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# **Growing up trans in Canada, Switzerland, England, and Australia: Access to and impacts of gender-affirming medical care**

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## **Abstract**

Trans and non-binary youth (TNBY) face high levels of interpersonal and social adversity as well as disproportionate rates of mental health issues such as depression, self-harm and suicidal ideation. Among protective factors, context plays a key role. In addition to parental support, access to gender-affirming medical care begins to emerge as crucial for young people needed them. This paper compares, through thematic analysis, the experiences of TNBY with regard to access and experiences to care in Canada, Switzerland, England, and Australia. It identifies similarities and differences in barriers to access to care, as well as impacts of gender affirming care on young people and their well-being. The article concludes with a discussion on the

importance of prompt and easier access to gender-affirming medical care, of training of professionals, and a hypothesis about the role of context in TNBY well-being.

### ***Introduction***

Despite recent social and legislative gains in the recognition and acceptance of gender and sexual diversity in many countries, trans and non-binary youth (TNBY) face high levels of interpersonal and social adversity (e.g., social exclusion, school withdrawal, or avoidance) and disproportionate rates of mental health issues, such as depression, self-harm, and suicidal ideation, when compared with their cisgender peers (Reisner et al., 2015). Although many factors influence TNBY's well-being, growing evidence indicates strong support and connectedness with their parents/caregivers (Katz-Wise et al., 2018; Travers et al., 2012) and acceptance and recognition of their gender by their wider social circle and environment, including schools (Pullen Sansfaçon et al., 2018; Taylor et al. 2020), are particularly important. Furthermore, access to gender-affirming medical care when needed (Clark et al., 2020; Chew et al., 2018; Cohen-Kettenis et al., 2011; Khatchadourian et al., 2014; Olson-Kennedy et al., 2018), including prompt access to puberty suppression (Turban et al., 2020; Sorbara et al., 2020), are crucial for the well-being of TNBY who need it.

The World Professional Association for Transgender Health (WPATH) is currently developing the eighth edition of its standards of care (SOC), which provide guidelines for professionals working with TNBY around the world. The SOC aim to guide interventions and to support the development of optimal health care for TNBY; these standards draw from best practice evidence and cover topics such as assessments, the mental health care of adolescents with gender dysphoria, and the medical options available to them. For example, the SOC's current version recommends reversible gender-affirming medical treatments such as puberty suppression medication for TNBY who

have parental consent and have experienced long-lasting gender dysphoria (Coleman et al., 2012). Partially reversible interventions, such as gender-affirming hormones, and irreversible interventions, such as genital surgeries, are also discussed in the SOC as suitable medical treatments under certain conditions (see Coleman et al., 2012, chapter 6 for a detailed description).

Although medical interventions for TNBY continue to be a frequent subject of debate (see, e.g., Ashley, 2019; Wren, 2019; Priest, 2019; DeVries 2020), the SOC clearly state that withholding timely access to medical care from TNBY comes with heightened risks of psychological distress and violence; hence, doing so is not a neutral option for TNBY (Coleman et al. 2012). In line with the SOC and their guidelines, gender-affirming research has recently begun to examine the experience of TNBY receiving medical gender-affirming treatments such as puberty suppression or hormones (hereafter 'gender-affirming care') and the barriers they face in accessing it; however, less is known about how the experiences of gender-affirming care affect these individuals. The present article explores the experience of the care received by TNBY in four countries, as well as the perceived impacts of accessing such care. The present study asks the following: What are the experiences of accessing gender-affirming care for TNBY? How does it affect them? How do these experiences compare internationally? Drawing on data from one Canadian study and three parallel studies developed using similar research protocols in England, Switzerland, and Australia, the present article explores TNBY's access to gender-affirming care, as well as how the young people's well-being evolved as a result. The paper concludes by hypothesizing the role that context plays in the observed differences.

