commented, in regard to their therapist’s insistence that their depression was linked to transphobia “it almost seemed odd for the depression of someone trans to have nothing to do with their being trans” (Goldberg et al., 2019, p.79). This demonstrates that the concern of TNB clients of being pathologised is indeed well founded.

Pathologising attitudes can lead to MHC providers attempting to provide therapy to "change" TNB clients' gender identity. For example, some participants in the US-based research conducted by Fitzpatrick (2023) described conversion practices from MHC providers, which happened while the participants were preteenagers or teenagers. These experiences were described as very harmful due to installing negative self-beliefs. Elder (2016) interviewed ten older (greater than 60 years old) TNB participants in the US about their experiences with psychotherapy. All participants described hurtful and transphobic experiences, as well as efforts to "cure" their gender identity (or disregard it completely) and being denied, or forced into, psychological interventions. Participants acknowledged, however, that this was much more frequent in their earlier experiences of therapy, as opposed to more recent ones (Elder, 2016). On a larger scale, the US Trans Survey 2015, which recruited 27,715 TNB people, found that 9% of the sample had experienced efforts by MHC professionals such as therapists or counsellors, to stop them from being transgender (James et al., 2016, p.109).

When discussing discrimination experiences, it is also relevant to consider how the intersecting identities of TNB clients relate to this. The second barrier identified in the review by White and Fontenot (2019), was intersectionality and the increased discrimination that TNB people of ethnic minorities experience in MHC settings. Kattari and colleagues (2017) analysed results from the US 2010 National Transgender Discrimination Survey (*N* = 6,451), finding that TNB participants of colour were significantly more likely to report discrimination experiences than their White

counterparts in four different MHC settings (e.g., 14.1% vs 9.1% in mental health centres; and 9.1% vs 5.6% in drug treatment programmes).

Affordability. The third major barrier identified by Snow and colleagues (2019) was cost and affordability, which is a theme that is likely to vary internationally across jurisdictions because of different funding models for services. Cost was reported as a barrier by 37% of survey participants in Shipherd and colleagues' (2010) research in the US, making it the most common barrier to accessing MHC among participants. Similarly, 30% of participants in Hunt's (2014) survey in the UK indicated that cost and affordability were a barrier they faced in seeking counselling. In Lehavot and colleagues' study (2017) with US veterans, cost was the most frequent reason for participants to delay mental healthcare in the last 12 months (38%). In China, She et al. (2022) found that cost was a perceived barrier by 36.5% of participants with a probable mental health problem and 38.5% of those reporting a need for MHC. By contrast, in the Canadian study by Simeonov and colleagues (2015), affordability was identified as a barrier (to MHC in the past 12 months) at a much lower rate (13.2%), by TNB participants with an unmet need for MHC. The different rates reported by research might be related to the unique characteristics of the healthcare system of each country. On a more specific topic, 72% of participants interviewed by Fitzpatrick (2023) reported that insurance caused barriers to MHC, as competent providers were sometimes not affiliated with their insurance company, meaning they could not afford them. Qualitative interviews with 22 TNB people in the US revealed that cost barriers for TNB might be heightened due to the social inequities that they face, such as increased housing instability or poorer employment conditions (Holt et al., 2023).

Additional barriers. Some additional barriers that did not fit within the themes identified by Snow and colleagues (2019), were TNB clients not knowing how to access MHC, and wanting to manage the problem on their own. Lacking information on how or where to get help, was the second most commonly reported barrier (18.4% of TNB participants who had an unmet need for MHC in the past year) in Simeonov and colleagues' (2015) research in Canada. Some participants interviewed by Fitzpatrick (2023) in the US reported finding their MHC providers through

recommendations of other TNB people due to lack of information. Additional reported barriers in She et al.'s survey in China (2022) were the belief that one would be able to manage the problem on their own and thinking that the problem would resolve on its own, which was reported by 33.3% and 21.4% (respectively) of TNB participants with probable depression or anxiety; and by 29.4% and 23.9% of those with a perceived MHC need.

Differences by demographic group for experienced barriers. Some research has been conducted on the relationship between demographic variables and experiencing unsupportive attitudes from providers specifically (Goldberg et al., 2019; James et al., 2016). Regarding age groups, limited research suggests that younger TNB people might be at greater risk of experiencing unsupportiveness as a barrier to MHC access than older counterparts. For example, in the US Trans Survey, the majority of participants (78%) who reported that a professional tried to stop them from being trans were under 25 years old (James et al., 2016, p.109). These results are in line with younger TNB people experiencing higher rates of unmet need and dissatisfaction with MHC services, as described previously.

Concerning ethnic identity, in their study with TNB university students from the US, Goldberg et al. (2019) found no significant differences by ethnic groups in misgendering experiences. However, in the US Trans Survey, Middle Eastern and American Indian people were the ethnic groups most likely to have reported a professional trying to stop them from being transgender (32% and 27% respectively), while Black and Asian participants were the least likely (16% and 14%) (James et al., 2016).

Goldberg et al. (2019) also found that binary-gender TNB participants reported significantly less misgendering from counsellors than non-binary participants; and AMAB TNB participants reported significantly less misgendering than AFAB TNB participants. These differences were significant after a regression analysis was conducted, as binary participants were 71% less likely to report misgendering than non-binary participants, and AMAB participants were 51% less likely than AFAB participants to do so.

Literature gaps for experienced barriers. There has been extensive research on the different barriers that TNB people encounter when accessing MHC, which is reflected in the broad variety of studies cited, which included a wide range of methodologies and study settings.

Research on differences by demographic subgroups, regarding experienced barriers, was limited to two studies based in the US, demonstrating limited knowledge concerning how MHC barriers relate to these.

Aotearoa/New Zealand research

Research studying general MHC experiences and access for TNB people living in Aotearoa/New Zealand remains very scarce. To date, Counting Ourselves has been the only study to address this topic specifically, which is an online survey of the health and wellbeing of TNB people living across the country (*N* = 1178 [Veale et al., 2019]). Fraser and colleagues (2022) explored MHC access for a wider population, focusing on rainbow people in Aotearoa/New Zealand (*N* = 955), rather than specifically TNB people. Nevertheless, they also produced some insights specific to TNB people.

The first version of Counting Ourselves (2018) collected quantitative data on satisfaction with different MHC providers, finding that participants presented higher satisfaction with community services than emergency or hospital services (Veale et al., 2019, p.49). Participants were the most satisfied with Māori services and other community support services, as 64% and 62% of those who had used them (respectively) indicated that they were satisfied or very satisfied with them. For community mental health services, 44% of participants reported they were satisfied or very satisfied with them. Participants were the least satisfied with MHC services from hospital wards, hospital emergency departments, and the crisis mental health team, as only 29%, 28%, and 26% responded they were satisfied/very satisfied with these providers (Veale et al., 2019).

Some differences in satisfaction levels were found across gender groups. Transgender women who had used the crisis mental health team reported higher levels of satisfaction with this service than transgender men (42% vs 11% indicated they were satisfied). In line with this, Fraser

and colleagues (2022) found that transgender men reported significantly more negative experiences in MHC settings than transgender women, non-binary, and cisgender participants. In addition, non-binary participants and transgender men reported more worries in MHC settings than transgender women and cisgender participants. In regard to age differences, Counting Ourselves adult participants who had used community mental health services were more likely to be satisfied with these than youth participants aged under 26 (53% vs 31%; Veale et al., 2019).

Through open-text responses, Counting Ourselves participants wrote about their unmet need for MHC and the difficulty of accessing MHC, even when they felt they needed for it. With respect to this, Fraser et al. (2022) found that, among rainbow people, TNB presented significantly more difficulty accessing MHC than cisgender people. Concerning barriers to access adequate MHC, Counting Ourselves participants discussed some providers' lacking knowledge about TNB identities and issues, as well as presenting pathologising attitudes and making efforts to change their gender identity (Tan et al., 2021). Moreover, 17% of participants indicated that a healthcare provider had attempted to change their gender identity (Veale et al., 2019, p.38). Participants also discussed the low availability and long wait-times of public MHC services, as well as the high financial cost of private providers (Tan et al., 2021. Fraser and colleagues (2022) found that TNB participants were significantly more likely to report worries in MHC settings than cisgender participants.

Rationale for this thesis and research questions

There is extensive evidence showing that TNB people face disproportionately higher mental health problems compared to cisgender people. Access to appropriate MHC might play an important role in contributing to these disparities, hence it becomes important to study the patterns of MHC use by TNB people, their satisfaction with these services, and the barriers they experience, to address these challenges.

Some international research has addressed this topic, offering important insights into issues such as the wide range of barriers TNB people experience in MHC settings, as well as the unique challenges that subgroups face within this community. There are, nevertheless, some remaining

gaps, such as exploring differences in MHC utilisation rates by demographic groups, satisfaction rates for specific MHC providers, satisfaction with residential MHC services, and expanding on the knowledge regarding demographic differences in experienced MHC barriers. Furthermore, there are scarce studies using larger samples to explore MHC indicators.

Research on MHC access among TNB people within the context of Aotearoa/New Zealand is still very limited, consisting mainly of the Counting Ourselves project, which this thesis draws data from. Studying the specific ways that TNB people use MHC nationally, as well as the difficulties they encounter, is key to providing context-specific insights and recommendations that can be used to inform providers and policymakers.

Considering the gaps identified in international and local research, the present thesis aimed to answer the following research questions concerning MHC access for TNB people living in Aotearoa/New Zealand.

- What is TNB people's rate of use for general MHC services?
    - What are the rates for specific MHC settings?
    - What is the rate for different demographic subgroups (age, gender/SAAB, and ethnicity)? Are there significant differences in rates of use across demographic subgroups?
- How satisfied are TNB people with MHC services received?
    - What is the rate of satisfaction for different demographic subgroups? Are there significant differences in satisfaction across demographic groups?
- What is TNB people's rate of unmet need for MHC?
    - What is the rate for different demographic subgroups? Are there significant differences in rates of unmet need across demographic subgroups?
- At what rates do TNB people experience general barriers to MHC such as cost, time, transportation or not knowing where to go?

- At what rates do TNB people experience trans-specific barriers to MHC, such as fear of provider's insufficient knowledge or lack of trust with personal information?
    - What are the rates for different demographic subgroups? Are there significant differences in reported barriers across demographic subgroups?

Based on the literature review, I expected to find relatively high rates of MHC use and unmet MHC needs, moderate-to-high satisfaction levels, and high rates of trans-specific MHC barriers and some general barriers. The limited literature on demographic differences would also warrant the following predictions: younger participants will report higher rates of unmet need, less satisfaction with MHC, and more rates of barriers; transgender men will report more satisfaction with MHC than transgender women; AMAB participants will be more likely to report barriers to MHC than AFAB participants; and non-binary participants will be more likely to report barriers to MHC than binary-gender participants.

Method

This section will describe the thesis' methodology, including the research procedure, its participants, the measures used, and how the data were analysed. The research design was cross-sectional and utilised data from Counting Ourselves 2022: The Aotearoa New Zealand Trans and Non-Binary Health Survey. This was the second wave of a series of surveys covering the health and wellbeing of TNB people living in Aotearoa/New Zealand. The survey included multiple-choice questions, rating scales, and open-ended questions, and this thesis utilised quantitative data from multiple-choice questions and rating scales.

Procedure

The Counting Ourselves 2022 survey received approval from the Health and Disability Ethics Committees (approval no. 18/NTB/66). The survey questionnaire was designed by the Counting Ourselves research team in collaboration with community advisors, organisations, and other key stakeholders. For this version of the survey, collaborators provided feedback on the questionnaire for the first survey, proposing changes, removals, or additions to the existing questions. The questionnaire was comprised of 25 sections which covered multiple topics, such as physical and mental health, employment and income, and discrimination experiences One of these topics was general healthcare, which is the section from which the data for this thesis is drawn. Some of the questions were sourced from Aotearoa/New Zealand population-based surveys, in order to compare indicators for TNB people and the general population. Survey branching was utilised to only display relevant questions to specific participants. For example, questions about satisfaction with MHC were only displayed to participants who responded they had used a MHC service.

Recruitment of participants was carried out through different strategies, including social media sites, community events in collaboration with relevant rainbow organisations, word of mouth, academic networks, and healthcare professionals. Participants were given the internet link for the survey or the choice to be sent a paper copy. The survey was open between September and December of 2022.

At the beginning of the survey, information was displayed to participants explaining the characteristics of the survey, its anonymous nature, and reminding participants they could choose to skip any questions they wished to. After this, they were asked to consent to participate. If they did not consent, an exit message was displayed to them. Participants completing the online survey could save their progress in the survey and return to it later.

Measures

Gender and SAAB

Participants were asked to select which term best described their current gender among three options, acknowledging that they might use a wider range of terms to describe their gender, which participants were given a chance to share in an earlier question. The three options were a) transgender man, man, or boy; b) transgender woman, woman, or girl; and c) non-binary, genderqueer, agender, or similar identity. In total, 2,612 participants responded to this question, which was 99.3% of the total sample.

For inferential analyses, non-binary participants were further divided into two SAAB groups: non-binary AFAB and non-binary AMAB. A separate question asked participants about their SAAB, which was worded “What sex were you assigned at birth?”. Eight non-binary participants did not provide their SAAB (0.3% of the total sample), these were excluded from gender/SAAB comparison analyses, as the group was not large enough to make comparisons to other groups. It is worth noting that none of those eight participants reported having an intersex variation (in a separate question that asked them about this).

Ethnicity

Participants were able to select one or more options from a list of given ethnicities or write additional ethnicities in an open text box. All participants responded to this question. Responses (selected and open-text responses) were then grouped into the level 1 ethnic groups indicated in the Ethnicity Data Protocol from the Aotearoa/New Zealand Ministry of Health (2017), which is used in national population-based surveys. Where participants selected multiple level 1 ethnicities, their

response was prioritised following guidelines from the Ministry of Health (2017). The goal of ethnicity prioritisation is to ensure the visibility of smaller ethnic groups that may be otherwise engulfed by larger ethnic groups. In prioritised order, these groups are Māori, Pacific Peoples, Asian, Middle Eastern/Latin American/African (MELAA), Other Ethnicity, European (New Zealand or other European ethnicities), and Residual Categories ("don't know", refused to answer, repeated value, response unidentifiable or outside of scope, and response not stated). For example, if a participant selected MELAA and Māori, the prioritised response would be Māori. The group Other Ethnicity was excluded from analyses due to the number of participants being very low (*n* = 6) and composed of very diverse ethnicities. The group Residual Categories (*n* = 12) was also excluded from analyses as these responses did not offer information about participants' ethnicities.

MHC measures

The MHC questions from which data from this thesis was drawn were placed in sections of the survey which asked participants about general healthcare experiences. The following message was displayed to participants before answering most MHC questions, except for the question about comfort discussing gender identity with MHC providers: "The next questions are about your use of mental health services where gender-affirming care was not the main reason for accessing them". The wording was chosen to exclude, as much as possible, experiences relating to MHC for gender-affirming needs, keeping in mind that making an absolute distinction is difficult, as discussed in the introduction. The wording of many of the MHC questions was sourced directly from the New Zealand Health Survey 2021/2022 (Ministry of Health, 2021), to be able to compare results from TNB people to those from the general population in other projects.

Rates of use of MHC

Participants were asked about their MHC use in the last 12 months from different MHC providers, using a question sourced from the New Zealand Health Survey 2021/2022 (Ministry of Health, 2021). The question wording and list of providers is presented in Table 1. The Counting Ourselves team also added “trans, rainbow, or takatāpui community service” as a response option,

as this is relevant to the TNB community. I also suggested to add “inpatient or residential mental health services”, as existing literature has indicated that these settings pose distinct challenges for TNB people. Participants could select as many providers as applicable. A total of 941 participants answered the MHC use question, which was 74% of the total sample.

Table 1

MHC Use Question-Wording and Response Options

Question	In the last 12 months, have you received help for concerns about your emotions, stress, mental health, or substance use from any of the following?
Response options	Hospital emergency department or an after-hours medical centre
	Hospital ward
	Crisis mental health team
	Māori health service (including Māori mental health or addictions services)
	Pasifika health service (including Pasifika mental health or addictions services)
	Community mental health or addictions service (including hospital outpatient appointments)
	Inpatient or residential mental health services (e.g., mental health unit, addiction residential service)
	Trans, rainbow, or takatāpui community service
	Private mental health professional or clinic
	Family violence or sexual violence service
	Other community support services, such as a 'youth one-stop-shop'
	Programme in prison or a youth justice centre
	Other service, please specify

As part of the data cleaning stage, the open text answers that were left by participants who selected the option “other service” in the MHC use question were reviewed and re-coded (where relevant) by another member of the Counting Ourselves team, to better reflect their content. A random sample of these (approximately 25%) was then cross-checked by this thesis' author to ensure reliability, and subsequently, any disagreements were discussed. In total, 228 participants

(24.2%) answered "other" and 42% of these were re-coded due to being covered by an existing response option, 1.8% due to not being applicable (the answer did not refer to a MHC provider), and 1.8% due to being covered by an existing response option already selected by that participant. Finally, a new response option (school or university counsellor) was created to recode 26.3% of the "other" responses, as the number of people responding to this was above the pre-selected threshold of 2% (out of the total sample) to create a new response option for questions. As a result, 28.1% of the original "other" responses remained coded as "other".

In order to analyse the relationship between MHC use and demographic variables, we created a new dichotomous variable which categorised responses into those who had used any service in the past year, versus those who had used none.

Satisfaction with MHC

Participants were asked how satisfied they were with the MHC services they had accessed This question was created by another Counting Ourselves team member and was only displayed to those participants who responded they had used at least one MHC service in the past year. Participants had to rate their satisfaction using a five-point scale that ranged from 1 being "very dissatisfied" to 5 being "very satisfied". In total, 1,081 participants answered this question, which was 96% of those who were displayed this question and 41% of the total sample. To explore the differences in satisfaction by demographic groups, a new variable was computed which included the average satisfaction with all MHC services rated by each participant.

Unmet need for MHC

Unmet need for MHC was measured using a question from the New Zealand Health Survey 2021/2022 (Ministry of Health, 2021). This question asked participants whether, in the last 12 months, they ever felt that they needed professional help for their mental health or substance use, but they didn't receive this help. The response options were “yes”, “no”, and “I don’t know”. A total of 2,047 participants answered this question, which was 78% of the total sample.

