A Review of the Needs of Older LGBT People in Later Life

PinkNews

Research sponsor:

AEGON

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About PinkNews

PinkNews is the world's largest LGBT media outlet. We stand for the fundamental rights of the entire LGBT community and its allies. Our goal is to acknowledge individual experience, and work towards representing a diverse and intersectional community.

"The first generations of LGBT+ people to have witnessed decriminalisation are ageing. For some, this means entering a care systemwhich still fails to meet the needs of our community. My hope is that thesegenerations who fought so hard and lost so much for the rights we now enjoy are not forgotten. The recommendations in this report, and the research that informs it, have the potential to drive meaningful progress inthe fight against inequality over the coming years."

Benjamin Cohen,
CEO and Editor-in-Chief,
PinkNews

Foreword from Aegon

"We welcome the publication of the Review which brings together a multitude of studies on the issues facing the LGBT+ community when it comes to ageing. Whether it's concern about ensuring financial assets are passed on to the right beneficiaries or a worry about the potential for discrimination in later life care, the Review points to a number of areas associated with finance, housing, care and health which warrant further investigation.

We were delighted to sponsor the initiative because as a business our purpose is to support customers achieve a lifetime of financial security. In the UK Aegon provides pensions, investments and protection products to over three and a half million customers. Our customer base is broad and represents all sections of society but one thing every customer has in common is a desire to prepare for the future and secure their finances. As a result, it's important that we understand the different challenges our customers face as they age to better inform how we support different groups. The Review will also inform Aegon's Inclusion and Diversity programme which seeks to ensure Aegon is an inclusive and welcoming employer which attracts talent from a broad range of backgrounds. Finally, I'd like to thank the Review's authors for the time and effort that went intoproducing the review."

Stephen McGee,
Chief Financial Officer,
Aegon UK

Table of Contents

Summary

This report was commissioned by PinkNews Media Group[1] . A rapid review of the existing empirical evidence was undertaken to identify key issues most relevant to older lesbian, gay, bisexual and trans ('LGBT')[2] adults in the contexts of health, social care, housing, financial and legal services in the UK. The findings from a total of 40 relevant papers were synthesised[3]. The findings of this report remain in line with previous reviews[4, 5]. The findings of this report are summarised below and have been used as the groundwork for a series of recommendations (see 'Recommendations'). Crucially, future directions for research which would serve to bring recognition to the heterogeneity of the LGBT community are indicated at the end of this report (see 'Future research').

Broadly, those who are LGBT are believed to be at a higher risk of suffering from poor mental and physical health throughout their lives. Though it is unclear how the likelihood of poorer health plays out in older age, a fear of prejudice acts as a barrier to LGBT people accessing health care services in later life. This lack of confidence in health care services is primarily a result of previous experiences of discrimination relating to gender identity or sexual orientation. Most recent studies (The Last Outing, 2015) indicate that two thirds of respondents reported experiences of discrimination, leading to delays in seeking treatment at the appropriate stage (see p.10-12 of this report). LGBT older people seeking care perceive a lack of acceptance from health care staff of non-heteronormative and non-cisnormative lifestyles. There is also evidence that services are often unable to cater to specific health needs due to a lack of specialised knowledge, which has an impact on the treatment of trans people (p.11). Additionally, LGBT people may not belong to traditional family structures where informal support can often be relied on, with many LGBT people turning to friends or 'families of choice' for support.

Prejudicial attitudes also have a negative impact on older LGBT people's experience in residential, nursing and assisted care, with an overwhelming number of LGBT people viewing care and nursing homes as undesirable options for care in later life. Overall, care homes were seen by LGBT people as heteronormative and cisnormative environments, where they would have to hide their identity in order to protect themselves from abuse (p.12-14). In many institutions, care is characterised by a sexuality-blind attitude that prevents specific care needs from being addressed. Studies suggest that sexuality and sexual orientation is seen as peripheral to care by care staff (see p.15). Staff also reported that they lacked the communication tools and confidence to address the sexual identity and life histories of LGB residents. Training emerges as an essential tool for combatting issues surrounding lack of knowledge and confidence, with evidence suggesting that exposure to LGBT individuals, participatory leadership from managers and the introduction of LGBT advisors to committees are all effective in shifting anti-LGBT attitudes (p.15).

Surveys also indicate inequalities in housing provisions: older LGB adults are more likely to live alone, and that their social networks are less immediately accessible (p.16). LGBT communities provide support and resources to their members, helping to alleviate feeling

of loneliness and social isolation through social integration. Voluntary sector projects fill gaps in accessibility and offer a wealth of support to older people. For many LGBT people who faced historical discrimination, intimate relationships (including close friendships) were isolated to the safety and privacy of a home. As public spaces did not always feel safe, home became a key setting for communities and personal connections to develop. As such, the safety and connectedness they felt within the home remains intimately tied to the quality of life of older LGBT people. Currently, there are no specialist LGBT housing provision options in the in the UK. Reports suggest a split in preferences within the LGBT-community, with older LB women reporting that gender (rather than sexual orientation) is an important issue in relation to sheltered housing and residential housing (p.19). According to the SAFE – Secure, Accessible, Friendly and Equal study (see p.19), the majority of LGB residents felt safe in their neighbourhoods. By contrast, trans people reported a high level of concern regarding safety in their neighbourhoods, and transphobia in care homes and other forms of sheltered housing. Additionally, though a high number of older LGB people are single and live alone, many express a high degree of ambivalence towards the prospect of receiving social care services in the home.

Regarding access to financial services, though LGB people have been found to be at a material disadvantage by comparison to their heterosexual counterparts, they are also more likely to have made financial plans for later life (p.19-20). Within the LGB community, lesbians are likely to be at more of a disadvantage in employment due to their status as women, particularly if they had roles as carers and mothers. Previous marriages also open up the possibility of financial insecurity, with pension rights being lost upon entering a Civil Partnership (p.20). Though some evidence exists on the gender income disparity between LGB individuals, there is a lack of information concerning trans experiences of financial services. As for legal services, wills are particularly important to LGBT people in later life. LGB adults may choose to pass on 'family money', or prioritise their children, even in spite of poor family relations; they may also choose to nominate friends, partners or ex-partners in cases where families are not in contact. In cases where relatives are estranged, giving Lasting Power of Attorney to 'families of choice' ensures that end of life wishes are fulfilled. Broadly speaking, the tools available for financial and legal protections in later life are thought to be more accessible to those who are affluent than those in poverty. The expense of writing a will is a barrier to many who wish to declare their end of life choices, as well as nominate those closest to them as beneficiaries of their estates (p.21).

Introduction

Current UK Policy & Legal Context

Older LGBT people have suffered legal, medical and social discrimination across their life course, which can impact their perceptions of social and political institutions, including health, social, housing and financial services. There is now a requirement for public and private services to ensure anti-discriminatory services to older people on the basis of sexual orientation, gender identity and age. The extent to which recommendations have been implemented is presently unclear since health outcomes that are related to gender identity and sexual orientation are not routinely monitored in population-level censuses or health indicators such as the Public Health Outcomes Framework ('PHOF'). A companion document[6] to the PHOF supported by Public Health England, the Department of Health and the National LGB&T Partnership outlines recommendations for action at a local, regional and national level, and is intended for local authorities, Health and Wellbeing Boards, NHS England, specialist public health teams, Clinical Commissioning Groups, NHS and social care providers, and voluntary and community organisations working with LGB&T people[7]. Additionally, development of LGBT 'cultural competence' for service staff is not mandatory[8].

