Seeing people as people:

Final Report of the Trans Age Project

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Commissioned by Age UK Cheshire

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Executive Summary

The Trans Age project involved

- a systematic search for existing relevant literature, and
- interviews with older (age 50 plus) trans individuals and with health and social care personnel to seek experiences and views on the health and social care of older trans individuals.

Key learning from the literature is:

- ***Common to mental and physical health care and social care:*** fear of hostility/ discrimination/ disrespect; need for health and social care staff training/ education; the importance of respect, sensitivity, and an individualised person-centred approach; the inflexibility of recording/ IT systems; and the importance of future planning
- ***Specific physical health care themes:*** higher rates of physical morbidity in trans older adults; concern about the long term effects of hormonal treatments and need for screening
- ***Specific mental health care themes:*** higher rates of psychological morbidity*:* and the complex relationship between mental health and trans identity
- ***Specific social care themes:*** possible increased reliance on formal services

Analysis of the interviews identified:

- ***Levers:*** forces that might influence a person's contact with health and or social care in a positive or negative direction. This included the following: age; experiences good and bad; family relationships; LGBT identity/ communities; and money/ finances.
- ***Contextual forces***: powerful contextual factors that shape encounters in health and social care but are not located in the person's personal experience and have a negative influence. This included: discrimination/ hate; they hadn't a clue; and vulnerability.
- ***Areas for positive practice*** including: administrative practices; demonstrating inclusivity; learning/ training; personalised care; and service redesign

The Report includes six positive practice case studies.

Nine recommendations come from the study:

- Training/ education of health and social care staff
- Visibility in the health and social care environment
- Ready access to peer and psychological support
- The role of primary care in transgender medicine
- Specialist versus generalist social care
- Monitoring
- Further research
- Media/ publicity
- Sharing learning and good practice

Part 1: Background

Project brief

Older Mind Matters Ltd was commissioned by Age UK Cheshire to investigate older trans people's experience of accessing health and social care. The project was designed to deliver the following:

- Engaging with local (Cheshire and surrounding counties) trans communities
- Holding a series of interviews/focus groups with people aged over 50 who identify as trans
- Holding a series of interviews/focus groups with health and social care professionals
- Determining what, if any, are the barriers in accessing health and social care provision
- Determining good practice as voiced by the trans community
- Presentation of findings in a number of ways that make it accessible to wide range of audiences, particularly so it can be shared with health and social care providers in a user friendly way.

Primary outcomes identified were:

- Ensure that older trans people in Cheshire have a voice
- Influence professionals and policy decision making within Cheshire West and Chester
- Set good practice guidelines for future health and social care provision
- Identify specific areas for future, further research

Work on the project commenced in July 2017.

Language and definitions

In this report we use the term transgender and the shortened form trans. There are a number of definitions of the term transgender or trans:

A trans person is someone who feels that the sex they were assigned at birth (male or female) does not match or sit easily with their sense of their own gender. Trans people come from all walks of life and include those who may describe themselves as transsexual, transgender, a cross-dresser (transvestite), non-binary and anyone else who may not conform to traditional gender roles. It includes those who have transitioned from male to female (transgender women) or from female to male (transgender men) as well as those who do not have a typically 'male' or 'female' gender identity (non-binary). (Government Equalities Office & Gendered Intelligence, 2015) page 3

Trans – an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) Transgender, Transsexual, Gender-queer (GQ), Gender-fluid, Non-binary, Gender-variant, Crossdresser, Genderless, Agender,

Nongender, Third gender, Two-spirit, Bi-gender, Trans man, Trans woman, Trans masculine, Trans feminine and Neutrois. (Stonewall, 2017)

Stonewall's glossary also defines trans women, trans men and cisgender:

Transgender man – a term used to describe someone who is assigned female at birth but identifies and lives as a man. This may be shortened to trans man. (Stonewall, 2017)

Transgender woman – a term used to describe someone who is assigned male at birth but identifies and lives as a woman. This may be shortened to trans woman. (Stonewall, 2017)

Cisgender - someone whose gender identity is the same as the sex they were assigned at birth. (Stonewall, 2017)

The Gender identity Research & Education Society (GIRES) uses a different definition:

'Trans men' are those born with female appearance but identifying as men; and 'trans women' are those born with male appearance but identifying as women. The terms may also be used to imply a direction of travel, towards a more masculine or feminine gender expression, rather than a complete transformation of a person's gender status. (Gender identity Research and Education Society, 2018)

We also use in this Report the abbreviation LGBT, which Stonewall describes as:

the acronym for lesbian, gay, bi and trans. (Stonewall, 2017)

Medical classifications

Authors Note: We include below information about how medical classifications have historically regarded trans people and have assigned them a 'psychiatric diagnosis'. The reason for including this here is that this is important context that may influence trans people in their contact with services, particularly psychological and mental health services. We regard this practice as outdated. The American Psychiatric Association states that

It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition. (American Psychiatric Association, 2013)

Nevertheless, in order to access treatment for gender identity, trans individuals have in the past been required to accept a psychiatric diagnosis. In discussions about updating ICD10 and producing ICD11 it was recommended that 'gender incongruence' be removed from Mental and Behavioural Disorders and moved to a chapter on Conditions Related to Sexual Health. Whilst taking gender variance away from a

psychiatric classification in ICD11 represents progress, conflating gender with sexual health is unlikely to be helpful.

In the International Classification of Diseases ICD10 version 2016 code F64 applies to Gender Identity Disorders and under F64 lists the following disorders (World Health Organization, 2016): transsexualism, dual role transvestism, gender identity disorder of childhood, other gender identity disorders, and gender identity disorder unspecified. Transsexualism is defined as:

A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex. (World Health Organization, 2016)

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) uses the term gender dysphoria, which is defined as:

a difference between one's experienced/expressed gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:

1. *A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics*
2. *A strong desire to be rid of one's primary and/or secondary sex characteristics*
3. *A strong desire for the primary and/or secondary sex characteristics of the other gender*
4. *A strong desire to be of the other gender*
5. *A strong desire to be treated as the other gender*
6. *A strong conviction that one has the typical feelings and reactions of the other gender* (American Psychiatric Association, 2016)

Thus, until the publication of ICD11 in 2018, people who experience gender variance have been given a diagnosis by western psychiatry using either ICD or DSM (Winter et al., 2016). How might this influence their contact with and expectations of services?

Trans Population Demographics

The Gender Identity Research & Education Society (GIRES) updated their information on the prevalence of people who had sought medical care for gender variance in 2011: in 2007 the Society had estimated a prevalence of 20 per 100,000 with a ratio of 4 trans women to 1 trans man. Their update suggests that the prevalence of people experiencing gender variance could be as high as 1% (although the prevalence of those seeking transition is much smaller, perhaps 0.2% of the population) and that the ratio of trans women to trans men may eventually become more equal (Gender Identity Research and Education Society, 2011). The update also notes that the number of gender variant people seeking treatment is growing and that gender variant people may present for treatment at any age, quoting a median age at presentation of 42.

Legal context

Gender reassignment is one of nine "protected characteristics" in terms of the Equality Act 2010 alongside age, sex, sexual orientation, disability, race, religion or belief, marriage and civil partnership, pregnancy and maternity.

A person has this characteristic if he or she: is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.
Such a person is referred to in the statute as a "transsexual person".

People with protected characteristics are legally protected from indirect and direct discrimination, harassment and victimisation. The Gender Recognition Act 2004 enables trans people whose birth was registered in the UK to have their affirmed gender recorded on their birth certificate. This is done by an application to the Gender Recognition Panel for gender recognition. If successful, the applicant is issued a Gender Recognition Certificate (GRC), which enables that person to be recognised for all legal purposes as belonging to their affirmed gender.

Project Methods

The project methods were:
1. a systematic search for existing relevant literature
2. interviews:
a) with trans individuals recruited to speak about their experiences and views through trans support groups/ organisations
b) with health and social care personnel recruited to seek their experiences and views

Initially we intended to apply for ethical approval of the project but were advised that since the TransAge Project is a service improvement project, ethical approval is not required.