General Barriers to MHC

For those participants who responded they had an unmet need for MHC, two questions were displayed asking them about the barriers preventing them from seeking this care. The first question was sourced from the New Zealand Health Survey 2021/2022 (Ministry of Health, 2022), which asked them about barriers to MHC that are also experienced by the general population. Table 2 presents the wording and barriers listed in this question. A total of 1,214 participants answered this question, which was 99.5% of those participants to whom this question was displayed, and 46% of the total sample.

As part of the data cleaning, the open-text answers that were left by the 208 participants (18.1%) who originally selected the option "other reason" were reviewed by another member of the Counting Ourselves team. A random sample of these (approximately 30%) was then cross-checked by me to ensure reliability. As a result, 35% of the "other reason" responses were re-coded due to being covered by an existing response option already selected by that participant, and 12% due to being covered by an existing response option. As a result, 52.4% of the original responses remained coded as "other".

Table 2

General MHC Barriers Question-Wording and Response Options

Question	Thinking about the most recent time when you felt you needed this professional help for your mental health or substance use but didn't receive it, why was that? *Select all that apply.*
Response options	Wanted to handle it alone and/or with the support of family, whānau, and friends
	Couldn't spare the time
	Costs too much
	Problems with transportation or childcare
	Unsure where to go or who to see
	Couldn't get an appointment at a suitable time
	Time taken to get an appointment too long
	Available services did not meet my cultural or language needs
	Health professionals unhelpful or unwilling to help
	Not satisfied with available services
	Didn't think treatment would work
	Concerned what others might think
	Other reason, please specify I don't know

Trans-specific barriers to MHC

The second question on MHC barriers asked participants about barriers that are specific to TNB people and was worded very similarly to the general barriers question (see Table 3). I designed this question based on common barriers found in the literature review. Subsequently, other Counting Ourselves team members supplied feedback to revise the response options. Participants could select as many barriers as applicable. In total, 1,148 participants answered this question, which was 94% of those who were displayed this question, and 44% of the total sample.

Concerning the re-coding of responses left by participants who selected "other", out of the 61 initial responses (5.3% of those who answered the question), 60.7% were re-coded due to not

being applicable (e.g., barrier not related to being TNB), and 23% due to being covered by an existing response option already selected by that participant. As a result, 16.4% of the original “other” responses remained coded as "other". This re-coding was also carried out by another member of the Counting Ourselves team, and then a random sample (50%) was cross-checked by me later.

Table 3

Trans-Specific MHC Barriers Question and Response Options

Question	Thinking again about the most recent time when you felt you needed professional help for your mental health or substance use but didn’t receive it, which of the following reasons apply to you? (These are specific to being trans or non-binary). Select all that apply.
Response options	Did not trust them with personal information about me being trans or non-binary.
	Afraid that health professionals did not have enough understanding of trans and non-binary people
	Afraid that health professionals did not have enough understanding of the difficult experiences (such as being treated unfairly or harassed) that trans and non-binary people often face
	Afraid my gender identity would be seen as a mental health issue or as the cause for any mental health issue.
	Afraid that I would be misgendered or that incorrect names would be used to refer to me.
	Afraid that offensive language would be used or that I would be verbally harassed for being trans or non-binary.
	Afraid of how I might be treated by other patients or users for being trans or non-binary.
	Afraid I would be mistreated in other ways. *Please specify.*

An additional question from the survey was analysed, which focused on discomfort discussing gender identity with providers (framed as MHC access barrier in this thesis). This question was designed by another member of the Counting Ourselves team and asked participants how comfortable they felt discussing being TNB with different healthcare providers, including MHC providers. Participants were asked to rate their comfort using a 5-point scale that ranged from 1 being "very comfortable", to 5 being "very uncomfortable". They could also answer "not applicable"

if this was not relevant to them. In total, 2,276 participants answered this question, which was 86.5% of the total sample. Those who answered, "this does not apply to me" (*n* = 78, 3.4%), were excluded from analyses involving this variable.

This question was the only one placed in a different section than the other questions, and it was not preceded by the same message as the other MHC questions (the message which asked participants to focus on general MHC). Due to this, the results might relate to MHC for gender-affirming needs to a greater degree than other questions.

Participants

The inclusion criteria to participate in the survey were: 1) identifying as transgender or non-binary, 2) 14 years or above, and 3) currently living in Aotearoa/New Zealand. There was a total of 3,584 initial responses to the survey. These were first filtered by me to exclude those responses where the person did not consent to participate (*n* = 57), did not meet the inclusion criteria noted above (*n* = 73), or were incomplete (i.e., did not complete the first three sections, *n* = 492). Subsequently, several Counting Ourselves team members (including this thesis' author) identified those responses that were suspected not to be genuine, based on the inclusion of transphobic comments, repetitive comments about retransition, and conflicting information across questions. After a case-by-case review, 13 responses were finally excluded based on transphobic comments and 138 based on repetitive comments (with most of them also including conflicting responses). Furthermore, 122 responses were excluded based on many duplicate IPs, and one based on overseas geolocation. As a final step, those responses that had duplicate unique identifiers were cross-referenced to assess whether they were filled by the same participant, and if this was the case, the most complete attempt was maintained, while the other one was removed. As a result, 57 responses were excluded due to duplicate unique identifiers. The data cleaning process left 2,631 valid responses for analysis. Almost all participants (99.8%) completed the online version of the survey, with five participants answering the paper version.

The most frequent gender/SAAB group among participants was non-binary AFAB (43.7%), followed by transgender women (22.1%), transgender men (21.9%), non-binary AMAB (12.1%), and non-binary SAAB not provided (0.3%). Comparisons of participants aged 18 and above, to data from TNB participants in the Aotearoa/New Zealand Household Economic Survey (HES) 2020-2021 (which only included participants aged above 18 years old) indicate that the percentage of non-binary participants in this study was larger than the percentage found for TNB people in population surveys (56.1% vs 43.5%; Stats NZ, 2022); whereas the percentage of transgender men was smaller (19.2% vs 28.5), and the percentage of transgender women was slightly smaller (24.7% vs 28.0%; Stats NZ, 2022).

Participants' ages ranged from 14 to 86, and the average age was 27.05 (*SD* = 11.67), revealing a higher proportion of younger participants in our sample. Comparisons of data from participants aged 18 and above, with data from TNB participants in the Aotearoa/New Zealand HES 2020-2021, suggested that participants in this study were younger than TNB participants in general population surveys (77.0% vs 47.2% were aged 34 years old or less; Stats NZ, 2022). This pattern is also observed when comparing the full study sample to general Aotearoa/New Zealand population estimates, based on data from the 2018 Census (75.5% of this study's sample was aged 31 years old or younger vs only 31.1% of the general population [aged over 14]; Stats NZ, 2022). A one-way ANOVA showed that there were significant differences in age across gender/SAAB groups (F [3, 2600] = 70.36, η^2 = .075, p <.001). Pairwise comparisons revealed that both transgender men (M = 24.33, SD = 10.75) and non-binary AFAB participants (M = 25.28, SD = 9.17) were significantly younger than non-binary AMAB participants (M = 27.75, SD = 11.04) and transgender women (M = 32.71, SD = 14.75). Non-binary AMAB participants were also significantly younger than transgender women (see Table A1 for p-values for pairwise comparisons).

Concerning ethnicity, the majority of participants were European (75.3%), followed by Māori (13.9%), Asian (6.5%), Pacific Peoples (1.9%), MELAA (1.7%), Other Ethnicity (0.2%), and Residual Categories (0.5%). Comparisons of ethnicity data from participants aged 18 and above, with data

from TNB participants of the Aotearoa/New Zealand HES 2020-2021, suggest that the percentage of Māori participants in the survey was similar to the one found for TNB people in population surveys (13.9% vs 14.3%); whereas the percentage of Asian (6.5% vs 14.9%) and Pacific Peoples (1.9% vs 5.8%) were lower, and the percentage of European participants (75.7% vs 72.7%) was slightly higher (MELAA and Other Ethnicity percentages were suppressed from the HES data set; Stats NZ, 2022). This pattern is also observed when comparing the full study sample to general Aotearoa/New Zealand population estimates based on the New Zealand Survey 2021/2022 (13.9% vs 14.3% Māori participants, 6.5% vs 14.9% Asian participants; 1.9% vs 5.8% Pacific Peoples; and 77.2% vs 65% European/other ethnicities, respectively; Ministry of Health, 2022).

Analysis

All descriptive and inferential analyses were conducted in IBM SPSS version 25. A significance level of $p < 0.05$ was utilised to determine the statistical significance of all the findings in this thesis. To explore the relationship between categorical MHC access variables (use, unmet need, and barriers) and categorical demographic variables (ethnicity and gender/SAAB) chi-square goodness of fit (χ^2) tests were performed. Effect sizes were measured with Cramer's V. Residual values that were larger or smaller than ± 1.96 indicated that the percentage of participants that answered a particular response option (for that demographic group), was significantly higher or lower than expected by chance.

The continuous variables used in this thesis were non-normally distributed (see Table A2 for *p*-values, kurtosis and skewness). Nevertheless, the departure from normal distribution was small based on the suggested threshold of ±2 for skewness and ±7 for kurtosis (Hair et al., 2010), particularly for average satisfaction and discomfort discussing gender identity. In addition, our sample size was large, as well as the sample size for sub-groups in all analyses, making the normality assumption less critical. Due to these considerations, parametric tests were carried out.

To explore the relationship between dichotomous MHC access variables (use and barriers) and age, independent sample *t*-tests were conducted, to analyse the differences in the mean ages

for each group. Depending on whether homogeneity of variance was met, standard student's t-tests or Welch's *t*-tests were utilised. Cohen's *d* was used to measure the effect size of the relationships.

To analyse the association between non-dichotomous categorical variables (unmet need, ethnicity, and gender/SAAB) and continuous variables (age and average satisfaction with MHC), one-way analyses of variance (ANOVA) were performed. Depending on whether homogeneity of variance was met, standard ANOVAs or Welch's ANOVAs were conducted, and either Tukey's HSD or Games-Howell post-hoc tests to examine pairwise comparisons for significant results. Eta squared (η^2) was used to measure the effect size of the categorical variable on the continuous variable.

In order to explore the relationship between continuous MHC access variables (average satisfaction, and comfort discussing gender) and continuous demographic variables (age), a bivariate Pearson correlation (*r*) analysis was conducted.

Results

Use of MHC

The percentage of participants who had used MHC from different providers in the last 12 months is displayed in Table 4, organised from most frequent to least frequent. Slightly over half of participants had accessed at least one MHC service in the past year. The most frequently accessed providers were private MHC professionals, which presented a rate of use over 20% higher than the following four most commonly accessed providers: rainbow community services, the crisis mental health team, community mental health services, and hospital emergency departments. The least frequently accessed providers were Māori health services, prison-based services, and Pasifika health services, with rates of use of under 1%. In between were other community support services, family violence services, school/university services, hospital wards, and inpatient mental services with rates of use between 2% and 4%.

Table 4

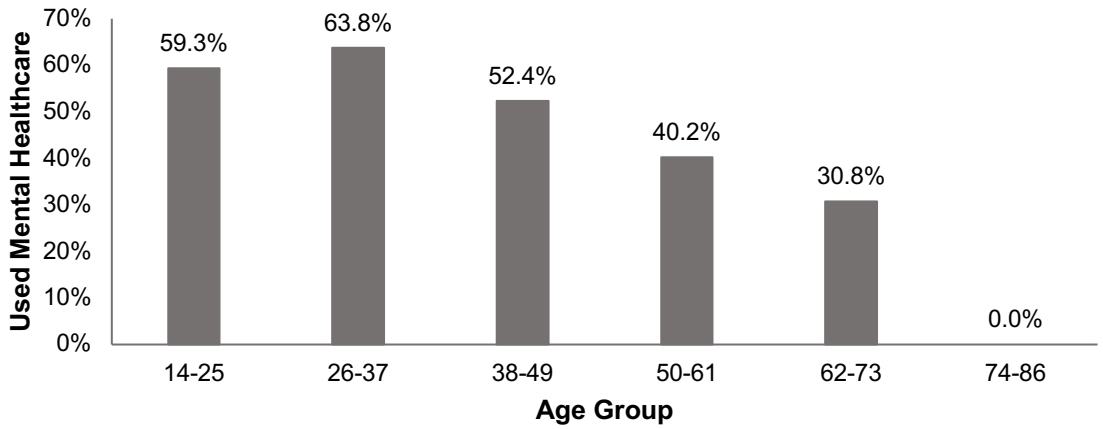
Frequency and Percentage of Access to Different Mental Healthcare Providers in the Last 12 Months

Mental healthcare provider	Use in the last 12 months	
	n	*%*
Any provider	1127	58.1
Private mental health professional or clinic	663	34.2
Trans, rainbow, or takatāpui community service	222	11.4
Crisis mental health team	191	9.8
Community mental health or addictions service	186	9.6
Hospital emergency department or an after-hours medical centre	138	7.1
Other community support services	76	3.9
Other service	67	3.5
Family violence or sexual violence service	65	3.3
School or university service	60	3.1
Hospital ward	42	2.2
Inpatient or residential mental health services	39	2.0
Māori health service	16	.8
Programme in prison or a youth justice centre	3	.2
Pasifika health service	1	.1

Regarding MHC use across age groups, Figure 1 shows the percentage of participants who had used a MHC service in the last year, across different age ranges. Participants aged 14-37 years old were the most likely to have used MHC, whereas participants aged 62-86 were the least likely Welch's t-tests confirmed that participants who had used MHC in the last year (M = 26.89, SD= 10.34) were significantly younger than those who had not (M = 30.01, SD = 14.1); t (1413.51) = 5.35, p <.001). However, the effect size of age on MHC use was small (d = .3).

Figure 1

Percentage of Participants who Used Mental Healthcare by Age Group



In terms of differences in MHC use across other demographic groups, Table 5 presents the chi-square test results for associations between use and ethnicity. Ethnicity groups' rates of use varied only by 8% (between 52%-60%), and these differences were non-significant.

Table 5

Differences in Use of Mental Healthcare in the last 12 Months by Ethnicity

	Had used mental healthcare in the last 12 months	
	n (% [a])	Adj. std. residuals
Ethnicity		
European	877 (59.2)	1.6
Pacific Peoples	16 (53.3)	.6
Asian	78 (59.5)	.3
MELAA	24 (58.5)	.0
Māori	130 (52.0)	-2.1
χ^2 (4) = 4.921, *V* = .05, *p* = .296		

[a] Percentage of demographic sub-group.

Gender/SAAB was significantly associated with MHC use, with a small-to-medium effect size (see Table 6). Specifically, non-binary AFAB participants were significantly more likely to have accessed MHC (see Figure 2 for a visual representation), with the number of them who had used MHC being 6.8 standard errors above what would be expected by chance.

Table 6

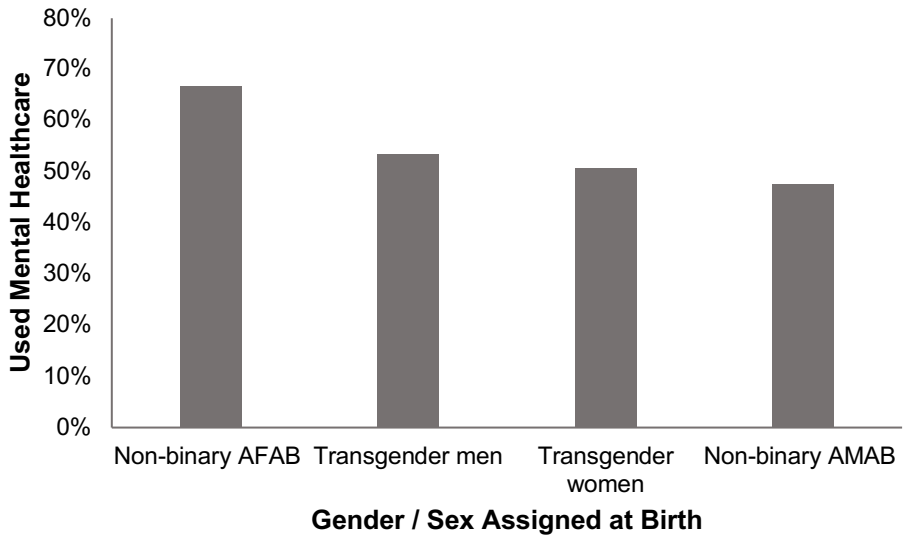
Differences in Use of Mental Healthcare in the last 12 Months by Gender / Sex Assigned at Birth

	Had used mental healthcare in the last 12 months	
	n (% [a])	Adj. std. residuals
Gender/SAAB [b]		
Non-binary AFAB [c]	560 (66.7)	6.8
Transgender men	225 (53.4)	-2.1
Non-binary AMAB [d]	101 (47.6)	-3.2
Transgender women	230 (50.8)	-3.5
	χ^2 (3) = 48.52, *V* = .16, *p* < .001	

[a] Percentage of demographic sub-group. [b] Sex assigned at birth. [c] Assigned female at birth. [d] Assigned male at birth.

Figure 2

Percentage of Participants who Used Mental Healthcare by Gender/ Sex Assigned at Birth



Note. AFAB and AMAB are acronyms referring to assigned male or assigned female at birth.

Satisfaction with MHC

Table 7 presents the frequencies of average satisfaction of all participants with all MHC providers they rated, on a scale ranging from 1 (Very Dissatisfied) to 5 (Very Satisfied). The mean average satisfaction across all participants was 3.73 (*SD* = 1.11), which sits close to the "satisfied" point in the rating scale. Nevertheless, approximately a third of participants presented an average

satisfaction that ranged from 1 (very dissatisfied) to 3 (neither dissatisfied nor satisfied), as shown in Table 7.

Table 7

Frequencies of Average Satisfaction with Mental Healthcare Providers

Average satisfaction with mental healthcare providers [a]	1.0 ≤ x ≤ 2.0	2.0 < x ≤ 3.0	3.0 < x ≤ 4.0	4.0 < x ≤ 5.0
Percentage	12.4	20.8	34.9	31.9

[a] Based on the Five-Point Likert Scale ranging from Very Dissatisfied (1) to Very Satisfied (5)

The average satisfaction with specific MHC providers across participants is shown in Table 8. Rainbow community services, private mental health professionals, other services, and other community services were the highest-ranked providers, with an average satisfaction of over 3.6. The providers that participants were the least satisfied with (with ratings between "dissatisfied" and neutral) were the hospital emergency department, the crisis mental health team, and the hospital ward, with average satisfaction under 2.8. Prison-based services and Pasifika health services were excluded from this table as the number of participants rating them was extremely low (*n* = 3 and *n* = 1, respectively).

