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Lesbian, Gay, Bisexual, Trans + (LGBT+) Care in Later Life: A short review of the research and evidence to improve inclusive and affirmative practice

1. Introduction

There is a substantial, rich and cumulative body of evidence on the experiences of lesbian, gay, bisexual, trans, queer and questioning people (LGBTQ+) in later life. This provides some benchmarks and a base for identifying the knowledge, understanding and insights needed by the social care workforce to work effectively with gender and sexually diverse communities. The development of the learning framework for LGBTQ+ ageing was informed by a literature review from the UK context. International sources have been drawn on to address any gaps or to take advantage of transferable examples of best practice.

This body of evidence reveals a range of concerns and challenges for people who identify as Lesbian, Gay, Bisexual and Trans and other sexual and gender minoritised groups as they enter into their later years. It also documents the strengths, contributions of the community and their recommendations for what can be done to support the workforce in developing and improving affirmative LGBTQ+ ageing care.

Language and terminology is important when talking about or communicating with members of the Lesbian, Gay, Bisexual and Trans community and is as much about our approach as the words we use. This review uses the acronym LGBT+ in recognition that everyone has a right to self-identify and that people will use a variety of terms and labels to express themselves. Adding a plus (+) sign signals recognition of other less articulated sexual and gender identities. The term Queer has been reclaimed over the last two decades as a deliberately provocative and political radical alternative to LGBT and as an umbrella term for people who are not heterosexual or cisgender. Some people in the older community have not used this to describe their identity perhaps due to its very negative connotations from earlier life.

The Learning Framework for LGBT+ Ageing

While LGBT+ older individuals may experience the same challenges as their heterosexual and cisgender peers[1] they also face very unique challenges in accessing healthcare directly related to their gender or sexual identity. The literature strongly points to a lack of appropriate and inclusive health and social care and support.[2 3 4 5 6 7]

A key and consistent message recommended in the research literature concerns the gaps in education and training needed to equip the care workforce with better knowledge, skills and confidence on LGBT+ issues in ageing and how to address heteronormative and cisgendered assumptions in care provision.[8 9 10 11 12 13 14 15] The social work and social care curriculum on ageing and the learning resources that it relies upon, tends not to address LGBT+ issues[16 17] and/or lacks diversity when it does.[18 19 20]

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The learning framework for knowledge, skills and values for working with LGBT+ people in later life therefore identifies and articulates the key topics that should underpin best practices with LGBT+ older people and their carers' in social care. Whilst a framework can't cover everything, it aims to direct learners, educators, leaders, practitioners, providers and commissioners in social care, to the essential knowledge, skills and values that help to underpin and enable better engagement with the delivery of more affirmative inclusive care for LGBT+ people in later life.

Most of the resources signalled in the framework were developed from research findings, and as a means of exchanging research knowledge with those in practice. These resources give particular emphasis to the personal stories and narratives of people with lived experience and are co-produced with LGBT+ older people and their advocates.

2. Who are the LGBT+ ageing population?

There is a lack of large-scale quantitative data in the UK on its older LGBT+ population and a general invisibility of LGBTQ older people in official statistics, epidemiological research and the media. Historically, this has been problematic and contributed to a detailed lack of knowledge about the lives and needs of the LGBT+ population. This is partly due to a lack of monitoring for sexual orientation/gender identity in routine public services data collection[21] and reluctance of care providers and practitioners to ask[22] and an understandable reluctance for individuals to share, which can be particularly pronounced in the older community due to life experience and living at a time when it was illegal to be gay.[23]

In 2017, the UK Government conducted a national survey of LGBT people. One hundred and eight thousand (108,000) people provided information about their experiences of living in the UK and of accessing public services such as education, healthcare, personal safety and employment. Some of the findings demonstrated stark and continuing inequalities for the LGBT+ population in the UK.[24]

The subsequent LGBT cross-Government action plan[25] spelt out 75 commitments to improve the lives of LGBT people. Relevant for this framework, is the Government's commitment to undertake further work to improve understanding of the needs of older people as a specific group (p24, to access and make use of research and evidence (p7); to ensure LGBT people's needs are taken into account in health and social care regulation; and to tackling the injustices that LGBT people face in their everyday lives.