Part 2: Learning from existing relevant literature

Method

We carried out an initial systematic search for literature using the keywords transgender and old*. We then reviewed the papers identified (n=34) for relevance to physical and mental healthcare and social care, and have added grey literature that has been identified during the project and through contacts with a variety of agencies, plus further papers from the reference lists of a range of documents (total n=67). Figure 1 shows the breakdown of categories of the papers collected. Fifteen are specific to older transgender persons but the definition of older adult varied: ages 50+; 55+; 60+ and 65+ were all used as cut-offs.

A computerized software package (NVivo) was used to assist a narrative analysis of the papers collected. NVivo is a qualitative data analysis computer software package (Bazeley & Jackson, 2013; QSR International, 2016) used to analyse rich text-based data. It facilitates the organization, storage, and retrieval of data and incorporates advanced data management, interrogation and visualization tools. It is useful in qualitative research and complements a variety of theoretical approaches.

The collected literature was read and re-read to allow familiarization with the literature, and then subjected to thematic analysis in order to explore commonalities and differences in the literature by identifying recurring themes and patterns (Braun & Clarke, 2006). The approach was not situated in a particular philosophical stance or theoretical framework. Thematic analysis followed the following process after the familiarisation stage; search for themes; review and clarification of themes; naming and definition of themes; and overall synthesis. Emerging themes were discussed, refined, clarified and named by the research team members in partnership.

Results: Learning from the literature

The literature on older trans adults is limited and studies that are published as focussed on "LGBT" participants may include a very small number of trans participants or none, with the study being extrapolated to include trans people. Much originates from the USA, and UK research literature relevant to older trans adults is even more limited. An additional complication is that studies use a range of different cut-offs for older age.

Key themes identified to date are:

Common to mental and physical health care and social care

1. Fear of hostility/ discrimination/ disrespect: this is prominent in a number of papers and links with previous negative experiences in health and/or social care and possibly fear of being judged. Writers suggest that services need to proactively address this concern eg by displaying that they are "LGBT friendly"

or that staff have undertaken specific trainings and by cultivating links with local groups. ((Latham & Barrett, 2015a; C. A. Walker, Cohen, & Jenkins, 2016; R. V. Walker, Powers, & Witten, 2017; T.M. Witten, 2014)

2. Health and social care staff training/ education: this is often regarded as helpful and important. It indicates that agencies are aware of the importance of gender variance and of addressing the distinct needs of trans adults of all ages. Trans people often report that they are put in a tricky position of educating the health and social care professionals they work with, and may be subjected to intrusive questioning which they do not regard as relevant, ie. trans people may be put in a position where they have to come out as trans to health and social care providers despite not seeing their trans status as relevant to their health and/or social care needs. They may perceive this in terms of over-medicalisation of their lived experience. (Fredriksen-Goldsen et al., 2014; Latham & Barrett, 2015a, 2015b; Mahan, Bailey, Bibb, Fenney, & Williams, 2016; Siverskog, 2014; T.M. Witten, 2014; Witten, 2015)

3. The importance of respect, sensitivity, an individualised person-centred approach and the need to understand the broader life context and experiences of older trans adults. (Latham & Barrett, 2015a, 2015b; Siverskog, 2014; C. A. Walker et al., 2016; R. V. Walker et al., 2017; T.M. Witten, 2014)

4. Inflexibility of recording/ IT systems so that they may contribute to mis-gendering and eg that reference ranges for physical test results may not apply to trans persons.

5. Future planning – including the importance of advance care planning and nominating next of kin. (Latham & Barrett, 2015a; R. V. Walker et al., 2017; T.M. Witten, 2014)

Specific physical health care themes

1. Higher rates of physical morbidity. Older trans adults have been reported to have higher rates of physical ill-health, disability, obesity and lack of physical activity than older non-trans LGB adults (Fredriksen-Goldsen et al., 2014). Drug and alcohol use and smoking are areas of concern at all ages, although drug and alcohol use has been reported to be less prominent in older trans age groups (Grant et al., 2011).

2. Concern about the effects of long term hormone treatments on physical health, need for appropriate screening (which may be associated with the person's gender assigned at birth) and whether healthcare providers are knowledgeable about aspects of caring for older trans adults. (Mahan et al., 2016; Siverskog, 2014; C. A. Walker et al., 2016)

Specific mental health care themes

1. Higher rates of psychological morbidity. Older trans adults have been found to be at higher risk of depressive symptomatology and perceived stress than older

non-trans LGB adults (Fredriksen-Goldsen et al., 2014). They also have high rates of self-harm: 16% of trans people aged 65+ in a USA survey reported having made a "suicide attempt" (Grant et al., 2011). Hoy-Ellis and colleagues found that nearly 50% of trans adults aged 50+ had clinically significant depressive symptomatology in a secondary analysis of data from a large community survey in the USA (Hoy-Ellis & Fredriksen-Goldsen, 2017).

2. There is a complex relationship between mental health and identifying as trans, and mental ill-health should be diagnosed in the same way amongst trans people as non-trans people. In the past being trans was itself regarded as indicating mental ill-health and the term gender dysphoria is still in use. Societal attitudes are changing and identifying as trans should not be taken in and of itself as indicating mental ill-health, although in the past this is how it has been understood. Older trans people may be sensitive to suggestions that they are psychologically unwell and concerned that psychological symptoms will be attributed to their trans identity. Seeking counseling might be associated with getting a diagnosis in order to access medical care rather than as a way to access psychological help (Fabbre, 2015; T.M. Witten, 2014).