Table 8

Average Satisfaction with Different Mental Healthcare Providers

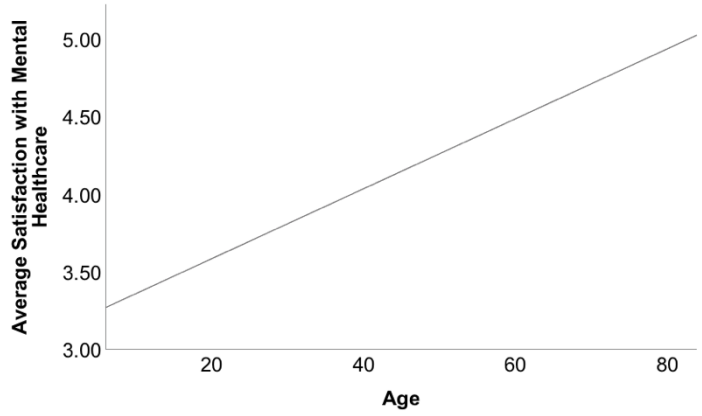
Mental healthcare provider	Average Satisfaction [a]	*SD*
Trans, rainbow, or takatāpui community service	4.26	0.85
Private mental health professional or clinic	4.06	0.99
Other service	3.81	1.26
Other community support services	3.61	1.08
Māori health service	3.56	1.50
Family violence or sexual violence service	3.46	1.37
Inpatient or residential mental health services	3.46	1.10
School or university service	3.42	1.20
Community mental health or addictions service	3.35	1.29
Hospital ward	2.76	1.23
Hospital emergency department or an after-hours medical centre	2.54	1.23
Crisis mental health team	2.39	1.30

[a] Based on the Five-Point Likert Scale ranging from Very Dissatisfied (1) to Very Satisfied (5)

Correlation analyses revealed a weak yet significant positive correlation between age and satisfaction with mental health services ($r = .21$, $p < .001$), meaning that older participants tended to have higher satisfaction than younger ones. Figure 3 includes a regression line representing this relationship.

Figure 3

Regression Line Depicting the Relationship between Age and Average Satisfaction with Mental Healthcare



The differences in average satisfaction with MHC across ethnicity are presented in Table 9. One-way ANOVA results showed that satisfaction across ethnicity groups was not significantly different, with average satisfaction across these varying only by 0.2.

Table 9

Differences in Average Satisfaction with Mental Healthcare by Ethnicity

	Average Satisfaction with Mental Healthcare [a]	
	M	*SD*
Ethnicity		
MELAA	3.97	.99
European	3.73	1.12
Māori	3.73	1.08
Asian	3.70	1.12
Pacific Peoples	3.65	1.01
	F (4, 1075) = .29, η^2 = .001, p = .88	

[a] Based on the Five-Point Likert Scale ranging from Very Dissatisfied (1) to Very Satisfied (5)

Average satisfaction across gender/SAAB groups was significantly different, with a small effect size of gender/SAAB on satisfaction (see Table 10 and Figure 4 for a visual representation). Pairwise comparisons revealed that this was explained by transgender women showing significantly higher levels of satisfaction than transgender men (p = .03), with a 0.3 difference on the five-point scale. All the remaining pairwise comparisons were non-significant (see Table A4 for p-values).

Table 10

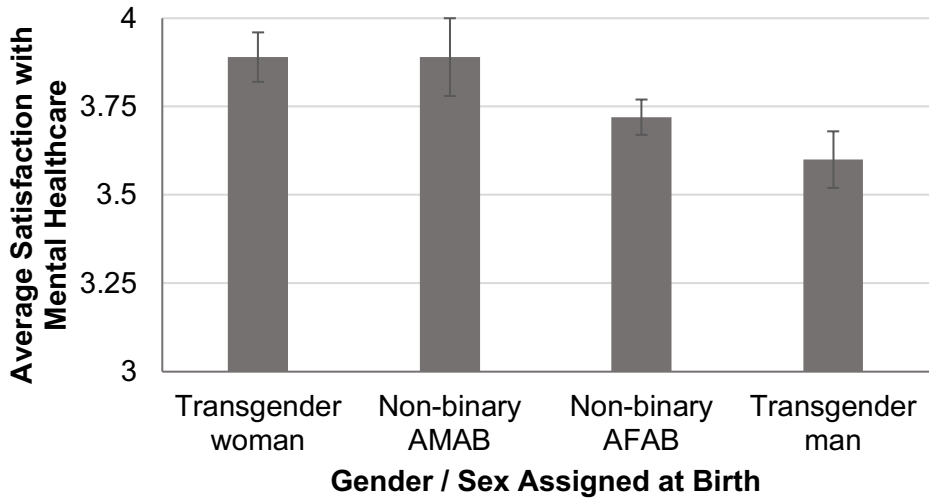
Differences in Average Satisfaction with Mental Healthcare by Gender/ Sex Assigned at Birth

	Average Satisfaction with Mental Healthcare [a]	
	M	*SD*
Gender/SAAB [b]		
Transgender women	3.89	1.11
Non-binary AMAB [c]	3.89	1.04
Non-binary AFAB [d]	3.72	1.08
Transgender men	3.60	1.15
	F (3, 1066) = 3.23, η^2 = .009, p = .022	

[a] Based on the Five-Point Likert Scale ranging from Very Dissatisfied (1) to Very Satisfied (5).
[b] Sex assigned at birth. [c] Assigned female at birth. [d] Assigned male at birth.

Figure 4

Average Satisfaction with Mental Healthcare by Gender / Sex Assigned at Birth



Note. Error bars show standard errors. AFAB and AMAB are acronyms referring to assigned male or assigned female at birth.

Unmet need for MHC

The majority of participants reported an unmet need for MHC in the past year (59.6%), while 36.5% noted that their MHC needs had been met, and 3.9% did not know if their MHC needs had been met. A Welch's ANOVA showed significant age differences in unmet MHC needs, with a small effect size (see Table 11). Pairwise comparisons revealed that participants who had their MHC needs met were significantly older than both participants who had an unmet need (by 5.1 years) and those

who did not know if they had an unmet need (by 7.3 years). There was no statistically significant difference in age between those participants who had an unmet need and those who did not know whether they had an unmet need (see Table A3 for specific *p* values). Figure 5 displays the differences across the three groups.

Table 11

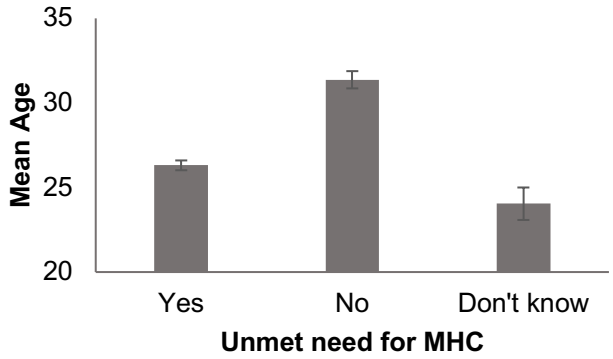
Age Differences of Participants who had an Unmet Need for Mental Healthcare

	Unmet Need for Mental Healthcare								
	Yes		No		Don't know		*F* (2, 224.36)	η^2	*p*
	M	*SD*	*M*	*SD*	*M*	*SD*			
Age	26.31 [a]	10.41	31.37 [a b]	14.03	24.04 [b]	8.63	42.52	.04	<.001

Note. Pairwise comparisons sharing the same superscript letter indicate that they were significantly different at $p < .001$.

Figure 5

Mean Age of Participants Across Different Unmet Need Groups



Note. Error bars show standard errors.

Chi-square test results displaying the associations between unmet need for MHC and ethnicity are presented in Table 12. The relationship between ethnicity and unmet need was non-significant. The unmet need rates for all ethnicity groups varied only by 9%.

Table 12

Differences in Unmet Need for Mental Healthcare by Ethnicity

	Unmet need for mental healthcare					
	Yes		No		Don't know	
	n (%[a])	Adj. std. residuals	*n* (%[a])	Adj. std. residuals	*n* (%[a])	Adj. std. residuals
Ethnicity						
Māori	166 (64.1)	1.5	85 (32.8)	-1.3	8 (3.1)	-.7
Pacific Peoples	21 (67.7)	.9	9 (29)	-.9	1 (3.2)	-.2
MELAA	27 (65.9)	.8	12 (29.3)	-1.0	2 (4.9)	.3
Asian	82 (60.3)	.1	46 (33.8)	-.6	8 (5.9)	1.2
European	922 (58.7)	-1.8	589 (37.5)	1.9	61 (3.9)	-.2
	χ^2 (8) = 6.351, *V* = .04, *p* = .608					

[a] Percentage within demographic group.

On the other hand, small yet significant gender/SAAB differences were found regarding unmet need (see Table 13, and Figure 6 for a visual representation). This was explained by non-binary AFAB participants being more likely, and transgender women being less likely, to have an unmet need for MHC than expected by chance. This difference was especially high for transgender women, with the number of them reporting an unmet need being 4.9 standard errors below the expected by chance.

Table 13

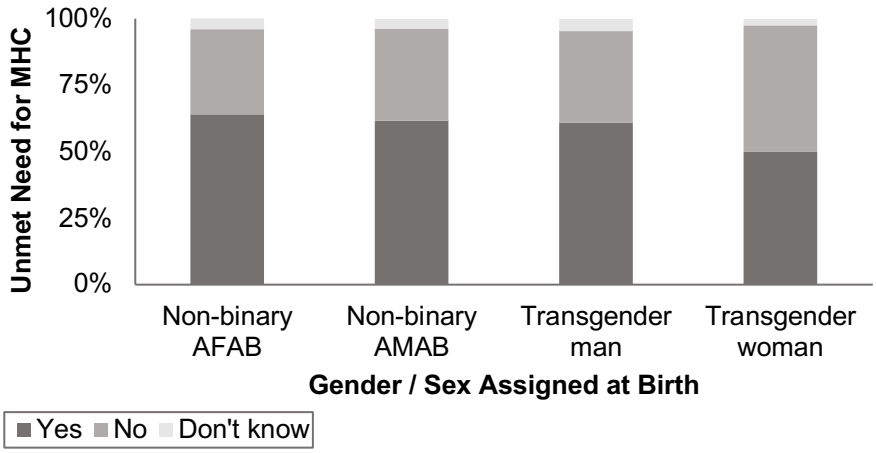
Differences in Unmet Need for Mental Healthcare by Gender / Sex Assigned at Birth

	Unmet need for mental healthcare					
	Yes		No		Don't know	
	n (% [a])	Adj. std. residuals	*n* (% [a])	Adj. std. residuals	*n* (% [a])	Adj. std. residuals
Gender / Sex assigned at birth						
Non-binary AFAB [b]	565 (64.1)	3.4	281 (31.9)	-3.7	36 (4.1)	.6
Non-binary AMAB [c]	138 (61.6)	.6	78 (34.8)	-.5	8 (3.6)	-.2
Transgender men	274 (60.9)	.5	155 (34.4)	-1.0	21 (4.7)	1.1
Transgender women	236 (50.1)	-4.9	223 (47.3)	5.7	12 (2.5)	-1.6
	χ^2 (3) = 34.48, *V* = .09, *p* = < .001					

[a] Percentage of demographic sub-group. [b] Assigned female at birth. [c] Assigned male at birth

Figure 6

Differences in Unmet need for Mental Healthcare by Gender / Sex Assigned at Birth



Note. AFAB and AMAB are acronyms referring to assigned male or assigned female at birth.

Barriers to accessing MHC

Participants experienced the different general barriers to accessing MHC to greatly varying degrees. As presented in Table 14, cost was the most frequent general barrier and the only barrier that was reported by the majority of participants (57%). Cost was reported by 13% more participants than the second most frequent general barrier, which was lacking information on where to go. The third most common was occupied by dissatisfaction with services, reported by 35% of participants. The least frequent general barriers (excluding "other reason") were services not meeting cultural needs and transportation problems (3% and 6% respectively). Concerning trans-specific barriers (also displayed in Table 14), the most frequently reported ones were fear of professionals lacking enough understanding of TNB people, fear that gender identity would be pathologized, and fear of professionals lacking enough understanding of difficult experiences faced by them (reported by 50%-43% of participants). The least frequent ones included fear of other forms of mistreatment, verbal harassment, and how they would be treated by other patients (ranging between 2%-12%).

Table 14

Frequency and Percentage of Barriers Preventing Participants from Accessing Mental Healthcare Last Time They Needed it

Mental Healthcare barrier	*n*	*%*
General barriers		
Costs too much	697	57.4
Unsure where to go or who to see	544	44.8
Not satisfied with available services	427	35.2
Time taken to get an appointment too long	391	32.2
Health professionals unhelpful or unwilling to help	320	26.4
Wanted to handle it alone or with the support of family and friends	315	25.9
Didn't think treatment would work	255	21.0
Couldn’t spare the time	248	20.4
Couldn't get an appointment at a suitable time	224	18.5
Concerned about what others might think	221	18.2
Other reason	109	9.0
Problems with transportation or childcare	76	6.3
Available services did not meet my cultural or language needs	37	3.0
I don’t know	20	1.6
Trans-specific barriers (“Afraid that/of…”)		
Health professionals did not have enough understanding of TNB people	576	50.2
Gender identity would be pathologised	561	48.9
Health professionals did not have enough understanding of the difficult experiences that TNB people face	491	42.8
Misgendering or use of incorrect names	400	34.8
Did not trust them with personal information about me being TNB	305	26.6
How I might be treated by other patients or users for being TNB	133	11.6
Offensive language or verbal harassment for being TNB	132	11.5
Other forms of mistreatment	26	2.3

Table 15 displays the percentage of participants who reported different levels of discomfort discussing their gender identity with a MHC provider, which was an additional trans-specific barrier. Although over half of participants responded they felt comfortable or very comfortable discussing their gender identity, almost a quarter reported they felt uncomfortable or very uncomfortable. The mean score for discomfort discussing gender identity was 2.5 (on the scale from 1 being "Very Comfortable" to 5 being "Very Uncomfortable").

Table 15

Frequencies of Ratings of Comfort Discussing Gender Identity with Mental Healthcare Provider

Discomfort discussing gender identity	*n*	%
Very Comfortable	444	20.2
Comfortable	854	38.9
Neither Comfortable nor uncomfortable	409	18.6
Uncomfortable	348	15.8
Very uncomfortable	143	6.5

Differences across demographic groups were explored for all trans-specific barriers. The age differences between participants who reported different trans-specific barriers versus those who did not are displayed in Table 16. Welch's *t*-tests were conducted to explore age differences across all trans-specific barriers except for fear of mistreatment by other users and fear of other forms of mistreatment (standard *t*-tests were used for these because the homogeneity of variance was met). Results showed that participants who reported barriers were significantly younger than those who did not across most trans-specific barriers, except for fear of other forms of mistreatment and fear of how they might be treated by other patients. The effect sizes for these differences ranged from small to medium, with the mean age of those reporting barriers ranging from 2 to 5 years younger. The strongest effect sizes were from fear of misgendering/use of incorrect names and fear of verbal harassment. Figure 7 depicts significant results from Table 16.

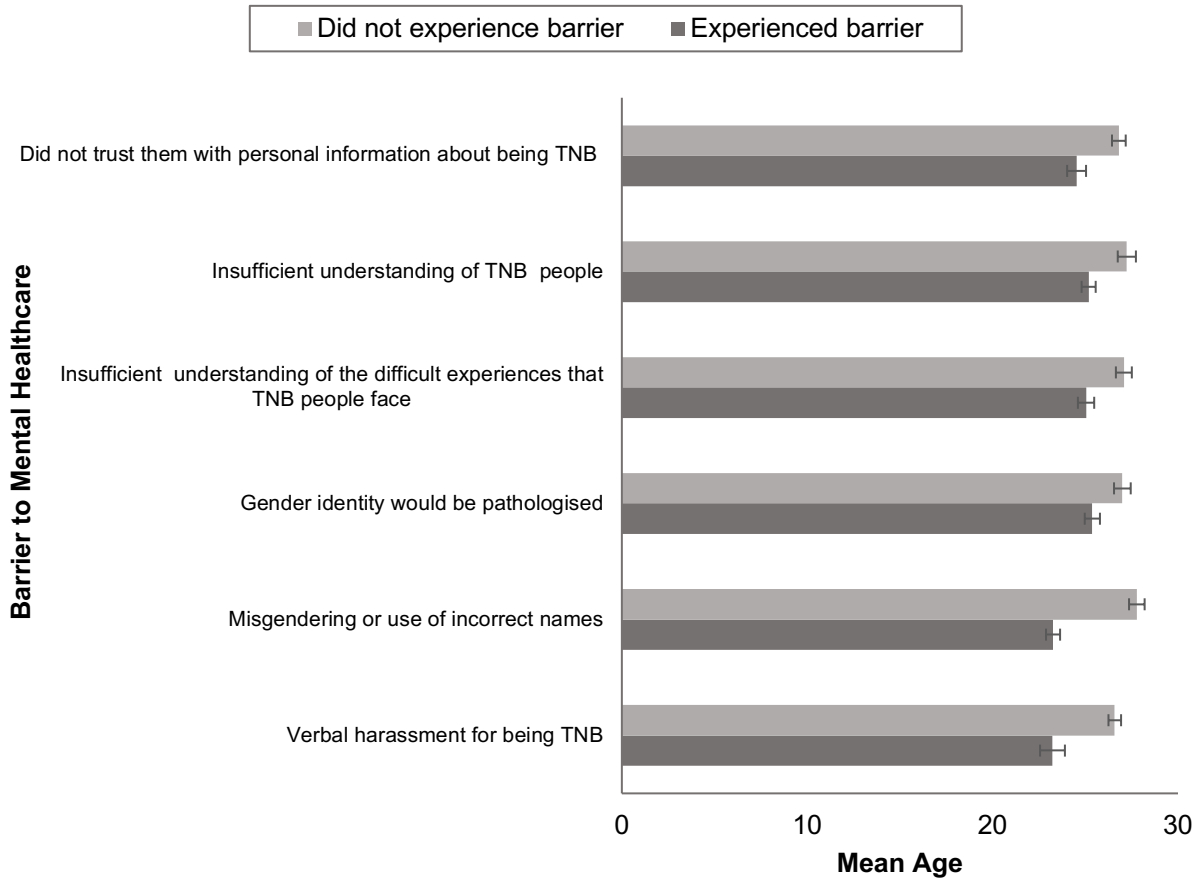
Table 16

Age Differences of Participants who Reported Different Trans-specific Barriers to Mental Healthcare

	Experienced barrier		Did not experience barrier		*t*	df	*p*	Cohen's *d*
Afraid that/of	*M*	*SD*	*M*	*SD*				
Did not trust them with personal information about me being TNB	24.53	8.95	26.81	10.87	-3.59	648.07	<.001	.23
Health professionals did not have enough understanding of TNB people	25.18	9.03	27.24	11.60	-3.36	1077.45	.001	.19
Health professionals did not have enough understanding of the difficult experiences that TNB people face	25.04	9.68	27.08	10.89	-3.34	1112.13	.001	.19
Gender identity would be pathologised	25.38	9.77	27	10.99	-2.65	1140.19	.008	.16
Misgendering or use of incorrect names	23.26	7.61	27.78	11.37	-8.03	1090.06	<.001	.47
Offensive language or verbal harassment for being TNB	23.23	7.65	26.59	10.69	-4.5	204.27	<.001	.36
How I might be treated by other patients or users for being TNB	24.77	9.68	26.39	10.52	-1.68	1146	.092	.16
Other forms of mistreatment	27.73	11.36	26.17	10.42	.75	1146	.452	.14

Figure 7

Significant Age differences of Participants who Reported Different Trans-specific Mental Healthcare Barriers



The result of chi-square tests examining the relationship between ethnicity and trans-specific barriers is presented in Table 17. Significant ethnicity differences were found across the barriers fear of pathologisation and fear of other forms of mistreatment, but not across any other trans-specific barrier. The ethnicity effect for fear of pathologisation was weak, with Māori people being more likely (2.4 *SE*), and MELAA participants being less likely (2.0 *SE*) to report this barrier than is expected by chance (Figure 8 illustrates the differences across ethnicities). The relationship with other forms of mistreatment was moderate, with Asian participants being significantly more likely to report this (8.1 *SD*). “Other forms of mistreatment” was selected by a very small percentage of

participants overall (2%), and participants referred to a wide range of experiences in open-text responses.