Experiences of prejudicial treatment on the basis of gender and sexual orientation may be compounded by ageist assumptions about older people, such as the notion that older people are disinterested in sex[9]. It is these experiences that are thought to have given rise to a reluctance on the part of older LGBT adults to access health and social care services[10]. In recent times certain protections[11] from prejudice, hostility and discrimination have been afforded to LGB and trans people, namely the Human Rights Act 1998, the Civil Partnerships Act (2004), the Equality Act (Sexual Orientation) Regulations (2006), the Equality Act (2010), the Marriage Act (Same-Sex Couples – 2013), the Care Act 2014 in England, the Public Bodies (Joint Working) (Scotland) Act 2014 and the 2014 Social Services and Wellbeing (Wales) Act[12]. A recent UK national survey[13] of sexual attitudes also demonstrated increasing acceptance of same-sex relationships. Despite assurances of protection and recognition, a survey[14] of non-heterosexual ageing experiences showed that 84% of participants felt that their relationships are not validated in broader society, and 99% felt that the law does not place equal value on same-sex relationships as heterosexual ones.

Intersectionality

"It is important to acknowledge that LGBT is not a homogenous group but consists of individuals who may identify across several demographic groups, of which their sexual orientation and gender identity are only two. Individuals have multiple identities which they experience in an integrated and holistic way, although they may choose to emphasise and disclose these identities in different settings in different ways.[15]"

In addition to gender and sexual identity, there are various economic, social and cultural factors, such as socio-economic status, ethnicity and disability which impact how ageing is experienced. To address this, researchers suggest that an intersectional analysis will enable an enhanced understanding of the complexities of older LGBT narratives and experiences, and allows a way to account for the intersections between age, gender, sexual orientation and socio-economic factors. This is warranted, as there is evidence indicating that older people with lower socio-economic status ('SES') are more likely to experience poorer health outcomes, such as long-standing

illness or disability, and have shorter life expectancy compared with those of higher SES[16]. A nuanced and multi-faceted understanding of existing social constraints and opportunities as they relate to non-heterosexual and trans living and ageing is needed, rather than emphasising sexual and gender identity as the determining factor of LGBT experiences[17]. Indeed, significant differences in experiences for working-class lesbians, whose sexual orientation and class intersect to produce further inequalities, have been found[18]. Working-class lesbians reported feeling excluded from the LGBT 'scene' due to their class and also reported feeling excluded from working-class communities due to their sexual identity. Similar effects have been observed amongst older LGBT cohorts[19] and attention has been drawn to the dual impact of identifying as LGB and living with a disability or belonging to an ethnic minority group that could heighten vulnerability to discrimination or exclusion[20]. To be clear, an intersectional approach advocates less for a 'how-to-work-with older LGBT adults' as this would suggest uniformity and potentially obscure differences and diversity within the LGBT community, as well as sustain social divisions between heterosexual and homosexual identities[21]. Most importantly, researchers agree that when the ethnic, class and economic diversity of older lesbian, gay, bisexual and trans people[22] are not represented, then the distinctive needs of these groups are likely to be silenced or misrepresented.

Aims

Over the past decade the empirical evidence on older non-heterosexual and non-cisnormative gendered experiences of ageing has grown in line with legislative changes. The aim of this report[23] therefore is to review the peer-reviewed literature to identify key issues most relevant to LGBT older people in the UK in the settings of health, social care, housing and financial services. The objectives are to rapidly review the research to identify prevailing themes and limitations of the current evidence, and to develop a set of recommendations based on what is known about current services.

Access to Health Care

"You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age[24]. "

The majority of research exploring older LGBT people's experiences of health care has focussed on the experiences of gay men, with fewer studies focused on the perceptions and concerns of lesbians, and fewer still on the experiences of bisexual and trans people[25]. The health research that does exist tends to focus on a narrow range of health issues, often related to the health needs of younger LGBT people. A large population-based US survey (96,000 respondents) showed that older LGB individuals experience significantly poorer health outcomes than the heterosexual population, specifically in relation to higher risk of disability, poor mental health, smoking, and excessive drinking[26]. However, a survey of equivalent scale has not been conducted in the UK population, and therefore the ex-

tent to which these findings apply to the UK context is unclear. A survey[27] found that one-fifth of LGBT respondents had experienced a mental health problem in the past five years. Another report[28] indicated that bisexual people report higher levels of mental difficulties than heterosexual and LG populations. Lesbian and bisexual women are reported to be twice as likely to have long-standing psychological or emotional conditions than their heterosexual counterparts[29], though it is unclear from existing evidence how these differences emerge in older life.

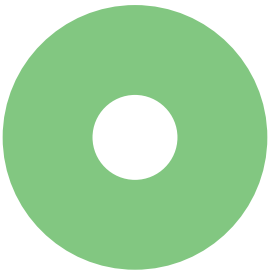
One-fifth of LGBT respondents had experienced a mental health problem in the past five years.

A fear of prejudice and transphobia has been shown to contribute towards a reluctance on the part of older trans people to access medical services[30,31]. The anticipated health care needs of older trans people may include the unknown long-term effects of hormone therapy and the particular effects of transition surgery[32]. It has also been reported that trans people may get legal recognition of their gender on their NHS record but are often not routinely invited to attend health screenings (e.g. breast, prostate) which may be medically germane to them. Another example is trans men who have undergone phalloplasty surgery may require specific assistance as they grow older. The use of hormones by trans people may precipitate illness later in life, while a fear of transphobia will act as barrier to older trans people accessing health care services to have regular check-ups or symptoms followed up. Drawing on population-level evidence from the US, barriers to health for trans people include fear of prejudice when accessing health services, internalised stigma, a lack of physical activity, victimisation and a lack of social support[33]. Relative to the LGB population, statistical analyses in the same study showed that older trans people showed a higher risk for poor physical health, disability and depression. It is unclear how these findings relate to older trans experiences in the UK context.

A UK survey[34] commissioned by Stonewall showed that older LGB adults lacked confidence in health and social care services. These findings were echoed in an interview study[35] with 10 gay men aged between 60 and 70 years who also viewed health services with caution, as well as in the 2015 study *The Last Outing*[36]. Participants talked about having experiences of, and expectations of, discrimination or poorer quality care or treatment, with services perceived as operating according to what has been described as a 'heterosexual assumption'[37]. That is, the idea that health professionals and health service providers worked from the presumption of heterosexuality. At the same time, participants described how it was difficult to say whether they had received poorer treatment because participants had been reluctant to talk openly to health workers about their sexuality in the first place. Irrespective of the sexual orientation of the health worker, the key qualities that participants valued in health workers cohered around empathy, namely: caring, showing interest, kindness, and respect. Analysis suggests that some older LGB adults may not feel comfortable disclosing their sexual orientation, the implications of which mean that they may have certain needs unmet. Researchers argue that harm is maintained when older LGB adults have to fit their experiences into biographies that are shaped by a heteronormative framework[38]. In terms of experiences with health professionals, a postal survey study[39] conducted with 266 LGB respondents from across the UK found that 45% of the women and 22% of the men reported they had encountered prej-

LGBT people may delay seeking appropriate treatment until a disease is at an advanced stage.

udice and discrimination. The same study showed that 62% of women and 45% of men reported that they would welcome health services and/or sources of information specifically for lesbian and gay communities. In a more recent study, 26% of respondents reported having experienced discrimination related to sexual orientation or gender identity from health and social care professionals, with two thirds stating a preference for services run by or for LGBT people due to a lack of confidence in mainstream services[40]. Due to these experiences, LGBT people may delay seeking appropriate treatment until a disease is at an advanced stage.[41] An interview study[42] with an older LG sample revealed that a number of participants had articulated plans for elective dying for reasons such as loneliness and isolation, being a 'burden' to others, recurrent depression, concerns about the adequacy of health and social care services, and a general lack of support in later life. The author concludes that older marginalised people may be more vulnerable to ending their lives because of insufficient informal care and support and deficiencies in the formal older age care system.