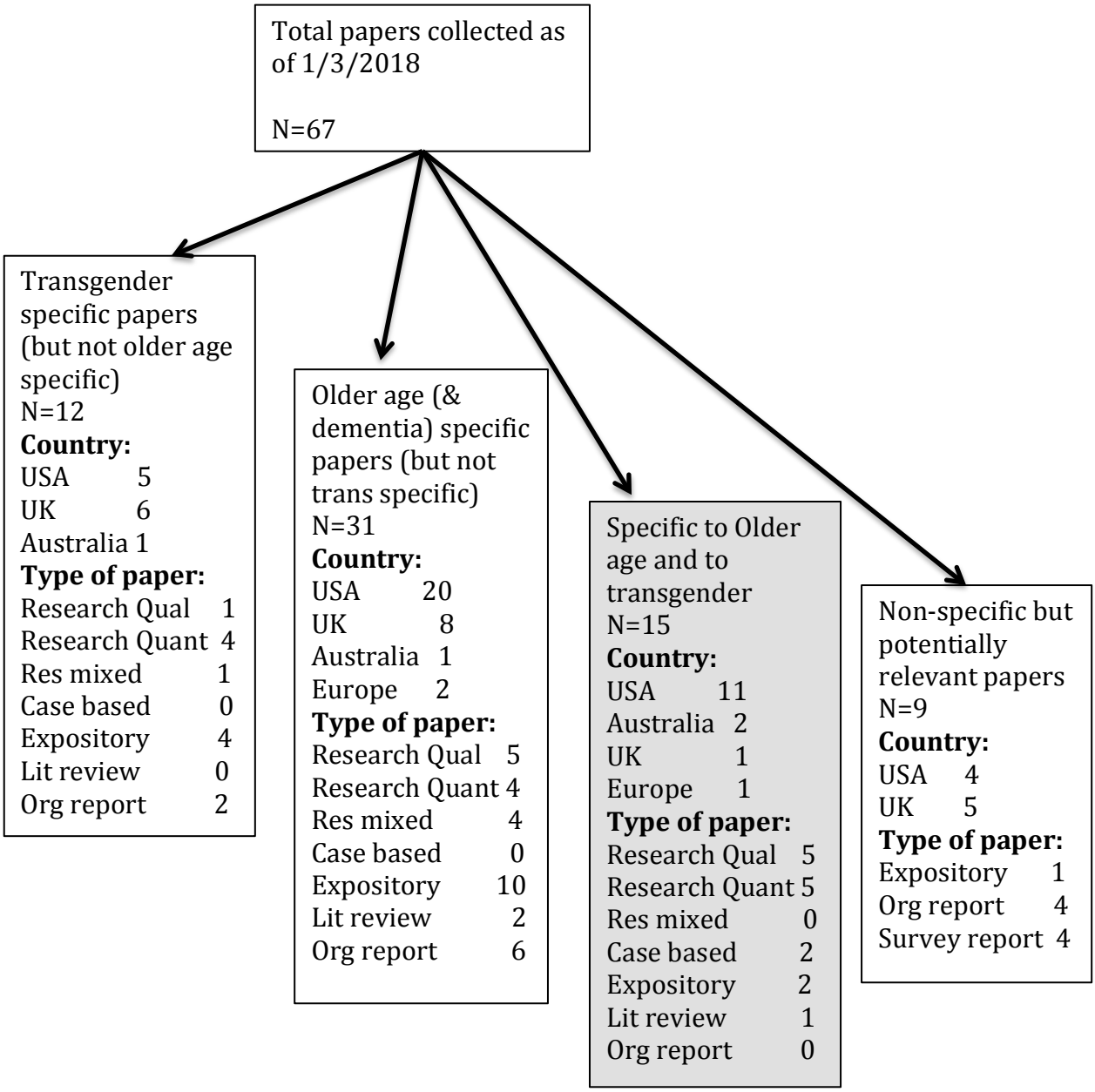
Social care

1. Possible increased reliance on formal services because of lack of family/ social support.

Specific areas of concern:

Four areas were identified as of specific concern. These are:
1. Care-giving
2. Dementia
3. End of life care
4. Gender identity clinics

Figure 1: Literature collected up to 1/3/2018



Part 3: Learning from people's experiences - interviews

a. Making contact with trans support groups/ organisations and speaking with people about their experiences and views

Contact was made with a range of groups that support trans individuals. Posters were circulated and various organisations agreed to display them. Information about the project was disseminated in organisational newsletters. Any invitations to meetings were taken up and suggestions of additional people/ organisations to contact were followed up. Interested trans individuals were invited to contact the project team by email, through a web-based contact form, or by post. Figure 2 shows the poster used. Supportive organisations are acknowledged in the Acknowledgements.

Interested people were supplied with a participant information leaflet and subsequently asked to complete a consent form, which asked for their consent to interview and to audiotape and transcribe interviews: these could take place individually (face to face or by telephone) or in a focus group. Face to face interviews/ group discussions took place at Age UK Cheshire offices, at the trans community house in North Wales, and at the LGBT Foundation in Manchester. We spoke with a wide range of people during recruitment including non-binary trans individuals but no non-binary individuals agreed to participate.

Interview transcriptions were analysed qualitatively assisted by a qualitative data analysis programme, NVivo.

b. Making contact with health and social care personnel to seek their experiences and views

Contact was made with a range of organisations and individuals involved in providing health and social care services in Cheshire and the North West and interested professionals were invited to engage in telephone or face to face discussion. The project team made notes during these interviews of key points raised and the key points were analysed qualitatively using the assistance of NVivo.

Qualitative analysis

The process followed in the qualitative analysis mirrored that employed in the literature search. The transcripts and interview notes were read and re-read to allow familiarization with them, and then subjected to thematic analysis in order to explore commonalities and differences in the accounts by identifying recurring themes and patterns (Braun & Clarke, 2006). The approach used was not situated in a particular philosophical stance or theoretical framework. Thematic analysis followed the following process after familiarisation; search for themes; review and clarification of themes; naming and definition of themes; and overall synthesis. Emerging themes were discussed, refined, clarified and named by research team members in partnership.

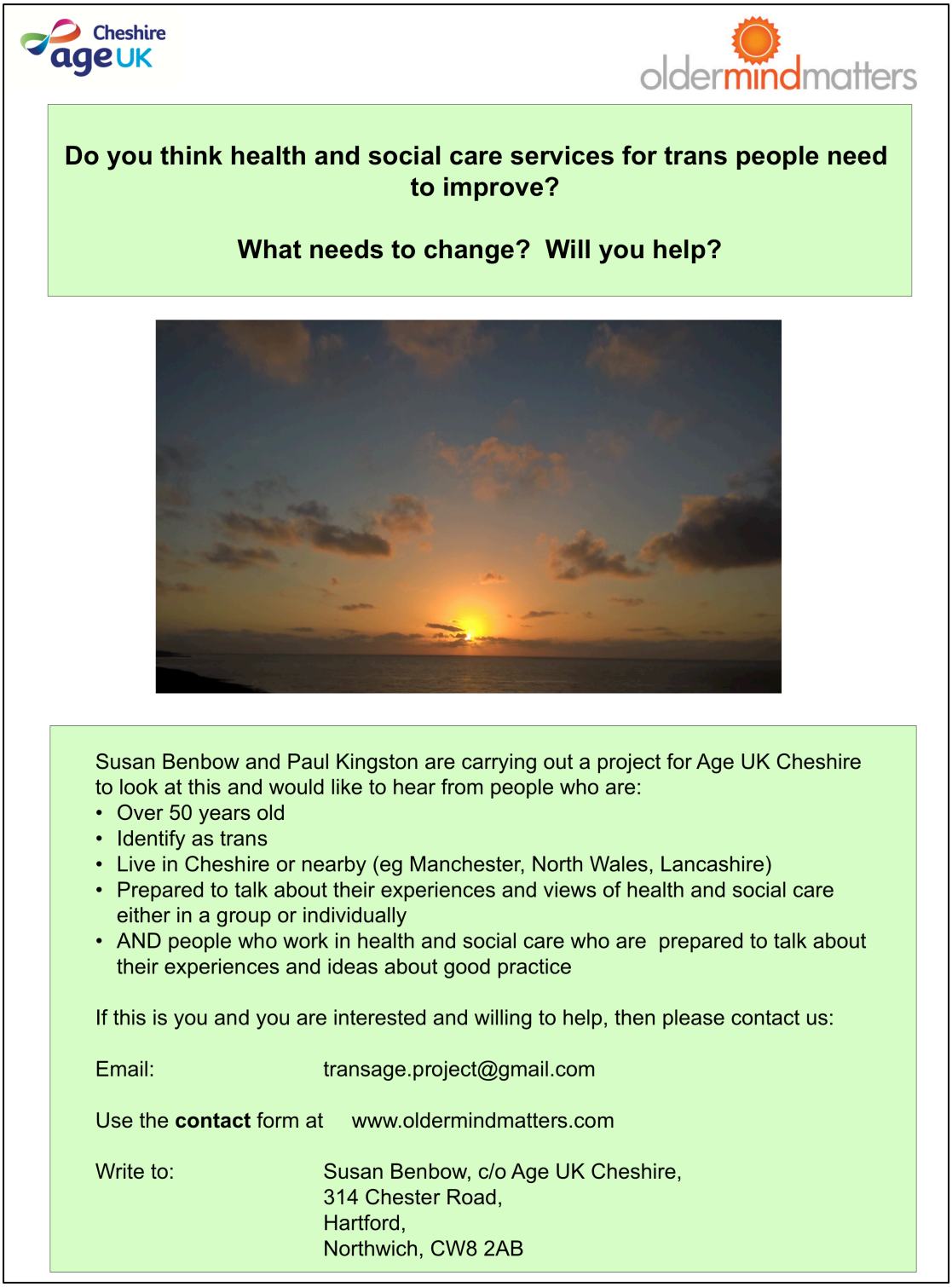


Figure 2: The poster used to assist in recruiting trans individuals.