Figure 8

Percentages of Participants Reporting Fear of Pathologisation as a Mental Healthcare Barrier Across Ethnicity Groups

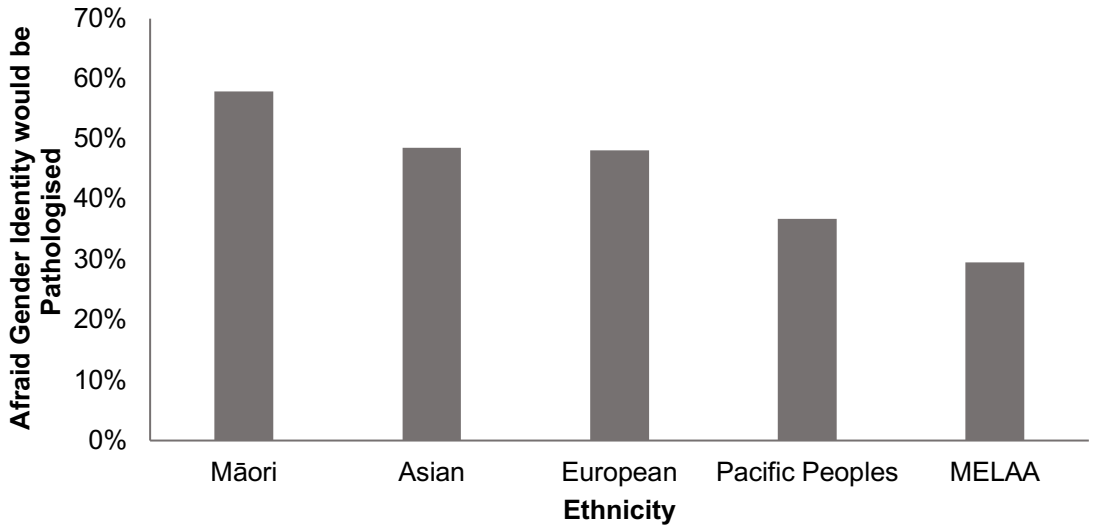


Table 17

Differences in Trans-specific Barriers by Ethnicity

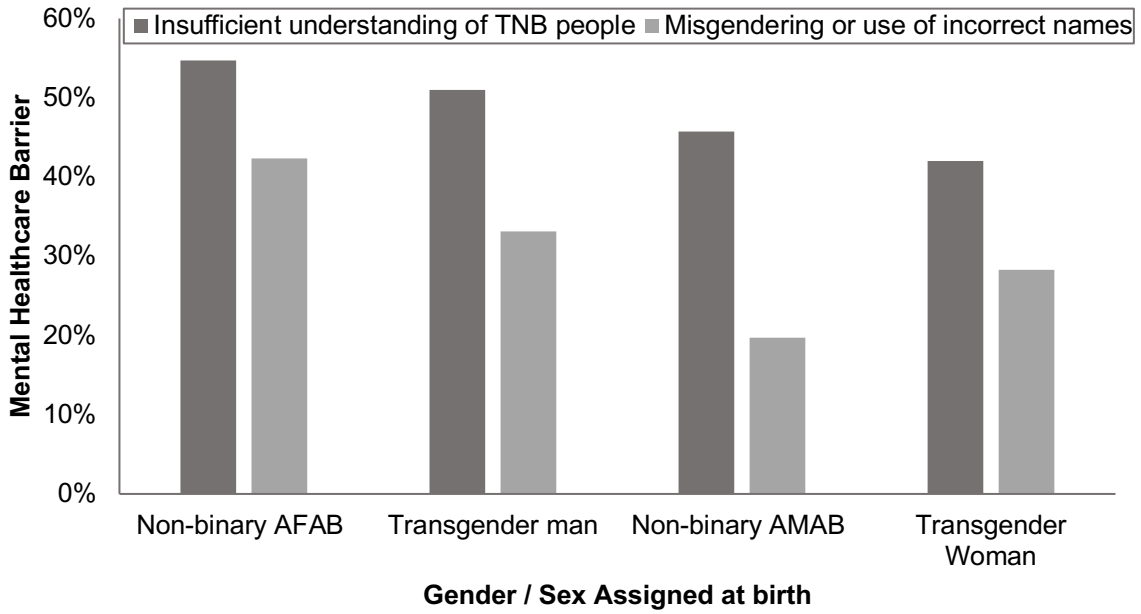
Barrier ("Afraid that/of…")	Ethnicity									
	Māori		Pacific Peoples		Asian		MELAA		European	
	n (%[a])	Adj. std. residuals	*n* (% [a])	Adj. std. residuals	*n* (% [a])	Adj. std. residuals	*n* (% [a])	Adj. std. residuals	*n* (% [a])	Adj. std. residuals
Did not trust them with personal information about me being TNB	48 (30.2)	1.1	7 (36.8)	1	19 (6.3)	-.2	10 (37)	1.3	220 (25.4)	-1.6
	χ^2 (4) = 4.279, *V* = .06, *p* = .370									
Insufficient understanding of TNB people	74 (12.9)	-1	7 (36.8)	-1.2	34 (45.9)	-.7	10 (37)	-1.4	449 (51.8)	2
	χ^2 (4) = 5.483, *V* = .07, *p* = .241									
Insufficient understanding of the difficult experiences that TNB people face	69 (43.4)	-2	9 (47.4)	.4	38 (51.4)	1.6	12 (44.4)	.2	361 (41.6)	-1.2
	χ^2 (4) = 2898, *V* = .05, *p* = .575									
Gender identity would be pathologised	92 (57.9)	2.4	7 (36.8)	-1.1	36 (48.6)	-.1	8 (29.6)	-2	418 (48.2)	-.9
	χ^2 (4) = 10.393, *V* = .10, *p* = .034									
Misgendering or use of incorrect names	60 (37.7)	.8	6 (31.6)	-.3	18 (24.3)	-2	10 (37)	.2	306 (35.3)	.5
	χ^2 (4) = 4.411, *V* = .06, *p* = .353									
Verbal harassment for being TNB	24 (15.1)	1.5	2 (10.5)	-.1	11 (14.9)	.9	3 (11.1)	-.1	92 (10.6)	-1.7
	χ^2 (4) = 3.531, *V* = .06, *p* = .473									
How I might be treated by other patients or users for being TNB	22 (13.8)	.9	2 (10.5)	-.1	7 (9.5)	-.6	5 (18.5)	1.1	97 (11.2)	-.8
	χ^2 (4) = 2.53, *V* =.05, *p* = .639									
Other forms of mistreatment	4 (2.5)	.2	0 (0)	-.7	6 (8.1)	3.5	0 (0)	-.8	16 (1.8)	-1.7
	χ^2 (4) = 13.192, *V* = .11, *p* = .01									

[a] Percentage within ethnicity group.

Gender/SAAB differences across trans-specific barriers are presented in Table 18. Significant differences were found across gender/SAAB groups for two trans-specific barriers, which were fear of MHC professionals lacking enough understanding of TNB people and fear of misgendering/use of incorrect names. The association with the first barrier had a weak effect size, and it was explained by transgender women being less likely, and non-binary AFAB people being more likely, to be afraid of professionals lacking enough understanding of TNB people. The association of gender with fear of misgendering/use of incorrect names had a moderate effect size, with transgender women and non-binary AMAB participants being less likely, and non-binary AFAB participants being more likely to report this barrier (see Figure 9 for an illustration). This significant difference was particularly high for non-binary AFAB participants, with the number of them reporting this barrier being 4.9 standard errors above what would be expected by chance.

Figure 9

Differences in Trans-specific Barriers by Gender / Sex Assigned at Birth, for Barriers Significantly Associated with Gender / Sex Assigned at Birth



Note. AFAB and AMAB are acronyms referring to assigned male or assigned female at birth.

Table 18

Differences in Trans-specific Barriers by Gender / Sex Assigned at Birth

Barrier ("Afraid that/of…")	Gender/ Sex assigned at birth							
	Transgender men		Transgender women		Non-binary AMAB [a]		Non-binary AFAB [b]	
	n (% [c])	Adj. std. residuals	*n* (% [c])	Adj. std. residuals	*n* (% [c])	Adj. std. residuals	*n* (% [c])	Adj. std. residuals
Did not trust them with personal information about me being TNB	72 (27.4)	.3	46 (15.1)	-2.1	31 (24.4)	-.6	155 (29)	1.7
	χ^2 (3) = 5.516, *V* = .07, *p* = .138							
Insufficient understanding of TNB people	134 (51)	.2	92 (42)	-2.8	58 (45.7)	-1.1	292 (54.7)	2.7
	χ^2 (3) = 11.253, *V* = .10, *p* = .010							
Insufficient understanding of the difficult experiences TNB people face	116 (23.6)	.4	93 (42.5)	-.2	44 (34.6)	-2	238 (44.6)	1
	χ^2 (3) = 4.310, *V* =.06, *p* = .230							
Gender identity would be pathologised	131 (49.8)	.3	97 (44.3)	-1.5	54 (42.5)	-1.5	277 (51.9)	1.9
	χ^2 (3) = 5.905, *V* = .07, *p* = .116							
Misgendering or use of incorrect names	87 (33.1)	-.7	62 (28.3)	-2.3	25 (19.7)	-3.8	226 (42.3)	4.9
	χ^2 (3) = 30.414, *V* = .16, *p* < .001							
Offensive language or verbal harassment for being TNB	28 (10.6)	-.5	21 (9.6)	-1	14 (11)	-.2	69 (12.9)	1.4
	χ^2 (3) = 2.052, *V* = .04, *p* = .562							
How I might be treated by other patients or users for being TNB	34 (12.9)	.8	30 (13.7)	1.1	11 (8.7)	-1.1	57 (10.7)	-.9
	χ^2 (3) = 2.917, *V* =.05, *p* = .406							
Other forms of mistreatment	2 (0.8)	-1.9	7 (3.2)	1	4 (3.1)	.7	13(2.4)	.3
	χ^2 (3) = 4.048, *V* = .06, *p* = .256							

[a] Assigned male at birth. [b] Assigned female at birth. [c] Percentage within ethnicity group.

Regarding differences in discomfort in discussing gender identity across demographic groups, age was found to be weakly and significantly associated with this barrier (r = -.08, p <.001). This correlation was negative, meaning that younger participants were more uncomfortable discussing their gender identity with a MHC provider.

Table 19 presents the results of one-way Welch's ANOVAs analysing the differences in discomfort discussing gender identity with a MHC provider by ethnicity. The analysis revealed no significant ethnicity differences in discomfort discussing gender identity, with discomfort levels varying only by .43 points across ethnicity groups.

Table 19

Differences in Discomfort Discussing Gender Identity with Mental Healthcare Provider by Ethnicity

	Discomfort discussing gender identity [a]	
	M	*SD*
Ethnicity		
MELAA	2.88	1.21
Pacific Peoples	2.76	1.21
Māori	2.59	1.28
Asian	2.53	1.19
European	2.45	1.14
	F (4, 135.51) = 2.4, η^2 = .005, p = .053	

[a] Based on the five-point Likert scale ranging from Very Comfortable to Very Uncomfortable.

There was a significant small gender/SAAB effect on discomfort discussing gender identity (see Table 20). Pairwise comparisons revealed that non-binary AFAB participants reported significantly higher levels of discomfort than transgender men and transgender women (0.3 and 0.5 points difference, respectively, on a 5-point Likert scale). In addition, non-binary AMAB participants reported significantly higher levels of discomfort than transgender women (0.3 points difference), and transgender men reported significantly higher levels of discomfort than transgender women (0.2 points difference; see Table A5 for *p*-values). Figure 10 illustrates these gender differences.

Table 20

Differences in Discomfort Discussing Gender Identity with Mental Healthcare Provider by Gender / Sex Assigned at Birth

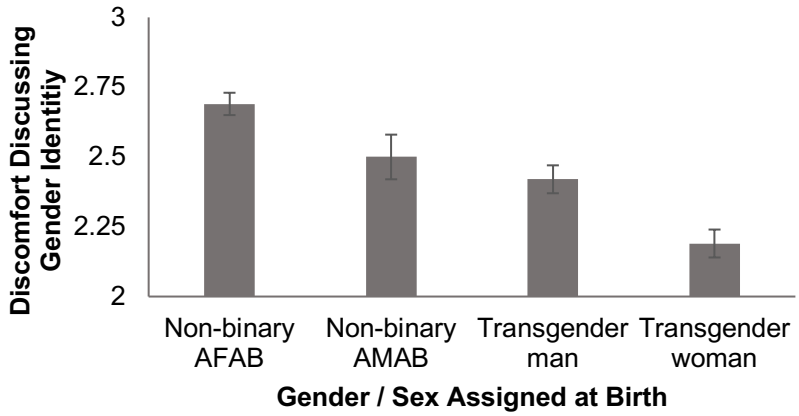
	Discomfort discussing gender identity [a]	
	M	*SD*
Gender/SAAB [b]		
Non-binary AFAB [c]	2.69	1.16
Non-binary AMAB [d]	2.50	1.19
Transgender men	2.42	1.12
Transgender women	2.19	1.14
	F (3, 809.18) = 21.60, η^2 = .029, p < .001	

[a] Based on the five-point Likert scale ranging from Very Comfortable to Very Uncomfortable.

[b] Sex assigned at birth. [c] Assigned female at birth. [d] Assigned male at birth.

Figure 10

Differences in Discomfort Discussing Gender Identity with Mental Healthcare Provider by Gender / Sex Assigned at Birth



Note. AFAB and AMAB are acronyms referring to assigned male or assigned female at birth.

Discussion

This thesis provides new insights into general MHC access for TNB people in Aotearoa/New Zealand as well as gender, ethnicity, and age disparities in MHC access. It examined a wide variety of MHC indicators and it builds on existing knowledge by addressing some literature gaps, including the limited availability of research on MHC for TNB people using larger sample sizes, the unavailability of research on rates of use across different MHC providers, and the scarce literature studying demographic differences in MHC indicators. This thesis also contributes to the emerging research on TNB people's MHC access in Aotearoa/New Zealand, which is currently comprised mainly of one study, offering local insights into the topic. This discussion section will contextualise the findings regarding MHC utilisation rates, satisfaction levels, unmet need, and barriers to accessing care within the wider research literature. It will first discuss findings from the general sample, and then the differences across demographic groups, as well as identifying some implications, limitations and future directions within each sub-section.

General findings

Use of MHC

The majority of participants (58%) had used MHC services in the last year, which is consistent with the high mental health disparities reported in international and Aotearoa/New Zealand research with TNB people (e.g., Fredriksen Goldsen et al., 2022; Tan, Ellis, et al., 2020). There are few other studies on MHC service utilisation, but existing data also suggests similarly high rates of MHC use for TNB people, as reported by Ellis et al. (2015) in the UK and Lombardi (2007) in the US. However, this thesis found a similar rate of use for a much shorter timeframe than the cited studies (one year vs lifetime), and a considerably higher rate than the previous study using the same timeframe (37%, Shipherd et al., 2010). These differences might be due to the mean age of participants in this thesis being younger than in some of these studies (*M* = 36 in Lombardi, 2007; *M* = 49 in Shipherd et al., 2010), with younger TNB presenting higher rates of MHC use in this study. The differences may also be related to variations across countries, recruitment strategies (Shipherd

et al. [2010] recruited participants at a conference), or MHC settings studied (Lombardi [2007] focused on substance use problems using a clinical sample). Another likely explanation is the different gender-identity-related MHC services excluded, as Ellis (2015) excluded MHC for medical transition, Shipherd et al. (2010) excluded gender identity counselling, whereas this study excluded MHC for any gender-affirming care purpose. Sampling bias may also be contributing to this difference, specifically, the over-representation of younger TNB people and non-binary people in this study. As mentioned in the method section, this study's sample had higher percentages of those demographic groups than those found for TNB people in Aotearoa/New Zealand population surveys (Stats NZ, 2022). Younger participants and non-binary AFAB participants were significantly more likely to use MHC than other groups (as discussed later), meaning that the overall rate of use might have been increased by the over-representation of these groups. Over-sampling of younger people may be due to this group being more likely to be reached by our social media recruitment strategies and have more familiarity with digital platforms, which may also partially account for the over-sampling of non-binary participants, as these were significantly younger than transgender women (but not transgender men). The greater participation of non-binary AFAB participants in research has been observed in other studies (Goldberg et al., 2019).