***Context: Same Standards, Different Models of Care***

Although the SOC provide treatment guidance for TNBY, care provision differs between countries. In Canada, gender identity and expression are protected from discrimination at the federal and provincial levels and TNBY have been increasingly visible in the mainstream media. Over the past few years, various educational and health policies have been passed to increase the inclusion of TNBY, but some disparities remain between provinces. In Canada, gender-affirming care is offered at the onset of puberty and is covered by provincial insurance. Prescription medication is also covered by public or private plans, and over 10 specialized clinics exist across the country. However, many challenges remain for TNBY seeking care, such as issues in finding a doctor or when parental consent is lacking (Taylor et al., 2020). In French Switzerland, gender identity is not yet protected from discrimination and TNBY are only just becoming visible. At the time of the data collection, only a few youth had come out and sought to access gender-affirming treatment, so this study captured the emergence of this new reality. No specialty clinics are prescribing puberty blockers, so no youth had received them at Tanner 2 to the best of our knowledge. Numerous obstacles remain in accessing gender-affirming care (Wahlen et al. 2020), such as gatekeeping by psychiatry. In England, there is only one public gender clinic situated in London with satellite branches in a few larger cities such as Leeds and Exeter. At the time of writing this paper, waiting lists for gender-affirming care are up to two years. Although British youth can also obtain gender-affirming care through their general practitioner, this is extremely rare, and a lack of knowledge among clinicians combined with other barriers such as poor collaboration with schools and mental health services make access challenging, leaving families with a sense of dissatisfaction, distress, and frustration (Carlile, 2020). Furthermore, access has been increasingly limited following the recent British High Court's judgement in Quincy Bell and A -v- Tavistock and Portman NHS Trust and others in December 2020, which challenged the idea that youth under 16 of age are Gillick competent and have the capacity to provide consent to treatment, stipulating instead that the decision should be made by the court. That said, another recent court case in March 2021, declared that parents can consent for

their youth to access puberty blockers, ostensibly making it easier for youth who have parental support to access puberty blockers (Dyer 2021), although the impact of Quincy Bell and A -v- Tavistock and Portman NHS Trust and others has, in practice, resulted in further delays and barriers to treatment, despite the subsequent judgment (Mermaids 2021). In Australia, youth must have parental consent to access gender-affirming care. In cases where both parents do not consent, court injunctions are required, which prevents some youth from accessing prompt, needed care. Gender-affirming care in Australia is available through the public health system, and at present there are five pediatric gender clinics spread across the country.

Although many studies have examined barriers to care, there exists a significant gap in the literature concerning TNBY's own perspectives and experiences in seeking medical care and how their well-being evolves as a result. This gap has been identified as a crucial one to fill in order to expand access to care and social support (Thompson et al., 2016) and the relevance of studies dating back several years (Corliss et al., 2007; Steensma et al., 2013) may be limited when addressing today's context, given the rapid evolution of trans rights, health care, service provision, and significant variation between countries and regions. The only international study that we found that compared the experiences and psychological functioning of youth accessing clinics covered four countries: Amsterdam in the Netherlands, Belgium, the German-speaking portion of Switzerland, and England (de Vries et al., 2016). That study's conclusions highlighted the differences in TNBY psychological functioning depending on their country of residence: the participants displayed the highest level of emotional and behavioral functioning in Amsterdam and the lowest in England. In their discussion, De Vries et al. (2016) hypothesized that these differences in well-being might be due to greater tolerance or acceptance of gender-diverse behavior in certain cultures. The scarcity of internationally comparable data on TNBY experiences clearly warrants further exploration, which is precisely what the current paper does. To the

best of our knowledge, no international comparative study has drawn on qualitative methodologies in an attempt to understand and compare TNBY experiences of clinical care in different countries.