Results from the analysis of interviews

Interview participants

22 professionals from health or social care contexts were interviewed, including:
4 GPs
1 primary care other
1 therapist
4 End of life care professionals
1 public health professional
4 Professionals from social care settings
1 Health service commissioner
3 Third sector persons
3 Secondary care professionals
1 person was also involved in medical school teaching

The professional interviews were conducted as follows:
3 Skype video call
6 Face to face
13 Telephone

17 trans individuals were interviewed as follows:
7 individual interviews (5 face to face, 2 by phone)
10 focus group contributions from trans individuals (all face to face) in two focus groups

In totals this represents contributions from:
15 trans women
2 trans men
Those participating were at different stages of their journey, ranging from pre-operative to over 25 years post-operative. Details of their ages are given in the table below.

Table 1: ages of trans participants

	Trans women	Trans men
40s	0	1
50s	5	1
60s	3	0
70s	5	0
Did not share age	2	0

Thematic analysis

Thematic analysis resulted in three main themes, each with several sub-themes. The thematic structure is set out in Table 2. The three main themes were:

1. Levers
2. Contextual forces
3. Areas for positive practice

We have added a fourth heading for specific issues.

Table 2: Thematic structure - themes and sub-themes

Theme	Sub-themes
Levers	Age Experiences good and bad Family relationships LGBT identity/ communities Money/ finances
Contextual forces	Discrimination/ hate They hadn't a clue Vulnerability
Areas for positive practice	Administrative practices Demonstrating inclusivity Learning/ training Personalised care Service redesign

General comments

There are three important practical issues that set the context for the themes arising in the interviews.

Firstly, although the remit of the interviews and focus groups was people's experiences and views or ideas about health and social care and how it might be improved for trans service users, in individual interviews trans participants usually wanted to start by talking about their journey and their main concern was overwhelmingly about gender identity services, although each participant was asked specifically about physical and mental health care (primary and secondary) and social care. Other physical and mental health services were set firmly in the context of experiences related to gender identity.

Secondly, the group of trans participants as a whole had limited experience of social care, so, in terms of their experiences, these were dominated by their experience of healthcare. For this reason we have added a short piece specific to social care under specific issues.

Thirdly, the analysis pools the qualitative data from professional interviews and interviews with trans individuals because there were commonalities shared by the two groups. We recognise that the professionals were to some extent self selected in that they were those people who agreed to talk to a project worker. Contact was made with a large number of organisations and individuals and the professional interviews are unlikely to be representative. It was particularly difficult to access interviewees from social care settings and it was suggested to us that this may be because social care professionals have limited experience of caring for older trans people.

The quotations from audiotaped interviews are set out below in italics. Where material is quoted from interviews that were recorded as contemporaneous notes this is indicated after the quotation, along with an indication of whether the piece quoted was recorded verbatim. In order to ensure confidentiality specific ages and names of towns, other people etc have been removed together with any other information that might identify the person concerned.

Thematic structure

1. Levers

We have called this theme levers to indicate that these are forces that might influence a person's contact with health and or social care in a positive or negative direction. There are five sub-themes.

- ***Age***

Age might make it more difficult for people to seek care for their gender variance, but, for an individual, increasing age might help that individual to make a decision since increasing age can bring with it a sense of urgency.

For example:

" *as you get older you know yourself, what kind of limit your lifespan is. Most blokes live until they are 76 if they are lucky. Average wise, ladies live until they are 84 – that's the average lifespan. So I am 50 now – 52 – and it is going to take five years to do all this and I will be 57 then and I am going to have another 10-15 years if I am lucky - remaining years of my life the way I want to be, so that is the urgency absolutely spot on*."

"*the doctor said, 'Do you want all this hassle at your age? ....at (my age) if I don't do something about it now, I am never going to."*

"*I am at the stage where it's now or never and, if it is never, I know that the older I get the more unhappy I am going to get with my body*."

People talked about having more life experience as a result of being older and pointed out that, for that reason, their wishes in respect of treatment related to their gender variance should be respected, however they also talked about the

medical conditions they had (examples were atrial fibrillation, severe arthritis, and previous heart attacks) and how these might limit their options.

The professionals interviewed also highlighted issues relating to age. For example a GP pointed out:

"The longer you live with the programming that the world wants you to have the harder it is to risk losing family members, position, status" (from notes of interview with GP)

and a secondary care professional commented:

"Older people have often done a very good job of presenting as their assigned gender – does that make it harder to convince their peers, families? So people have to try harder?" (from notes of interview)

- ***Experiences good and bad***

People often drew on past experiences with health and/or social care. Some people described good experiences:

"I haven't had any problems with healthcare. I've had a tour of North West Hospitals – (named three) all within about the last 12 months. I had my own room in all of them – they treated me as me. I was called my preferred name. I was never mis-gendered. Absolutely ok."

"I have a very good GP. She is wonderful and she listens and she understands. Yes, she is great. We really work well together."

Others described uncomfortable or bad experiences. Here a trans woman in her 70s describes an encounter with a GP about a health condition not related to her transition:

"This man as soon as I went in, he just turned his back on me and kept his face on the computer and wouldn't speak to me, while he was talking to me, and this was about a totally different thing."

- ***Family relationships***

A number of people described having no contact with their family, usually as a result of telling family members about their gender identity. A trans man in his 40s describes what happened:

"It's like I have thrown a bombshell in the middle of my relationship and I don't really know how to make it any better now... Because the relationship with my partner's mum and me has completely broken down, and her and her sister, my partner's sister, don't want anything to do with me at all."

In contrast, other people described family members who had supported them.

"So, my family were very accepting, but then I told my daughter and she lived in Central London and we lived in (another part of the country) and within a week she sent me a parcel of clothes, would you believe?" (trans woman aged 70s)

The parcel of clothes consisted of women's clothes for her trans parent to wear now that she had come out.

Two trans women talked about their "adopted daughters" who had now become their family of choice. Another trans woman talked about how she and her partner had wanted to formally adopt a number of years ago, but had been told that they couldn't because they suffered hate crime.

- ***LGBT identity/ communities***

Some people talked about the support they got from being connected with LGBT communities or trans organisations: for example:

"*If you are in the LGBT world it's no good looking for help from societies that are … it's not their fault but they are structured as straight. You cannot communicate – not the things you need to bring out, you can't do it."* (trans woman aged 60s)

Others felt that they didn't fit in, perhaps because of their age:

"*It is about younger people."* (trans woman aged 60s)

Another person commented that attitudes need to change in the LGBT community and that there is discrimination within LGBT communities.

- **Money/ finances**

Where people had money (savings, a good pension or a home) this opened up options for them. Several people talked about the costs of different treatments related to their gender variance, for example:

"unless you are a millionaire or very rich and earning good money it takes years to save up for all these operations." (trans woman aged 50s)

and

"I came out of the divorce with absolutely nothing. I left the house behind – I signed it all over. I left that world behind. I had nothing - but I ended up having everything in a plastic bag standing on a street corner with nowhere to live, no money, nothing." (trans woman aged 60s)

2. Contextual forces

We have called these forces since they are powerful contextual factors in people's accounts that shape encounters in health and social care but they are different from the levers in that they are not located in the person's personal

experience and they don't have the potential for positive as well as negative influence.

- **Discrimination/ hate**

Some people described frankly discriminatory experiences, for example:

"I had a bad experience with a GP – he threw a paper in my face and I made a complaint. I never heard any more. He was an Indian GP and I think it was prejudice. I know the reason is he didn't know what to do. I saw another GP and they were ok." (focus group 2 – trans woman aged 50s)

"*We become used to expecting rejection. We know what rejection is like. I have been sacked from jobs for being the way I am... I have been beaten up and left bleeding in the street for the way I am. I have been sworn at. Oddly enough it's horrible but that is something you learn to deal with and you get through it. The stuff that really hurts which I have come across is much less, it is much more subtle…*" (trans woman aged 60s)

Some participants were generous in their understanding of the other person's perspective and felt that some reactions resulted from embarrassment. For example:

"Even if people are hostile, you know, I see it from their point of view as well, so I don't get angry with them. I might get frustrated that they can't understand…" (trans woman aged 70s)

A domiciliary care provider made a telling statement from the perspective of an employer (noted verbatim during the conversation):

"*it's hard to police people's -isms*"

- ***They hadn't a clue***

Others stressed that some of the difficulties in services stemmed from the fact that:

"*they hadn't a clue, they had no answer whatsoever."* (trans woman aged 70s)

The result was often that the trans individual had to become an "expert patient" and teach both health and social care providers.