Access to Social Care

The studies considered in this section focus on residential, nursing and assisted care. The evidence on neighbourhood accessibility and sense of connectedness to local communities is also considered. Care homes can either be residential or nursing, or both, may offer day time activities and are often run by private companies, voluntary or charity organisations, or local councils. Residential homes will provide accommodation and help with personal care such washing and taking medicine. Nursing homes offer the same services with the addition of at least one qualified nurse on duty to provide care for complex medical conditions and severe learning and physical disabilities. Compared to the USA, Canada, Australia and Europe, where there are a growing number of specialist retirement facilities for older LGB people, specialist options for LGB older people in the UK are rare or non-existent[43]. Older LGB individuals remain concerned about lack of visibility, risks around being visible, the inequality of openness, and the current state of compulsory co-occupation in mainstream services[44]. There is evidence indicating that there are specific concerns held by older LGB people in relation to moving into care and residential housing, namely that services are perceived as not offering safe, welcoming and supportive accommodation[45]. Indeed, forms of prejudicial attitudes such as homophobia and biphobia have been found to be likely among older people[46] which means that older LGB are at

increased risk of exposure to it in aged care spaces. Researchers[47,48] note that some examples of good practice in care and residential settings at a local level may serve as practical guidance on how older LGBT people's needs can be met. At a national level, the Care Quality Commission[49] has produced guidance for inspectors in relation to assessing 'sexual orientation'.

A postal survey[50] showed that less than ten percent of LGB respondents had made plans for care in old age. The majority of participants also viewed residential care and nursing homes as a 'highly undesirable' option for care. Indeed, older LGB adults have expressed concern about having to return to being 'in the closet' or risk being on the receiving end of intolerance[51]. Another study[52] exploring the concerns and priorities for trans people in considering future care showed that participants had low confidence in the ability of care staff to meet the needs of trans elders. Low confidence in staff was reportedly due to staff possessing a limited understanding of trans needs in terms of health and social care. Trans participants described how it was easier for trans men to 'pass' in everyday life without surgery. However, 'passing' becomes complicated when in need of personal or health care and participants reported feeling 'outed' when it came to personal or health care interventions. For these reasons, the evidence suggests that a distinction should be made between trans people who have had surgery, and those who have not. Additionally, trans older adults expressed concerns that their gender identity will be respected in the event that they become incapable of expressing their own wishes, or after death[53,54]. These findings converge with a US study which found that prior experiences of discrimination compound the reluctance of LGBT people to access health and social care services[55].

Some older LG adults report that they have relied on their 'coming out' stories as a device for negotiating social inclusion at different points across their life course[56]. A concern reported by older LGB adults is the need to feel safe about 'coming out' and identifying as LGBT to other residents and staff[57]. Indeed, some participants report feeling like there are issues related to sexual identity which are 'unmentionable', especially in the presence of certain residents[58].

Older LGBT people also fear discrimination from other residents and expect to be forced 'back in the closet'.

A report[59] found that not many LGB participants felt strongly about having exclusively gay or lesbian care homes, and the majority reported that they would prefer there to be other gay residents. When considering moving into residential care, older LGBT people also fear discrimination from other residents and expect to be forced 'back in the closet'[60]. The 'Gay and Grey' project in south England[61] reported that respondents preferred 'gay-friendly' homes or 'gay mixed' facilities as future options for care, while the majority of respondents felt it was important for care professionals to know about their sexuality. A fear was that care homes are perceived as heteronormative environments, where heterosexuality is the norm and alternative sexualities become invisible[62]. A recent interview study of older bisexual adults also demonstrated that participants were concerned about receiving care due to experiences of biphobia[63]. In terms of gender, concerns were expressed that, with reduced capacity, participants may lose control over gender expression. There were specific worries from women participants that conventional gender roles and feminine attributes would be enforced on them by care staff without

their consent. It has been suggested that older LGBT people are less likely to complain about poor treatment in case they are 'outed' and subsequently have to face homophobia from care staff and residents. Another study highlighted concerns about other residents expressing homophobic views, and the need for care staff and managers to openly demonstrate their support for older LGBT residents[64]. Evidence from the US has also shown that hostility and homophobia towards older LGB adults can also come from other residents[65].

Personalisation of Care

The 'personalisation' agenda for adult social care in the UK aims to institute substantial change in the arrangements for responding to the care and support needs of older LGBT people[66]. The aim of personalisation of care is to ensure that individuals feel able to discuss their support needs with staff, and that staff feel confident in working with individuals regardless of sexual identities and relational and life histories[67]. Despite the promise of personalisation, researchers have referred to a 'sexuality blind' care practice where older people are treated as 'just the same'[68]. The concern with a 'one size fits all' approach is that it fails to account for 'difference' which risks worsening current inequalities for older LGBT people because there is evidence to suggest that their care needs are different. For example, there are specific surgeries and health issues that staff delivering care will need to become comfortable with. Older trans adults, for example, who have undergone surgical procedures such as vaginoplasty, require vaginal dilation with a stent for the entirety of their lives[69]. Further, the evidence clearly shows that the conditions of older LGBT lives are too diverse to be generalised and grouped together as a homogenous social group, yet at the same time those identifying within these categories may share certain experiences. The main issue is that generalisations give rise to the tendency to treat people with membership to these social categories as having a fixed set of common needs, and for this reason is at odds with the 'person-centred' emphasis in health and social care policy. Conversely, caution is warranted as focussing only on individual contexts may result in the widening of social inequities when it is equally important to identify the wider social processes that shape LGBT people's shared experiences of services[70].

Staff Attitudes

Older LGBT people fear discriminatory attitudes and practices from care staff at a time in life when they are particularly vulnerable[71] and there are particular concerns around disclosure due to the fear of discrimination and having to go 'back in the closet'. To this end, older LGBT people may be less inclined to complain about poor treatment in case they are 'outed' to others to face homophobia from those around them[72]. Older LGBT adults' experiences of caring will be shaped by the heteronormative nature of social relations within residential and care settings[73]. However, little research has been conducted in addressing practitioners' perspectives on meeting the distinct needs of older LGBT people living in care homes. A mixed-methods study[74] conducted in Wales examined the provision of inclusive care for older LGB adults in residential and nursing environments. The research set out to explore the attitudes, knowledge, skills of care staff and the support measures required to enable them to meet the needs of LGB residents. Residential care staff reported favourable attitudes towards caring for LGB residents despite receiving a lack of consistent and comprehensive training. However, the results demonstrated that staff commonly drew on statements such as, 'we don't have any at the moment' and 'I/we treat them all the

same' to open-ended questionnaire items. Such statements, the authors suggest, show the regulatory force of heteronormativity and cis-genderism, and it is the effects from these presumptions that can deny LGBT residents' identities and reinforce inequality and invisibility. Whilst staff failed to recognise LGB residents' health needs and social care needs as individual and distinct, encouragingly staff reported their motivation to be more attentive and responsive to the wishes of LGB residents. The research indicated that items capturing the intersection of religious views with support for sexual minority groups produced more conservative responses, and therefore potentially less supportive towards Non-hetero/cis-normative genders and sexualities. Managers in care environments demonstrated more permissive attitudes towards general sexuality than staff providing direct care, while care staff employed for more than five years report more positive attitudes towards the sexual desires of residents than those with fewer years of work experience[75]. Additionally, a focus group study[76] with staff found that care was commonly framed as disconnected from sexuality. That is, staff perceived sexual orientation as peripheral to providing good care to others. Staff reported that they lacked the communication tools and confidence to start a discussion with a view to being attuned to differences in sexual identity and life histories of LGB residents.

