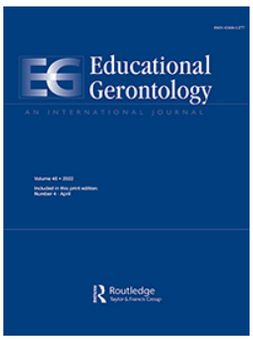

Educational Gerontology

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/uedg20

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To cite this article: Susan Mary Benbow & Paul Kingston (2022) Older trans individuals' experiences of health and social care and the views of healthcare and social care practitioners: 'they hadn't a clue', Educational Gerontology, 48:4, 160-173, DOI: 10.1080/03601277.2022.2027642

To link to this article: https://doi.org/10.1080/03601277.2022.2027642

Published online: 24 Jan 2022.

EDUCATIONAL GERONTOLOGY
2022, VOL. 48, NO. 4, 160–173
https://doi.org/10.1080/03601277.2022.2027642

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ARTICLE

Older trans individuals' experiences of health and social care and the views of healthcare and social care practitioners: 'they hadn't a clue'

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ABSTRACT

This study investigated older trans people's experiences of health and social care, and the experiences and views of practitioners in order to inform service development. Sixteen trans adults aged over 50 from Cheshire and nearby were recruited via community organizations and interviewed individually or in focus groups. Interviews were audiotaped and transcribed with consent. Health and social care service practitioners were interviewed remotely or face-to-face. Data were analyzed thematically supported by qualitative data analysis software. Three main themes were identified. 'Levers' indicated forces that influenced an individual's contact with health and or social care positively or negatively, and encompassed five sub-themes: age; experiences good or bad; family/close relationships; LGBT identity/communities; and money/finances. 'Contextual forces' encompassed societal forces that shape individuals' encounters in care, lack the potential for positive influence, and are more closely allied to stereotypes/myths: this theme included three sub-themes: discrimination/hate; ignorance; and risk from others. 'Positive practices' encompassed five sub-themes, including learning/training.

In conclusion older age increases the importance of access to treatment for gender variance whilst simultaneously complicating it; older trans service users may be sensitive to potentially discriminatory experiences because of historical experiences; services should endeavor to understand individuals in the context of life history and psycho-social context; practitioners benefit from training in positive inclusive approaches to care; local community services are advantageous. Further research is needed with particular attention to social care, the experiences of trans men, and how to translate findings into person-centered practice, education and training.

Since the number of people identifying as trans is increasing (Goodman et al., 2019), and, alongside this, the general population is aging (Office for National Statistics, 2021), older adult physical health, mental health and social services may reasonably expect the number of trans service users to increase over time, and need to ensure that all health and social services are trans-inclusive and appropriately address the needs of older trans people. Gender reassignment is a protected characteristic in the United Kingdom (UK) under the Equality Act 2010, which offers legal protection from indirect and direct discrimination (legislation.gov.uk, 2010), so services are required to be inclusive. In this paper we use the style trans (an abbreviated form of transgender), defined as follows:

'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 . . . 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, p. 3)

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Published literature on the physical health care, mental health care and social care of older trans adults was reviewed in 2018 (Benbow et al., 2021), and found that older age was most commonly defined as age over 50 (Benbow et al., 2021). Few papers identified in the review focused on older trans adults and few originated from the UK. The review found that older trans adults had high rates of physical and psychological morbidity (Fredriksen-Goldsen et al., 2014) and that differences in social and economic supports potentially increase the likelihood that older trans adults will rely on formal or public services in later life. Experience of (or anticipation of) discrimination, prejudice and disrespect in relation to health and social care was a recurrent theme (Siverskog, 2014): socio-economic inequalities another (Fabbre, 2014). A need for training and education was identified (Porter et al., 2016), covering definitions, concepts, and terminology; trans issues relevant to practice; and co-design approaches to involving trans service users.

Since then, further research has found areas of concern in respect of social care. Willis and coworkers identified a theme called 'ambivalent expectations of social care services' which encapsulated anxieties about transphobic or impersonalized care amongst trans and non-conforming individuals aged over 50 in Wales (Willis et al., 2020a, 2020b). They concluded that relevant education of social care workers is lacking. Similarly, Smolle and Espvall (2021) found a lack of knowledge and failure to prioritize issues related to gender identity and expression in social work with Swedish older trans adults.