The England and Wales 2021 Census was the very first time that (voluntary questions were asked about sexual orientation and gender identity.[26] Asking questions about gender and sexual identity is a first step to paint a more precise picture of LGBT+ older people's needs and their diverse characteristics to help to provide a comparison with other groups in the UK population. Asking this confidently and sensitively is an area that many people working in care admit to struggling with[27] [28] [29] and can signal a safe and comfortable environment or culture for older people to come out if they wish to do so.[30]

Monitoring sexual and gender diversity in the access and provision of care services is important to validate and provide a vehicle for LGBT+ voices from different ages and backgrounds. More robust data about LGBT+ people in later life will be essential to inform and drive changes in social care, to reach out to some of the most vulnerable people in our community and, to improve the health and wellbeing of particular marginalised groups such as trans and intersex[31] and non-binary people.

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For example, a meta-analysis of 29 datasets on health or care indicators on LGBT+ people[32] revealed that (LGB) men and women experiencing poor self-rated health 1.2 times higher than for heterosexual people. This type of analysis confirms how cumulative health inequalities are a strong predictor of future mortality, and poor outcomes for health, disability and life expectancy.[33]

In the context of not having a reliable source of how many people aged 65 years and over identify as LGBT+ in the UK, some conservative estimates have been put forward. One suggests that LGB people have risen from 0.7% in 2018 to 1.0% in 2019 of this age category (120,000, from a population of 12.0 million).[34] Another commonly used estimate is that 5-7 per cent of the population identifies as LGBT.[35]

On this basis, there are likely to be between 520k and 720k people, aged 60 years and over, who are LGBT (using the UK 2011 Census figures). Such demographic shifts signal an older, more dependent population[36]. A tentative estimate approximately of 200,000-500,000 trans people in the UK does not break these figures down by age.[37]

3. The legal framework and LGBTQ+ human rights

There has been greater recognition, equality and protection through the UK developing legal framework. This has a direct impact on care and support services, who will need to move with these changes and create opportunities to actively demonstrate to potential users from the LGBT+ ageing community that their services are affirmative and inclusive in line with the legislative, policy, principles and values of care.

In 2004 the Civil Partnership Act, allowed same-sex couples to legally enter into binding partnerships, similar to marriage. The subsequent Marriage (Same-Sex Couples) Act in 2013 then went further, allowing same-sex couples in England and Wales to marry; Scotland followed suit with the Marriage and Civil Partnership (Scotland) Act 2014. Northern Ireland enacted the Northern Ireland (Executive Formation etc) Act 2019, making same-sex marriage legal on 13 January 2020.

Despite legal recognition of relationships, there is extensive evidence of LGBT+ older people's partners, carers and 'families of choice' not being valued and recognised in some care settings.[38] [39] 'Families of choice', including friends, lovers, ex-partners and trusted biological relatives, have however been more recently been recognised as significant providers of care for LGBT+ adults.[40] [41]

This may be heterosexist assumptions that make the nature of relationships unclear and not taking them seriously. Some research has shown how it is necessary for significant others or LGBT+ people themselves to take action to educate and create safe contexts, not all LGBTQ people have someone 'fighting' for them.[42] [43]

The Gender Recognition Act 2004, which came into effect on 4 April 2005, gave trans people full legal recognition of their gender, allowing them to acquire a new birth certificate – although gender options are limited to 'male' or 'female'. In 2018, the UK Government consulted the public on reforming the Act, no action has since taken place. Trans people report the worst experiences of discrimination, across a range of settings such as the workplace, healthcare, and public services.[44]

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Experiences of discrimination can contribute to material disadvantage (for example poverty from workplace exclusion), poorer mental health, and create barriers to accessing services in the future.[45] People who transition in later life may have to wait up to five years for gender affirming interventions. Recent research on older trans people's access to gender-affirming treatments highlights the additional pressures on trans patients to educate primary care professionals, such as GPs, and inconsistencies in trans-inclusive care provided by healthcare workers.[46]

