The impact of COVID-19 on older lesbian, gay, bisexual and/or trans+ (LGBT+) people in the UK

A rapid response scoping study

SUMMARY REPORT

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We would like to thank the many individuals who were kind enough to complete our survey and/or participate in our interviews.

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Contents

1. Headline findings

Previous research has suggested that older LGBT+ people might be more at risk of isolation and have less access to support. These are the results of a survey of 375 people living in the UK, conducted during the COVID-19 lockdown, to find out how older LGBT+ people were affected by the lockdown.

<table>
<tr><td>Age</td><td rowspan="3">Sexuality
<u>Women</u>: of the women,
• 87% were lesbian,
• 5% were bisexual;
• Three identified as queer (<1%),
• one as heterosexual (<1%),
• one as asexual (<1%),
• Three women were ambivalent about their sexual identity. (<1%),
<u>Men</u>: of the men,
• 94% were gay,
• 4% were bisexual,
• one identified as queer (<1%),
• one as heterosexual (<1%),
• three men were ambivalent about their sexual identity. (<1%),
<u>Gender non-binary</u>: the nine gender non-binary participants described their sexualities in highly individualised ways.</td></tr>
<tr><td>• 34% were in the 60-64 age category
• 30% were in the 65-69 age category
• 20% were in the 70-74 age category
• 10% were in the 75-79 age category
• 2% were in the 80-84 age category
• < 1% of participants were in the 85-89 age category
• < 1% of participants were in the 90-94 age category</td></tr>
<tr><td>Living arrangements
• 51% lived alone
• 49% lived with other people (spouse, partner, adult children, parents, other family members, housemates/lodgers.</td></tr>
<tr><td>Gender</td><td>Gender Identity</td></tr>
<tr><td>45% of participants were women, 53% were men,
2% did not identify with the gender binary
One person identified as queer (for both gender and sexuality). (<1%)</td><td>93% of participants identified with the gender they were assigned at birth
7% did not.</td></tr>
</table>

Table 1 Overview of survey participant sample (n=375)

Emergency contact

- 90% of respondents had someone who they could call in an emergency. People who lived alone were more likely not to have anyone to contact in an emergency.

Impact of COVID on physical and mental health*:*

- 30% of respondents thought their physical health had worsened during lockdown, and 26% thought it had got better.
- 49% of respondents thought their mental health had worsened during lockdown and 9% thought it had got better.

Key concerns:

- Respondents raised many different concerns about the impact of COVID-19, but the most commonly raised concerns were fear of themselves or family getting ill, and concerns about social isolation and loneliness.
- The extent to which participants were affected by the COVID-19 lockdown was shaped by their social contexts. Some participants gave responses that suggested that identifying as lesbian, gay, bisexual and/or trans+ had had a big effect on their experiences of COVID-19, for example fears of discrimination or access to gender-affirming care for trans people. Many participants did not mention identifying as L/G/B/T+ in relation to COVID-19. A small number of participants thought that identifying as L/G/B/T+ did not make any difference.
- Older LGBT+ people in this survey had a wide range of social networks.
  - Some people had large, diverse networks that included many different types of people, such as friends, social clubs, partners and family, and a range of social activities. They missed seeing some of their contacts face-to-face, but had often found other ways of staying in touch, such as online or phone contact.
  - Others had networks that were closely focused on their partner/spouse, and were worried about what might happen if their partner got ill.
  - Some people had limited social networks, and were worried that relationships that had lost touch during lockdown might not recover.
  - Some respondents had been very isolated prior to the COVID-19 lockdown, and remained isolated.

2. Introduction

This summary report provides an overview of the survey findings from a mixed methods research project, which explores the impact of COVID-19 emergency regulations on older LGBT+ people in the United Kingdom (UK). It is a rapid response project or 'temperature check' of older LGBT+ people in the UK, in relation to COVID-19.

3. Background

3.1 The COVID-19 lockdown in the UK in spring/summer 2020.

Following the emergence of COVID-19 in early 2020, and its subsequent international spread, the UK entered a national 'lockdown' on 23 March 2020. The Government informed all members of the UK population that they should not leave their homes for any reasons other than shopping, exercise, caring for vulnerable people or employment that could not be performed from home.