We describe a service evaluation project (the TransAge Project) carried out in Cheshire and North West England that aimed to inform local health and social service development regarding: firstly, older trans people's experiences of health and social care, and secondly the experiences and views of health and social care practitioners with regard to caring for older trans adults. Practitioner-participants were volunteers who all had experiences of working with older trans adults and therefore contributed to an understanding of the interaction between older trans adults and services. The project was intended to inform local services in order that they might develop more person-centered and culturally competent care for older trans adults (Sundus et al., 2021). This paper draws out learning from the project applicable to education, training and practice in health and social care for older adults.

Methods

Recruitment

Contact was made with a range of groups supporting trans individuals. Posters were circulated and displayed, and information about the project was disseminated in organizational newsletters. Interested individuals were invited to contact the project team by e-mail, through a web-based contact form, or by post. Inclusion criteria were: age over 50 years old; identifying as trans; living in Cheshire or adjacent areas; and prepared to talk about their experiences and views of health and social care either in a group or individually.

Since this was a service evaluation project and participants were community volunteers recruited outside health and social care services, formal ethical approval was not required. In line with good practice, interested volunteers were supplied with a participant information leaflet, any questions were answered, and they were asked to complete a consent form, covering consent to interview, and consent to audiotape and transcribe interviews. They were offered individual interviews, face to face or by telephone, or participation in a focus group. Face-to-face interviews/group discussions took place in the premises of supporting organizations. Trans participants were not required to share their full name, date of birth or address, and could choose to use a pseudonym for interviews/focus groups.

To recruit health and social care practitioners, letters and e-mails were sent to a range of organizations and individuals involved in providing health and social care in Cheshire and the North West. This included letters to GP practices and e-mails to named contacts at Hospitals and Hospices, and in social services departments. Umbrella organizations (including the National Care Forum and Skills for Care) were asked to distribute information about the project. All communications included information about the project and invited interested professionals to make preliminary

contact with a view to engaging in telephone or face-to-face interviews should they consent to take part. A project worker made detailed notes during interviews and checked them with participants. (See Table 1 for details of practitioner-participants' work contexts.)

Interviews and focus groups

Interviews and groups started with a grand tour question (Cole & Knowles, 2001: Westby, 1990) which was sent to participants in advance with specific areas to think about before meeting (see Table 2 for details). This approach has been used previously (Benbow & Kingston, 2016).

Analysis

Data consisted of transcriptions of individual interviews and focus groups with trans-participants; and detailed notes from interviews with health and social care practitioner-participants. Data were analyzed qualitatively, assisted by a qualitative data analysis programme, NVivo 12 (Jackson & Bazeley, 2019). Transcripts and interview notes were read and re-read to allow familiarization, 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 initial coding was carried out line-by-line by one author, reviewed by the other author, and then both authors in discussion identified, reviewed, clarified, named, and defined broad themes to produce an overall synthesis, which was then further discussed, reviewed, and refined by the authors in partnership and with reference to the coded transcripts and interview notes.

Findings and discussion

Details of participants

Sixteen trans individuals participated: 6 people took part in individual interviews (5 face-to-face, 1 by phone), and 10 trans individuals contributed as part of two face-to-face focus groups. All gave written consent to the interviews/groups, to audiotaping and transcription, and to the use of anonymous

Table 1. Details of health and social care practitioner-participant interviews.

	Phone interviews	Face to face interviews	Online video interviews	Total
Secondary Care Practitioners (SCP)	4	2	1	7
Primary Care Practitioners (PCP)	3	2	1	6
Other healthcare practitioners (mental health = 1; public health = 1;) (Other)	0	1	1	2
Social care/ Housing (Social Care)	4	0	0	4
Third sector	2	1	0	3
Totals	13	6	3	22

Note. Secondary care practitioners include healthcare staff based in hospitals. Primary care practitioners include those based in primary care. Social care/ housing includes extra-care sheltered housing, Care homes, and home care services. Third sector includes voluntary/ charitable organizations providing a range of services including awareness training and consultation to other agencies.

Table 2. Interview structure.