The Equality Act 2010 gave LGBT employees protections from discrimination, harassment and victimisation at work. The legislation brought together existing legislation and added protections for trans workers, solidifying rights granted by the Gender Recognition Act. The Equality Act 2010 prohibits discrimination on the grounds of nine protected characteristics, including religion, sexual orientation and gender reassignment (expanded by case law to include transgender identities more broadly). Professional standards for social care professionals also mandate non-discriminatory practice.[47] [48] [49] [50]

The Equality Act 2010 strengthened previous equalities legislation in important ways to help tackle discrimination and inequality, with the potential to secure greater fairness and equality for older lesbian, gay, bisexual and trans people in the UK. The Act applies to all organisations that provide a service to the public or a section of the public and applies to anyone who sells goods or provides facilities whether or not a charge is made. Its Public Sector Equality Duty set out in section 149 of the Equality Act was created with the purpose of integrating equality and good relations into the day-to-day business of public authorities in addition to responding to discrimination.

For LGBT+ people in later life, this should lead to service providers taking positive steps to promote equality, for example by developing service standards that can inform service improvements and evaluated through its (e) quality assurance frameworks. This might involve targeted staff training, improving the collection of data on the needs of LGBT+ older people and to identify whether to target specific services to address the health and social care inequalities that people face as well as to ensure that mainstream services are affirming and inclusive.[51] Engaging with the many good practice guides and resources in this framework will support organisations, its stakeholders and workforce to demonstrate affirmative and inclusive services as well as eliminating discrimination and harassment.

An example of good practice in the Public Sector Equality Duty is the collaboration between the LGBT+ community organisation Opening Doors with Health and Wellbeing Boards in London to inform how they produced a Joint Strategic Needs Assessment (JSNA), which addressed the need of the older LGBTQ+ London population. Only 15% of the London boroughs have a dedicated LGBT+ section; only 9% of the boroughs show evidence of engagements with local LGBTQ+ people (e.g. through focus groups) and only 19% of the boroughs considered intersectionality in the context of the LGBTQ+ in their JSNA.[52] Since 2019, the Government Equalities Office now also works with a National Advisor for LGBT Health and NHS England.

In 2018, the Commission for Social Care Inspectorate found that of 400 quality assurance forms submitted by adult social care providers describing equality actions, only six reported any work undertaken on trans inclusion, in every case as a reactive response after a trans person began using a service.[53] More positively, direct engagement with the LGBT+ community has demonstrated some positive change to the regulation standards and themes in reviews.

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4. An overview of why LGBT+ older people face barriers to accessing care and support

Research clearly demonstrates that LGBT+ people in later life report poorer health than the general population and have worse experiences of care[54 55] synthesis of data from 25 different data sources and an unparalleled sample size (over 2,500 LGB men and women) enabled a better understanding the extent of health inequalities in later life. Some of the inequalities in self-rated health included, long-term illness, smoking, suicide attempts, and life satisfaction.

Such health inequalities are irrespective of whether LGBT+ people are accessing cancer, palliative/end of life,[56 57] dementia and/or mental health services.[58 59] LGBT+ older people for a number of reasons, may not have the expansive family networks of support as they enter old age when compared to people who do not identify as LGBT+.[60 61]

Current research focusing on the LGBT+ experience of dementia identifies two influences that significantly inform how dementia is experienced by members of the community.[62 63] Cognitive impairment often heightens and multiplies challenges for both LGBT+ carers and persons with dementia in specific ways, setting them apart from other aging members of the community, for example the loss of an LGBT+ identity as one loses one's own self and oneself within care settings which renders people doubly invisible.[64 65] For affected LGBT+ individuals, dementia highlights the intersectionality of sexuality, stigma, and sickness leading to greater isolation.[66 67]

Estimates indicate 3% of informal carers are LGBTQ+,[68] but this is likely to be an underestimation. Older LGBTQ+ informal carers report that services are not set up to take account of their information needs (e.g., end-of-life decisions and care for older adults who identify as LGBT+). Accessing information and support through formal and institutional channels is stressful for older LGBT+ informal carers as generic carers support is mostly inapplicable to the nuanced needs of older LGBT+ informal carers, who may be looking for information. Their relationships may be misunderstood or insensitively questioned by care providers.[69] Outside of LGBT+ own community based provision, there is a dearth of provision and the lack of tailoring services for older LGBT+ carers. Partners of LGBT+ people with dementia are not only having to grapple with the challenges of care giving and anticipatory grief – they are also often having to fight for their relationships to be recognised and valued at all.[70] King[71] has questioned the very way in how dementia is understood culturally and demonstrates from charity literature how this is framed in a heteronormative and cisgendered way which silences or writes out the experience of LGBT+ people.