Concerning the high rate of MHC use found in this study, research in other countries has also found that the rate of MHC use among TNB people is significantly higher than that of cisgender people (Bartholomew et al., 2019; Klein et al., 2020) and that of people from sexual minorities (Simeonov et al., 2015). This disparity is likely to also be present in Aotearoa/New Zealand, as data from the New Zealand Health Survey 2021/2022 indicate that only 12.9% of the general population had consulted a nurse/GP about mental health, and 6.9% a psychologist/counsellor/psychotherapist in the last 12 months (Ministry of Health, 2022), which, combined, are considerably lower than the percentage found in this thesis (21% vs 58%). Considering the high rates of MHC use, and the potential impact of MHC on ameliorating existing MHC disparities (WHO, n.d.), it is crucial to

regulate and ensure that MHC services are well-suited for TNB people and that existing barriers reported in this thesis are diminished.

Regarding MHC use by providers, the most frequently accessed providers by a significant margin were private providers (34%), followed by trans/rainbow community services (11%). Based on the systematic searches of the literature described in the introduction, this is the first study describing TNB people's rates of MHC use for specific providers. Utilising these providers (private providers and rainbow community services) might be a strategy to avoid discriminatory interactions with providers who lack competence or other negative experiences, which are frequently reported barriers (Snow et al., 2019). Public options (like community MH services) might expose TNB individuals to more inconsistent experiences or a higher risk of encountering these barriers, while private options offer higher control and choice, as reflected in the satisfaction rates discussed later. Trans and rainbow community services may provide a safer and more knowledgeable option for TNB people seeking MHC (Cahill, 2015; Haworth et al., 2023). In addition, access to public secondary MHC services (like community mental health and addiction services) in Aotearoa/New Zealand is restricted for individuals with the most severe mental health needs, approximately the top 3% (Government Inquiry into Mental Health and Addiction, 2018, p. 105), making it very difficult to access them for both TNB people and the general population. TNB may also have fears of being diagnosed with severe mental health difficulties as this might prevent them from receiving gender-affirming care. This is due to severe mental health problems potentially being perceived as a barrier to the capability of making gender-affirming healthcare decisions (Carroll et al., 2023), translating into an additional barrier to seeking these services.

The least frequently used providers (excluding prison-based services) were Pasifika health services (0.1%), Māori health services (0.8%), and residential MH services (2%). The low rate of use of Pasifika services might be related to the low percentage of Pasifika participants (2%). The rate of use of Māori services might be related to a lower availability of Kaupapa Māori providers compared to mainstream services, reflected in the substantially lower public funding given to these nationwide

and the call for more of these services by Māori (Te Hiringa Mahara, Mental Health and Wellbeing Commission 2023, p.22). The rates of use of residential services may reflect that this type of MHC is part of tertiary care, that is, care intended for an even more reduced group than those accessing secondary MHC services (as noted before). Comparisons to the use of these services by the general population are needed to make further conclusions.

Satisfaction with MHC

The average satisfaction participants reported with MHC was relatively high, sitting close to the "satisfied" point on a 5-point Likert scale. Considering the high use of private providers and rainbow services, which were the providers that participants were the most satisfied with on average (as discussed later in this section), the relatively high overall satisfaction might be more representative of these providers than providers more generally. This interpretation is strengthened by the high rates of trans-specific barriers and unmet needs reported in this thesis.

Furthermore, a considerable percentage of participants (33%) rated their satisfaction with MHC providers as neutral, "dissatisfied", or "very dissatisfied". These rates of satisfaction are similar to those reported by rainbow youth participants in Aotearoa/New Zealand (Fraser et al., 2022). This replicates findings in the UK and the US from Hunt (2014), Ellis et al. (2015), and Lehavot et al. (2017), which included 31-34% of their participants being slightly satisfied, dissatisfied, or very dissatisfied with MHC. This thesis' findings provide stronger evidence of generalisation as it utilised a larger sample size than said studies. These findings show that, even though TNB participants are generally satisfied with the MHC they receive, there is a significant portion of them that is unsure or dissatisfied with these services. The overall satisfaction of participants may be biased negatively by the overrepresentation of younger people (who were significantly more satisfied with MHC) but simultaneously biased positively by the underrepresentation of transgender men (who were significantly less satisfied with MHC), which complicates making interpretations. Despite this, previous research in Aotearoa/New Zealand has shown that TNB youth experience significantly more discomfort in MHC settings than non-TNB rainbow youth (Fraser et al., 2022). Once again, it would

be useful for future research to compare the satisfaction with MHC reported by TNB people to that of the general population to make stronger conclusions.

Regarding differences in satisfaction across different MHC providers, those which presented the highest satisfaction rankings were rainbow community services, private mental health professionals, and other community services (with average satisfaction ranging from 3.81 to 4.26), while the lowest ones were the hospital emergency department, the crisis mental health team, and hospital wards (with average satisfaction ranging from 2.39 to 2.76). This is similar to findings from Counting Ourselves 2018, as the same three MHC providers were the ones participants were least satisfied with (Veale et al., 2019). No additional studies had reported different rates of satisfaction of TNB people with specific MHC settings. These findings indicate that TNB people in Aotearoa/New Zealand are the least satisfied with public emergency/hospital services and the most satisfied with community services and private providers. This is consistent with previous studies showing that TNB people experience a higher degree of negative experiences in emergency rooms and hospitals, such as negative reactions and harassment (Allison et al., 2021; Grant et al., 2011). This may be explained by these settings exposing TNB people to unfamiliar providers who are more likely to be uneducated about TNB people or unfamiliar with determining when gender is relevant to the provision of care.

Interestingly, residential services were not among the providers that participants were the least satisfied with, as previous research has highlighted additional unsupportiveness barriers TNB people might face in the context of inpatient mental health services or residential addictions services (Acosta et al., 2019; Lombardi, 2007; Lyons et al., 2015). This might be related to the low percentage of participants who responded they had accessed them (2%). Nevertheless, satisfaction with these was still below the average satisfaction with all providers. Research making a bigger effort to specifically recruit TNB people who accessed these types of services and understand what contributes to satisfaction with service provision could fill this gap.

Unmet need for MHC

The rate of unmet need for MHC of participants was 59.6%, showing that during the last year, the majority of participants had experienced at least one instance of not accessing MHC even though they needed it. This rate is similar to the ones found in international research with TNB people (Shipherd et al., 2010; Simeonov et al., 2015), but it might have been inflated due to the over-representation of younger people and non-binary people in the sample, who were more likely to report an unmet need for MHC than other groups. Despite this, the rate is approximately seven times higher than the unmet need rate of the general Aotearoa/New Zealand population in 2021/2022 (8.8%) (Ministry of Health, 2022), which is a substantial gap that suggests an important disparity in terms of being able to receive MHC when needed. Results from Youth'19 also reveal that TNB adolescents in Aotearoa/New Zealand are two times as likely to report an unmet need for general healthcare than cisgender peers (Fenaughty et al., 2023). Additional local research has also found that, among rainbow youth, TNB people experience significantly more difficulty accessing MHC than cisgender peers (Fraser et al., 2022). This might be related to the higher rates of general barriers TNB people experience, as well as the considerable rates of trans-specific barriers (addressed later). This substantial disparity suggests an important gap that needs to be addressed within the MHC system, including identifying barriers that perpetuate this unmet need and reducing these so as to make MHC more approachable and suitable for the TNB community.

Barriers to accessing MHC

With respect to general MHC barriers experienced by participants, cost was the most frequently reported barrier by a large gap, being reported by the majority of participants (57%). It is noteworthy that cost was the most prevalent barrier across all barriers analysed in this study, which has also been the most commonly reported barrier in studies in the US and the UK (Lehavot et al., 2017; Shipherd et al., 2010). Contrastingly, research in Canada reports this barrier at a much lower rate (13.2%) (Simeonov et al., 2015), which may be due to different provisions of services across the two countries. Participants reporting this barrier may be referring to the cost of taking leave from

work, the costs of transport, or the cost of accessing private providers, with the latter being a common barrier reported by participants in Counting Ourselves 2018 (Tan et al., 2021). The cost of private providers is a likely explanation, as these were the most frequently accessed providers by participants in this thesis. Private options might be sought due to the limited availability and long wait times of public MHC services (Government Inquiry into Mental Health and Addiction, 2018), and the higher satisfaction that participants report with private providers (which might reflect that carefully chosen private providers are more supportive and competent). This suggests that for TNB people cost may be a more significant barrier than for cisgender people, due to the increased negative consequences of not being able to choose a private provider, such as the lack of provider competence and mistreatment experiences (discussed later). Data from the New Zealand Health Survey 2016/2017 supports this, as only 1.9% of the general population experienced cost as a barrier to MHC. Even though this data is from several years earlier, it raises a large disparity, which may be partially explained by the increased mental health needs of TNB people (due to existing inequities), This disparity is also present in general healthcare, as Youth'19 results reveal that TNB students in Aotearoa/New Zealand were approximately three times as likely to report cost as a barrier to general healthcare than cisgender peers (Fenaughty et al., 2023). This is consistent with the study by Simeonov and colleagues (2015), which found that TNB people experienced affordability as a barrier to MHC to a greater degree than cisgender participants. This raises the issue of existing MHC barriers, alongside mental health disparities, placing a higher financial burden on TNB people, which is concerning considering that financial barriers may be increased even further by existing social and structural disadvantages that TNB people face (Holt et al., 2023).

The second most common barrier reported by participants was lacking information about available services (45%). This barrier also ranked second in the study by Simeonov et al. (2015). TNB people might experience this barrier to a more significant effect due to the importance of finding trans-friendly MHC providers to avoid a lack of competency or negative experiences. Previous research has indicated that TNB people rely to a great extent on recommendations from other TNB

individuals and non-official channels to find this information (Fitzpatrick, 2023; Vupputuri et al., 2021). In contrast, general population estimates for Aotearoa/New Zealand from 2016/2017 indicate that only 1.4% experienced lack of information as a barrier to MHC. Future research could use more recent general population estimates to determine existing disparities between TNB people and cisgender people regarding this MHC barrier. Concerning general healthcare, more recent estimates indicate that TNB students in Aotearoa/New Zealand were two times as likely to report lack of information as a barrier to general healthcare than cisgender peers (Fenaughty et al., 2023). This significant disparity underscores the need for improved information dissemination about available MHC providers who are knowledgeable about TNB people.

Concerning trans-specific barriers, the majority of participants were comfortable or very comfortable discussing their TNB identity with their MHC provider, with an average discomfort score (2.5 on a five-point scale) consistent with the average score from rainbow participants in Aotearoa/New Zealand research regarding comfort discussing their gender with new MHC providers (although this score may have been positively biased by the inclusion of cisgender rainbow participants; Fraser et al., 2022). Nevertheless, a substantial percentage reported feeling uncomfortable or very uncomfortable (22%). This finding aligns with confidentiality concerns being one of the most common barriers reported by TNB people in a study in China by She and colleagues (2021), however, participants in that study were sex workers and the cultural context may imply different levels of acceptance of TNB people. Discomfort talking about gender identity with providers, across TNB people in general, might be related to the fear of encountering trans-specific barriers after sharing their gender identity, or the fear of being denied healthcare services, which has been a common issue reported in previous research (Lerner & Robles, 2017).

Two of the most common trans-specific barriers reported by participants were the fear that MHC providers would have insufficient knowledge about TNB people (50%) and would have insufficient knowledge of the negative experiences faced by TNB people (43%). Qualitative data from Counting Ourselves 2018 also indicated that providers lacking knowledge of TNB people was a

barrier to MHC (Tan et al., 2021), while research with rainbow people more generally has also confirmed they perceived MHC providers lacked knowledge about sexuality and gender diversity (Fraser et al., 2022). Low provider knowledge has also been found to be a widespread barrier to general healthcare in another Aotearoa/New Zealand study with TNB participants (Withey-Rila et al., 2023). Similarly, a lack of knowledge about TNB people and the social stressors they face appears to be the most commonly reported in international research with TNB clients (Panchal et al., 2021; Snow et al., 2019). Previous research has also found that TNB people experience unavailability of care to a higher degree than cisgender people (Simeonov et al., 2015). The literature, then, substantiates fears raised by participants in this thesis, as they reveal that experiences of insufficient provider competence are common. This is a concerning phenomenon, as these gaps in MHC providers' knowledge are typically accompanied by negatively biased attitudes and cisnormative expectations that are applied to TNB clients (Benson, 2013; Duffy et al., 2016; Ellis et al., 2015; Mizock & Lundquist, 2016).

One of these negative attitudes is pathologisation, which refers to providers treating gender-diverse identities as mental health problems or illnesses, or as the cause of these problems. Fear of experiencing pathologisation was the second most commonly reported trans-specific barrier by participants (49%). Over-focusing on or blaming sexuality or gender identity for difficulties, has also been reported as a negative experience by 25% and 21% of a sample of rainbow participants in Aotearoa/New Zealand research (Fraser et al., 2022). The percentage in this study may be higher due to Fraser and colleagues' study focusing on experiences, whereas this study focused on fears, as well as Fraser and colleagues studying a wider rainbow population. Fear of pathologisation was also the most frequent worry among participants in Ellis and colleagues' (2015) research and has been a frequent theme in previous qualitative studies (Goldberg et al., 2019; Mizock & Lundquist, 2016). It has been reported to negatively affect TNB clients' self-perception (Mizock & Lundquist, 2016), sometimes leading providers to attempt to change a TNB client's gender identity, viewing it as a pathology (Elder, 2016; Fitzpatrick, 2023; Tan et al., 2021).

Fear of misgendering or use of incorrect names was also reported by a significant percentage of participants (35%). Participants in other studies have reported experiences of misgendering that they perceived as invalidating (Acosta et al., 2019; McCullough et al., 2017). These studies employed qualitative methods, and a systematic search of the literature could not uncover any other research to report quantitative findings on this specific barrier in general MHC settings.

Fear of verbal harassment was not among the most frequently reported barriers, but it was still reported by a notable portion of participants (12%), indicating that these experiences are not entirely rare. This percentage is consistent with 15% of rainbow participants in Fraser and colleagues' research (2022) reporting MHC providers making hurtful comments about their identity. The percentage found in this thesis was lower than in research by Lehavot and colleagues (2017) in the US and She and colleagues (2021) in China. This difference might be explained by the settings of these two studies, which may increase the risk of discrimination, as the samples were war veterans (Lehavot et al., 2017) or sex workers (She et al., 2022). Previous research has highlighted that harassment in MHC settings can also be expressed through non-verbal language and microaggressions (McCullough et al., 2017), which may sometimes be unintentional and caused by a lack of training (Britt-Thomas et al., 2023). These behaviours were not covered in this research; thus, it would be beneficial for future surveys to incorporate specific questions about such behaviours, accompanied by illustrative examples. For example, Fraser and colleagues (2022) asked about MHC providers showing signs of discomfort when TNB patients disclosed their identity. This approach recognises the potential difficulty participants may face in identifying these subtler forms of harassment. Conducting interviews may also provide a more comprehensive insight into microaggressions, as it allows interviewers to pose follow-up questions, allowing interviewees to elaborate and offer additional details about their experiences of mistreatment (McCullough et al., 2017).

It is noteworthy that the rates of trans-specific barriers might have been inflated due to the over-representation of younger people and non-binary people, which were groups who were significantly more likely to report some of these barriers.

Several implications arise from the findings concerning barriers to accessing MHC. Fear of insufficient knowledge, pathologisation, offensive attitudes, and misgendering are barriers experienced to a high degree by TNB people in Aotearoa/New Zealand. This is consistent with previous research on anticipation of negative experiences as barriers to MHC for TNB people, which prevents them from seeking MHC or engaging with it (De Vries et al., 2023; Holt et al., 2023; Lyons et al., 2015; She et al., 2022; Snow et al., 2019). Counting Ourselves 2018 found that these fears (lack of knowledge, misgendering, insulting language) were indeed experienced frequently by participants when accessing general healthcare (17%-46% had ever experienced this) (Veale et al., 2019), substantiating participants' fears. These barriers can result in a culturally unsafe and invalidating environment for TNB clients (Curtis et al., 2019), which violates TNB people's right to adequate healthcare and to be treated with respect and dignity, rights established in Aotearoa/New Zealand (Health and Disability Commissioner Act 1994). Appropriate healthcare is also essential to protect TNB people's right to health, which is the universal right to achieve one's full physical and psychological potential, regardless of one's demographic characteristics (Whitehead & Dahlgren, 2007).

Addressing this issue may involve increasing education on TNB people and transgender health in the training programs of MHC professionals and staff. Research with medical school staff from Aotearoa/New Zealand suggests that increasing content on TNB people is considered important by course convenors, but they perceive barriers such as time restrictions and relevance to the subject they are teaching (Treharne et al., 2022). Carroll and Gray (2021) have suggested that content on gender diversity can be integrated into all aspects of medical training rather than in stand-alone sessions, by incorporating TNB clients into practice clinical cases, to normalise TNB clients as a standard part of routine care. This can also be incorporated into the training of other

MHC professionals such as clinical psychologists and counsellors. International research suggests that, even when TNB training for MHC providers may be more widely available, it may still be very varied and possibly inconsistent in quality (Obasi et al., 2023) calling for more uniform educational curriculum at base-level training in educational institutions or across employment training opportunities offered by employers. Training for MHC providers and staff should also include the development of reflective skills to identify personal biases and harmful attitudes that they might hold towards TNB people, which contribute to disrespectful behaviour, as per the broader principle of cultural safety in healthcare (Curtis et al., 2019). Research has shown that training increases professionals' confidence in working with TNB people (Burgwal et al., 2021). In addition to increased training, some routine procedures can be incorporated into MHC settings so as to avoid these barriers, such as routinely asking for patients' pronouns at the intake (M.E. Eisenberg et al., 2020), creating a welcoming physical environment, and ensuring correct documentation of names/pronouns/gender, as well as accurate communication of this information other providers (Britt-Thomas et al., 2023).