Grand tour question (sent to participants in advance)	Potential participants were also asked to think about these specific areas before meeting:
'We would like you to tell us about your experiences of/as trans people accessing health and social care, what barriers to care you are aware of, or concerned about, what might help to overcome these barriers, and what you would regard as good practice. We are as interested in positive experiences as difficulties. Please take your time and give details. We are interested in everything that is important to you.'	• your experiences of/ as trans people accessing health and social care • what barriers to care you are aware of, or concerned about • what might help to overcome these barriers

quotations. The 16 participants consisted of 15 trans women and 1 trans man, all of whom were white British. Those participating ranged from pre-operative to over 25 years post-operative. Details of trans-participant ages and pseudonyms are in Table 3.

Twenty-two health and social care practitioners were interviewed either by telephone, face-to-face, or online using a video-conferencing platform. Key points were noted by the interviewer during the conversation and checked out with participants during the call, including some direct quotations. Table 1 gives details of the work contexts and chosen interview media for practitioner-participants. Quotations from audiotaped interviews are italicized, and quotations from notes taken during practitioner interviews are not, unless recorded verbatim. To ensure confidentiality, specific ages and names of towns, other people, organizations, etc., have been removed: pseudonyms are used for trans-participants.

Thematic analysis

Thematic analysis identified three main themes with several sub-themes (see Table 4 for thematic structure with illustrative quotations and notes from practitioner interviews). The three main themes are levers, contextual forces, and positive practices.

Theme 1: levers

The theme 'levers' indicates forces that might influence an individual's contact with health and or social care either positively or negatively.

Subtheme 1: age impact on seeking care

Age might make it more difficult for people to seek care since it might involve difficult adjustments, social and psychological, for close family members as well as the trans individual, who might lose status and roles that they had undertaken over a long period. For a trans individual, however, older age might help them make decisions about their care, since older age may bring a sense of urgency to their wish to align their body with their gender. Willis and colleagues found a similar theme in their study of older trans and gender non-conforming adults' expectations of and concerns for later life (Willis et al., 2020b). They described how some older trans individuals experienced regrets over missed opportunities earlier in life. Several participants in our study described how they had considered and rejected treatment for their gender variance when younger for reasons related to work and family, but that now they needed to act before it became too late, sometimes despite

Table 3. Ages and pseudonyms of trans-participants.

Age range	Trans women	Trans women Pseudonyms & age in years	Trans man	Trans man Pseudonym & age in years	Total
50s	5	Christine, 52 Helen, 50 Kathy, mid 50s Marion, 50s Nell, 53	1	Ian, 50	6
60s	2	Ann, 68 Olivia, 60s	0		2
70s	6	Emily, 70s Fiona, 79 Gemma, 75 Jackie, 79 Penny, 75 Ros, 71	0		6
Age over 50 but did not specify exact age	2	Brigid Debbie	0		2

Table 4. Themes and sub-themes with illustrative quotations from trans-participants and notes from practitioner-participants.

	Quotations from older trans adults' interviews/ focus groups	Quotations (italics)/ notes from practitioner-participant interviews
(1) **Levers**		
Subtheme 1: Age impact on seeking care	*'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.'* (Penny) *' 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.'* (Christine) *'By the time I had gone through the NHS system it would have taken 5 years and they would have said 'you are too old to have the operation [so she went privately]'* (Stephanie)	*'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'* (PCP) Allowing people to be themselves – older people have lived through a lot of change – previous illegality affects openness and people may not be themselves for fear of things that happened decades ago. They need to be able to live their lives as they want. (Third sector) 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 [of being trans]? So people have to try harder? (SCP)
Subtheme 2: Influential contacts with care	*'I've had a tour of North West Hospitals . . . 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.'* (Kathy) *'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 . . . '* (Ros) *'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 there was an open doorway there . . . that would have made an ocean of difference.'* (Ann)	*'Past experiences screw up things for older trans people . . . '* (PCP) People whose GPs wouldn't treat them (SCP)
Subtheme 3: Partner and family relationships	*' . . . 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?'* (Ros) *'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 . . . nothing to do with trans, purely relationship counseling.'* (Jacqui)	Role of family rejection. Influence of social pressures and stigma by association for family members. (PCP) Do adult children react badly as they don't want their beloved parent hurt? (PCP) How [family is affected by] other people (friends/ social contacts) reacting to people who have transitioned. (Other)
Subtheme 4: LGBT identity/ communities	*'LGBT structure . . . it is about younger people.'* (Ann) *'I have got gay friends . . . and they don't have any issue . . . I haven't come across bad negative vibes.'* (Christine)	Doctors and other staff coming out and openly identifying as LGBT – how far are staff prepared to talk about their sexuality and gender identity? And how does this influence their work? (Social Care) Most of the discrimination comes from within LGBT. (Third sector)
Subtheme 5: Economic context	*'unless you are a millionaire or very rich and earning good money it takes years to save up for all these operations.'* (Christine) *'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.'* (Ann)	