### **Method: A Comparative International Perspective**

The 'Stories of Gender-Affirming Care' project in Canada interviewed trans and gender-diverse children and youth and their parents/caregivers who had been referred to three specialty gender-affirming clinics in Canada; the aim of this study was to learn more about their well-being and the issues affecting them, why they sought care, and the quality of their experiences of care. After beginning the project in Canada, the principal investigator of the study invited researchers from England, Australia, and Switzerland to each develop and undertake a local iteration of the study to generate a sufficiently diverse pool of participants seeking gender-affirming care in each of their respective countries. Each project was adapted slightly to accommodate the contextual specificities, such as the organization of gender-affirming care in each country and each host university's ethics requirements, but each study's design followed the Canadian one as closely as possible. For example, all four projects were based on a combination of grounded theory and thematic analysis (Pullen Sansfaçon et al 2019b), with semi-structured interviews conducted using an interview guide adapted from the original Canadian study. The protocol was also adapted according to the cultural and legal specificities of each country, as follows. The parent and child were interviewed separately in England, Switzerland, and Canada, except for a few younger participants who requested their parents' presence during their interview, whereas youth and parent were always interviewed together in Australia. Although all youth were all under the age of 18 in Canada and Australia, the maximum age was raised to 20 in England and 21 for the Swiss study to recruit enough participants and to account for the fact that access to gender-affirming care at the time of data collection was only available at a more advanced stage of puberty.

The combined sample of the four research projects discussed in the current article includes participants from two Australian states (South Australia and Victoria), three Canadian provinces (Quebec, Ontario, and Manitoba), the French-speaking part of Switzerland (Suisse Romande), and several cities and towns across the North, Midlands, and South-East of England. Local organizations, clinics, or community organizations assisted in recruiting the participants. In Canada, recruitment was conducted through the three specialty clinics, who invited potential participants from their patient list based on their gender and current stage of puberty, whereas in Australia, England, and Switzerland, recruitment was facilitated by nonprofit/parent organizations which work with the families of TNBY, without the participation of gender-affirming clinics. In total, 68 dyads of young people and their parents participated in the four projects, for a total of 138 participants (since both parents were interviewed in one dyad, and two siblings were interviewed in another). The young people's ages ranged from 5 to 21. The sample included various genders: most children and youth identified as transmasculine/boy/male and roughly a third as transfeminine/girl/woman. A few described themselves as non-binary. Table 1 shows the main sociodemographics of each sample.

*Table 1 about here*

Ethical approval was obtained by the principal investigators in each country and from the coresearchers' universities and clinics, when relevant. For each project, informed consent/assent was obtained from the participants before conducting the interview. The participants were given the opportunity to withdraw from the study at any time before data were published, but none requested this.

Initially, the international project discussed in the current article was not developed as a single study that would draw on data from four countries, but rather as four independently funded projects, so participants did not consent to having their data shared with other international sites at the time of the interviews. Therefore, the authorship team based its analysis for this paper on data that was published



in nine articles presenting the results from each country. Each article's findings were reviewed using thematic analysis procedures (Braun & Clarke 2006) and the themes were then compared by region, allowing local differences to emerge. We identified themes related to the following questions: What are the experiences of accessing gender-affirming care for TNBY? How does it affect them? How do these experiences compare internationally? We then produced a comparative table of themes found in each article. Some themes were covered in certain articles and not in others. When a theme was only discussed in one paper/country (e.g., "access to medical care supports gender identity consolidation"), the theme was noted, but the lack of a discussion in the other papers made it impossible to make a comparison. Table 2 presents the themes that were sufficiently covered by each country's articles to provide a solid basis for comparison:

*Table 2 about here*

After the thematic analysis was completed, the team reviewed the analysis in light of their contextual specificities and their in-depth knowledge of the local data. The next section discusses the main themes and provides a comparative analysis of findings in each country.

## **Findings**

Table 2 presents the themes that were identified through analysis of the articles. An "x" indicates that a given theme (row) was covered in at least one article from a given country sample (column). While some themes appeared in all four samples, others were specific to one country only, revealing local differences. In this section, we discuss each theme to build an understanding across the country samples.