"*I researched it myself. I had to do it all myself off the internet… "* (trans woman aged 50s)

In contrast another trans woman made the point that some older adults will not be comfortable accessing information using the internet and may be disadvantaged by that.

- ***Vulnerability***

People described a range of vulnerabilities. Here a trans woman describes how she feels that the label of "trans" stops her being seen as a person and influences her care:

"*they see the trans thing and they don't think of us as … they see the trans label, rather than there is a patient that needs care and, alright, this is their problem…* "

The case vignette below is a trans woman's account of an encounter that put her at risk.

Case vignette 1 – vulnerability and risk

"I have nearly been raped... through naivety. (I put)… an advert in the back of (a trans publication), you know '(geographical area, age), looking for friends' and so on and a mobile phone number, and a chap rung a few times, talking to me and you know seemed nice and, you know, 'Well I would like to come and meet you'. After a while I said, 'Well yes if you want to'. He said, 'You will be… you will be dressed won't you'? I said, 'Yes of course', I said 'Yeah'. (and the meeting was arranged) … when I was going to be on my own and I made some sandwiches and was going to give him a cup-of-tea and just be hospitable … And I thought it would be nice and I was flattered that he wanted to meet as well. Oh my God! He came to the door, and as I opened it, I knew I was in trouble. He was bigger, a lot younger and he had the most massive erection you have ever seen … it was so obvious… Well I said, 'well come on in', I said, 'I will put the kettle on and would you like a cup-of-tea and a sandwich and…'. 'Where's the bedroom'? And I was lucky, I said … '(My friends) are all next door'. I said, 'And if I shout or make a row', I said 'They will be in here, now please'… and he backed down… He had a cup-of-tea and he went. There was nobody next door!"

Another participant described an encounter with a professional that involved similar risk. Prostitution was also mentioned as a risk for people who were lonely and needed money to fund procedures related to their transition.

3. Areas for positive practice

These are areas where people described what positive practice might look like, although sometimes they themselves had different experiences. There are five sub-themes.

- ***Administrative practices***

One person described how they knew someone who wanted their gender changed at the GP surgery and was told to go to the front desk and tell the receptionist, with no concern for privacy or confidentiality. Another person described how her GP changed her gender on the system:

"*When we did all the paperwork, my Doctor actually did it on the computer and then we went down to actually speak to the Practice Manager and she took me to the back room and filled the forms out there*." (Focus group 1 – trans woman age not given)

There were two areas of particular concern. One was laboratory tests and norms for men and women. People wondered whether there should be norms for trans men and trans women. The second related to screening and whether trans individuals were screened appropriately for conditions they had a risk of by virtue of their assigned gender. This person talks below about PSA tests – the test measures the level of prostate-specific antigen (PSA) in blood and as a trans woman she still had a prostate.

"*there is a glitch in some of the software that won't let me have a PSA test. When I go to my GP and book a PSA test, the system says because I have a female NHS number, I can't have a PSA test, because women don't need PSA tests.*"

One focus group made the point that trans individuals may need encouragement and education to engage in appropriate screening:

"*quite a lot of trans people don't own the parts of their body that don't match their gender… So, they are quite likely to neglect them, not ask for screening, and we know in some cases people have got so ill, that it is almost impossible to treat them, before they say something is wrong.*"

- ***Demonstrating inclusivity***

A theme in several interviews with professionals was how to make the visible environment more trans-friendly and suggestions came in a number of interviews with trans individuals, who spoke positively about the impact of these environmental changes.

- gender-neutral toilets
- information/ posters about LGB and T organisations in the waiting room
- something on the website to show the organisation is trans-friendly - perhaps a rainbow flag
- advertising that staff have had relevant training,
- LGBT officers in organisations, ie a named person to contact
- attention to use of language
- policies and procedures addressing trans patients/ clients

A trans woman in her 60s said:

"*in business, as is required by law, there should be…..you have a discrimination statement that falls into your policies and health and safety statement and policies and all the rest of it, that you will support no discrimination on the basis of age, race, religion, sex, gender orientation, sexual orientation and so on…*"

Another aspect of inclusivity is being sensitive to an individual's sensitivities. One participant described having surgery unrelated to her trans identity. She

was asked about her history of gender reassignment surgery. She could have reacted to this as intrusive questioning but she understood why they asked and felt ok about it, once staff explained that they wanted to know about her experience of and reaction to the anaesthetic. The information led to her being given a different anaesthetic.

The case vignette below demonstrates staff advocating for respectful inclusive treatment of a trans woman.

Case vignette 2 – inclusivity and support

One trans woman described an experience in an accident and emergency department:

"I actually ended up with a head injury, ended in the hospital in A&E and I am there because I wear a wig, I had the wig off because I was bleeding from a head injury so, I am sort of sitting in a cubicle surrounded off, and I heard the conversation from one of the specialists sort of saying 'can you go and treat (name) for a head injury' and they said 'I am not treating a … that is not a woman, that is a 40-year old man and I am not treating them'. And it was the consultant, I think, said 'you will treat that patient with dignity and respect. If you're not, then you will have to reconsider your post in here and possibly the hospital, and even your career'. So, it were dealt with at the time but it should never have occurred in the first place."

- ***Learning / training***

Both professionals and trans individuals talked about the importance of staff being trained but some people commented that training does not change attitudes, which may continue to be a problem. Involving trans individuals in training was regarded as important. One person noted that less time and effort has gone into training related to discrimination on the grounds of gender and/or sexuality than discrimination related to race or culture. One person from primary care highlighted that some nurses or doctors will not be comfortable with gender variance "at all" but expressed the hope that this is a generational effect and that future generations are likely to be more "accepting".

Most of the professionals commented that they themselves had not received any training relevant to working with trans people, leading to the idea that embedding trans/ perhaps LGBT awareness throughout health and social care qualification level training might be helpful in the long term. One professional from the social care sector noted that older adult services might have been less tuned in to trans (and maybe also LGBT) issues.

In talking with a number of people about training it was clear that awareness training is also seen as a potential business opportunity.

Trans individuals related how they need to educate professionals themselves, for example:

"*I have to educate the GP" (*trans woman aged 70s)

One aspect of training might be encompassed within trans awareness. Another aspect is factual training in relation to the particular medical needs of trans individuals, eg in relation to hormone treatment, long term side effects etc. A trans man described an experience when his hormone treatment was inadequate and he became concerned that he might be pregnant:

"We went to that place where you have to go for emergency if you want pills or anything. A sexual health clinic basically… And they didn't understand why a trans man would want a pill."

- **Personalised care**

A GP who had initially learned about trans issues after meeting a trans patient said:

"I stopped trying to see people as a medical problem but I see them more as people – the stories that people come with - I think they're absolutely fascinating" (written down verbatim in interview notes)

A doctor working in end of life care described individualised care as:

"*identify what their illness means to their life now within the context of the life they had before and how it influences their current relationships and expectations, and what this means for their future*". (written down verbatim in interview notes)

And an end of life care facilitator asked:

"If services were truly individualised, asking people what is important to them/ being guided by service users etc, then would we need transgender awareness?"

Listening to people and not judging them seemed to be keys for trans individuals: people pointed out that health and social care staff need to recognise that people aren't all the same and that each person is an expert in their own life. As one trans woman said, what is needed is:

"*please listen to the patient and a bit of empathy.*"

- ***Service redesign***

Several people could have redesigned the health service. They wanted services (including those related to their gender identity) to be focused in primary care with GPs taking the lead on all aspects of their management and environments

that are visibly trans-friendly. This meant that specialists would give clear advice on management to GPs.