(*Continued*)

Table 4. (Continued).

	Quotations from older trans adults' interviews/ focus groups	Quotations (italics)/ notes from practitioner-participant interviews
(2) **Contextual forces**		
Subtheme 1: Fear of discrimination/ hate	*'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 . . . I think it was prejudice.'* (Marion) *'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 . . . '* (Ros) '*I have heard it said that discrimination, certainly in the private care system, is rife*.' (Debbie) '*As a trans person you are always worried about personal care'* (Brigid)	If rejected by the culture [named] you're twice stigmatized. (PCP) Need to change society attitudes. (PCP) There will always be bigots, haters – the majority of people aren't nasty, they're ignorant. (Third sector) *Some GPs have views that border on prejudicial*. (PCP)
Subtheme 2: Practitioner ignorance: They hadn't a clue	'They *hadn't a clue, they had no answer whatsoever.'* (Jacqui) '*I researched it myself. I had to do it all myself off the internet . . . '* (Christine)	It's not part of our training yet we're asked to provide medical skills. (PCP) Lack of skills. (PCP)
Subtheme 3: Risk from others	*'You are still extremely vulnerable . . . I don't know whether it is blatant curiosity or sexual curiosity'* (Ann) *'You are going to be a target for ridicule, bullying'* (Brigid) *'I don't want to embarrass anybody else.'* (Penny)	
(3) **Positive Practice**		
Subtheme 1: Administrative practices	'*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*.' (Debbie) '*there is a glitch in some of the software that won't let me have 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.*' (Jacqui) '*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.'* (Emily)	Should we ask people routinely about sexuality and gender – is it the business of healthcare providers? But if we don't ask how will we know? Problem may be bigoted people labeling those individuals and expressing prejudice toward them. (SCP) Clear discharge summary [from secondary care] with longer term issues flagged. (SCP) Maintaining confidentiality [in respect of trans status] (SCP)
Subtheme 2: Demonstrating inclusivity	'*in business, as is required by law . . . 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 . . . '* (Ann) *'I . . . ended in the hospital in A&E . . . I wear a wig, I had the wig off because I was bleeding from a head injury . . . I heard the conversation from one of the specialists, sort of saying "can you go and treat for a head injury" and they said " . . . 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."'* (Helen)	Require people to demonstrate inclusivity and positive attitudes. Statistics to back it up. Policies help. Advertise the rainbow flag. (Social Care) [Teach] students and others how to challenge other staff who show prejudice. (PCP) We know that transgender staff work in the Trust – maybe it would be helpful to find out what they think. (SCP)
Subtheme 3: Learning/ training	'*I have to educate the GP'* (Jacqui) *'We went to that place where you have to go for emergency . . . A sexual health clinic . . . they didn't understand why a trans man would want a pill.'* (Ian)	Nurses and doctors may have had nothing in their training to prepare them for working with trans patients. (PCP) [Training] should be experiential not didactic or online. (SCP)

(*Continued*)

Table 4. (Continued).

	Quotations from older trans adults' interviews/ focus groups	Quotations (italics)/ notes from practitioner-participant interviews
Subtheme 4: Personalized care	*'not assume that everybody is going to be the same.'* (Ann) *'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 . . . '* (Helen)	*'take my doctor's hat off . . .. Try to see people as people and listen to like, their own world view.'* (PCP) *'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.'* (SCP)
Subtheme 5: Reshaping services	*'I want her guarded [the GP]. I want her in a position where she is confident; she is prescribing with authority behind her.'* (Ann) *'there is no . . . practical reason why they couldn't have one GP in each Clinical Commissioning Group who specializes [in trans healthcare].'* (Helen)	Some GPs would be interested to become more specialist in the area and that would have a ripple effect. (PCP) Trying to de-medicalize the process and move people into primary care with clear long-term plans. (PCP) One stop shop in primary care (SCP)

having developed physical health problems. This fits with Fabbre's (2014) observations about the importance of awareness of time left to live, and a sense of time wasted/lost in connection with late gender transition.