Service providers' reluctance to ask questions about sexual and gender identification can exacerbate the invisibility and silencing of LGBT residents.

Service providers' reluctance to ask questions about sexual and gender identification can exacerbate the invisibility and silencing of LGBT residents[77]. Indeed, there is reportedly an absence of discussion about older LGB identities and experiences compared to the openness around the biographies of their heterosexual counterparts. LGB histories have been shown to be equally absent from staff development activities to the extent that none of the staff in the study could recall attending training about issues of sexuality, identity and equality. Using appropriate gender pronouns is essential and educating staff to understand older adults' preferences for less familiar pronouns (e.g. they, ze) was considered important in helping people to understand the spectrum of gender expressions and identities. There is international evidence to suggest that increased exposure to lesbian and gay residents will help counter-act heteronormative assumptions[78] and that exposure to lesbian and gay people will mitigate homophobic attitudes held by nursing staff[79]. However, it is unclear what type and level of exposure to LGB individuals is effective in shifting anti-homosexual attitudes and more research is needed. It should be noted that the potential barriers to engaging care staff might relate to existing issues around high-staff turnover, low pay, low morale, being under-valued and a lack of incentives, which has a detrimental impact on quality of life and care[80]. Research[81] in this area suggests that participatory leadership on the part of managers (and researchers) could help to promote open dialogue and challenge heteronormative thinking and ageist assumptions about sexuality in later life. The use of advisory sessions between managers and staff will help to identify sources of assumptions and stereotypes as well as developing critical thinking skills and mutual trust. Additionally, testimonies from 'out' older LGBT residents who could act as peer educators and advocates could help staff and other residents to question pathologizing notions of gender variance and sexual orientation.

Neighbourhood Connectedness & Social Networks

LGBT communities may provide support and resources, through places, spaces and relationships. A sense of place and connectedness in the community can alleviate feelings of loneliness and social isolation through social interaction and activity[82]. Identity and how older LGBT adults negotiate disclosure of their gender and sexual orientation may influence the ways in which individuals make connections within the wider community. A survey[83] reported that 80.4% of women and 62.2% of men said that their sexuality had enriched their life, and 20.6% of women and 34.8% of men said that they experienced loneliness and isolation when they thought about their sexual identity. A survey[84] indicated that older LGB adults are more likely to be single and live alone and are less likely to have regular contact with biological family. Additionally, older LGB people are less likely to have seen a friend the previous day (63.9 vs 72.1%), which the authors suggest shows that the social networks of older LGB people are not as immediately accessible as those of non-LGB people[85].

Communities may have a preventative role in supporting individuals to remain socially active. Social support may include assistance with everyday tasks such as preparing meals, shopping, housework and transportation as well as informational, emotional and financial support[86]. It has been suggested that there will be many parts of the UK, especially rural areas, where there are no support networks to turn to for older LGB people, who will remain isolated[87]. There are instances in which older LGB people have responded to service marginalisation by beginning to explore alternative ways of doing things for themselves. There is value placed on mutual support within LGB communities, with voluntary sector projects such as Opening Doors providing a vital social network for isolated older LGBT people[88]. Other examples include organisations such as LGBT Health and Wellbeing (Scotland), Older and Out (Brighton), and SAND (Shropshire). An interview study[89] exploring friendship and community amongst older lesbians found that strong friendships and social bonds were key themes. The author suggests that older lesbian friendships emerged from the secrecy and stigma of the lesbian and gay past. However, the experiences of local places and people for those who keep their sexual and gender identity concealed may tell a different story. A study[90] describes how one participant had only been open about his sexuality with his sister, and to the rest of his family and friends presented as heterosexual, which he attributed to growing up during a time when 'no one mentioned homosexuality'. The consequences of non-disclosing had left the participant with a 'very deep sense of isolation and loneliness'[91]. Other participants described how they felt they had a lot to lose by coming out, such as the risk of violence and discrimination, to the extent that 'you're asking for trouble if you're out'.

21.6% of women and 32.9% of men reported feeling isolated.

Previous research[92] indicates that, for those who are open about their sexual orientation, active engagement through voluntary work provides an opportunity to develop a sense of connectedness to their local communities. The study showed that 21.6% of women and 32.9% of men reported feeling isolated from other non-heterosexuals: most had little or no access to community supports, principally due to the lack of non-heterosexuals in the areas where they lived. Around a third of respondents reported that, as they aged, they gradual-

ly felt less included by such communities. Some participants reported how they felt unwelcome or uncomfortable in gay bars or clubs, due to a youth-orientated scene, overt ageism or commercialism, which exacerbated a sense of exclusion. There may be additional transport costs incurred in travelling outside their geographic area to access LGBT community resources[93]. In another survey[94], around a quarter of older LGB adults in the sample stated that they did not go out socially because they had no one with which to go. Similar findings were echoed in an interview study[95] where views were expressed, particularly by lesbian women, that the commercial gay scene was ageist and sexist, and therefore felt a sense of exclusion. The expense of the scene was a particular barrier for older lesbian participants who were retired or on a low income. A study[96] with lesbian and bisexual women found that participants had different reasons for attending LGBT social groups. Specifically, participants who expressed that they would be happy in mixed (LGB) groups or inter-generational groups were in the minority, whilst the majority of participants reported a preference for same-sex, same-sexuality and same-generation groups. This was at odds with a few bisexual participants who preferred not to be in women-only groups. There are some reports of religious-based discrimination encountered by older LGB people within the family, care settings, as well as non-inclusive churches and church-led activities such as choirs and tea parties[97,98]. Due to these experiences, some participants, particularly gay men, described attempting to lead 'normal' heterosexual lives in order to prevent religious-based discrimination from their families and beyond[99]. A need to conceal in this way may also affect LGB older adults who depend on much-needed pastoral care and community support from churches.

Family of Choice[100]

There are diverse compositions structuring older LGB personal communities, and a wide range of 'family forms'[101]. A UK mixed methods study[102] provides evidence that older LGBT adults have significantly weaker kinship networks than older heterosexual adults, with around one third never seeing members of their family. The significance of friendship was emphasised by participants, in that 52.9% of the women and 48.8% of the men agreed with the statement that 'my friends are my family'[103]. Another mixed methods study[104] showed that almost 75% of women and 67% of men lived close to friends, and that 96% of women and 94% of men considered friendships to be important or very important, and 76% of women and 84% of men felt that friendships had become more important as they got older. Researchers[105] have called for a wider recognition that LGB adults may rely on alternative families and networks, or 'families of choice' (e.g. partners and friends), to a greater extent than their families of kin, meaning that families of birth and adult children cannot be assumed to be an automatic source of unpaid support. However, families of choice are not awarded the same legal rights as biological families or legally partnered people.