A scoping review of empirical research on the lived experience of LGBT+ people with dementia and their care partners[72] found only one single study[73 74] included people who were trans. None focused explicitly on people who were intersex, non-binary or queer thus obscuring the nuance and distinctions between the experiences of older people with dementia. They also found considerable difference in the literature on how trans people in formal care settings were described as 'forgetting that they have transitioned or starting to associate with gender in a different way with strong critiques on how expressions of gender fluidity among trans people with dementia should be supported, not pathologised.[75]

Small studies have captured the narratives of people involved in research and themes concerning how older LGBT+ people's life stories and relationships are invisible, overlooked and undervalued when they interact with care services.[76 77 78 79]

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These inequalities in outcomes are attributed to a number of issues, including a lifetime of exposure to prejudice and discrimination resulting in 'minority stress'[80] and/or use of adaptive or behaviours to compensate for example, problematic substance use.[81] The theory of minority stress has posited that LGBT+ people are at risk of mental health issues from chronic social stressors related to the experience of stigma and prejudice and which in turn can manifest in physical signs of stress.[82]

LGBT+ older people frequently report the anticipation or experience of discriminatory attitudes among care providers in the form of heterosexism, homophobia, biphobia and transphobia. These fears and experiences in turn contribute to delay in access and a lower uptake of health services which further impacts health and wellbeing.[83 84 85 86]

The lack of affirmative and inclusive care has been linked to conflicting religious and cultural beliefs in the social care workforce[87 88 89] and to ageist attitudes in relation to sexuality and ageing.[90 91 92 93] Sexual identity categories do not reflect the diversity of older LGBTQ+ people's lived experiences.[94] Experiences of health, wellbeing, social support and caring vary according to intersections across gender, ethnicity, and disability and, of course, age.[95] Attributing common features to older LGBQ people's relationships that may, at best, disregard areas of commonality shared with other older people or, at worst, lose focus on the individuality of older people's life-experiences and significant relationships.[96]

Research demonstrates a 'one size fits all' approach in some areas of care,[97] where greater awareness and knowledge of the lifestyles and cultural needs of LGBTQ+ older people could lead to better tailoring of health and social care. There is an urgent need to address this within care homes[98 99 100] and provide advocacy and support for people as they transition to long-term care. Alarmingly, some trans people have describe being open to euthanasia as a strategy to avoid residential care where the level of fear of being misunderstood, misgendered and ridiculed is so great.[101] The process of disclosure about sexual and gender identities within closed care environments can thus be extremely stressful for someone and may exacerbate anxiety around 'who knows what'.[102] For example, in some circumstances, displays of same-sex affection can jeopardize heterosexual friendships and relationships with care staff.[103]

Advanced care planning is important for LGBT+ people and raises distinct issues such as providing protection for partners and significant others who might otherwise not be recognised and to make and record plans for future care.[104] Distinct issues identified include not knowing who to nominate in decision making roles as well as being able to nominate 'important others' as next of kin, which might mean same-sex partners or significant friends. A study by Almack et al,[105] highlighted the problematic heteronormative default position to refer to people related by blood or (heterosexual) marriage. This can deny a person's wish to involve significant others in their lives and for them to be acknowledged, respected and involved in their care (and in some cases keeping family of origin at a distance or explicitly NOT wanting family of origin involved (p4. The researchers[106] commented on the many anecdotal stories of LGB people who had died and whose partners and/or friends had been excluded from the funerals by families of origin. For trans people, particular concerns were expressed about being buried by family of origin under their assigned gender at birth, despite knowledge of legal protection of one's acquired gender identity.