Here a trans woman in her 60s talks about her GP:

"*I want her guarded. I want her in a position where she is confident; she is prescribing with authority behind her."*

Alongside this trans participants appreciated continuity of care with their GP and felt this is being lost in large practices: without continuity

"*you just get asked the same stuff over and over and over again.*"

People wanted signposting to local support services and ready access to psychological therapies/ support for themselves and for partners and families at an early stage of their journey.

4. Specific issues

- **End of life care**

Case vignette 1 (below) is taken from an interview with a doctor working in end of life care. Case vignette 2 is a condensed account of a person with dementia and their end of life care taken from an audiotaped interview with another doctor working in end of life care.

Case vignette 3 – end of life and confusion

A trans woman towards the end of life. Nurses found it difficult – tried to correct her in her choice of clothes. When she first chose female underwear they thought she was confused (common at end of life). Then embarrassed about it. Wife's views were difficult. She was now more reliant on nurses and wife. The wife had tolerated it in the past but now she dressed her how she thought she should be dressed despite the fact she had completed an advance care plan (stating that she wanted to dress as a woman). Nurses found it difficult to challenge the wife and worried that she was going to overrule the individual's expressed advance care plan (which laid out how she wanted to be dressed).

People have concerns about dementia and end of life care, about care at the end of life in general, and about support when they are bereaved. The quotation below is taken from an interview of a trans woman whose partner died suddenly and who felt that she had no one to turn to who would understand her loss because of her particular circumstance:

"I was in the situation I was in where I was bereaved, I had nobody to turn to, nobody came to help me. It was a terrible time. If I just felt if there was an open doorway there I could at least talk….. Even if you didn't understand the situation, just the fact that you are saying yes there is a door we will try to help you – that would have made an ocean of difference."

- **Gender identity services**

Gender identity clinics came in for a lot of criticism: people felt they were "grossly badly run", "a nightmare place", "a shambles", in need of project management, "just not fit for purpose", "a lottery of disorganisation", and "woeful". A consistent concern was the waiting period before people were seen. One person wondered whether the waiting was designed to test a person's resolve.

"*whatever they tell you to do you do, you don't argue. If they say jump off a bridge, you jump off it – whatever you do not argue!*"

- **Mental health services**

There were several important issues in relation to mental health.

"*if there is a mental health issue it is treated in parallel with the medical issue, not in series, which is the way the Gender Identity Clinics tend to do. 'We will solve your mental health problems then we will start treatment'. Not thinking that if you start treatment you solve the mental health problems.*"

"*I know a number of people who have found it very difficult to find counsellors who help them, that's in the private sector. This is purely with relations, nothing to do with trans, purely relationship counselling.*"

Case vignette 4 – end of life care and dementia

A woman who had transitioned in her 40's, prior to transitioning she had lived as a man, married and had children. When she transitioned, all relations with her family broke down completely. A doctor working in end of life care described the experience of this person who she was supporting at home, before the Gender Recognition Act in an audiotaped interview.

"*I met her in her early 70's. She had no contact with (her family) at all and was in fact living with a male partner. … (she and her partner) had a lot of concerns about what would happen when she died and whether she would be recognised as a woman, what they would be able to put on her headstone… what was quite good was that these conversations were able to be had while she still had enough capacity to take part in the decisions… it was very positive from that point of view in that we were able to come up with a plan. The headstone was something that to her was particularly important and so what in the end the headstone was going to have her … the name that she had chosen from transition and then underneath was nee as in you know born, because on legal documentation she was still Mr X … So the legal name had to go on the headstone, but that was put as you know like when some people put their maiden name … So, she was Samantha and she had been Samuel, so it was nee Samuel… She was OK, she was alright with that as long as there was acknowledgement of who she was. She wanted to be buried as who she was.*

What became more difficult was that as her dementia progressed, there would be days when she forgot that she had transitioned… So her conversations and things and the people she had been asking for were her ex-wife… and the children… – her partner found that very difficult… They had had a lot of help with coming to terms with that and then the other thing that made it difficult was because sometimes she woke up forgetting that she had transitioned, when her partner was trying to help her get dressed into a dress, she totally freaked! … Because in her head she had gone back to being a man… (What) was worked out was that each morning the partner would offer her a choice of two sets of clothes. A female set and a male set and then what would happen would be, it might be a couple of hours later, she would be back more in the present, but she would have been dressed as a man and would then want to get redressed as a woman… and it was the same at night. There would be a nightie and a pair of pyjamas laid out, so she could choose… it was very difficult, but with a lot of support and making the partner understand, have more understanding of dementia, and that this was not a personal thing that this was … and by telling stories about other dementia patients, not transgender ones, but about them, how they can at times their memories of their earlier lives are much stronger, and they ask their mothers and this sort of thing."

- **Social care**

Whilst most trans participants had no experience of social care, they did have concerns about it, for example:

"*I have heard it said that discrimination certainly in the private care system is rife.*"

"*As a trans person you are always worried about personal care.*"

"*If there is one thing that terrifies me it is the thought, as I get older, I have no family to support me, nobody to look after me, nobody to argue my….. If dementia or whatever comes I am going to be totally at the mercy of health care and you want to believe that everybody…… If I have to go into care housing or whatever, I want to believe that everyone who looks after you is wonderful and friendly. The truth is they are not.*"

One trans participant was employing a private carer to help with the care of her wife but this arrangement was suddenly terminated when the carer's family insisted she should stop her caring role because of the partner's trans status, causing distress for all involved.

Case vignette 5 – social care

"I was actually in the process of going full-time when she (the speaker's mother) went into full-time Care ... I told my Mother and she was incredibly accepting… but she said I don't want you to appear here as (a woman), it would confuse the Filipino care assistants …"

Part 4: Learning from people's practice - Positive Practice Case Studies

In contacting people, meeting them and hearing about their experiences and ideas, and attending meetings we came across examples of what we, and those we met, consider positive practice. We include here six examples of positive practice, included with permission of the organisations and people concerned. None of these case studies has been quality assessed but all contribute to learning about positive practice and possibilities for change.

The first two positive practice case studies are in the field of social care. Case Study 1 describes a specialist LGBTQI+ domiciliary care service. Case Study 2 describes a training initiative directed at Care Homes and evaluated by a local University.

Case studies 3 and 4 are in the field of healthcare. Case Study 3 describes Trans Health Sefton, which is a new general practice based service for trans people. Case Study 4 is a quality assurance service for primary care.

Case Study 5 is relevant to health and social care services for people with dementia and was developed in partnership with local trans activists (Page et al., 2016). It offers a practical model to guide staff working with trans individuals living with dementia based on the work of Tom Kitwood (Kitwood, 1997) and reflective exercises that staff can use in their learning and development.

Case Study 6 demonstrates how to bring people together across organisational boundaries to focus on improving a defined focussed area of health in a defined geographical area and offers a model that could potentially be applied in a number of areas of health and social care practice.

The Case Studies as a whole show what energetic people thinking outside the box can achieve.

Positive Practice Case Study 1
Domiciliary Care

The team learned about a specialist LGBTQI+ domiciliary care service, which aims to provide high quality tailored support to ageing members of the LGBTQI+ community so that people never have to 'go back into the closet'. The care provider actively employs staff from the LGBTQI+ communities and the founder says that the service's goal is "to maintain the lifestyle our clients values, identities, and individualities, giving them peace of mind and a safe space to enjoy their lives without the fear of judgment or discrimination." Their staff members are trained in the areas of HIV, transgender and dementia care.

The website of the service states their mission as: "to be the world's best LGBTQI+ adult care provider. We allow everyone we serve to be supported without the fear of judgment, transphobia, biphobia, discrimination, homophobia or stigma."

The service was registered in September 2017 and is based in London. Due to being in the first year of operation, it had not been inspected by the CQC at the time of writing, so we cannot comment on how far the service is meeting its aims, but the aspiration of tailored specialist support to service users and commitment to specialist staff training has to represent positive practice. It raises the issue of specialist versus generic services for trans people and, in our view, should not be understood as implying that the care of older trans people is outwith the expertise of 'generic' care providers, instead it should challenge generic care providers to make sure that they are providing non-discriminatory dignified and person-centred care to trans people using their services.