### Accessing and receiving gender-affirming care

Gender-affirming interventions were not available to Swiss minors at the time of data collection.

Puberty suppressants were not prescribed at all, and although hormone therapy was desired by many

young people in this group, the process to access it was described as too long and complicated, requiring multiple assessments, which had the effect of discouraging the participants and resulting in no Swiss youth being able to access this treatment at the time of the interview. Unsurprisingly, accessing gender-affirming care was identified as a core concern among this group, and Medico et al (2020a) hypothesized that the high rate of suicide attempts among this cohort is specifically linked to this delay. Some young people in England, Canada, and Australia were able to access gender-affirming care. However, numerous challenges in seeking and accessing services were identified, including delays, protocol restrictions, and the affordability of care.

#### Barriers and issues faced in attempting to access gender-affirming care

Policy or administrative delays included issues such as waiting lists and clinic-specific protocols, but also country-wide regulations. These delays were linked to the ways services are provided or steps individuals had to go through before being able to access care. The length of time young people waited to access desired medical interventions varied from one country to the other, but similar issues relating to delays were identified across all samples. The Canadian young people said they were generally satisfied with the speed of access to care, though some expressed frustration about delays and assessment, especially at one clinic, where the waiting list was longer and the protocol was more restrictive. In this instance, the clinic protocol was said to cause one young person and his parent in particular to be denied care several times over many years:

The clinic still rejected him, and he was still like “Well, I guess you will have to wait”... and I am “Are you guys insane?”, talking about, you read any of the documentation, you don’t fucking wait. You know what I mean? [...] And at time of extreme frustration, probably closer to rage, um, you know, I often think, “do I send the funeral bills to [the clinic]?” (Extract from Sophia, parent of a fluid transmasculine 13-year-old, cited in Article b)

The requirement for multiple assessments was also identified as an important cause of delays. This, combined with long waiting lists to see a professional and long travel distances for some made the experience of accessing care very challenging for many young people. In Australia some young participants also mentioned the recently eliminated requirement that court approval be obtained before accessing certain services, which was still vivid in their minds though it was no longer in force at the time of interviews. Until recently, approval by a family court was required before any young person could access gender-affirming care, which generated further delays and costs for families, as Kya and her parent explain:

It would've been a lot more annoying and exhausting if that was a thing I would've had to do [go to court] and I probably wouldn't have honestly done it, I would've just waited. (Kya, 17 years old)

Waited until you were 18. Which would've definitely been bad for Kya's mental health to have to tread water for that long, so we're very fortunate and very grateful that the law got changed (Parent of Kya). (cited in Article e)

Faced with such barriers, some families sought and obtained gender-affirming care for their children through private providers. For example, in Australia and England, participants described having to be proactive in seeking services, going through repeated trial-and-error processes before finding affirmative services outside the public specialty clinic. In England, families struggled to find gender-affirming care from the national Child and Adolescent Mental Health Service, and coming across a rare practitioner who was supportive was described as "lucky" compared to what they had come to expect as the norm. Finding a clinic was not identified as an issue by Canadian participants, but the youth were recruited directly from those clinics, so this may have influenced their perspective. In Canada, the youth

described having received mostly good gender-affirming care in specialty clinics and only having had bad experiences when they had to go to other clinics or departments within or outside the hospital. Hence, the *lack of connectedness* between services was mentioned in Canada, as in the other countries, but did not seem to have an impact on *access* to gender-affirming care; rather, it affected the experience of accessing it. In addition to experiencing administrative issues (mistakes with name and gender) or discomfort in waiting rooms, there was a lack of services geared toward meeting the needs of the rest of the family. The Australian data also highlighted the lack of specialized services for children with autism.

Participants in all four countries talked about *issues emerging from a lack of consensus between young people, parents, and sometimes providers*, including the presence of parental conflict, which was said to affect decisions about the young person's care, and often resulted in additional barriers to access.