Two categories of individuals who were at higher risk were identified within lockdown guidance. The 'clinically vulnerable' category included everyone over 70, as well as individuals with specified health conditions, many of which are particularly common in older populations, such as heart disease, respiratory disease, diabetes, kidney disease and liver disease. This clinically vulnerable group were advised to follow the lockdown rules particularly carefully, but were not specifically advised to take additional actions. A second group, the 'clinically extremely vulnerable' included those with a narrower range of conditions, including severe respiratory conditions, organ transplant recipients and certain cancers. This group was advised that they should be "shielded", and should not leave their homes for any purpose at all, meaning that they could have no interaction with people outside their household, and food and medication would have to be delivered to them. In practice, there was some confusion over terminology and criteria for the two categories, and it is possible some individuals shielded either when they were not required to, or did not shield despite meeting the criteria for being "clinically extremely vulnerable". Some individuals may also have chosen to follow stricter restrictions than advised on a precautionary basis.

From May 2020 onwards, lockdown measures began to be lifted. In England, individuals were permitted to meet people from other households outdoors on 1 June, and most retail shops and places of worship reopened on 15 June. Hospitality venues such as pubs reopened on 4 July, and businesses providing personal services such as beauty salons and nail bars reopened on 13 July. Shielding arrangements ended on 31 July, and support for those who had been shielding were withdrawn. However, attending venues and meeting others continued to be subject to restrictions, such as advice on social distancing, restrictions on meeting people from other households and guidance (later legislation) requiring the wearing of face masks in shops.

The devolved governments of Scotland, Wales and Northern had powers to direct their own countries' response to COVID-19. While restrictions during lockdown were largely similar between the countries, measures around coming out of lockdown, such as the dates when businesses were permitted to reopen and limits on numbers of people from different households who could meet, noticeably diverged between the four countries.

3.2 Impact on older people

The restrictions imposed by the COVID-19 lockdown disproportionately affected older people. All adults over the age of 70 were advised not to leave their homes at all, and many of those in their 60s would have been included in the list of 'vulnerable' groups who were not told to "shield" but were advised to follow restrictions particularly closely. It was clear early on in the pandemic that older people were at increased risk of serious illness or death because of COVID-19, and much of the media messaging emphasised risk to older people, often in terms of "vulnerability". Residential care homes were affected very badly, with a number of outbreaks of COVID-19 and subsequent deaths (ONS, 2020).

Consequently, many older adults were partly or completely cut off from face-to-face contact with existing social networks and loved ones. They experienced reduced access to food, household items and medication and to ongoing health services, they would normally visit. Those who lived alone were at risk of increased loneliness and isolation. Those who lived with others were at risk of new and/or heightened tensions

associated with living with one another in close confines, including a potential increased risk of abuse (Westwood, 2019). Some individuals may also have experienced anxiety or fear around the potential impact of the virus on themselves and loved ones.

Within the overall older population, however, some older adults were more severely affected by COVID-19 and the lockdown than others were. It was identified relatively rapidly that Black, Asian and Minority Ethnic (BAME) communities were more likely to be severely affected by COVID-19 (PHE, 2020), as were men (Sharma, Volgman and Michos, 2020). The list of conditions identified as making individuals 'vulnerable' or 'extremely vulnerable' are ones that are often associated with inequalities, for example socio-economic exclusion. Those who were already receiving care, or had long-term health conditions, are likely to have been more affected by disruptions to those services. Experiences of spending large amounts of time at home, as well as risk of catching the virus, are likely to have been mediated by factors such as the size of the individual's home, access to a private garden, and living in communal or overcrowded accommodation. Many community and support organisations moved to providing support and social activities online or telephone. In relation to the known digital divide, some older adults already comfortable and familiar with technologies such as video calling software, while others have limited experience or skills with such technology. For example in 2019, of the 4 million people in the UK who have never used the internet, 94% were aged 55 and over, 84% were over the age of 65, and 62% were over the age of 75 (Tabassum, 2020). People may also be restricted by other factors such as poor connectivity in rural areas, or the loss of access to libraries and other community sources of internet access. For those not required to completely shield, urban and rural populations may have had different experiences regarding access to open space, but also the ease of accessing shopping and medication without using public transport (Ranscombe, 2020).