For more information about the service:

Contact info@alternativecareservices.co.uk
See the website at www.alternativecareservices.co.uk

Positive Practice Case Study 2
Older and Out The Older People's LGB&T Service:
Care Homes Training and evaluation

The University of Central Lancashire has evaluated an Age Concern Central Lancashire project called Older and Out The Older People's LGB&T Service, which trained care home staff in central Lancashire with the aim of improving care experiences for LGBT individuals in care settings. The training involved films, exercises and discussion. Those Homes completing the training were awarded a display plaque and staff badges using the Older & Out and rainbow insignia. The evaluation involved quantitative and qualitative information from pre and post course questionnaires administered to those involved and concluded that:

- There was greater awareness of pertinent issues and staff were more prepared to respond appropriately after the training
- Relevant policies were likely to be adopted post-training
- There was evidence suggesting the working practices changed as a result

Author's note: this project addresses training/ education and visibility in relation to care homes staff as well as including an evaluation of the project, thereby contributing to knowledge.

For more information about the service and its evaluation:

- E-mail contact rogerjones@55plus.org.uk
- Website see www.ageisjustanumber.org.uk

Positive Practice Case Study 3
Trans Health Sefton

Trans Health Sefton is a local service for people whose gender identity is different from the gender they were assigned at birth. Service users will be referred by a healthcare professional, eg their GP, and will initially be seen by a local GP with a special interest in trans healthcare and who has more than a decade of experience in the local area. The clinic is based in a general practice surgery in Bootle.

The clinic sees people who:

- are questioning their gender identity and would like further information or help to manage their feelings
- consider themselves to be transgender, gender neutral, gender queer, non-binary or otherwise gender variant, but who have not previously sought formal medical help
- have an established diagnosis of gender incongruence, gender identity disorder or gender dysphoria, and may/ may not already have had some form of medical and/or surgical treatment

The clinic offers the following services:

- Support for those with gender issues
- Referral to local Gender Support Specialists, a group of therapists with many years experience of working in the field of gender care
- Referral to national Gender Identity Clinics (GICs) for assessment, hormone therapy or surgery
- Referral to a local specialist for initiation of 'bridging hormones', these are cross-sex hormones which are given to a patient whilst they await a formal assessment in the Gender Identity Clinic
- Prescribing, administration and monitoring of hormones which have either been initiated locally or by one of the Gender Identity Clinics
- Referrals to other services such as speech and language therapy or fertility clinics
- Referral to support groups and charities

Author's Comment: this is an exciting development and addresses a number of points made by trans people in focus groups and interviews in that it brings services nearer to home and hopefully will support them in more rapid access to treatment in a sympathetic setting and with a GP and support team who have a special interest in trans healthcare. It offers a possible model for other areas and is likely to have an influence on local primary care services by providing specialist support for their trans patients. Evaluation of the project will be important.

For more information contact: Jenny Owen – Commissioning Manager-Transformation, NHS South Sefton CCG & NHS Southport and Formby CCG, Merton House, Stanley Road, L20 3DL
T: 0151 317 8377
E: jenny.owen@southseftonccg.nhs.uk
W: southseftonccg.nhs.uk | southportandformbyccg.nhs.uk

Positive Practice Case Study 4
LGBT Foundation - Pride in Practice quality assurance support service (Greater Manchester)

We had positive feedback from professionals about the Pride in Practice project run by LGBT Foundation. Primary care services throughout Greater Manchester are entitled to receive free quality assurance support via the service which aims to strengthen and develop their relationships with lesbian, gay, bisexual and trans (LGBT) patients within the local community.

The service is funded by Greater Manchester Health & Social Care Partnership and NHS England and is endorsed by The Royal College of GPs.

Practices taking part can achieve an accreditation award, including a wall plaque, posters and resources and may use Pride in Practice logos on their letterheads and websites. These are ways they may "promote their equality credentials, and demonstrate(s) their commitment to ensuring a fully inclusive, patient-centred service".

Pride in Practice involves access to training around LGBT inclusion, "which provides information on how to provide appropriate services to LGBT people, support around Gender Identity, Trans Status and Sexual Orientation Monitoring, myth busting, and confidence building with staff around terminology and appropriate language." The training was highly valued by people we met and spoke with during this project.

Author's comment: This is an initiative including training relevant to trans issues and gender variance, and it addresses two of our recommendations in the area of primary care services, i.e. training/ education and visibility. An initiative like this also acts as publicity amongst primary care user populations.

For more information about the service:

- E-mail contact: pip@lgbt.foundation
- Website : https://lgbt.foundation/who-were-here-for/pride-in-practice

Positive Practice Case Study 5
Betsi Cadwaladr University Health Board:
Supporting me to be the person I want to be

This is described as a reflective guide "written in partnership with activists from within the transgender community of North Wales". It aims "to offer a model for promoting effective and compassionate dementia care for transgender people" and draws on Tom Kitwood's "flower" of six psychological needs: love, comfort, identity, occupation, inclusion, and attachment. It sets personhood in the context of the stories of several trans individuals and information about the Equality Act (2010) and the Human Rights Act (1998) and includes a set of five exercises that staff members may work through to promote reflection and learning about how to support the well-being of trans people with dementia.

Author's comment: this is a document that can be used in staff training and development and is potentially valuable across the whole of dementia health and social care.

For more information and a copy of the document:

- Email Sean.Page@wales.nhs.uk
- The work leading up to the production of the document is described in a published paper (Page, Burgess, Davies-Abbott, Roberts, & Molderson, 2016)

Reference: Page, S., Burgess, J., Davies-Abbott, I., Roberts, D., & Molderson, J. (2016). Transgender, mental health, and older people: An appreciative approach towards working together. *Issues in Mental Health Nursing, 37*(12), 903-911. doi:10.1080/01612840.2016.1233594

Positive Practice Case Study 6
The LGBT Cancer Support Alliance

The LGBT Cancer Support Alliance was started in 2015 to improve care and support for LGBT people with a cancer diagnosis in Manchester and in recognition of the need to work across organizational boundaries.

The Alliance has several aims, the first being "to improve services and support available to members of the LGBT community who have a cancer diagnosis, are living beyond a cancer diagnosis, or caring for someone with a cancer diagnosis, to the benefit of all." Its approach depends on collaboration, partnership, and integrating the voices of patients and carers with those of a wide range of organisations. It also aims to support relevant research and learning, and in line with this aim supported the Trans Age project.

The Alliance also provides focused training for professionals, although there may be a small cost for accessing the training.

Author's comment: this is an example of an initiative centred on an area of health that aims to bring people together across boundaries to learn from one another in the interests of improving services to LGB and T service users. It is a model that could potentially be employed in other areas of healthcare and has resonances with the initiative to produce guidance on working with trans people with dementia described in Positive Practice Case Study 5. The Project Report (2017) sets out in detail outputs that have been achieved.

For more information:

Contact Ben Heyworth, Macmillan Survivorship Network Manager / Survivorship Network, Macmillan LGBT Strategy Manager / LGBT Cancer Support Alliance The Christie Hospital NHS Foundation Trust on (+44) 7917 628 672

See the Report at https://issuu.com/lgbtcancersupportalliance/docs/lgbt_project_year_two_report_final

Part 5: Recommendations

Recommendations in health and social care

1. Training/ education of health and social care staff

There was a strong view amongst the older trans people we met that training/ education of staff working in health and social care is helpful, and that it should include input from trans individuals. The literature we reviewed also regarded training/ education as helpful and important. Training could be situated within broader LGBT "awareness" training and as part of diversity training. Staff in all areas would benefit from training (ie all those working within healthcare not only doctors and nurses, and all those within social care and housing including those outside statutory agencies). It might be helpful if such training were to be inter-disciplinary. Training also needs to include the relevance of an individualised person-centred approach set within the life context and experiences of older trans adults.