Families of birth and adult children cannot be assumed to be an automatic source of unpaid support.

Another study[106] exploring the complex social networks and relationships of older LGB adults showed that those participants who had not been able to develop strong and supportive relationships with parents and close family members were subsequently unable to ask or rely on them for social support. Findings of a survey[107] ex-

ploring friendship and community among older lesbians found that participants were more likely to turn to family members than friends for help with physical illness or disability. However, for mental health and emotional support, participants were more likely to confide in friends than family.

Access to Housing

"What is obvious to us is that it is not bricks and mortar that older LGBT people are concerned with in relation to housing later in life per se, but the social relationships that those structures contain. Housing is a space where social networks, connections, questions of trust and reciprocity converge; in short, a site concerning questions of social capital[108]. "

The point made above by the authors is that social networks and connections are key for older LGBT people and that housing is a forum in which these relationships are played out. Indeed, home is especially important for the older LGBT population who often have not felt safe in the wider world, and for whom home becomes a safe and private space[109]. As noted earlier, no alternative or specialist LGBT provision options for sheltered housing and residential/nursing care provision exist in the UK[110]. A review[111] showed that a number of LGBT-only housing communities exist and thrive internationally, and indicated that there is an increased likelihood of 'LGBT-friendly' rather than 'LGBT-only' services will prove easier to sustain in the long-term. A longitudinal study[112] exploring the role of minority stress amongst older LGB people found that 18.3% had been in a relationship for longer than 20 years and were more likely to have had a greater number of co-habiting histories. Older LGB adults are more likely to be single and live alone, and as highlighted in the previous section, express a high degree of ambivalence towards the prospect of receiving social care services in the home[113].

Little evidence exists of a link between identifying as LGBT and experiencing exclusion from decent housing, public transport or neighbourhood resources[114, 115, 116]. These claims are supported by a survey[117] based on data from the English Longitudinal Study on Ageing ('ELSA') which found a lack of evidence to suggest that older LGB people are more likely to be excluded from decent housing, neighbourhoods and access to local neighbourhood amenities. Little difference in levels of exclusion from public transport was also indicated. An interview study[118] conducted with older LGB adults exploring meanings attached to home and place showed that varying and contradictory meanings were attached to home life in rural places. The study also highlighted the importance of connection to communities of identity across geographical and online localities. One of the first mixed methods studies[119] on the housing needs of older LG adults living in the UK showed that as respondents had aged, they were reportedly more likely to experience difficulties with the condition and maintenance of their home, a finding that was also common amongst non-LG older people. Most participants cited a lack of money for necessary repairs and an increasing inability to undertake DIY jobs which was sometimes linked to health problems. Additionally, some participants reported how they found getting into and round their home difficult. Participants expressed their worries about their health in the future and what declining health might mean for their

housing situation and their lives more generally. Strikingly, a participant commented that they were concerned that their house might become a 'prison'. A key finding was the need for more social contact for older lesbians and gay men.

Another report[120] suggests that there is much variation in housing policy vis-à-vis older LGBT across different local authorities and housing associations. Research has shown that there are significantly different, gendered, housing preferences between older lesbian, gay and bisexual women, and older gay men[121]. Indeed, older LGB women have expressed preferences for gender- and/or sexuality-specific housing[122].

Home is especially important for the older LGBT population who often have not felt safe in the wider world.

Older LB women have reported gender as an important issue in relation to sheltered housing and residential housing, with both men and women reporting that mixed LGB provision would not necessarily be their preferred option[123]. The evidence from these studies demonstrates a need to discern these differences rather than to homogenise diverse experiences through a collective 'older LGBT' discourse. Differences in preference were a key feature of the SAFE ('Secure, Accessible, Friendly and Equal') Housing study[124] which indicated that the majority of survey respondents reported that they felt safe where they currently lived. However, trans respondents were particularly concerned about safety in their neighbourhoods. Respondents reported that they were most comfortable with health professionals in their home, and home care workers the least. Older lesbian respondents were less comfortable than gay men with allowing workers to enter their home. Trans participants also expressed concerns about transphobia in care homes and other forms of sheltered housing, and also reported their concerns about transphobia in LGBT-specific housing, should this be made possible in the future. There is a dearth of evidence relating to the experiences of older LGBT people in sheltered accommodation and no common policy currently exists to address LGBT couples living in rented or shared accommodation. This gap is important to address remaining questions such as whether an individual is permitted to continue a tenancy if their partner moves into a care facility and they are not registered in a civil partnership. Additionally, older LGBT people may be in an interdependent relationship without living with their partner(s), yet there is no clear direction or recognition on how the care needs of one partner financially impact the other[125,126].

5 Access to Legal and Financial Services

Employment & Pensions

A study[127] of poverty and sexual orientation that presented data from the UK Household Longitudinal Study (UKHLS)[128] suggested there is some material disadvantage for gay men, and bisexual men and women. The author concludes that the

poverty experienced by lesbians is most likely to be a consequence of their status as women rather than their sexual orientation. A survey showed that LGB people are more likely than the heterosexual population to have made financial plans for their needs in older age and less likely to see a partner, children or family as a source of financial support[129]. In a financial crisis, respondents reported that they would turn to partners first (32.0%), then friends (30.8%) or family (25.2%), indicating that the expectations of material support from the three groups were broadly similar[130]. Another survey highlighted how lower levels of home ownership for LGB individuals may however mean that they are less likely to have available housing wealth from which to draw on in older age[131]. There is some evidence to suggest that there are financial and retirement gender inequalities between gay men and lesbians, with the former being better off, and the latter facing different barriers[132]. Lesbians in later life are likely to be disadvantaged by gendered processes in the labour market[133], particularly those who were married previously and had roles as carers and mothers[134]. It is thought that these women are more likely to have diminished chances of accumulating financial security through adequate pensions and savings[135,136]. These differences mean that the most economically resourced may be able to choose the care they want in later life, while the least-well-resourced often have no choice but to settle for the supports they are given.

Older LGB individuals chose to work in certain lower-paid jobs because they assumed their sexuality would be accepted.

The social and legal sanctions associated with non-hetero/cis-normative sexual and gender identity of older adults may have influenced their working life in ways that have affected their access to material resources in later life. For example, a study demonstrates how older LGB individuals chose to work in certain lower-paid jobs because they assumed their sexuality would be accepted[137]. However, the economic differences between LGB individuals at the level of gender for instance have not been properly accounted for, if at all in the case of bisexual and trans experiences of financial services[138]. In terms of pensions, a recent development in the form of new 'stakeholder pension schemes' means that it is now possible for partners of choice to be nominated[139]. However, few provisions have been made for same-sex partners in public sector pension schemes[140]. There are concerns highlighted in the literature, particularly for older lesbians who may have been previously married, that a Civil Partnership could make a settlement from a previous marriage invalid, and thus risk losing pension rights from both the former and current partner. There is a need for more research to clarify the financial consequences as they relate to LGBT people in light of the Civil Partnership Act 2004. It should also be noted how current policy is underpinned by the notion of the coupled relationship, which may be at odds with the prevalence of non-monogamy in non-heteronormative cultures[141].