Trans-participants talked about a number of medical conditions (including atrial fibrillation, severe arthritis, and previous heart attacks), the care they had received for them, and how these might limit possible treatment options for them in future. They also talked about having more life experience as a result of being older and for that reason felt that their wishes in respect of treatment should be respected.

Practitioners were aware of the complex influence of older age: some referred to historical changes in the lives of older people from lesbian, gay, bi and trans (LGBT) communities and how they felt these still influenced older trans adults in their contacts with health and social care today.

Subtheme 2: influential contacts with care

Trans individuals often drew on specific past contacts with health and/ or social care: some described good experiences, others uncomfortable or bad experiences (see Table 4).

Concerns about dementia, care at the end of life, and bereavement support were often linked with care experiences that other trans people had described to them. One trans woman whose partner had died suddenly described how she felt that she had no one to turn to who would understand her loss.

Practitioner-participants were aware that older trans adults encountered practitioners in health and social care settings who did not treat them well, for example, GPs who refused to prescribe treatments that had been recommended by secondary care specialists.

Other evidence suggests that shared anecdotal accounts of bad experiences may influence trans individuals' openness to engaging with care. Almack et al. (2015) reported learning of anecdotal stories of families of origin excluding partners and/or friends from funerals of LGB individuals: terminal care and care after death, particularly being buried in line with their expressed wishes, was a particular concern for older trans adults. With regard to engaging with mental health services, in the past being trans was regarded as an indicator of mental ill-health and this knowledge may still influence some older trans service users (Benbow et al., 2021).

Subtheme 3: partner and family relationships

A number of trans-participants had no contact with their family, usually as a result of telling family members about their gender identity. Other people described family members supporting them: Ros described how her daughter sent a parcel of women's clothes for her after she had come out. Two trans

women (Ann and Jacqui) talked about adopted daughters who had become their family of choice. Another trans woman (Helen) talked about how she and her partner had wanted to formally adopt some years earlier when living elsewhere, but had been told that they couldn't: they understood this to be because they had suffered hate crime.

There was a fear that members of a person's family of origin might influence the trans individual's care in a way that disrespected, ignored, or negated an older trans adult's gender identity and their family of choice, when they were not in a position to advocate for themselves, for example, during end-of-life care or dementia care in particular (Almack et al., 2015).

Some trans-participants commented on lack of access to relationship counseling.

Practitioner-participants talked about the role of families which might be rejecting or accepting, and possible differences between coming out to parents and peers and coming out to adult children. One primary care practitioner referred to stigma by association relating to a family member's trans identity, and noted that stigma by association may itself cause distress for family members.

Subtheme 4: LGBT identity/ communities

Some people gained support from connections with LGBT communities or trans organizations: whereas others felt that they didn't fit in with LGBT communities, perhaps because of their age, or because they felt or feared being discriminated against. A social care practitioner noted that organizations will have staff who are trans, who may or may not be open to talking about their gender identity and questioned how gender identity might influence their work with older trans service users.

Previous research has acknowledged that older trans adults may not only hide their gender identity in wider society but also in lesbian and gay communities, as a result cutting off potential access to care and support within LGBT communities (Fredriksen-Goldsen, 2011).

Subtheme 5: economic context

Trans-participants who had economic resources (savings, a good pension or a home) said this opened up options for them. Several people talked about the costs of different treatments related to gender variance and the way that coming out had impacted on their economic resource. Economic context was not raised by practitioner-participants, and may be a greater concern for older trans adults in countries where insurance payments fund care (Ferron et al., 2010; Waling et al., 2020). Past experiences of discrimination/inequities in education and employment are known to increase older trans adults' risks of poverty and homelessness (Finkenauer et al., 2012).