Age differences

Concerning age differences in MHC use, participants aged between 26 and 37 were the most likely to have used MHC, and participants who had used MHC in the last year were, on average, significantly younger than those who did not (but only by 3 years). This is the first evidence regarding age differences in MHC use for TNB people, based on the literature review carried out for this thesis. This may be explained by younger TNB people having a higher need for MHC due to increased mental health problems, which is supported by data from Counting Ourselves 2018 (Veale et al., 2019, p.43) and international studies (Hyde et al., 2014, p. 18; James et al., 2016, p.106; Navarro, Johnston, et al., 2021, p. 5). In addition, younger TNB people may have a higher urgency to address MHC problems to access gender-affirming care for the first time. Furthermore, this finding is also consistent with evidence of younger people being more likely to utilize MHC in the general population (e.g., Robb et al., 2003), which may be partially explained by younger generations having

more positive beliefs regarding mental health treatments and reduced stigma regarding MHC problems (Farrer et al., 2008; Jang et al., 2009; Robb et al., 2003).

As for satisfaction with MHC, there was a significant weak positive correlation between age and satisfaction, showing that satisfaction increased with age among participants. This is consistent with Counting Ourselves 2018 findings, including adult participants being significantly more satisfied with some MHC services than youth participants (Veale et al., 2019). This was slightly different from the finding from Lehavot et al. (2017), who found that TNB people aged 35-60 were the most satisfied with MHC. However, this study was set in a more specific setting (veteran care in the US) and still shared the finding of younger people being less satisfied than those in their middle adulthood. Furthermore, the differences found by Lehavot et al. (2017) were not significant after controlling for other variables. Younger people also appear to report lower satisfaction with MHC in the general population (e.g. Blenkiron & Hammill, 2003). As proposed by Blenkiron and Hammill (2003), an additional explanation for this is that younger people may have higher expectations for MHC and are less reluctant to complain about it. This means that they evaluate their providers to higher standards and are more critical of inappropriate or inadequate practices, resulting in lower reported satisfaction levels.

Regarding unmet need for MHC, participants who had an unmet need were significantly younger than those who did not, although the average difference was small (5.1 years). This is consistent with research from the US indicating that younger TNB individuals are more likely to delay accessing MHC (Lehavot et al., 2017), however, this relationship was not significant when controlling for other variables. Younger people being more likely to use MHC is a pattern that is also present in the general population, both in Aotearoa/New Zealand (Ministry of Health, 2022) and in international research (Lopes et al., 2016). The first version of the Counting Ourselves survey also found that youth participants (14-25 years old) presented higher rates of postponement of general healthcare (Veale et al., 2019). This may be explained by young people possibly experiencing increased cost barriers to MHC due to a lower income and relying on their guardians' income. In

addition, the findings discussed later suggest that young TNB people experience additional trans-specific barriers, such as increased fear of verbal mistreatment or fear of insufficient provider knowledge, contributing to their unmet need for MHC. Moreover, older TNB people have possibly had more time and opportunities to try different providers and find suitable MHC.

Regarding trans-specific barriers, age was significantly and negatively correlated with discomfort discussing being TNB with an MHC provider; that is, younger participants were more uncomfortable doing this than older participants. In addition, younger participants were significantly more likely to report most trans-specific barriers to MHC, with the strongest differences found for the barriers fear of misgendering/use of incorrect names and fear of verbal harassment. Previous international research has also suggested that younger TNB people experience negative experiences to a higher degree than older ones when accessing MHC (James et al., 2016). This is also consistent with Counting Ourselves 2018 youth participants being more likely to have certain negative experiences with a general healthcare provider (e.g. provider discouraging them from exploring their gender and telling them they were not TNB) suggesting that young TNB people in Aotearoa/New Zealand are also more likely to experience barriers in general healthcare. Younger age usually means a larger age difference between provider and patient, which may act as an additional barrier for youth TNB patients. Furthermore, the larger age difference might make the power dynamics inherent to the provider-patient relationship more pronounced, increasing the risk of misuse of power by the provider (Goodyear-Smith & Buetow, 2001).

The striking age differences in experienced barriers might explain why younger people present higher rates of unmet needs and lower satisfaction with MHC. This may be compounded by younger people having higher standards for MHC (Blenkiron & Hammill, 2003), with young TNB people possibly having higher standards for both general MHC competence and trans-specific competence. At the same time, younger TNB people's higher use of MHC might reflect that they have a higher need for MHC but are also more aware of mental health issues and more actively engaged with MHC. These findings suggest that among TNB people, this demographic group requires

further efforts from policymakers to address the barriers experienced, by putting a particular focus on working with TNB youth when providing education about TNB people to MHC providers. This should include educating providers to create a safe space when working with TNB youth, which is particularly important due to their increased vulnerability and the potentially increased negative impacts that harmful MHC experiences may have. Special focus should be put on avoiding harmful behaviours which participants in this thesis reported being fearful of, such as offensive verbal statements or incorrect names/pronouns, as well as providers keeping up-to-date with TNB terms and language, which is particularly important in younger generations.

On the other hand, age-difference findings may need to be taken with caution in the absence of analyses statistically controlling for other demographic variables, as research from Lehavot and colleagues (2017) suggest that may be not significantly associated with some MHC indicators when controlling for other demographic variables. Nevertheless, this study was conducted, once again, in a very specific setting (veteran care) and may not be representative of the general MHC experiences of TNB people.

Ethnicity differences

There were no significant differences across ethnicity groups for rates of MHC use, with rates of use varying only by 8% across ethnicity groups. This is consistent with Counting Ourselves 2018 researchers finding no ethnicity differences in psychological distress among TNB people (Veale et al., 2019; p. 46), suggesting no differential need for MHC. This contrasts with Māori in the general population being significantly more likely (45%) to present high psychological distress, and 10% to 20% less likely to have consulted MHC providers than non-Māori people (Ministry of Health, 2023), which is usually explained by evidence of under-assessment/under-treatment and lower likelihood to access MHC for Māori people (Baxter et al., 2006; Theodore, 2022). This thesis' findings suggest that the decreased rate of MHC use for Māori people found in the general population may not be present in the TNB population.

Average satisfaction with MHC was also not significantly different across ethnicity groups, with variations of up to 0.2 points on a 5-point Likert scale. Only one previous study has analysed this topic (Lehavot and colleagues, 2017), which found significant ethnicity differences in dissatisfaction with MHC, but these were not significant after controlling for other variables. This thesis' finding is unexpected considering non-Māori and non-Pasifika MHC services (which were the most commonly used providers in this thesis) use Western models that are usually not culturally responsive to them, as well as the insufficient Māori and Pasifika mental health workforce (Government Inquiry into Mental Health and Addiction, 2018). These would suggest that Māori and Pasifika people (TNB or cisgender) would be less satisfied with MHC. The lack of significant ethnicity differences on satisfaction may be explained by Māori and Pasifika participants being more likely to access Māori or Pasifika MHC providers. The type of provider most commonly used by each ethnicity group was not a question examined by this thesis, and may be addressed by future studies to complement these findings.

No significant differences were found across ethnicity groups regarding rates of unmet need, with all groups sitting between 59% and 68%. This is in line with Lehavot et al. (2017) finding no significant differences in delaying MHC across ethnicity groups, which is the only study analysing ethnicity differences on unmet need, based on systematic searches of the literature. Nevertheless, Lehavot et al.'s study was set in a different cultural context, with different ethnic groups. This thesis' finding contrasts with Asian and Pacific peoples in the general Aotearoa/New Zealand population being significantly less likely to present an unmet need for MHC (Ministry of Health, 2023), as well as evidence of under-treatment and under-assessment for Māori people (Theodore, 2022) and higher likelihood to experience one of the trans-specific barriers measured in this study. A possibility is that because the rate of unmet needs for MHC is already very high among TNB people, ethnicity does not influence the risk of having an unmet need.

With respect to trans-specific barriers, there were small to moderate significant differences across ethnicity groups in reporting fear of other forms of mistreatment and fear of pathologisation.

"Other forms of mistreatment" was selected by only 2% of participants overall, and participants referred to a wide range of experiences in open-text responses specifying which forms of mistreatment these were, limiting interpretations of ethnic differences. This may be explored in the future through qualitative analysis of these responses. The significant differences across fear of pathologisation were explained by Māori participants being more likely to report fear of pathologisation. This is consistent with Māori rainbow participants presenting significantly more worries in MHC settings in Aotearoa/New Zealand research (Fraser et al., 2022). This may be accounted for by most MHC services utilizing mainstream models of mental health and gender diversity that do not align well with Māori understandings of these topics (Harris, 2014; Kerekere, 2017). This can make it more likely for practitioners to pathologise Māori beliefs or practices, including their gender identity and expressions. Having experienced stigmatisation regarding their ethnicity, and being a minority group within a minority group, might also make Māori participants more likely to anticipate pathologisation concerning their gender.

There were no ethnicity differences for other trans-specific barriers, such as discomfort discussing gender identity, fear of insufficient understanding of TNB people, or fear of misgendering. This is consistent with findings from Goldberg et al. (2019) in the US, who found no significant differences across ethnicity groups regarding misgendering experiences. However, it contrasts with findings from Counting Ourselves 2018, which included Pacific people reporting insulting language from a healthcare provider at significantly higher rates, and European people reporting that providers treated them the same as other patients at higher rates. This might indicate that these findings are restricted to general healthcare settings rather than MHC settings.

Overall, ethnicity was not a considerable predictor for MHC indicators in this study. This might suggest that unlike in the general population, ethnicity is not a significant predictor for MHC access indicators among TNB people. A possible explanation is that, because TNB people experience such high rates of MHC use, unmet needs for MHC, and barriers to MHC, ethnicity does not further increase the rate of these indicators. Nevertheless, these results might also reflect the limitations of

using an additive approach to analysing multiple marginalised identities in TNB people, that is, treating these identities as independent of each other and analysing their effects separately (Tan, Treharne, et al., 2020). Future studies analysing interaction effects between gender and ethnicity, as well as qualitative studies exploring the nuances of this relationship (and its impact on MHC experiences), would provide a better understanding of how the intersection between both relates to MHC access. Furthermore, ethnicity findings might also be explained by sampling bias, as participants from ethnic minorities who completed the survey might be more aligned with Western research methods and views of MHC, than those who did not. Due to the sampling method (convenience sampling), and the scarcity of previous evidence to compare these findings to, it is difficult to make conclusions about the representativeness of these findings. This may be addressed by future research through probability sampling methods and through methodologies that suit the cultural preferences of participants from ethnic minorities (e.g., conducting a wānanga for Māori participants; Smith et al., 2019).

Gender/SAAB differences

Gender/SAAB groups had significantly different rates of MHC use, with non-binary AFAB participants being significantly more likely (67%) than other gender/SAAB groups to have accessed MHC in the past year (transgender women were the least likely [51%]). Although there is existing research on gender differences in other MHC indicators (e.g., satisfaction, Riggs et al., 2014), there is none on differences in rates of MHC use, based on systematic searches of the literature. This finding is consistent with non-binary people being more likely to report psychological distress or worse mental health than other groups in local and international surveys (James et al., 2016, p.106; Navarro, Lachowsky, et al., 2021, p.5; Veale et al., 2019 p.46), with one Australian study showing that non-binary AFAB people in particular were the most likely to present several mental health problems (Hyde et al., 2014, p.17) suggesting a higher need for MHC for this group. This thesis' findings suggest that the higher MHC needs of non-binary people evidenced by previous research may be largely explained by the needs of non-binary AFAB people specifically, which may be tested

by future studies on mental health inequities analysing these groups (non-binary AFAB and AMAB) separately.

There were also significant gender/SAAB differences in satisfaction with MHC, with transgender women reporting higher satisfaction than transgender men. This is consistent with Counting Ourselves 2018 data indicating that transgender women reported significantly higher levels of satisfaction with some MHC services than transgender men (Veale et al., 2019), and local findings from Fraser and colleagues (2022) showing that transgender men report significantly more negative experiences in MHC settings than transgender women and non-binary participants. It also resembles US findings from Lehavot and colleagues (2017), who found that transgender men were significantly more likely to be dissatisfied with MHC than transgender women. The difference they found, however, was much larger than the one found in this study (in their study, transgender men were over three times as likely to be dissatisfied, whereas, in this study, transgender women's average satisfaction was only 0.3 above transgender men's, on a 5-point scale). Differences in barriers to MHC do not seem to explain these findings, as transgender men were not significantly more likely to report any trans-specific barrier. This might reflect additional problems transgender men may face that are not measured by this thesis, such as having lower visibility than transgender women due to being a historical minority (Leinung & Joseph, 2020). This is consistent with this study's transgender men participants being significantly younger than transgender women participants, as described in the methods section. The minority status of transgender men has changed, as the proportions of transgender men and transgender women are now similar (reflected in this study's sample characteristics and findings from Leinung & Joseph, 2020), but the lack of awareness and familiarity from MHC providers might be slower to change.

Regarding unmet needs for MHC, some significant differences were also found across gender/SAAB groups, specifically, non-binary AFAB participants were significantly more likely (64%) and transgender women were significantly less likely (50%) to have an unmet need for MHC in the past year. This contrasts with transgender men in Thailand being more likely to find it difficult to

access MHC than transgender women and non-binary people (Moallef et al., 2022); nevertheless, these differences were not tested for statistical significance. This thesis' findings are somehow consistent with those from Lehavot et al. (2017), who found that that transgender men were more likely to delay accessing MHC than transgender women (they did not include non-binary as a gender categorisation), however these differences were non-significant after controlling for other demographic variables. This is the first evidence, based on this thesis' literature review, indicating that non-binary AFAB individuals might experience unmet needs to a higher degree, than other gender/SAAB groups, among TNB individuals. Higher rates of unmet needs might be explained by a higher risk of experiencing barriers for non-binary AFAB individuals, as evidenced by this thesis' results. This finding, along with the higher rates of use for non-binary AFAB people, reveals that, even though non-binary AFAB people are the highest users of MHC, there is still a substantial gap in meeting their MHC needs, which is concerning considering their increased mental health needs (James et al., 2016; Navarro, Lachowsky, et al., 2021, Veale et al., 2019).

Concerning trans-specific barriers, non-binary AFAB participants reported significantly more discomfort discussing gender identity with a MHC provider than both transgender women and transgender men, with the largest difference being with transgender women. In addition, non-binary AFAB participants were more likely, and transgender women were less likely, to report fear of insufficient understanding as a barrier to accessing MHC. This is consistent with transgender women being less likely to have to educate a provider about TNB people when accessing general healthcare, as reported in Counting Ourselves 2018 (Veale et al., 2019). Furthermore, non-binary AFAB participants were more likely to report a fear of misgendering or the use of incorrect names as barriers to accessing mental healthcare (MHC), while transgender women and non-binary AMAB participants were less likely to report such barriers.

The gender/SAAB differences on trans-specific barriers may be attributed to gender and SAAB as separate variables. This pattern may also explain a broader trend observed in this thesis' findings, that is, non-binary AFAB participants reporting the highest rates and transgender women

reporting the lowest rates of various MHC indicators, including MHC use, unmet need, and MHC-related barriers. The study by Goldberg and colleagues (2019) analysed gender and ASAB as separate variables, revealing that AMAB participants were significantly more likely to report misgendering in MHC settings than AFAB participants and non-binary participants were significantly more likely to report this than binary-gender participants. Research in general healthcare settings has also indicated additional negative experiences for non-binary participants compared to binary-gender TNB participants (Moallef et al., 2022). This is consistent with transgender men and non-binary participants reporting the highest worries in MHC settings in the local study by Fraser and colleagues (2022). The literature aligns with the findings in this thesis, where AMAB groups (transgender men and non-binary AMAB) were the least likely to report misgendering. Given that AMAB and non-binary participants tended to be younger, this could contribute to their lower visibility and providers' reduced familiarity with these groups. Moreover, non-binary genders challenge cisgenderist beliefs, particularly the notion that only two mutually exclusive genders exist (binarising, Bartholomaeus & Riggs, 2018). Therefore, the observed findings, with non-binary AFAB participants reporting the highest rates and transgender women reporting the lowest rates of various MHC indicators, may be attributed to the intersection of ASAB and gender. This makes non-binary AFAB individuals particularly vulnerable, while transgender women occupy the opposite end of this spectrum. Future studies should consider examining gender and ASAB as separate variables to validate these interpretations and explore this intersection.

An additional consideration is the co-occurrence of gender/SAAB and age in the sample, which raises questions about the individual contribution of gender/SAAB to the prediction of MHC access indicators. As mentioned earlier, AFAB participants (non-binary AFAB participants and transgender men) were found to be significantly younger than AMAB participants (non-binary AMAB participants and transgender women); whereas non-binary AMAB participants were also significantly younger than transgender women. As discussed, younger participants in this and other studies were more likely to have used MHC, present an unmet need for MHC, report several trans-specific

barriers, and report lower satisfaction. This suggests that the gender/SAAB differences found in this and previous research may be accounted for by age differences across gender/SAAB groups. In support of this, findings from Counting Ourselves 2018 showed that gender differences on mental health problems were not significant once controlling for the interaction between age and gender (Tan, Ellis, et al., 2020). This thesis did not conduct analyses that statistically controlled for age when analysing gender/SAAB differences, or tested interaction effects between these variables, because the aim was to test differences by individual demographic factors. Most of the previous studies reporting gender differences in MHC indicators did not control for age (e.g., Goldberg et al., 2019; Moallef et al., 2022), except for Lehavot et al. (2017), however, they did not include non-binary as a category for gender groups. Lehavot and colleagues (2017) found that gender differences in delaying MHC were not significant once controlling for multiple demographic variables (including age), but gender differences regarding satisfaction with MHC did remain significant after doing this. This suggests that age (or other demographic factors) may contribute to gender/SAAB differences in some MHC indicators, but not others. Analyses statistically controlling for age may be conducted by future research to strengthen the understanding of gender/SAAB differences and test these hypotheses.

Further limitations and future directions

The study involved certain limitations regarding its sampling and analysis strategies. Counting Ourselves utilised multiple diffusion methods to reduce sampling bias, with a particular emphasis on reaching harder-to-access populations, and using community sampling through TNB networks so as to establish trust within the TNB community. Nevertheless, the study utilised mainly convenience sampling as a recruitment strategy, which may still limit the generalisability of the findings. This is reflected in the possible under/over-representation of certain demographic groups, as discussed previously. Future surveys could benefit from using more representative sampling methods, such as probability sampling and household surveying (e.g., Baxter et al., 2006). Household surveying may also work to improve the likelihood of participation of under-sampled groups (older

TNB people, Asian people, Pacific Peoples, and transgender men) by providing them with the opportunity to give their responses orally in a one-to-one setting.