Wills & Inheritance

Little UK empirical research exists on inheritance and non-normative genders and sexualities[142]. Prior to the legal milestone of the Civil Partnership Act,[143] the estate of a deceased member of a same-sex relationship would pass automatically to family (as 'next of kin') and not the same-sex partner[144]. A study with a relatively affluent LG sample found that 88% considered drawing up a will particularly important, and 82% had already taken this step[145]. The study shows that there are different reasons

why older (affluent) LGB people nominate beneficiaries on their will. The expense of writing a will was mentioned as a barrier for some participants and there is no UK evidence available on the will-writing experiences of older LGBT people from lower income groups. Some participants with children, and no will, expressed how they would be happy for their children to be beneficiaries by default through intestacy rules. There is some research showing that older LGB adults may dispose of their assets along biological family and/or intergenerational lines, even when these biological family relationships are poor, for the sake of passing on 'family money'[146]. This finding shows that biological family members, particularly children, may be prioritised in a will and not necessarily those people who are primary sources of care and social support, such as partners and friends, during times of need[147]. On the other hand, beneficiaries can also be friends, especially in cases where biological families are on the margins or not in contact at all, or ex-partners. Additionally, whilst partners and family of choice might not be named as beneficiaries in wills, some participants reported how they would nominate to give them Lasting Power of Attorney (LPA), that is, to make decisions about their care and welfare if their capacity is lost. The same study, carried out with 15 lesbians and gay men, found that participants' will-writing can be sorted into four types of prioritisation: prioritising children; prioritising friends; prioritising siblings; mixed priorities. A sense of duty, especially towards biological family members, was evident in a number of interviews. The study also reported how partners who were both financially secure may not see the need for their finances to become entwined. For others, decisions about beneficiaries of wills were based on perceived level of need and 'deservedness'. Another study described the heightened importance of funeral wishes as part of gay men's wills, seen as a symbolic way of including those who they consider to be closest in their end of life plans.[148] Wills are seen as an important means of self-expression, and of ensuring the recognition of kinships that remain marginalised by convention.

Advance care planning, and the ability to nominate 'important others' as next of kin emerged as particularly important for LGBT people.

It is worth noting that advance care planning, and the ability to nominate 'important others' as next of kin emerged as particularly important for LGBT people in a 2015 study.[149] Despite an absence of legal clarity on who can be nominated as 'next of kin', the default practice reflects heteronormative assumptions as it is assumed a blood relative or spouse will take on this role. Motivations to complete advance care plans include some issues similar to those reported for the general population (e.g. not placing burdens of care on others) but also distinctly LGBT issues such as providing protection for partners and significant others who might otherwise not be acknowledged as relevant to end of life care. Barriers to completing advance care plans included: feeling daunted by the paperwork or costs involved and not wanting to think about or plan for the end of life. Distinct issues identified for LGBT people include not knowing who to nominate in decision making roles due to their personal networks comprising people of the same age or ongoing social isolation. An important finding was the need for LGBT older people access to specialist advice and advisors, who are aware of the diversity and specificities of LGBT lives.

Future Research

Notwithstanding the difficulties inherent to statistical measurement of the complexities of gender and sexual expressions and identity, future research should explore ways of incorporating sexual and gender identity variables into population-level surveys. This would enable the production of UK-based LGBT probability samples that could be used to inform services and support. More research is needed that explores the experiences of older LGBT people from black and ethnic minority communities, those with disabilities, as well as participants aged 80 years or over, and clinical LGBT populations enduring poor health.[150] There is also a need to identify the needs of older LGBT experiences across different regional contexts, such as remote rural, rural, and suburban, especially outside of London and large cities. Further investigation of the mechanisms and impacts of social and familial support in mitigating risks for depression and other health outcomes is warranted.

Despite attempts to overcome this through snowball sampling and by contacting bisexual communities online, difficulties have been highlighted in the existing evidence in relation to accessing older bisexual and trans adults. Funding should be allocated to the development of recruitment strategies and data collection methods to recruit 'hard-to-reach' populations who have concerns about public disclosure of their sexual and gender identity. Further exploration of the ambivalent attitudes towards sexual and gender diversity in older adults on the basis of religion is needed. In relation to the intersection of religion and support for LGBT, training initiatives that invite staff to reflect on their beliefs should be explored, in order to develop practical strategies for addressing religious-based conflicts that may arise across staff–resident and resident–resident interactions. Researchers also suggest examining the efficacy of using narrative material from older LGBT service users to promote understanding amongst staff and residents[151]. Finally, more research is needed to assess levels of knowledge, skills and attitudes of staff working in each of the respective settings across different geographic regions of the UK. Methodologies, such as participatory action research, have also showed promise in terms of engaging volunteers who work alongside older lesbian and gay adults and should be explored further[152].

Conclusion

The review of the literature on LGBT older people's health, social care and housing needs aimed to identify key issues. The main themes identified were: the issue of disclosure due to the fear of discrimination and having to go 'back in the closet'; the willingness of staff to engage with training on LGBT issues; the importance of lesbian and gay communities for the establishment and maintenance of non-heterosexual identities and lifestyles; and a need to disaggregate homogenising categories of sexual orientation and gender identity. The key issues identified highlight how the heteronormative values underpinning policy and law may exacerbate a sense of exclusion among older lesbians and gay men in ways that are rarely accounted for. The studies show that LGB and trans individuals, both throughout life and in older age, are often grouped together ('LGBT') but in actuality form a diverse and heterogeneous group with varied needs. Caution is warranted when attempting to generalise the findings of these studies across the entire LGBT community, as many studies in this review were based on small, self-selected

samples of white, middle-class, well-educated, urban men who actively participate in the gay community. With the absence of sufficient information on hidden or hard-to-reach populations, the full scope of these issues remains unclear and may be wider once ethnicity, race, religion, disability and socio-economic status are taken into consideration. The majority of studies included focussed on sexual identity and sexual practices, particularly amongst gay men and lesbians; therefore, the needs of trans and bisexual people remain unclear. In particular, the care needs of older trans adults and how they negotiate the gendered assumptions of care staff and residents requires more attention. A consistent theme expressed across all settings was that older LGBT participants held the expectation that they will be discriminated against on the basis of their sexual orientation, gender and age. Finally, very little research that exists in relation to older LGBT financial needs, and how quality of life is dictated by their socio-economic status. In conclusion, it is important for policy makers and service providers to develop an understanding of the experiences and what it means to be an older LGBT individual in a social system that not only overlooks their sexual orientation and gender, but also overlooks how non-normative sexualities and genders may intersect with ageing.

Recommendations

The LGBT Action Plan (2018), published by the Government Equalities Office, does not address the needs of LGBT older people to a great enough extent. Consequently, the LGBT Action Plan should be amended to address the needs of LGBT older people with specific action points related to the sectors discussed in this report.

A central repository of evidence containing studies, policy outlines, toolkits for practitioners and educators, and case studies would be invaluable to those who are committed to implementing best practices. Such a repository would ease the transfer of knowledge between services specialising in provision for LGBT people, and mainstream services. A central authority, such as the Government Equalities Office or the Social Care Institute of Excellence (who previously developed such a repository) would be well placed to implement this measure.