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5. The value of education and training on LGBT+ ageing

The provision of affirmative care for LGBT+ older people requires cultural competence in the health and social care workforce. Baiocco et al[107] model includes cultural awareness, cultural knowledge, cultural sensitivity and compassionate attitudes towards LGBT+ service users.

The targeting of education and training also needs to be supported by policies and benchmarking standards[108 109 110 111 112] and reflect all of the areas in developing an equity framework. These should include leadership;[113] organisational initiatives to improve care[114] and community engagement.[115]

Two systematic reviews of education on LGBT+ ageing,[116 117] have focused on identifying the pedagogic principles that can improve how training is delivered and received and looked at the outcomes from interventions used to educate the health and social care workforce. The reviews recommended areas for improvement such as; giving more attention to the curriculum content and improving teaching and assessment strategies that tackle barriers to including LGBT+ in the curriculum. These two reviews call for more explicit standards, benchmarks and learning outcomes within professional education on ageing inequalities and broader issues of care that impacts on LGBT+ populations.[118 119]

Skills for Care launched a national quality standard for care services, Pride in Care, which is supported by Care England.[120] Most importantly, making sure that learning interventions are diverse to meet a range of learner's needs and ensuring that older people with lived experience are involved in the design, delivery and evaluation of educational interventions would further improve efforts and have a more sustained impact on LGBT+ ageing inequalities.[121] A review of the literature on professional practice learning in medicine, nursing and social work (p.1629)[122] observed that in eleven of the studies the influence of gender, ethnicity and religion contributed to discriminatory [learning] environments due to pre-existing cultural and religious prejudice against LGBT+ people. There can be a reluctance to challenge or maintain a silence where discriminatory views exist.[123]

Further, LGBT+ older people themselves do not form a homogenous group and have multiple and complex identities including, ethnicity, gender, disability, class, geographic location, religion, and age[124 125] Intersectional approaches to understand how belonging to a number of different minority populations can lead to increased resilience and person-centred support.[126 127] All of these factors are important for how health and social care professionals' work with LGBT+ older people and how they acquire the knowledge and skills to do so. The topics in this learning framework seek to address many of the different areas to contribute to holistic care.

One illustrative finding from the UK Government Equalities Office[128] survey of LGB (and trans) people is the differences across those reporting experiences of conversion therapy. Older respondents were more likely to report this (10 per cent of those 65+ years) than younger age groups and respondents identifying as Black, Asian and minority ethnic were more likely to report this compared to White respondents. This finding highlights how experiences of conversion therapy are compounded by minority status and by older age, casting light on the additional heteronormative stressors and institutional racism experienced by LGBQ+ people within these groups. It reiterates the value of recognising how oppressive professional interventions experienced in earlier decades impact on older people's understanding of their sexual identity, agency and resilience.[129] In 2022, the UK government announced plans to ban conversion therapy, but at the time of writing, did not plan to include trans conversion in their plans.

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6. Unique history of LGBTQ+ people in later life

Understanding the history of the LGBTQ+ community is essential to appreciating the context as to why there are challenges for the community in accessing and engaging with care services. Older LGBT+ people's lives, histories and legal landmarks, and the physical and mental impacts of growing up within institutions that criminalised sexuality and pathologised their sexual and gender identities has had a lasting legacy.[130] Many from LGBTQ+ communities were referred by parents or schools for "treatment" to "cure" them via health/psychological health services – which for many caused long lasting trauma and has entrenched in some a lifetime of fear/distrust of health services. Older LGBT+ people (born before the 1950s) have had a unique experience from the rest of the LGBT+ population in that they have lived much of their lives in a social and political context where their human rights were not protected by legislation. Some will have been criminalised before (and since) the partial decriminalisation of homosexuality in 1967 for engaging in consensual same-sex relationships. Homosexuality was only removed from the manual of mental disorders in 1987 LGBTQ+ older people have also witnessed the loss of many friends from HIV/AIDS with whom they had hoped to grow old.[131] The HIV/AIDS crisis and the government at the time also politicized homosexuality and galvanized the gay rights movement in the United Kingdom, leading to the establishment of two of the United Kingdom's best known gay rights movements, Stonewall and OutRage!, in 1989 and 1990, respectively.[132]