Theme 2: contextual forces

Contextual forces shape individuals' encounters in health and social care but are extrinsic, lack the potential for positive influence, and are closely allied to societal stereotypes/myths.

Subtheme 1: fear of discrimination/ hate

Fear might sometimes be anticipatory, but some frankly discriminatory experiences were described (see Table 4). Yet some trans-participants were generous in their understanding of other people's perspectives and felt that some reactions resulted from embarrassment.

Whilst most trans-participants had no experience of social care, they had concerns about it, mainly in relation to discrimination and the possibility of disrespect, particularly in connection with personal care needs.

One trans woman employed a private carer to help with the care of her wife but this arrangement stopped suddenly when the carer's family insisted that the carer should stop providing care, because of the partner's trans status, causing distress for all involved. Practitioners also cited examples of the impact of discrimination encountered by trans individuals they had worked with.

In the literature older trans adults' fears about discrimination in care settings are a recurrent theme (e.g. Fredriksen-Goldsen et al., 2014; Latham & Barrett, 2015) and a factor in delayed care (Seelman et al., 2017).

Subtheme 2: practitioner ignorance – 'they hadn't a clue'

Some of the difficulties described in services by trans-participants stemmed from the fact that practitioners were not uncommonly experienced as ignorant of older trans people's healthcare needs with the result that trans individuals often had to become 'expert patients' and to research treatments and care on the internet for themselves. However, other trans-participants pointed out that some older adults may not be comfortable accessing information using the internet, resulting in disadvantage, and that information on the internet may be misleading, inaccurate and unreliable. Practitioner-participants acknowledged that their knowledge of trans issues and experiences of working with trans individuals were limited. One GP talked about actively researching what they should know and understand when a trans person registered as their patient, but this was not the experience of other older trans adults.

Subtheme 3: risk from others

Trans-participants described a range of occurrences where they had felt at risk. One trans woman described an encounter where she felt at risk of rape. Another participant described an encounter with a professional that involved similar risk. Prostitution was cited as a risk for people who were lonely and needed money to fund procedures/treatments related to gender variance. Risks from others to trans individuals, apart from the risks involved in accessing hormones using the internet, did not feature in practitioner interviews, and were not identified as a theme in a literature review (Benbow et al., 2021), but trans-participants described specific encounters where they felt physically or sexually at risk or subject to inappropriate curiosity, and which influenced their decisions about whether to engage or come out to service providers: Witten (2014a, 2014b) has suggested that fear of ill-health and potential abuse by care-givers toward the end of life may lead some older trans adults to consider self-euthanasia or suicide.

Theme 3: positive practices

People suggested what positive practice might look like, although sometimes they themselves had found differently.

Subtheme 1: administrative practices

One trans woman described how a friend, who wanted their gender changed on the GP surgery records, was told to go to the front desk and tell the receptionist, with no concern for privacy or confidentiality. Another described a different respectful practice where the need for confidentiality was acknowledged and confidentiality was maintained.

There were two areas of particular concern. One was laboratory tests and norms for men and women. People questioned 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 were at risk of by virtue of their birth-assigned gender. Jacqui referred to concerns about tests to measure the level of prostate-specific antigen (PSA) in blood: as a trans woman she had a prostate, and Emily, with others, made the point that trans individuals may need encouragement and education to engage in appropriate screening.

Screening was also an issue for practitioners, who had different concerns about administrative practices, wondering whether it is the business of care providers to ask about, and monitor, sexual orientation (LGBT Foundation, 2017).

Subtheme 2: demonstrating inclusivity

The positive impact of environmental changes was a recurrent theme, and the suggestions made by trans-participants included: information/posters about LGB and T organizations in waiting rooms; website material to show an organization is trans-friendly; and advertising that staff have had relevant training. Practitioners also suggested ways to demonstrate inclusivity, including: changing language (social care/housing); providing information and correct use of pronouns (secondary care practitioner); links with local support groups (primary care practitioner).

Table 5 summarizes practical suggestions made. One aspect of inclusivity is being sensitive to individuals' sensitivities. One trans-participant described having surgery unrelated to her trans identity. She was asked about previous gender reassignment surgery and could have regarded this as intrusive questioning, but staff explained that they wanted to know about her reaction to previous anesthetics and she felt ok about it. Another trans woman described a health practitioner advocating for her respectful inclusive treatment in an Emergency Department (see Table 4, Helen).