3.3 COVID-19, lockdown and older LGBT+ populations

Older LGBT+ people can be differently affected by COVID-19 restrictions. There is substantial previous research highlighting that older LGBT+ people, and sub-populations within the acronym, have additional specific concerns relating to gender,

sexuality and/or trans issues (Almack, Seymour and Bellamy, 2010; Traies, 2016; Simpson, 2016; Jones, Almack and Scicluna, 2018; Jen and Jones, 2019; Toze, 2019; Witcombe et al, 2018), many of which are impacted by mandatory isolation. These include social isolation and loneliness; access to instrumental support; access to specialist health services; access to specialist social support provision and bereavement concerns.

Social isolation and loneliness are shown to have a detrimental impact on the physical and mental health and wellbeing of older people. Older LGBT+ people are more likely to experience both (Porter et al, 2016; Hawthorne, Camic and Rimes, 2020). This is for several reasons: social marginalisation and exclusion resulting from adaptive responses to lifelong prejudice and discrimination; smaller social networks; more likely to be living alone and/or affecting by partner bereavement; and less intergenerational support (Fenge and Fanin, 2009). Evidence suggests that older gay men are particularly affected by loneliness and social isolation due to ageism on the gay male commercial scene (Simpson, 2013). Secondly, they are less likely to have children than older lesbians (and older heterosexual women and men) (Westwood, 2016); and also gendered social networking styles which mean they can find it more difficult than older lesbians to replenish their social networks in older age (Knocker et al, 2012). Older trans women and trans men often become estranged from their biological families post-transitioning (Bailey, 2012), making those who transition in older age particularly vulnerable to diminished social network support.

Many older LGBT+ people are not physically located alongside one another, although this may be less so for some older lesbians who build communities of support with other lesbians leaving nearby (Traies, 2015). However, many older LGBT+ people do not enjoy close communities of support (Fredriksen-Goldsen et al, 2015). Those living in rural areas face particular challenges (Willis, Raithby and Maegusuku-Hewett, 2018). Many have to travel some distance to connect physically with other older LGBT+ people and any limitations on travel places particular constraints upon their ability to access to local and/or extended community support (Heaphy, 2009). Mandatory social isolation due to COVID-19 is therefore likely to have particular implications for older LGBT+ people in the UK, due to higher initial baselines of loneliness and isolation, and due to their greater need to travel to connect in person with other older LGBT+ people (Fenge, Jones and Read, 2010).

Many older LGBT+ people avoid using formal social care, even if much needed, due to fears and concerns about prejudice and discrimination by care providers (Addis et al, 2009; Cronin et al, 2011; Bailey, 2012; Willis et al, 2020). They may have been less likely than the majority population to have existing care in place prior to lockdown, and have more concerns about requesting help for the first time from formal services. Older LGBT+ people are also less likely to be able to access informal intergenerational support (e.g. they are more likely to be ageing without children (Reilly, Hafford-Letchfield and Lambert, 2020), and some may have experienced family estrangement, and so may have experiencing heightened unmet need. Neighbours, faith organisations and voluntary sector groups can also be sources of informal instrumental support for community-dwelling older people (Knocker, 2012). However, experiences or fears of prejudice within the local community may mean older LGBT people have reduced access to such sources. With insufficient home delivery services from private businesses available at key points in lockdown, that unmet need might pose challenges to physical health and wellbeing.

Some groups of older LGBT+ people, such as those living with HIV (Rosenfeld, Bartlam and Smith, 2012), and those with multi- and/or co-morbidities associated with health inequalities (Westwood et al, 2020), are at increased risk from COVID-19, above and beyond issues of age, and hence subject to even greater restrictions on social contact. Some trans women and men are currently undergoing gender transitioning with support from their GPs and/or specialist gender identity clinics (Bouman et al, 2016), and associated face-to-face-treatments are likely being interrupted during the healthcare crisis. Older LGBT+ people are at increased risk of mental health problems, particularly anxiety and depression (Semlyen et al, 2016; McNeil et al, 2012). Although many avoid specialist mental health services due to concerns about homophobia and biphobia, many do use those services, including counselling and psychotherapy, interrupted by the lockdown. This too could affect their mental (and consequent physical) health and wellbeing.