Being a lesbian was never illegal, but was subject to severe sanctions and social stigma. [133] [134] Lesbians' lives and lifestyles were viewed as unnatural; they experienced harassment, rejection, and faced losing their jobs and families and especially their children.[135] [136] The social and sexual movement that has since changed the lives of (many) younger lesbians, may be too late to liberate some older women from their isolation and strongly ingrained privacy which can lead to loneliness in later life particularly where mobility and access issues might arise.

For bisexual individuals who report coming out later in life and are more likely to experience marriages with individuals of multiple genders. [137] [138] This can contribute to internal conflict, confusion, and felt invisibility.[139] A comparative study of bisexual ageing in the UK and USA highlighted the hypervisibility or hypersexuality that is associated with bisexuality and can give rise to negativity and stereotypes both within and outside of the LGBTQ community. This in turn limits access to support and smaller social networks compared to lesbians and gay men. The limited research on older bisexual individuals intersects with other marginalised experiences such as being trans or a person of colour.[140] [141]

Pearce[142] and Toze[143] have talked about the different timelines for trans people coming out in later life who may use an alternative chronology to describe their identities and make sense of their lives. A trans person's lifecourse is not solely defined by their 'transition' but depending on when their gender was affirmed and their stories about their identities can be very diverse. For example, people often wait to affirm their gender in later life after they have retired or their family members are established in their own lives.[144] [145] Tran's issues have a long and complex history in the UK, which is helping shape the present legal landscape. Even though the first woman to have 'gender reassignment' surgery in 1951, it is only since 2000, that the legal rights of trans people have begun to be entrenched more seriously in UK law.

Equally, these identities do not tell us much about the sexual practices and sexual health of older LGBQ adults, a topic we know little about, and how sexual experiences differ across gender, social environments and power dynamics.

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7. Positive and negative aspects of the LGBT+ ageing experience

Some research shows that as older members of the LGB community have lived much of their lives in heterosexist and homophobic societal contexts, they have developed skills to deal with crises that reinforce their ability to deal with future stressors.[146] [147] Becoming older (and wiser) may also offer an opportunity for a person to consolidate their own individual strengths and resilience.[148] Resilience in later life for LGBT+ people has been shown to come from a variety of sources.[149] For example being politically active in the LGBTQ+ social movement, becoming an advocate for others,[150] staying close to the networks and alliances with their own community, allies and families of choice,[151] [152] and through spirituality and religion.[153]

Some research findings into the experiences of LGBT+ older people during lockdown in the UK demonstrated that the impacts of COVID-19 have been mixed and very different for some groups within the LGBTQ+ umbrella [154] [155] [156] Lockdown appeared to have magnified LGBT+ older people's overall experiences, for example those people happy with their living circumstances prior to COVID, reported stoicism, adaptability and determined positivity and some even reported an improved quality of life, better personal relationships and increased neighbourly support.[157] There were some gender differences in that gay men placed a stronger emphasis on independence, distinguishing between social contacts and the provision of support.[158] Specific issues for trans and gender non-conforming older people (TGNC experiences, were again dependent upon the quality and availability of their family and support networks which often centred around friends and non-kin.[159] One study identified increased risks for transgender and gender non-conforming (TGNC people from a perceived rise in social intolerance and increasingly hostile environment as well as restricted access to gender affirming care.[160] [161]

On the other hand, the ability of LGBTQ+ older people to maintain supportive relationships with their families becomes increasingly challenging as they get older, [162] resulting in situations where their support networks are disproportionately dependent on friends.[163] [164] These relationships can be further compromised for those living in rural areas[165] [166] or when moving into supported living environments. One study has identified the potential for social exclusion in housing and care schemes for LGBT+ older people. [167] This included feeling disconnected from other residents due to different personal interests and life experiences, and overhearing homophobic and/or racist comments from other residents, which compounded a sense of marginalisation.