Subtheme 3: learning/training

Trans individuals identified a need for training of health and social care practitioners, describing finding that they needed to educate professionals themselves and, in effect, become expert patients.

Training might involve trans awareness, and, in healthcare settings, factual knowledge in relation to the particular medical needs of trans individuals, for example, in relation to hormone treatment, long-term side effects, etc. In social care settings it would involve how to ensure respectful dignified support for personal care.

Table 5. Positive practice actions derived from interviews.

Area	Suggested actions
Administrative	• Ensure privacy of sensitive information. • Ensure use of an individual's preferred name and pronoun • Electronic Patient Record highlights preferred name and pronoun • Gender inclusive terms used in admin e.g. partners • LGBT officers in organizations with named person to contact • Setting up service user experience feedback systems
Environmental	• Gender-inclusive rest rooms • Gender-inclusive materials e.g. posters, magazines in shared/waiting areas • Information about relevant local community groups available in shared/waiting areas • Gender-inclusive material on website • Consider use of appropriate logos e.g. rainbow • Privacy of interview/treatment rooms
Treatment/ management	• Non-intrusive and respectful questioning by practitioners • Attention to inclusive language by practitioners e.g. partners • Maintaining a list of trans-accepting/affirming resources/clinicians/practitioners in an area and referring people to them when necessary • Information about available community resources/support groups • Person-centered/life course/biographical treatment approach • Ready access to relational counseling
Staff training	• Including gender diversity in equality training for staff • Advertising that staff are trained e.g. on website • Encouraging staff to reflect on their own biases/ prejudices
Policies	• Recognizing non-biological kin and/or carers • Protection from biological kin who disrespect an individual's gender identity • Recruiting staff from diverse communities • Co-design of policies with a wide range of service users including gender-diverse persons
Service design/ development	• Co-design approach to service design and training at all levels involving a wide range of service users, including gender-diverse individuals • More service emphasis on primary care/community hubs with knowledgeable staff and easy access to a range of relevant services
Other	• Awareness programs for staff in residential and domiciliary care services • Awareness programmes for staff in older adult specialist housing developments • Encourage future planning actions e.g. Powers of Attorney, Wills, Advance Care Plans

Most practitioners commented that they themselves had not received training relevant to working with trans people, and they also often mentioned the need for training, which was regarded as a particular issue for older adult services.

One primary care practitioner referred to the education of practitioners as '*the key*' and commented on a need for members of trans communities to support education. Although both practitioners and trans individuals talked about the importance of staff being trained and of involving trans individuals in training, some noted that training does not change attitudes, which may continue to be problematic: indeed, one third sector practitioner noted that '*it's hard to police people's -isms*.' Another practitioner-participant noted that less time and effort has gone into training related to discrimination on the grounds of gender and/or sexuality than other forms of discrimination. Similarly, Willis and colleagues (Willis et al., 2020a) have described how older trans adults find themselves positioned as '*reluctant educators and self-advocates*' in primary healthcare.

Subtheme 4: personalized care

Trans-participants talked in general terms about wanting to be treated as individuals in encounters with care and for their wishes and preferences to be respected. The words listen and communicate were used repeatedly in relation to positive practice: listening to people and not judging them was important. Trans-participants pointed out that health and social care practitioners need to recognize that people are all different and that each person is an expert in their own life, and one person referred to the values of respect, dignity, compassion, and kindness set out in the NHS Constitution for England (Department of Health & Social Care, 2021).

For practitioner-participants personalized care and avoiding labeling people was similarly important. One secondary care practitioner-participant wondered whether, if services were truly individualized, asking people what is important to them, and being guided by service users, would service staff need transgender awareness? The implication of this is that all service users might benefit from 'truly' person-centered care, but it fails to acknowledge the contextual forces of discrimination and ignorance that impact on trans service users, and the powerful impact on older trans service users in particular of previous/historical contacts with care services.