Further research is needed on inequalities faced by people at the intersections of LGBT ageing and: disability, socio-economic status, religion, race and ethnicity. Adoption of an intersectional approach to LGBT ageing is required to enable a complex understanding of the interrelationships between the influence of various social and cultural factors. To fill the research gaps, funding for outreach work is essential, as certain specific groups are not easily reachable through methods such as online surveys. Specific funding will be required to develop recruitment strategies and data collection methods that appeal to rural cohorts and marginalised minorities (including service staff) who may find it challenging to openly discuss themes pertaining to non-hetero/cis-normative sexual orientation and gender variance. Research on the viewpoints of health and social care practitioners on the provision of better care for LGBT elders is also sparse. One provision of the LGBT Action Plan is the improvement of understanding and collection of further data on specific groups within the LGBT population; it is vital that resources are dedicated to tackling ageing-related inequalities under this action point.

Anticipation of discrimination is a barrier to accessing health and social care provision for older LGB and trans people. A firm commitment to elevating standards of care in all settings would mitigate this. Service providers must ensure their services are promoted as non-judgemental, supportive and well-informed. Staff must be provided with the opportunity to develop the knowledge, skills and confidence to engage with older LGBT people. Three key strands of development have been highlighted:

- **Knowledge-based training:** giving health and social care practitioners insight into the specific needs of older LGBT people with the goal of being able to offer relevant advice and treatment.

  This type of training can be addressed at a **foundational level** (e.g. by medical schools educating pre-qualifying students on the specific health and care needs of LGBT people) and would serve to address the lack of information available to health practitioners.

  Awareness of particular LGBT ageing-related issues can be done by introducing the topic in curricula, using examples that showcase these issues, or by facilitating placements in LGBT organisations.

  This measure would benefit from the introduction of an **educational standard for embedding LGBT age-related health and care issues within teaching curricula.**

- **Communication training**: giving staff the confidence to display positive acceptance of non-heterosex-

ual lifestyles as opposed to meeting statements from LGBT older people with mere tolerance, or silence.

This can take the form of **ongoing skills training**, but also a broader **familiarization with LGBT topics**. A diverse pool of resources is required to accommodate the particularities of various care providers.

The designation of an LGBT staff advocate (either an LGBT ally or an LGBT member of staff) who receives more extensive training than their peers and provides a first port of call for both residents and other staff members was seen as a favourable measure.

To mitigate for higher staff turnover in certain care institutions, collaborations could be developed between external community advisors who are LGBT and care organisations.

Narratives (films, plays) provide excellent resources for raising awareness and changing the culture of a care institution, with storytelling playing a vital role in aiding the provision of person-centered care.

- **Salutogenesis**: improving staff understanding of the importance of support networks in treatment, and the role played by 'families of choice' in treatment. It is vital to work towards involving willing carers who are part of the patients' social networks in treatment choices, and providing support to informal carers.

Effectively tackling homophobic, biphobic and transphobic abuse, or hate crimes from other recipients of care has the upshot of attenuating the fear of discrimination. Guidelines with clear benchmarks which state and demonstrate how to implement a zero-tolerance policy against prejudice and discrimination in relation to age, sexual orientation and gender identity should be implemented for services. One successful example of this is the Pride in Care quality standard developed by Opening Doors London – an extensive resource which sets benchmarks for safety and security, policy and procedures, publicity and promotion, recruitment and training, as well as customer service. Such a provision would enable health and social care providers to reassure their LGBT residents that their complaints will be taken seriously.

To address isolation and exclusion, providing a space for an LGBT community to grow socially and discuss personal issues would be of great value. Alternatively, ensuring that social groups which are provided community spaces are LGBT-inclusive, and their practices are consistent with current policy that recognises that marginal sections of the older population require specific provision. Local authorities or housing associations are well-placed to implement this measure.

To extend the reach of LGBT community groups, social care and housing service providers should hold discussions on the idea of collaborating with LGBT-specific voluntary groups, charitable organisations and advocacy services. This measure would prove effective particularly in rural areas, to address isolation in older LGBT people who cannot easily access urban centres where LGBT services are concentrated. Creating partnerships in this way could also prove useful in enhancing patient and public involvement in health and social care services.

To address the lack of data faced by local authorities on LGBT housing and care needs, strategic housing and care commissioning assessment processes must be re-evaluated with a view to making LGBT people comfortable to self-declare and self-identify as LGBT. A holistic, personal approach, aimed at identifying specific needs, is needed when conducting individual assessments – particularly when those

assessments have a statutory role.

LGBT inclusive policies must be applied across all social care and housing providers. Such internal policies and practices must be reviewed by the appropriate regulatory body (e.g. the Care Quality Commission, Homes England). In time, this measure will ensure that all services are aligned on the issue of LGBT inclusion.

Older LGBT people are placed at greater financial risk than their heterosexual and cisgender counterparts given the lifetime disparities in earnings, employment and opportunities to build savings. The need emerges for specialist advice on the benefits and possible disadvantages of registering or dissolving a civil partnership or marriage, entitlement to pension rights, interdependence, wills and inheritance in the context of older LGBT lives. Clear information should be provided on ageing and end of life care issues for LGBT couples (either registered or unregistered), including advanced directives, appointing executors, and Lasting Power of Attorney. Providers of legal and financial services should ensure that they are able to provide advice that is both salient and tailored to the specific needs of their clients.

Legal information campaigns (e.g. Free Wills Month, Make a Will Week) should be targeted at the LGBT community with the purpose of encouraging LGBT people to make informed preparations and decisions for later life. These information campaigns must be supported by robust advice on the specifics of marriage law and how this impacts existing wills.

To mitigate the damaging effect of other laws written under heteronormative assumptions, the dissemination of knowledge to both providers and users of legal or financial services must be updated with information on lesser-known areas of vulnerability for LGBT people. Case law can be used to identify these areas of potential vulnerability as certain laws do not present obvious LGBT rights issues. One such example is Housing Law, under which cohabitation rights require proof of individuals being in a relationship, openly. Many LGBT couples who are cohabiting but desire to keep their relationship private, especially in older age, risk being at a disadvantage.

Awareness about intergenerational issues within the LGBT community is vital, as is ensuring that those working towards improving the quality of life of older LGBT people are supported. Private sector companies are encouraged to draw upon employee resource groups, create and participate in befriending schemes, and offer support to those in the third sector by organising fundraisers, or entering partnerships with third sector organisations.

For clarity, Table 1 (below) provides a list of action points and possible stakeholders.

Actions	Stakeholders
1. Make amendments to the LGBT Action Plan (2018) to include provisions for ageing populations.	Government Equalities Office
2. Establish a central repository of evidence on LGBT Ageing, collecting existing studies and toolkits.	Government Equalities Office
3. Fund further research into the experiences of hidden and hard to reach populations.	Government Equalities Office Funding bodies
4. Provide knowledge-based training.	Universities Health Education England Professional bodies Medical colleges (e.g. RCGP, RCN)
5. Embed an educational standard for teaching LGBT Ageing issues within healthcare and social care education curricula.	Health Education England
6. Provide cultural sensitivity training for staff members.	NHS England Social care providers
7. Nominate members of staff as LGBT advocates who will be offered extensive training on specific health and care needs.	NHS England Social care providers
8. Provide and enforce guidelines and benchmarks for tackling homophobic incidents in care and housing provision.	Regulatory bodies (Care Quality Commission, Homes England)
9. Provide social spaces that are inclusive of older LGBT people or dedicated to LGBT social groups.	Local authorities Housing associations
10 Partner with LGBT community advisors, voluntary groups, charitable organisations and advocacy services when creating policies and developing programmes.	Social care providers Housing providers