Existing LGBT+ support organisations report challenges in running services during Lockdown, due to underfunding, loss of income, staff being ill, self-isolating or having caring responsibilities, and the need to rapidly pivot to online provision. Some organisations suggest that the financial challenges are severe enough to jeopardise their long-term survival (LGBT Consortium, 2020). It is possible that some strategies

adopted by LGBT+ community groups to temporarily mitigate the impact of social distancing, such as offering meetings and events via social media or video conferencing may be less accessible to some older people, further exacerbating their isolation from LGBT+ communities. In reaction to COVID-19, there has been a rapid community response in the development of informal local volunteer groups and networks to undertake tasks such as offering telephone befriending to local older people. However, the rapid establishment of new informal networks may result in a failure to recognise and consider the needs of diverse groups within the local community, while older LGBT+ people who have previously experienced discrimination within their local community may have concerns about accessing support from local volunteers.

Many older LGBT+ people have 'families of friends' (Weston, 1997; Fredriksen-Goldsen et al, 2014) which complement and/or supplement biological family networks, which can sometimes be fragmented especially due to homophobic/transphobic family rejection (Willis et al, 2016). There are long-standing concerns about unequal recognition of 'families of friends' in palliative and end-of-life care. With increasing restrictions on who can 'say goodbye' to a person dying from COVID-19 there is a real risk that older LGBT+ people will find themselves excluded, especially if they are not recognised as 'next of kin'. There then may be a lot of unsupported death-related loss that older LGBT+ people are experiencing whilst isolated in their homes (Fenge and Fanin, 2009).

Moreover, older LGBT+ people are known to experience 'disenfranchised grief', i.e. grief that is not recognised or validated by society, and which can become complicated' (unresolved) grief as a result (Bristowe, Marshall and Harding, 2016). Some older LGBT+ people find themselves excluded by biological families from loved-ones funerals, while others are welcomed and included. However, the initial COVID-19 regulations regarding funerals during lockdown stated that friends could 'only' attend a funeral if the deceased does not have close family or a household member attending. This has obvious implications for chosen family, privileging of 'kin' over other relationships, and not necessarily showing awareness of structures common among older LGBT people. It is potentially extremely significant for older LGBT+ people who may be excluded from loved-ones funerals because their friendship

networks do not have equal status with other relationship networks in law (Westwood, 2018).

3.4 Rationale for research

A range of research is being conducted on the impact of particular populations during the unique circumstances of COVID-19. Given the existing inequalities faced by LGBT+ older people (Westwood et al, 2020; Almack and King, 2019) and the emerging evidence on how the pandemic has exacerbated existing inequalities (Blundell et al, 2020), it was anticipated that this early first survey results on LGBT+ older people's pandemic experiences would enable us to appreciate the diversity of experience within the LGBTQ* community. We were also interested in the variability of individual circumstances and personal responses to the pandemic and lockdown.

4. Methodology

The survey findings reported here form part of a large mixed-methods research project, which also comprised interviews with older LGBT+ people and professionals working to support them. This study aimed to take a temperature check of how older LGBT+ people in the UK were impacted by mandatory social isolation during the Spring-Summer 2020 lockdown, and to understand what coping strategies they are using to manage their situations. It was approved by the University of York's Economics, Law, Management, Politics and Sociology (ELMPS) ethics committee.

The survey is based on a non-validated questionnaire (Westwood, Hafford-Letchfield and Toze, 2020, see Appendix One) designed by the project team. The questionnaire comprised 19 meta-questions which asked participants about a range of issues, including their health and wellbeing, whether they lived alone or with others, whether they had an emergency contact, the impact of the UK COVID-19 lockdown upon their lives, and their top concerns in relation to COVID-19. The survey was shared via the research teams' professional networks, organisations representing older LGBT+ people and social media. The survey data were collected in Qualtrics©[1] and this document describes early preliminary findings alongside some initial thematic analysis of responses to open-ended questions. More detailed reports of findings will be produced in due course.

[1] https://www.qualtrics.com/uk/

5. Results

Four hundred and eleven (411) people completed the full survey. Of these, 36 either were excluded from the final analysis because their responses indicated that the participants were not eligible to participate or were not complete. This provided a final included sample of 375.

5.1. Sample profile

5.1.1. Age

Question (1) asked participants to indicate their age by ticking one of a range of age categories.