Across the samples, a few participant narratives highlighted how the absence of consent by one parent contributed to issues and delays in accessing care. For example, Riggs et al. (2020) (Article e) described how one young person in Australia had been through a particularly distressing time while waiting an extended time for his father to consent to his treatment. Medico et al. (2020b) described a situation in Switzerland in which the young person was affirmed by the mother but unacknowledged by the father, resulting in the young person being unable to live in their authentic gender full-time. Although care was not accessible for this particular young person in Switzerland because of a lack of services in the region, the parental conflicts here show how this issue can arise when it comes to decisions about moving forward with transition and how it may cause additional burdens and delays in accessing care and centering the needs of the child.

Issues related to the *affordability* of gender-affirming care arose in Canada and England, but the form they took varied. Cost was an issue in England, where barriers to accessing the public system, as described above, led families to seek care from private practitioners. In Canada, where gender-affirming

care was more readily available, some youth still worried about the financial burden on their parents due to the cost of some medication that was not always fully covered by insurance or the cost of mental health services, which are usually not covered by national health programs or involve an extremely long wait when they are. Finally, several TNBY voiced their concern about how they would pay for certain surgeries they wished for that were not covered by their local insurance plan.

Issues related to *professionals who lack training* were identified by the participants in all four countries, especially outside the context of gender-affirming clinics. In psychiatric or emergency care departments for example, the attitude of health care professionals was described by participants as a source of distress and an important obstacle to care. In England, Carlile et al. (2020) provide a detailed account of one young trans man's experience of the mental health assessment required to access gender-affirming care at a public specialty clinic. Although the young man was living in his affirmed gender in many spheres of his life, including his ballet company, the therapist at the mental health service forced him to undergo an assessment, dismissing the family's viewpoint and questioning his seriousness about his gender dysphoria and desire to transition using because of his involvement in ballet. The young man said he was told by the mental health service: "I'm wrong, I have to be a girl because I like doing ballet because ... it's not football, that's why and ... I'm not trans, I'm a type of lesbian" (Article i). The narratives from young people in England echo those from the Swiss sample, despite the significant difference that specialized clinics existed in England, whereas Switzerland had none. Families in Switzerland noted the persistence of pathologizing theories of being trans in the medical field, and ongoing abusive practices. Some families even felt that professionals sometimes refused to discuss being trans in the context of psychotherapeutic interventions, which had the effect of increasing suicidal thoughts in youth who experienced this. Misgendering was also frequently experienced, and such incidents could have important negative consequences for the young person, as related by Richard, the father of a 14-year-old young person living in French Switzerland:

The anger, he's turning it on himself. Because there were... two, well, one stay where he was in psychiatry, there was one of the nurses who... Persisted and worse, really for me it was the malevolence because she was saying hello to him using "Miss." She could have only used "Hello" [...] it affected him very much... and then at one point, I said I am taking him back home because he is depressed... (Quoted in Article g)

In Switzerland, half of the sample had been hospitalized at least once as a result of depression, self-harm, or suicide attempts, and the experience of these hospitalizations was said to be very negative. The Swiss team reported a consensus between the young people's and parents' narratives that showed that misgendering was experienced both within health services and residential care; this occurred in addition to the denial of the young person's affirmed gender identity. Misgendering also happened in non-specialist clinics in England and Canada, but in Canada, specialty clinics offering gender-affirming care were more consistently trans-affirming in this respect and misgendering experiences only happened outside the clinics (article b).

In Switzerland, England, and Canada, participants voiced concern about the type of trans narrative that was judged to be valid by providers. A few TNBY recounted that they had to adjust their narrative to align with mainstream trans narratives to receive care. In Canada, non-binary youth said they were often unsure whether or how medical care would help them achieve what they were hoping for, whereas the youth in Switzerland and England explained that they sometimes presented a narrative that did not correspond to their experience or identity so that they would be considered trans and thus be able to access treatment. Most notably, the youth felt compelled to "prove" they were trans by adopting a stereotypical gender presentation or interests. These issues could all be seen as reflecting a lack of training of trans health professionals.