Subtheme 5: reshaping services

Several trans-participants talked about redesigning the health service. They wanted services (including those related to gender identity) to be focused in primary care with GPs taking the lead on all aspects of management and visibly trans-friendly environments. They mentioned commissioning more than practitioners. Reshaping services meant that specialists would give clear advice to GPs and support GPs in prescribing for, and managing, their trans service users. Alongside this, trans-participants appreciated continuity of care with GPs and felt its loss in large practices. One focus group discussed continuity of relationship with care providers and referred to the 'underground' where experience of 'good' GPs is shared, with the result that trans individuals might transfer to a different, well-regarded and trans-friendly GP: this led them to suggest that some GPs might take a lead in relation to trans primary healthcare. Trans-participants also wanted signposting to local support services and ready access to psychological therapies/support in the community for themselves and for partners and families at an early stage.

Health and social care practitioner-participants also acknowledged a need for services to change with more emphasis on primary care or community hubs providing easy access to a wide range of relevant services. Most participants in both groups, practitioner-participants and trans-participants, felt that the current system is not working well for older trans service users and needs to change.

Limitations of the study

This was a service evaluation project and relied on recruiting trans participants through community organizations, and health and social care practitioners by disseminating information through local agencies/service providers. There are a number of limitations in this approach. 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 started by talking about their transition and concerns about gender identity services, although each participant was asked specifically about physical and mental health care (primary and secondary) and social care. Physical and mental health services were set firmly in the context of experiences related to gender identity. Gender identity clinics attracted much criticism. Secondly, the group of trans-participants as a whole had limited experience of social care, so accounts were dominated by healthcare experiences and it is difficult to draw conclusions about social care. Thirdly, the trans-participants were self-selected in that they were those people who agreed to talk to a project worker and who were connected with organizations supporting the project. Similarly, practitioner-participants from health and social care were those who volunteered, are likely to have an interest in trans health and social care, and are unlikely to be representative of practitioners generally. The project method involved both individual interviews (some remote, some face-to-face) and focus groups. Health and social care practitioner interviews were mostly not recorded: contemporaneous notes were made and checked afterward by participants. It was difficult to access interviewees from social care settings and it was suggested that this may be because social care professionals in older adult services have limited experience of caring for trans people. Trans men are under-represented amongst our participants, and it is possible that further investigations that include more trans men might find differences between trans men's and trans women's views and experiences.

Conclusions

The data give powerful insights into the experiences of a group of people whose voices have historically had little influence in older adult services, and has striking parallels with the accounts of practitioners. Age-related imperatives, historical and recent experiences of health and social care, relationships with partners and family members, links with community groups, and access to (or lack of) economic resources are all factors that can support older trans adults in living life as they choose or undermine their autonomy.

It is evident that further research is needed in order to inform future development of training and education. The works of Siverskog (2014) and Smolle and Espvall (2021) carry far-reaching implications for social workers, and, if health and social care services are to address the needs of older trans adults, change will need to extend to all practitioners and across all services. Our main conclusions are directly relevant to the ongoing education and training of a wide range of health and social care practitioners and cover three main areas: understanding service users; practice; and training. With regard to understanding service users: older age increases the importance of access to treatment for gender variance, whilst simultaneously complicating it when physical health problems develop and there is a greater need for contact with health services; and older trans service users may be sensitive to potentially discriminatory experiences because of historical experiences. With regard to practice: services should aim to understand individuals in terms of their family and personal history, prior life experiences, psychosocial context, broad socio-historical context and relational context, all of which affect physical health, mental health, and well-being in later life. Simple changes made by service providers can increase accessibility to trans service users (see Table 5). Service users need ready access to individual and relationship counseling. In addition, services might usefully link with relevant local community organizations, and devolving services as much as possible into local communities would normalize trans healthcare and increase service accessibility and acceptability. Further exploration of older trans adults' concerns about, and experiences of, social care should be a priority, although

integrated care systems may address this (Charles, 2021). In relation to training and education: health and social care practitioners at all levels need training in positive inclusive approaches to care, with older trans service users as co-trainers, to give them knowledge and confidence to address issues facing older trans individuals.

Acknowledgments

The authors would like to thank everyone who supported the TransAge Project including a large number of people and organisations who contributed in a wide range of ways.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The work described in this report was commissioned by Age UK Cheshire and funded by Cheshire West and Chester Council's Equality and Diversity Fund.

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