As mentioned above, this thesis did not conduct analyses that statistically controlled for other demographic variables that demonstrated a significant association with MHC indicators as predictors, because the aim was to test differences by individual variables (age, gender, and ethnicity). This limitation may be addressed by future research to explore potential interaction effects or the individual contributions of these variables. These studies will need to have adequate subgroup sizes to allow specific interaction tests, which is particularly important for smaller ethnicity groups, as having any small subgroups would bias the results. This may be achieved through quota sampling.

In addition, this thesis examined the association of solely three demographic variables with MHC indicators (age, gender/SAAB, and ethnicity). Several other sociodemographic variables might be relevant for MHC indicators, such as socioeconomic status (D. Eisenberg et al., 2007), location (Fraser et al., 2022), or psychological variables such as mental health-related beliefs (Vogt, 2011) and perceived need for mental health treatment (Bonabi et al., 2016). Future research may analyse the effect of these variables and their interaction with the ones analysed in this thesis. It would also be beneficial for future studies to test how different MHC indicators for TNB people relate to their mental health outcomes (e.g., what is the relationship between having an unmet need for MHC and psychological distress) or how they relate to components of gender minority stress (e.g., what is the relationship between fear of mistreatment in MHC settings and internalised gender minority stressors).

As noted at various points, general Aotearoa/New Zealand population estimates for MHC indicators from similar dates are still unavailable, which complicates drawing conclusions about some of the findings. Future research may compare the data presented in this thesis to mental healthcare data from the New Zealand Health Survey 2021/2022 or other relevant sources. Additionally, inferential analyses should be conducted to examine the significance and effect sizes of

these differences. Comparisons to the general population regarding MHC satisfaction, unmet need, and general barriers also appear to be quite limited internationally for TNB people (for exceptions, see McDanal et al., 2022; Koffer Miller et al., 2022; Simeonov et al., 2015).

Conclusion and recommendations

This thesis sought to examine MHC access indicators among TNB people in Aotearoa/New Zealand, including rates of use, unmet need, satisfaction levels, and access barriers. The study was cross-sectional, drawing quantitative data from a nationwide online survey which recruited a large sample of TNB individuals. Differences in MHC indicators across age, gender, and ethnicity were also tested through inferential analyses. The findings revealed that a majority of participants had used MHC services in the past year, with rates higher than those reported in previous research in the US and UK. Despite high utilisation, a significant proportion of TNB individuals reported an unmet need for MHC, with rates approximately seven times higher than the general population. Satisfaction with MHC was generally high, but this might represent satisfaction with the most frequently used providers, and a notable percentage expressed neutral or negative sentiments. Private providers and trans/rainbow community services were the most accessed, possibly due to concerns about provider competency and negative experiences in public services. Frequent barriers to MHC included cost, lacking information on where to go, fear of lack of knowledge among providers, pathologising attitudes, and misgendering. Younger TNB individuals were more likely to use MHC but also reported lower satisfaction and more barriers. There were few ethnicity differences in MHC access, and gender differences existed in MHC utilisation, satisfaction, and barriers, with non-binary AFAB individuals being the most active users but also reporting the most barriers.

Overall, this thesis provides evidence of the need for tailored efforts to address these disparities, improve provider training, and reduce barriers to MHC for TNB individuals in Aotearoa/New Zealand, as well as evaluating these interventions to assess their impact on accessibility indicators. Table 21 presents a summary of recommendations for policy makers, MHC providers, and MHC professional education programmes, based on the findings of this thesis and

their discussion. Further research is needed to examine interaction effects between demographic variables that were significantly associated to MHC indicators, explore other MHC predictors, and identify disparities with the general population.

Table 21

Recommendations Based on Findings on Mental Healthcare Access Indicators for Trans and Non-Binary People in Aotearoa/New Zealand

Agent	Recommendations
Public Health Policymakers	1. Establish and enforce cultural competency standards for mental healthcare providers, ensuring they undergo adequate training on transgender and non-binary (TNB) issues. 2. Implement policies aimed at increasing the representation of TNB individuals within mental healthcare staff to reflect the demographics of the TNB community. 3. Ensure widely available and high-quality TNB training for mental healthcare providers to address potential disparities in knowledge and competency. 4. Set national guidelines for safety and inclusion in mental healthcare services, promoting a safe space for trans and non-binary people. Hold providers and institutions accountable for maintaining inclusive and respectful environments, with consequences for non-compliance. 5. Increase public funding for mental healthcare services for TNB individuals, addressing the disproportionate barriers faced by this population. This should be accompanied by reducing other barriers in public services that drive TNB individuals to seek private providers. 6. Prioritise funding for community-based TNB services that have demonstrated higher satisfaction rates among participants. 7. Develop initiatives to enhance information dissemination about available mental healthcare services, particularly those that are trans-friendly, to address the barrier of lacking information. 8. Collaborate with TNB organisations and community leaders to improve awareness of mental healthcare resources and eliminate information gaps. 9. Support and fund research initiatives focusing on TNB mental healthcare disparities and exploring effective interventions. 10. Prioritise policies that make mental health services more accessible to youth, considering their increased need for mental healthcare, including addressing financial barriers and improving outreach programmes.

Agent	Recommendations
	11. Target support for non-binary assigned female at birth individuals, recognising their higher rates of mental health care use and unmet needs, by ensuring access to specialised services and removing barriers specific to this group. 12. Launch public awareness campaigns focusing on social determinants, such as healthcare access barriers, of mental health disparities, to destigmatise mental health issues within the TNB community.
Mental Healthcare Professional Education Programs Staff	1. Advocate for a uniform and consistent educational curriculum at the base level in educational institutions. Develop and implement comprehensive training programmes for mental healthcare professionals that specifically address TNB health issues. 2. Integrate TNB content into routine and stand-alone training sessions, fostering understanding of both general and trans-specific mental health needs. 3. Ensure training content covers general transgender concepts, gender diversity, social stressors, mental health inequities faced by TNB individuals, and gender-affirming mental health needs. 4. Emphasise training programmes in raising awareness about non-binary identities and assigned male at birth TNB people. 5. Incorporate reflective skills training into mental healthcare provider education to identify personal biases and harmful attitudes contributing to disrespectful behaviour, such as pathologising attitudes towards TNB people. Emphasise the broader principle of cultural safety in healthcare to create an environment that respects and validates TNB clients.
Mental Healthcare Providers	1. Offer employment training opportunities to address knowledge and experience gaps in working with TNB individuals for professional and administrative mental healthcare staff. 2. Implement routine procedures, such as asking for patients' pronouns during intake or displaying visual signs of inclusivity, to create a welcoming and respectful environment. 3. Ensure accurate documentation of names, pronouns, and gender identity, as well as the regular use of these by staff and their accurate communication to other providers. 4. Adopt patient-centred approaches prioritising the unique needs and preferences of each TNB individual in mental healthcare settings. 5. Encourage collaboration between mental healthcare providers and TNB individuals in developing personalised care plans aligned with their mental healthcare goals. 6. Establish formal processes for TNB individuals to raise and address issues with staff.

Agent	Recommendations
	7. Create safe spaces within mental healthcare settings for TNB youth to minimise potential mistreatment and ensure a supportive environment, minimising power imbalances due to age differences. 8. Recognise the higher expectations of younger TNB individuals for mental health care, providing communication strategies to manage expectations and enhance satisfaction. 9. Regularly update mental healthcare staff on TNB terminology and language to build trust and improve communication. 10. Adopt culturally responsive practices, acknowledging the diverse backgrounds of TNB individuals, especially when working with Māori TNB people, to avoid pathologisation of beliefs or values. 11. Pay particular attention to providing adequate and respectful care to non-binary AFAB individuals, considering their higher rates of unmet need for mental healthcare and barriers to access care, which are related to the intersection of their sex assigned at birth and gender identity.

References

Acosta, W., Qayyum, Z., Turban, J. L., & van Schalkwyk, G. I. (2019). Identify, engage, understand: Supporting transgender youth in an inpatient psychiatric hospital. *Psychiatric Quarterly*, *90*(3), 601–612. https://doi.org/10.1007/s11126-019-09653-0

Allison, M. K., Marshall, S. A., Stewart, G., Joiner, M., Nash, C., & Stewart, M. K. (2021). Experiences of transgender and gender nonbinary patients in the emergency department and recommendations for health care policy, education, and practice. *The Journal of Emergency Medicine*, *61*(4), 396–405. https://doi.org/10.1016/j.jemermed.2021.04.013

American Psychological Association (n.d.). Mental health care. In *APA Dictionary of Psychology.* https://dictionary.apa.org/mental-health-care

Barr, S. M., Roberts, D., & Thakkar, K. N. (2021). Psychosis in transgender and gender non-conforming individuals: A review of the literature and a call for more research. *Psychiatry Research*, *306*, 114272. https://doi.org/10.1016/j.psychres.2021.114272

Bartholomaeus, C., & Riggs, D. W. (2018). *Transgender people and education*. Palgrave Macmillan.

Bartholomew, T. T., Gundel, B. E., Sullivan, J. W., Pérez-Rojas, A. E., & Lockard, A. J. (2019). Pretreatment counseling experiences, stressors, and support differences between transgender and cisgender university students seeking mental healthcare. *Journal of Clinical Psychology*, *75*(6), 933–957. https://doi.org/10.1002/jclp.22742

Baxter, J., Kokaua, J., Wells, J. E., McGee, M. A., & Oakley Browne, M. A. (2006). Ethnic comparisons of the 12 month prevalence of mental disorders and treatment Contact in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian & New Zealand Journal of Psychiatry*, *40*(10), 905–913. https://doi.org/10.1080/j.1440-1614.2006.01910.x

Benson, K. E. (2013). Seeking support: Transgender client experiences with mental health services. *Journal of Feminist Family Therapy*, *25*(1), 17–40. https://doi.org/10.1080/08952833.2013.755081

Bess, J., & Stabb, S. (2009). The experiences of transgendered persons in Psychotherapy: Voices and recommendations. *Journal of Mental Health Counseling*, *31*(3), 264–282. https://doi.org/10.17744/mehc.31.3.f62415468l133w50

Blenkiron, P., & Hammill, C. A. (2003). What determines patients' satisfaction with their mental health care and quality of life? *Postgraduate Medical Journal, 79*(932), 337–340. https://doi.org/10.1136/pmj.79.932.337

Bohlmeijer, E., & Westerhof, G. (2021). The model for sustainable mental health: Future directions for integrating positive psychology into mental health care. *Frontiers in Psychology*, *12*, 747999. https://doi.org/10.3389/fpsyg.2021.747999

Bonabi, H., Müller, M., Ajdacic-Gross, V., Eisele, J., Rodgers, S., Seifritz, E., Rössler, W., & Rüsch, N. (2016). Mental health literacy, attitudes to help seeking, and perceived need as predictors of mental health service use: A longitudinal study. *Journal of Nervous & Mental Disease*, *204*(4), 321–324. https://doi.org/10.1097/NMD.0000000000000488

Britt-Thomas, J. Y., Kridel, M., Velez, J., Kouame, G., Tharrington, S., Barrett, T., & Casanova, T. (2023). A scoping review of institutional policies and recommendations for trans inpatient mental health care. *Journal of Psychiatric and Mental Health Nursing*, *30*(6), 1043–1053. https://doi.org/10.1111/jpm.12933

Bryant, T., Leaver, C., & Dunn, J. (2009). Unmet healthcare need, gender, and health inequalities in Canada. *Health Policy*, *91*(1), 24–32. https://doi.org/10.1016/j.healthpol.2008.11.002

Burgwal, A., Gvianishvili, N., Hård, V., Kata, J., Nieto, I. G., Orre, C., Smiley, A., Vidić, J., & Motmans, J. (2021). The impact of training in transgender care on healthcare providers competence and confidence: A cross-Sectional survey. *Healthcare*, *9*(8), 967. https://doi.org/10.3390/healthcare9080967

Cahill, S. (2015). Community resources and government services for LGBT older adults and their families. In N. A. Orel & C. A. Fruhauf (Eds.), *The lives of LGBT older adults: Understanding*

challenges and resilience. (pp. 141–169). American Psychological Association. https://doi.org/10.1037/14436-007

Carroll, R., & Gray, L. (2021). Diversifying clinical education case studies. *The Clinical Teacher, 18*(5), 494–496. https://doi.org/10.1111/tct.13369

Carroll, R., Nicholls, R., Carroll, R.W., Bullock, J., Reid, D., Shields, J.., Johnson, R., Oliphant J., McElrea, E., Whitfield, P. & Veale, J. (2023). *Primary care gender affirming hormone therapy initiation guidelines.* Professional Association for Transgender Health Aotearoa. https://patha.nz/resources/Documents/Primary-Care-GAHT-Guidelines_Web_29-Mar.pdf

Christian, R., Mellies, A. A., Bui, A. G., Lee, R., Kattari, L., & Gray, C. (2018). Measuring the health of an invisible population: Lessons from the Colorado Transgender Health Survey. *Journal of General Internal Medicine, 33*(10), 1654–1660. https://doi.org/10.1007/s11606-018-4450-6

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., Fraser, L., Goodman, M., Green, J., Hancock, A. B., Johnson, T. W., Karasic, D. H., Knudson, G. A., Leibowitz, S. F., Meyer-Bahlburg, H. F. L., Monstrey, S. J., Motmans, J., Nahata, L., … Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse People, Version 8. *International Journal of Transgender Health*, *23*(sup1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

De Vries, J., Downes, C., Sharek, D., Doyle, L., Murphy, R., Begley, T., McCann, E., Sheerin, F., Smyth, S., & Higgins, A. (2023). Irish transgender voices on mental health and mental health care. *Mental Health and Social Inclusion*. https://doi.org/10.1108/MHSI-12-2022-0085

Duffy, M. E., Henkel, K. E., & Earnshaw, V. A. (2016). Transgender clients' experiences of eating disorder treatment. *Journal of LGBT Issues in Counseling*, *10*(3), 136–149. https://doi.org/10.1080/15538605.2016.1177806

Eisenberg, D., Golberstein, E., & Gollust, S. E. (2007). Help-Seeking and access to mental health care in a university student population. *Medical Care*, *45*(7), 594–601. http://www.jstor.org/stable/40221479

Eisenberg, M. E., McMorris, B. J., Rider, G. N., Gower, A. L., & Coleman, E. (2020). "It's kind of hard to go to the doctor's office if you're hated there." a call for gender-affirming care from transgender and gender diverse adolescents in the United States. *Health & Social Care in the Community, 28*(3), 1082–1089. https://doi.org/10.1111/hsc.12941

Elder, A. B. (2016). Experiences of older transgender and gender nonconforming adults in psychotherapy: A qualitative study. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 180–186. https://doi.org/10.1037/sgd0000154

Ellis, S. J., Bailey, L., & McNeil, J. (2015). Trans people's experiences of mental health and gender identity services: A UK Study. *Journal of Gay & Lesbian Mental Health*, *19*(1), 4–20. https://doi.org/10.1080/19359705.2014.960990

Farrer, L., Leach, L., Griffiths, K. M., Christensen, H., & Jorm, A. F. (2008). Age differences in mental health literacy. *BMC Public Health*, *8*(1), 125. https://doi.org/10.1186/1471-2458-8-125

Fenaughty, J., Fleming, T., Bavin, L., Choo, W. L., Ker, A., Lucassen, M., Ball, J., Greaves, L., Drayton, B., King-Finau, T., & Clark, T. (2023). *Te āniwaniwa takatāpui whānui: te irawhiti me te ira huhua mō ngā rangatahi | Gender Identity and young people's wellbeing in Youth19.* Youth19 Research Group, The University of Auckland and Victoria University of Wellington, New Zealand. https://www.youth19.ac.nz/publications/gender-identity-wellbeing

Fitzpatrick, J. (2023). *Barriers to accessing gender affirming mental health care in California's central valley for transgender and non-binary individuals* (Order No. 30426091) [Master's thesis, California State University]. ProQuest Dissertations and Theses Global. (2806353629).

Fraser, G., Brady, A., & Wilson, M. S. (2022). Mental health support experiences of rainbow rangatahi youth in Aotearoa New Zealand: Results from a co-designed online survey. *Journal of the Royal Society of New Zealand, 52*(4), 472–489. https://doi.org/10.1080/03036758.2022.2061019

Fredriksen Goldsen, K. I., Romanelli, M., Hoy-Ellis, C. P., & Jung, H. (2022). Health, economic and social disparities among transgender women, transgender men and transgender nonbinary adults: Results from a population-based study. *Preventive Medicine*, *156*, 106988. https://doi.org/10.1016/j.ypmed.2022.106988

Gender Minorities Aotearoa (n.d.). *Trans 101: glossary of trans words and how to use them.* https://genderminorities.com/glossary-transgender/#A.F.A.B.-and-A.M.A.B.

Goldberg, A. E., Kuvalanka, K. A., Budge, S. L., Benz, M. B., & Smith, J. Z. (2019). Health Care Experiences of Transgender Binary and Nonbinary University Students. *The Counseling Psychologist*, *47*(1), 59–97. https://doi.org/10.1177/0011000019827568

Goodyear-Smith, F., & Buetow, S. (2001). Power issues in the doctor-patient relationship. *Health Care Analysis*, *9*(4), 449–462. https://doi.org/10.1023/A:1013812802937

Government Inquiry into Mental Health and Addiction (2018). *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.* https://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey.* Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Hair, J., Black, W. C., Babin, B. J., & Anderson, R. E. (2010) Multivariate data analysis (7th ed.). Upper Saddle River, New Jersey: Pearson Educational International.