Other research shows that older gay men are significantly less likely to have a partner when compared to heterosexual men as well as being more likely to age without children. [168] Bisexual men are more likely to have children than any other sexual orientation group.[169] A review of studies on loneliness in later life for LGBTQ+[170] suggests that the characteristics and circumstances, including living arrangements, housing tenure, minority stress, and geographical proximity, in the lives of older LGB people may mean that they are at increased likelihood of loneliness. Another study[171] also found that across older LGB populations, families of choice do not compensate for weaker kinship ties, this needs further investigation. A potential consequence of the lack of informal support is that people rely on more formal sources of social support as they age.

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The framing of 'successful ageing' in UK ageing policies has been critiqued for its failure to recognise the individual experiences of LGBT+ people in later life from diverse backgrounds.[172] Taking a lifecourse approach[173] helps to consider how the accumulation of advantages and disadvantages over time can shape outcomes in later life. In other words, a negative experience or instance of adversity will have a more detrimental impact on an individual if it has been preceded by several similar negative instances.[174] This highlights the importance of intersectionality as we explore ageing in the LGBT community. Intersectionality describes how multiple identities contribute to a person's sense of self and how these different aspects are themselves potentially subject to forms of discrimination and marginalisation.[175]

There is much less research into the experiences of LGBTQ+ people from diverse racial and cultural backgrounds. Research[176] has described the unique challenges for older LGBTQ+ people of color who have experienced discrimination based on race, gender, and sexuality in all phases of their lives, often bearing witness to and helping to start various equal rights and social justice movements. These unique challenges may involve the importance of religion and spirituality which can be a support but also a potential site of further oppression. These experiences call for particular skills in later life around coping and developing resilience to a wider range of situations the individual might face.

In one London Health and Wellbeing Board,[177] it was found that certain population groups are more likely to be affected by HIV, namely men who have sex with men (MSM) and people identifying as black African. High population turnover, including high rates of external migration, higher diverse population of LGBTQI+ people in terms of ethnicity. Leaders must ensure a continuous process of strategic assessment and planning with a core aim to develop local evidence-based priorities for commissioning. This will improve the peoples' health and reduce inequalities by analysing the populations' needs, and agreed priorities, to determine the actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

8. Participation and co-production with LGBT+ older people

There is a growing movement among LGBTQ+ ageing research and practice which promotes partnership with LGBTQ+ community members. People are more than willing to share their expertise given their stake in using services in later life if this is properly supported and valued. This requires creativity, commitment and resources to facilitate this. For example, Smith et al [178] found that the lives of LGBT+ people with dementia themselves seem almost entirely absent from literature about them and suggested that the use of photovoice was found to be the most common innovative method for engaging people with dementia in research.

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There are many and growing examples of partnerships involving LGBT+ older people.[179] [180] Another example is[181] work carried out with a large care home provider which showed that enabling structured interaction and personal exchange with staff and managers and making best use of different types of expertise, such as that of the volunteer community members is a powerful learning opportunity. This involved engaging rather than alienating staff in learning by creating safer, non-judgemental spaces for critical exploration of what makes good care. Action research involving members of the LGBTQ+ community as 'community advisors' to enhance inclusive care in residential homes demonstrated that collaboration, participation and co-production can be valuable in producing new, multi-faceted knowledge and understandings. Reflecting lived experiences served to enhance the depth, credibility and authenticity of challenge and change to care home cultures.[182] [183] Another example is the Trans Ageing and Care delivered in collaboration with the Unique Transgender Network and the Older LGBT Network for Wales, Age Cymru.[184]

9. Summary

This short review of some of the most relevant research evidence conveys a range of complex issues to be considered when interacting with LGBTQ+ people in later life. These require the engagement of everyone involved in the social care workforce, who may be in contact with service users and carers, be involved in assessment and providing direct services and particularly those responsible for meeting the challenge of engaging with the community to ensure that appropriate affirming and inclusive high quality services are developed, commissioned and evaluated. We suggest four domains incorporating subjects essential to educating, training and developing the workforce to meet the challenges of LGBTQ+ ageing individuals and communities.

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Appendix 1

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