The question was raised of what training professionals received before they qualified and most of the professionals we met could not remember any training specific to the care of trans individuals. It would be appropriate to ensure that relevant trans awareness is included in pre-qualifying training of all professionals as well as in NVQ and vocational training.

Another point raised is that there is little specialised education in trans healthcare. There is a CPD module on the Royal College of General Practitioners website: this is a start but the module is basic and contributes little to increasing specialist knowledge of trans healthcare. One of us recently attended a meeting at the Royal Society of Medicine on Transgender healthcare in the community and the criminal justice system. One possibility would be to explore a more in depth CPD module or similar on trans healthcare with interested parties.

2. Visibility in the health and social care environment

Most trans individuals spoke positively about visible indications that organisations are LBGT friendly, examples include:

- having the rainbow flag (or similar) on the organisational website,
- publicising that the organisation has an LGBT officer (or equivalent) who makes themselves available for queries or concerns,
- having trans inclusive policies and procedures.

Visible indications of being trans-friendly address the fear of hostility, discrimination or disrespect that is evident in the literature and the contextual force of discrimination/ hate identified in the thematic analysis.

There might be concerns that this marks people out as different: would some people argue that visible insignia are in themselves potentially stigmatising? The reality is that older trans people currently do not feel included, and visible indications that they can be open and will meet with an understanding response are necessary.

Visible indications of being trans-friendly in relation to the environment might include the following:

- gender- neutral toilets
- use of appropriate language
- visible posters about LGBT organisations in publicly accessible areas

In relation to the relationship between the trans service user and those staff supporting them, staff need to make visible unconditional positive regard of their service users and show that they are person centred in their approach.

3. Ready access to peer and psychological support

Many of our participants were linked with organisations, trans and/or LGBT, that provided them with support and information. Some spoke about how important these links are to them in a number of ways, including combatting isolation, providing space where people can be themselves, and providing practical information that is difficult to access via other routes. We recommend that health and social care organisations should signpost trans service users to relevant local trans organisations and wherever appropriate seek their views about services.

Psychological support was identified as an issue in the literature review and was also raised by trans participants in our project. A particular area of need identified was psychological support/ counselling with relational issues, particularly partner relationships and family relationships. People told us this was not currently available to them and they felt they needed it at an early stage. It would logically link with developments such as the Trans Health South Sefton as work with partners and/ or families needs to be local to those concerned.

4. The role of primary care in transgender medicine

It was only late in the course of this project that we learned about the initiative at South Sefton that is described in the positive practice section of this report. This development fits with the changes to healthcare that a number of participants talked about with us and we strongly recommend that Cheshire should explore a similar model. Although it focuses on treatment for gender variance it will undoubtedly have an impact on services for trans people more widely and is likely to influence attitudes towards trans service users across primary care and beyond. Local initiatives like this, whilst not targeted at older adults, may be particularly beneficial for older service users who are more likely to have comorbid physical illness than their younger counterparts.

5. Specialist versus generalist social care

One of our positive practice case studies raises the issue of specialist versus generic services for trans people. It is our view that including it in the report as positive practice should not be understood as implying that the care of older trans people is outwith the expertise of 'generic' care providers, instead it should

challenge generic care providers to make sure that they are providing non-discriminatory dignified and person-centred care to trans people using their services. In practice there is likely to be a need for both specialist and generalist care providers so that people can have a choice of what best meets their individual needs.

6. Monitoring

Monitoring is a tricky issue. People told us that they only wanted to be asked about their trans status when it's relevant to their care, but they do want access to appropriate screening and that may rely on health staff knowing about their trans status. Several people were concerned that, if staff members know that they are trans, then their health condition becomes a trans condition rather than being treated on its merits. If health (and social care) staff were consistently respectful and empathic, approaching service users with unconditional positive regard, and not making assumptions then being out to them as a trans individual might be ok. For commissioners of health and social care services it is important to know whether trans users are accessing and using those services. The LGBT Foundation has a useful briefing on this topic (LGBT Foundation, n/d).

7. Further research

Areas where further local research might be helpful include the following:

- end of life care -
- management of cognitive impairment/ dementia including support for carers/ significant others
- long-term care
- training/ education - survey local training organisations to determine what LGBT training their courses include. (This might also act as an intervention in moving the issue of LGBT training up the agenda of the organisations involved.)

Over-arching recommendations

8. Media/ publicity

The reporting of trans related issues in the media was raised in a number of meetings we attended and was a concern to many people we met. We also came across an example of an organisation that had done some good work relevant to the care of older trans service users but was reluctant to publicise it: the inference appeared to be that the organisation was concerned about stigma by association in being seen publicly to have done the work or perhaps that there was concern that publicising it might deter non-LGBT service users. It is unhelpful to take this position and we regard it as reinforcing exclusionary practice.

We recommend that health and social care organisations developing new initiatives publicise them in their local media and consider whether they should also do so via social media. It is important that good work (such as the work

included here in the Positive Practice Case Studies) is celebrated and shared. We recommend that publicising this report is a start.

9. Sharing learning and good practice

In the spirit of sharing learning, increasing visibility and positive publicity we propose that there should be a half day conference to share and celebrate learning and good practice from this project.

Part 6: Conclusions

This Report is entitled Seeing People as People. This is a short paraphrased quotation from the words of a GP who spoke with a member of the team, and said:

"*I stopped trying to see people as a medical problem but I see them more as people…"*

and it sums up the core of what trans service users want from staff working in health and social care. If we see people as people, we treat them as people and we acknowledge and respect their priorities and wishes. Unconditional positive regard is a term attributed to the psychologist Carl Rogers: it means accepting, respecting and trying to understand other people without judgement. That is what services need to ask of their staff and demonstrate to their users.

Acting on the recommendations set out in Part 5 of this Report will support health and social care organisations and the staff working in them to improve services for trans service users.

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- Silver Rainbows and Body Positive who helped us get started, supported and publicised the project
- The LGBT Foundation in Manchester
- The LGBT Cancer Support Alliance
- The ALL OUT Radio Show
- And thank you to a large number of people too numerous to list who have contributed to the work in a wide range of ways with generosity and honesty – we are sorry that we can't credit everyone individually. Particular thanks to those individuals who gave of their time, shared their experiences and ideas, and took part in interviews.
- Keep up your good work everyone – we have seen that you do make a difference!

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GLOSSARY

Acquired or affirmed gender - a trans person's gender after transitioning is often referred to as their acquired gender, but the term affirmed gender is now often preferred.

Assigned gender - this is the gender that a baby is assigned at birth.

Cisgender - someone whose gender identity is the same as the sex they were assigned at birth.

Gender dysphoria – a term used in the Diagnostic and Statistical Manual of Mental Disorders (DSM5) to describe the experience of discomfort or distress related to a mismatch between a person's biological sex and their gender identity.

Gender identity disorders – a diagnosis used in the International Classification of Diseases ICD10 to encompass transsexualism, dual role transvestism, gender identity disorder of childhood, other gender identity disorders, and gender identity disorder unspecified.

Gender transition - this term is used when a person transitions from the gender that they were assigned at birth to their affirmed gender. The process may be referred to as gender reassignment, although trans people may prefer the term gender confirmation.

Gender variance or gender incongruence – terms used to refer to behaviour and interests that are outside what is generally considered "normal" for a person's assigned sex. Other terms used include the abbreviation "trans*", gender non-conforming, gender diverse or gender atypical.

LGBT - the acronym for lesbian, gay, bi and trans.

Non-binary – someone who identifies as having a gender which is in-between or beyond the two categories man and woman, or who fluctuates between man and woman, or who identifies as having no gender.

Transgender man – a term used to describe someone who is assigned female at birth but identifies and lives as a man. This may be shortened to trans man.

Transgender woman – a term used to describe someone who is assigned male at birth but identifies and lives as a woman. This may be shortened to trans woman.

Transition or transitioning – this is the process whereby trans people may change their gender presentation to bring it into alignment with their gender identity. It may (or may not) involve various medical/ surgical treatments.

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