Hall, S. F., & DeLaney, M. J. (2021). A trauma-informed exploration of the mental health and community support experiences of transgender and gender-expansive adults. *Journal of Homosexuality*, *68*(8), 1278–1297. https://doi.org/10.1080/00918369.2019.1696104

Halliday, L. M., & Caltabiano, N. J. (2020). Transgender experience of mental healthcare in australia. *Psychology*, *11*(01), 157–172. https://doi.org/10.4236/psych.2020.111011

Harris, P. E. T. K. (2014). Wāhine Whaiora: Māori women's experiences of bipolar disorder and their pathways to recovery (Thesis, Master of Social Sciences (MSocSc)). University of Waikato, Hamilton, New Zealand. Retrieved from https://hdl.handle.net/10289/8782

Haworth, B. T., Barros Cassal, L. C., & De Paula Muniz, T. (2023). 'No-one knows how to care for LGBT community like LGBT do': LGBTQIA+ experiences of COVID-19 in the United Kingdom and Brazil. *Disasters*, *47*(3), 584–607. https://doi.org/10.1111/disa.12565

Health and Disability Commissioner Act 1994. https://www.legislation.govt.nz/act/public/1994/0088/latest/DLM333584.html

Holt, N. R., Botelho, E., Wolford-Clevenger, C., & Clark, K. A. (2023). Previous mental health care and help-seeking experiences: Perspectives from sexual and gender minority survivors of near-fatal suicide attempts. *Psychological Services*. https://doi.org/10.1037/ser0000745

Holt, N. R., Hope, D. A., Mocarski, R., & Woodruff, N. (2019). First impressions online: The inclusion of transgender and gender nonconforming identities and services in mental healthcare providers' online materials in the USA. *International Journal of Transgenderism*, *20*(1), 49–62. https://doi.org/10.1080/15532739.2018.1428842

Hunt, J. (2014). An initial study of transgender people's experiences of seeking and receiving counselling or psychotherapy in the UK. *Counselling and Psychotherapy Research*, *14*(4), 288–296. https://doi.org/10.1080/14733145.2013.838597

Hyde, Z., Doherty, M., Tilley, P.J.M., Kieran, M., Rooney, R., & Jancey, J. (2014) *The first Australian national transgender mental health study: summary of results.* School of Public Health, Curtin University, Perth, Australia. https://www.researchgate.net/publication/273775827_The_First_Australian_National_Trans_Mental_Health_Study_Summary_of_Results#:~:text=In%20the%20first%20trans%20mental,...

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality

Jang, Y., Chiriboga, D. A., & Okazaki, S. (2009). Attitudes toward mental health services: Age-group differences in Korean American adults. *Aging & Mental Health*, *13*(1), 127–134. https://doi.org/10.1080/13607860802591070

Kattari, S. K., Walls, N. E., Whitfield, D. L., & Langenderfer Magruder, L. (2017). Racial and ethnic differences in experiences of discrimination in accessing social services among transgender/gender-nonconforming people. *Journal of Ethnic & Cultural Diversity in Social Work*, *26*(3), 217–235. https://doi.org/10.1080/15313204.2016.1242102

Kerekere, E. (2017). *Part of The Whānau: The Emergence of Takatāpui Identity He Whāriki Takatāpui.* [Doctors thesis, Victoria University of Wellington]. University Library Papers and Theses. http://researcharchive.vuw.ac.nz/handle/10063/6369

Klein, D. A., Schvey, N. A., Adirim, T. A., Rayne, A. K., Susi, A., Roberts, T., & Hisle-Gorman, E. (2020). 56. Mental healthcare utilization among transgender and gender-diverse youth and their cisgender siblings in the U.S. Military healthcare system. *Journal of Adolescent Health*, *66*(2), S30. https://doi.org/10.1016/j.jadohealth.2019.11.059

Koffer Miller, K. H., Cooper, D. S., Song, W., & Shea, L. L. (2022). Self-reported service needs and barriers reported by autistic adults: Differences by gender identity. *Research in Autism Spectrum Disorders*, *92*, 101916. https://doi.org/10.1016/j.rasd.2022.101916

Lee, H., Operario, D., Van den Berg, J. J., Yi, H., Choo, S., & Kim, S.-S. (2020). Health disparities among transgender adults in South Korea. *Asia Pacific Journal of Public Health, 32*(2-3), 103–110. https://doi.org/10.1177/1010539520912594

Lehavot, K., Katon, J. G., Simpson, T. L., & Shipherd, J. C. (2017). Transgender veterans' satisfaction with care and unmet health needs. *Medical Care*, *55*(Suppl 2), S90–S96. https://doi.org/10.1097/MLR.0000000000000723

Leinung, M. C., & Joseph, J. (2020). Changing demographics in transgender individuals seeking hormonal therapy: are trans women more common than trans men? *Transgender Health*, *5*(4), 241–245. https://doi.org/10.1089/trgh.2019.0070

Lerner, J. E., & Robles, G. (2017). Perceived barriers and facilitators to health care utilization in the United States for transgender people: A review of recent literature. *Journal of Health Care for the Poor and Underserved*, *28*(1), 127–152. https://doi.org/10.1353/hpu.2017.0014

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health, 12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Lombardi, E. (2007). Substance use treatment experiences of transgender/transsexual men and women. *Journal of LGBT Health Research*, *3*(2), 37–47. https://doi.org/10.1300/J463v03n02_05

Lopes, C. S., Hellwig, N., E Silva, G. D. A., & Menezes, P. R. (2016). Inequities in access to depression treatment: Results of the Brazilian National Health Survey – PNS. *International Journal for Equity in Health*, *15*(1), 154. https://doi.org/10.1186/s12939-016-0446-1

Lyons, T., Shannon, K., Pierre, L., Small, W., Krüsi, A., & Kerr, T. (2015). A qualitative study of transgender individuals' experiences in residential addiction treatment settings: Stigma and inclusivity. *Substance Abuse Treatment, Prevention, and Policy*, *10*(1), 17. https://doi.org/10.1186/s13011-015-0015-4

McCann, E. (2015). People who are transgender: Mental health concerns: Transgender mental health. *Journal of Psychiatric and Mental Health Nursing*, *22*(1), 76–81. https://doi.org/10.1111/jpm.12190

McCullough, R., Dispenza, F., Parker, L. K., Viehl, C. J., Chang, C. Y., & Murphy, T. M. (2017). The counseling experiences of transgender and gender nonconforming clients. *Journal of Counseling & Development*, *95*(4), 423–434. https://doi.org/10.1002/jcad.12157

McDanal, R., Rubin, A., Fox, K. R., & Schleider, J. L. (2022). Associations of LGBTQ+ identities with acceptability and efficacy of online single-session youth mental health interventions. *Behavior Therapy*, *53*(2), 376–391. https://doi.org/10.1016/j.beth.2021.10.004

Ministry of Health (2017). *HISO 1001:2017*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/569DDB6A56F7E726CC2581FC00665BEB/$file/hiso-10001-2017-ethnicity-data-protocols.pdf

Ministry of Health (2021). *New Zealand Health Survey Adult Questionnaire (Year 11).* https://www.health.govt.nz/publication/questionnaires-and-content-guide-2021-22-new-zealand-health-survey

Ministry of Health (2022). *Annual Data Explorer 2021/22: New Zealand Health Survey [Data File]*. https://minhealthnz.shinyapps.io/nz-health-survey-2021-22-annual-data-explorer/

Ministry of Health (2023). Annual Data Explorer 2022/23: New Zealand Health Survey [Data File]. URL: https://minhealthnz.shinyapps.io/nz-health-survey-2022-23-annual-data-explorer/

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, *3*(2), 148–155. https://doi.org/10.1037/sgd0000177

Moallef, S., Salway, T., Phanuphak, N., Kivioja, K., Pongruengphant, S., & Hayashi, K. (2022). The relationship between sexual and gender stigma and difficulty accessing primary and mental healthcare services among LGBTQI+ populations in Thailand: Findings from a national survey.

International Journal of Mental Health and Addiction. https://doi.org/10.1007/s11469-021-00740-7

Navarro, J., Johnstone, F., Temple Newhook, J., Smith, M., Wallace Skelton, J., Prempeh, K., Lopez, L. S. C., Scheim, A., & Bauer, G. (2021). *Health and well-being among trans and non-binary youth.* Trans PULSE Canada. https://transpulsecanada.ca/results/report-health-and-well-being-among-trans-and-non-binary-youth/

Navarro, J., Lachowsky, N., Hammond, R., Burchell, D., Arps, F. S. E., Davis, C., Brasseur, J., Islam, S., Fosbrook, B., Jacobsen, K., Walker, M., Lopez, C., Scheim, A., & Bauer, G. (2021). *Health and well-being among non-binary people*. Trans PULSE Canada. https://transpulsecanada.ca/results/report-health-and-well-being-among-non-binary-people/

Obasi, S. N., King, R. E., Holt, N. R., Mocarski, R., Hope, D. A., & Woodruff, N. (2023). Educational preparedness to care for transgender and gender diverse adults: Perspectives of mental health professionals. *Journal of Gay & Lesbian Social Services*, *35*(2), 204–217. https://doi.org/10.1080/10538720.2022.2056782

Oliphant, J., Veale, J., MacDonald, J., Carroll, R., Johnson, R., Harte, M., Stephenson, C., & Bullock, J. (2018). *Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in Aotearoa, New Zealand*. Transgender Health Research Lab, University of Waikato.

Panchal, Z., Piper, C., Whitmore, C., & Davies, R. D. (2021). Providing supportive transgender mental health care: A systemized narrative review of patient experiences, preferences, and outcomes. *Journal of Gay & Lesbian Mental Health*, 1–37. https://doi.org/10.1080/19359705.2021.1899094

Parent, M. C., & Tebbe, E. A. (2022). The impact of mental health care provider website transgender and nonbinary affirmation on site user experience for transgender/nonbinary and cisgender

people. *Professional Psychology: Research and Practice*, *53*(1), 1–13. https://doi.org/10.1037/pro0000428

Readler, C. A., Shumate, B. A.; Griffiths, J. R., & Coppolino, A. J. (2017). *Defendants' Motion to Dismiss and Opposition to Plaintiffs' Application for a Preliminary Injunction, Civil Action No. 17-cv-1597 (CKK)*. National Center for Lesbian Rights. https://www.nclrights.org/wp-content/uploads/2017/08/Govt-Brief.pdf

Riggs, D. W., Coleman, K., & Due, C. (2014). Healthcare experiences of gender diverse Australians: A mixed-methods, self-report survey. *BMC Public Health*, *14*(1), 230. https://doi.org/10.1186/1471-2458-14-230

Robb, C., Haley, W. E., Becker, M. A., Polivka, L. A., & Chwa, H.-J. (2003). Attitudes towards mental health care in younger and older adults: Similarities and differences. *Aging & Mental Health*, *7*(2), 142–152. https://doi.org/10.1080/1360786031000072321

She, R., Mo, P. K. H., Cai, Y., Ma, T., Liu, Y., & Lau, J. T. F. (2022). Mental health service utilisation among transgender women sex workers who are at risk of mental health problems in Shenyang, China: An application of minority stress theory. *Health & Social Care in the Community*, *30*(4). https://doi.org/10.1111/hsc.13501

Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender Clients: Identifying and Minimizing Barriers to Mental Health Treatment. *Journal of Gay & Lesbian Mental Health*, *14*(2), 94–108. https://doi.org/10.1080/19359701003622875

Simeonov, D., Steele, L. S., Anderson, S., & Ross, L. E. (2015). Perceived satisfaction with mental health services in the lesbian, gay, bisexual, transgender, and transsexual communities in Ontario, Canada: an internet-based survey. *Canadian Journal of Community Mental Health*, *34*(1), 31–44. https://doi.org/10.7870/cjcmh-2014-037

Smith, L., Pihama, L., Cameron, N., Mataki, T., Morgan, H., & Te Nana, R. (2019). Thought Space Wānanga—A Kaupapa Māori Decolonizing Approach to Research Translation. *Genealogy*, *3*(4), 74. https://doi.org/10.3390/genealogy3040074

Snow, A., Cerel, J., Loeffler, D. N., & Flaherty, C. (2019). Barriers to mental health care for transgender and gender-nonconforming adults: A systematic literature review. *Health & Social Work*, *44*(3), 149–155. https://doi.org/10.1093/hsw/hlz016

Sperber, J., Landers, S., & Lawrence, S. (2005). Access to health care for transgendered persons: results of a needs assessment in Boston. *International Journal of Transgenderism*, *8*(2–3), 75–91. https://doi.org/10.1300/J485v08n02_08

Stats NZ. (2019). *2018 Census totals by topic – national highlights* (Update 04 11 21) [Data set]. https://www.stats.govt.nz/information-releases/2018-census-totals-by-topic-national-highlights-updated

Stats NZ. (2022). *LGBT+ population of Aotearoa: Year ended June 2021* [Data set]. https://www.stats.govt.nz/assets/Uploads/LGBT+-population-of-Aotearoa/LGBT+-population-of-Aotearoa-Year-ended-June-2021/Downloads/lgbt-plus-population-of-aotearoa-year-ended-june-2021.xlsx

Tan, K. K. H., Ellis, S. J., Schmidt, J. M., Byrne, J. L., & Veale, J. F. (2020). Mental health inequities among transgender People in Aotearoa New Zealand: Findings from the Counting Ourselves survey. *International Journal of Environmental Research and Public Health*, *17*(8), 2862. https://doi.org/10.3390/ijerph17082862

Tan, K. K. H., Schmidt, J. M., Ellis, S. J., Veale, J. F., & Byrne, J. L. (2022). 'It's how the world around you treats you for being trans': Mental health and wellbeing of transgender people in Aotearoa New Zealand. *Psychology & Sexuality*, *13*(5), 1109–1121. https://doi.org/10.1080/19419899.2021.1897033

Tan, K. K. H., Treharne, G. J., Ellis, S. J., Schmidt, J. M., & Veale, J. F. (2020). Gender Minority Stress: A critical review. *Journal of Homosexuality*, *67*(10), 1471–1489. https://doi.org/10.1080/00918369.2019.1591789

Te Hiringa Mahara, Mental Health and Wellbeing Commission. (2023). *Te huringa tuarua 2023: Kaupapa Māori services report*. https://www.mhwc.govt.nz/news-and-resources/kaupapa-maori-services-report/attachment/272/

Te Whatu Ora (n.d.). *Health system overview*. https://www.tewhatuora.govt.nz/our-health-system/health-system-overview/#:~:text=The%20Ministry%20of%20Health%20is,and%20provide%20true%20national%20planning.

Theodore, R. (2022). Mental health inequities for Māori youth: a population-level study of mental health service data. *New Zealand Medical Journal, 135*(1567), 79–90.

Treharne, G. J., Blakey, A. G., Graham, K., Carrington, S. D., McLachlan, L. A., Withey-Rila, C., Pearman-Beres, L., & Anderson, L. (2022). Perspectives on expertise in teaching about transgender healthcare: A focus group study with health professional programme teaching staff and transgender community members. *International Journal of Transgender Health, 23*(3), 334–354. https://doi.org/10.1080/26895269.2020.1870189

Veale, J. F., Byrne, J., Tan, K. K. H., Guy, S., Yee, A., Nopera, T., & Bentham, R. (2019). *Counting ourselves: The health and wellbeing of, trans and non-binary people in Aotearoa New Zealand.* Transgender Health Research Lab, University of Waikato.

Veale, J. F., Watson, R. J., Peter, T., & Saewyc, E. M. (2017). Mental health disparities among Canadian transgender youth. *Journal of Adolescent Health, 60*(1), 44–49. https://doi.org/10.1016/j.jadohealth.2016.09.014

Vogt, D. (2011). Mental health-related beliefs as a barrier to service use for military personnel and veterans: a review. *Psychiatric Services 62*(2):135–142

Vupputuri, S., Daugherty, S. L., Yu, K. C., Derus, A., Vasquez, L. E., Wells, A., Truong, C., & Emanuel, E. W. (2021). A mixed methods study describing the quality of healthcare received by transgender and gender nonconforming patients at a large integrated health system. *Healthcare*, *9*(5), 530. https://doi.org/10.3390/healthcare9050530

White, B. P., & Fontenot, H. B. (2019). Transgender and non-conforming persons' mental healthcare experiences: An integrative review. *Archives of Psychiatric Nursing*, *33*(2), 203–210. https://doi.org/10.1016/j.apnu.2019.01.005

Whitehead, M., & Dahlgren, G. (2007). *Concepts and principles for tack-ling social inequities in health: Levelling up part 1*. World Health Organization Collaborating Centre for Policy Research on Social Determinants of Health. http://www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf

Withey-Rila, C., Morgaine, K. C., & Treharne, G. J. (2023). Understanding the context of positive experiences of primary care for transgender and gender diverse adults: An email interview study in Aotearoa New Zealand. *International Journal of Transgender Health*, 1–15. https://doi.org/10.1080/26895269.2023.2234899

World Health Organization. (2022). *Mental health: strengthening our response.* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

World Health Organization. (n.d.). *Social Determinants of Health.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Appendix A

Table A1

Pairwise Comparisons on Age by Gender / Sex Assigned at Birth

	Gender / Sex Assigned at Birth			
	Transgender men	Transgender women	Non-binary AMAB	Non-binary AFAB
Transgender men	-	<.001	<.001	.346
Transgender women		-	<.001	<.001
Non-binary AMAB			-	.003

Note. Values indicate the *p*-value for that comparison

Table A2

Homogeneity of Variances for Continuous Variables Used in Study

	KS	*p*	Skewness	Kurtosis
Age	.14	<.001	1.58	2.59
Average satisfaction with MHC	.21	<.001	-.69	-.15
Discomfort discussing gender identity with MHC provider	.26	<.001	.54	-.62

Table A3

Pairwise Comparisons on Age for Participants who had an Unmet Need for Mental Healthcare, those who did not, and those who did not know

	Unmet Need for Mental Healthcare		
	Yes	No	Don't know
Yes	-	.000	.068
No		-	.000

Note. Values indicate the *p*-value for that comparison

Table A4

Pairwise Comparisons on Satisfaction by Gender / Sex Assigned at Birth

	Gender / Sex Assigned at Birth			
	Transgender men	Transgender women	Non-binary AMAB	Non-binary AFAB
Transgender men	-	.03	.144	.580
Transgender women		-	1	.181
Non-binary AMAB			-	.479

Note. Values indicate the *p*-value for that comparison

Table A5

Pairwise Comparisons on Discomfort Discussing Gender Identity with Mental Healthcare Provider by Gender / Sex Assigned at Birth

	Gender / Sex Assigned at Birth			
	Transgender men	Transgender women	Non-binary AMAB	Non-binary AFAB
Transgender men	-	.01	.808	< .001
Transgender women		-	.005	< .001
Non-binary AMAB			-	.114

Note. Values indicate the *p*-value for that comparison