[Access to gender-affirming interventions: Some impacts](#)

Without exception, accessing gender-affirming intervention was identified as an important contributor to improving young people's well-being. The themes developed in the four samples show that for those who were able to access them, gender-affirming interventions decreased suicidal thoughts and self-harm. Some Australian youth also reported that accessing hormones changed their sense of self, particularly regarding their gender, describing it as having had a positive effect on their well-being.

The youth who were able to access care without too many hurdles noted that it had a tangible positive impact on their well-being. In the three countries where blockers were available, they generated greater optimism and positively impacted the mental health of the participants (Articles a, e, and i). In Australia and Canada, where care was said to be easier to access, well-being continued to improve as different interventions were provided. For example, in the Canadian sample, only one young person had had top surgery, but he reported that this intervention had the most significant positive impact on his well-being out of all the interventions he had received:

[Top surgery] definitely [made me feel] more comfortable. All of them [medical interventions] have made me feel more comfortable about my body. Probably the one that made the biggest difference was top surgery. (Steve, transmasculine, 17 years old, quoted in Article a)

Conversely, in Switzerland, Medico et al. (2020a) found that gender dysphoria increased as care was found to be very difficult or even impossible to access. The authors recounted that when 21-year-old Raphaël was asked what kept him depressed, he simply answered, "Because they didn't want me to have the operation." Based on reoccurring statements made by parents and youth, the authors hypothesized that a loss of hope and an inclination to self-harm become a way of externalizing, mourning, and soothing the suffering experienced by young people in the French Swiss sample:

How to describe mental pain... I was just so upset that I wonder what I could do to get better, actually. I had... I had dark thoughts, I did not want to die but I just felt so bad that I curled up in

a ball and I cried, cried, cried, cried and I wanted to do this so much more that I did this [suicide attempt]. (Extract from Raphaël, translated from Medico et al 2020a)

Despite the challenges still facing youth and their families while accessing care, the parents and caregivers from all four countries emphasized the important role of health professionals in accessing gender-affirming care, which helped them support their child. These professionals were said to play a crucial role in reassuring parents that they were doing the right thing by supporting their child—whether in accessing treatments or by supporting their child in expressing their affirmed gender. In Australia, for example, Riggs et al. (2020a) reported that the children noticed that accessing professional help at the clinic “helped my parents get a boost in confidence with [supporting my gender identity].” Conversely, when the family did not have access to specialist clinics to address their child’s medical needs, the parents expressed the need for support from professionals to help them better support their child in other ways. This was identified as crucial to help them with their feelings of uncertainty about whether they should support their child in expressing their gender identity, which some parents from the Swiss sample also linked to feelings of guilt.

## ***Discussion***

Examining the data collected in four countries through projects that used a similar methodology is helpful because it confirms that access to gender-affirming care remains challenging, even in countries where universal access to care is supposed to be guaranteed. The analysis also allows us to identify important regional differences in how WPATH SOC are applied, despite their intended global scope (Coleman et al., 2012). Although our research did not assess specific compliance with SOC, we note that some TNBY were still unable to access gender-affirming care promptly whereas current standards explicitly state that risks of psychological distress and violence increase when care is withheld (Coleman et al., 2012).



Our research has also identified that TNBY self-reported well-being differed between the samples. Although the research methodology did not allow us to draw firm conclusions in comparing self-reported mental health difficulties, it appears from our analysis that such difficulties were greater among participants in the Swiss and English samples, where access to care is limited. Conversely, in countries where gender-affirming care was more easily accessible, TNBY described an important improvement in their overall well-being after accessing such care (see, e.g., Articles a and e). Although this finding must be interpreted with caution, it adds to the small but growing body of literature on the mental health benefits of gender-affirming care including medication such as puberty blockers (Turban et al., 2020; Sorbara et al., 2020).