11. Evaluate housing and care commissioning assessment processes and ensure they are inclusive; considering a personalised approach to surveys.	Local authorities
12. Apply and enforce LGBT inclusivity policies across the care and housing sectors.	Regulatory bodies Local authorities Ministry of Housing, Communities and Local Government (or MHCLG)
13. Train staff to be able to offer salient legal and financial advice to customers.	Law firms Financial services companies
14. Raise awareness within the LGBT community of the need for specialised legal and financial advisory services.	Advocacy services Professional networks Third sector organisations Law firms Financial services companies Media outlets
15. Educate and raise awareness amongst LGBT employees about intergenerational and older age issues they may face to encourage advance preparation.	Private sector employers Public sector employers
16.Consider raising funds and awareness for LGBT older people's issues.	Private sector organisations
17. Creating intergenerational befriending schemes to foster understanding and raise awareness.	Third sector organisations

Table 1: Actions and stakeholders

Methodology

A search strategy used in a previous review[153] was replicated. Search terms included 'health need', 'access', 'housing', 'social care' 'financial needs' and combined with 'lgbt', 'lgb', 'gay', 'lesbian', 'trans', 'bisexual' and 'older people'. The following databases were searched: MEDLINE (Ovid), MIC Health Management Information Consortium (Ovid), EMBASE (Ovid), PsycINFO (Ovid), CINAHL (Ebsco), Web of Science and Google Scholar without time limits. To avoid biases associated with initial electronic databases searches, three types of supplemental searches were undertaken:

citation searching, reference list checking, related article searching and contact with experts. Additional searches identified non peer-reviewed empirical studies published by UK voluntary or charity organisations or local councils which were also synthesised. The population of interest was older LGBT adults residing in the UK: the 'young-old' (50–64 years), the 'old' (65–74 years) and the 'old-old' (75+ years)[154]. To be included, studies had to contain original quantitative or qualitative research data on LGBT experiences of ageing within the UK context. Due to time restrictions, studies about health and well-being in special clinical populations (e.g. Dementia, Alzheimer's, COPD) were excluded. Once identified, articles were screened for data on experiences of ageing in the domains of health and social care, housing and financial needs, followed by synthesis of the main themes reported in the paper.

Policy recommendations were sourced from one-to-one interviews with researchers who have conducted specialist work within the relevant fields, and practitioners. Additional recommendations were added by the author as a result of the review, but only after seeking approval from the afore-mentioned researchers and practitioners

Limitations

No accurate census data exists about the number of older LGB and trans adults living in the UK, and therefore for the quantitative studies included in this review it has not been possible to compare research findings with a representative sample. Further, statistical measures in existing population-level census do not account for the fluidity in sexual orientation and gender over the life course. In addition, researchers have reported that self-administered questionnaires frequently produced missing responses to some items. This is a limitation of utilising this mode of questionnaire to gather responses on a highly sensitive topic, where some items may have presented challenges to some respondents for their frankness. The small convenience samples, mostly conducted with urban and inner-city cohorts, also limit the generalisability of findings of the studies included in this review. Included studies were reliant on the self-selection of participants who were comfortable talking openly about their experiences. To this end, it is unclear what the needs are of those who are 'in the closet', and to what extent, if any, their needs differ to those who openly self-identify as LGBT[155]. This review also demonstrates how much of the existing evidence focusses on matters of sexual orientation and sexual identity, with issues relating to gender identity, and trans people being represented less. More generally there is also an underrepresentation of older bisexual and trans experiences, despite concerted attempts by some authors to utilise snowball sampling and recruit from online communities. There was also underrepresentation of perspectives from older LGBT people from ethnically diverse and less affluent backgrounds, as well as service staff from ethnically diverse backgrounds. Where studies do not reflect the ethnic, class and economic diversity of LGB and trans adults, then the distinctive needs of these groups are likely to be silenced or misrepresented. Finally, reviews (including this one) are limited by the databases and search terms used to locate relevant studies. While experts were contacted and hand-searches of reference lists from included papers were carried out, the review might have benefited from a wider range of search terms. Time restrictions may also mean that that eligible studies were missed.

Annex A

Who do we mean by 'LGBT' people?

Sexual Orientation

Sexual orientation is defined as a combination of emotional, romantic, sexual or affectionate attraction to another person, and people may experience this attraction towards people of the opposite sex (heterosexual); towards people of the same sex (lesbian/gay); or towards both people of the same sex and of the opposite sex (bisexual)[156]. From a research perspective there are known issues in attempting to estimate the size of the older LGB population (see demographics section below), namely that many individuals may not have necessarily identified as such due to stigmatising and discriminatory legal, political and social policies and attitudes. For example, research has shown that older gay men (aged sixty and over) who grew up in a period before homosexuality was decriminalised are more likely to attempt to 'pass' as heterosexual to a degree greater than those who grew up after decriminalisation[157]. An awareness is required that older LGBT generations have endured painful experiences of rejection, discrimination and abuse, and as a consequence may be fearful or reluctant to identify themselves openly as LGBT. It is also important to note that there are conceptual differences around how fluid sexuality and sex acts have been conceived versus fixed notions of sexual identity. A further limitation to the existing studies of older LGBT populations is how the responses of bisexual people are rarely separated from those of lesbians and gay men, and data are often analysed by gender (bisexual women with lesbians, bisexual men with gay men) rather than sexual identity.

Gender Variance

Trans is an umbrella term to describe many different types of people whose gender identity or expression differs from the sex they were assigned at birth[158,159]. Personal experience of gender may well be different from conventional gender constructs. Trans may include transgender, transsexual and transvestite individuals, though such descriptive categories are over-simplistic in terms of accounting for the diversity amongst people who identity as trans, whether permanently or fluidly. Broadly speaking, a trans person may not follow the conventions and norms of gender whether through clothing, in presenting themselves, or having surgical procedures to correspond with their preferred gender role. In the UK there are certain protections for trans people under the Gender Recognition Act 2004, namely in relation to issues of confidentiality. However, not all trans people wish to pursue proceedings for legal recognition of their gender for a variety of reasons. It is important to note that sampling with trans-identified people is a complex issue, as trans people are considered a 'hidden' population, and some people who are identified by others as trans may or may not define themselves that way, especially those who decide to keep their trans identity or history private[160].

Estimated Size of UK Population

The UK has a growing ageing population compared with preceding cohorts of older people, and it is expected that future generations of older people are likely to be more diverse than before in terms of their sexual and gender expressions, identities, behaviours and attitudes[161]. A widely accepted estimate indicates that 5-7 per cent of the total adult UK population is LGB[162]. More conservative estimates indicate that 1.6 per cent of adults in the UK may identify as lesbian, gay or bisexual[163]. On the latter estimate, this proportion is 0.6 per cent amongst people aged 65 and over. Historically, population-level surveys have not included questions about sexual orientation, and existing data on civil partnerships is not representative of diverse LGBT populations. In terms of gender identity, it has been estimated that there are around 300,000 transgender/non-binary people in the UK which is the equivalent to 0.4% of the total population[164]. No official demographic statistics are currently available and therefore no representative samples against which study samples can be compared,[165]. Similar to sexual orientation, current census data is unable to statistically account for gender fluidity across the life course, particularly in relation to those individuals who identify as neither men or women, or female or male, often referred to as gender fluid and non-binary.

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1 The views expressed in this report are those of the author, not necessarily those of PinkNews Media Group

2 Throughout this review the first three letters (LGB) refer to sexual orientation, the 'T' refers to gender identity, and the '+' signifies other marginalised and minority sexuality or gender identities

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