Our research also underlines that many important barriers remain while accessing care. TNBY in all four countries described staff working with them as lacking training to varying degrees, noting that they and their families had to educate professionals from whom they sought care, as has been pointed out in previous research (Gridley et al., 2016; Guss et al., 2019; Heard et al., 2018). This also aligns with findings on American medical students, who self-reported lower knowledge of transgender health than of gender minority individuals (Liang et al., 2017).

Based on these findings, we recommend that professionals and clinics apply SOC as a minimum while also building greater flexibility into their treatment protocols and applying them in a manner that takes into account the specific needs and reality of each patient, family, and context. We also recommend that providers work in collaboration with youth and their families to determine the best course of treatment and help families move toward more effective support of the TNBY (Clark et al., 2020; Daley et al., 2019) and to foster their empowerment and autonomy. Our findings also support the position that recent court judgments, such as Quincy Bell and A -v- Tavistock and Portman NHS Trust and others, which restrict access to puberty blockers to young people aged 16 years or over, will be detrimental to young people and heighten the risk of psychological distress among TNBY (WPATH et al., 2020) but will

also greatly impact their parents, who often benefit from the relationship with professionals to better understand and support their child. The research also supports the importance for all professionals working with TNBY inside and outside specialty clinics to gain additional training on the needs and realities of TNBY. As a starting point, providers should turn to recommendations from TNBY themselves, who have concrete suggestions on the basic information that providers should know about their experiences and needs (Turban et al., 2017), moving toward interventions that promote age-appropriate informed consent, support and accompaniment. Finally, in showing how the larger context and access to gender-affirming care may influence TNBY well-being, our results complement de Vries et al.'s (2016) hypothesis linking greater social acceptance of trans identities with better mental health.

### ***Limitations***

The contextual differences in the way the samples were built warrant the conclusions to be interpreted with caution. To begin with, the original Canadian study only involved youth who were already accessing gender-affirming care in clinics that were considered trans-affirming (Pullen Sansfaçon et al, 2019a). The participants were recruited through the clinics' patient lists, and the interviews were conducted in a clinical setting. In Australia and England, the youth were all in the process of, or already accessing, gender-affirming services, but no clinics were involved in recruiting participants; instead, recruitment was done in collaboration with a parent support organization. The experiences of clinical care that were shared may greatly differ depending on where that care was accessed and the means through which recruitment occurred. In contrast, the specific context of French Switzerland is one where no gender clinic existed at the time of the study. These differing contexts also affected the questions that were asked and the format of the interviews. Furthermore, there are very few non-binary youth in the sample. This prevented the team from presenting an analysis that highlights their needs or experiences, which may differ from those who identify as binary, who constituted the bulk of the sample here.

Finally, as demonstrated in Table 1, we note a certain homogeneity in some of the participants' sociodemographic characteristics across the four samples, especially regarding an overrepresentation of white families. Hence, the conclusions cannot be generalized to other groups.

## **Conclusion**

The present paper compared results from four studies that were conducted using similar methodologies; this was done by examining the experiences of TNBY and their families accessing gender-affirming care in four countries: Canada, Switzerland, England, and Australia. Among the themes that occurred in all four samples, we found that prompt access to gender-affirming care was crucial to ensuring and improving the well-being of the young people who sought it. It was generally found that those who were prevented from prompt access to care self-reported mental health difficulties more often than those who had ready access to care. Most notably, TNBY from the samples in England and French Switzerland self-reported many mental health difficulties, strengthening the hypothesis that challenges in accessing care may impact youth well-being. Indeed, although many of the themes and experiences were found to recur in all four countries, the results shed light on how the local context and variations in application and interpretation of SOC must be taken into consideration when examining the overall well-being of trans and non-binary youth.

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