Age categories of respondents ranged across categories between 60-64 and 90-94. Sixty was the lowest possible participant age to be included in the survey. As can be seen from Figure 1 below, in terms of the total sample of 375 people:

- N=126 (34%) were in the 60-64 age category,
- N=111 (30%) were in the 65-69 age category,
- N=77 (20%) were in the 70-74 age category,
- N=39 (10%) were in the 75-79 age category,
- N=9 (2%) were in the 80-84 age category,
- N=1 (%neg) were in the 85-89 age category,
- N=2 (%neg) were in the 90-94 age category

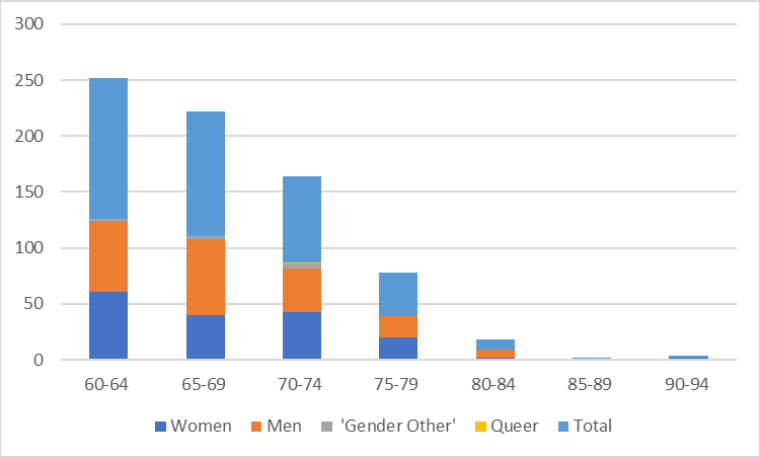

Figure 1 Overview of survey participant profile by age

Out of the 168 ‘Women’ participants:

- N= 61 (36%) were in the 60-64 age category,
- N=40 (24%) were in the 65-69 age category,
- N=43 (26%) were in the 70-74 age category,
- N= 20 (12%) were in the 75-79 age category,
- N=2 (% neg) were in the 80-84 age category,
- N= 2 (% neg) were in the 90-94 age category

Out of the 197 ‘Men’ participants:

- N= 63 (32%) were in the 60-64 age category,
- N= 68 (35%) were in the 65-69 age category,
- N= 39 (23%) were in the 70-74 age category,
- N= 19 (11%) were in the 75-79 age category,
- N= 7 (4%) were in the 80-84 age category,
- N= 1 (% neg) was in the 85-89 age category,

Out of the 9 ‘Gender Other’ participants:

- N= 2 were in the 60-64 age category,
- N= 3 were in the 65-69 age category,
- N= 4 were in the 70-74 age category,

The ‘Queer Person’ (gender and sexuality queer) was in the 70-74 age category.

Of the 28 participants who did not identify with the gender assigned at birth:

- N=15 (53%) were in the 60-64 age category,
- N=4 (14%) were in the 65-69 age category,
- N=7 (25%) were in the 70-74 age category,
- N=2 (7%) were in the 75-79 age category.

5.1.2. Age

Question 2a asked participants to identify their gender in an open-ended question allowing for a free-text answer.

In total there were over 34 unique responses to the open-ended question about gender. The majority made direct reference to the categories Male/Man or Female/Woman, or used a term closely associated with one of these categories, such as ‘lesbian’. These responses were classified as man or woman. Respondents who did not make any reference to the terms man/male or female/woman, or who actively indicated that their gender was fluid, non-binary or otherwise not falling in such categories, were classified as ‘Gender Other’. As can be seen from Figure 2, below, out of a total sample of 375 people, 168 (45%) participants were classified as 'Woman’, 197 (53%) participants were classified as 'Man', and 9 (2%) were categorised as 'Gender Other'. One participant identified as queer in relation to both gender and sexuality). 'Gender Other' encompassed: ‘gender fluid’; ‘nonconforming’; ‘Both [gender & sexuality] are fluid’; ‘I don't define myself’; ‘Fluid’; ‘transgender’ (no gender specified)’; ‘trans’ (no gender specified); ‘non-binary’; and ‘non gender binary’.

Question 2b asked participants to give a yes/no answer to the question ‘Is your sex/gender the same you were assigned at birth?’

348 (93%) identified with the gender they were assigned at birth and 28 (7%) did not. Of the latter, 23 were Trans Women, three were Trans Men and two came under the ‘Gender Other’ category, identifying as ‘transgender’ (gender not specified) and ‘gender non-binary’ respectively.

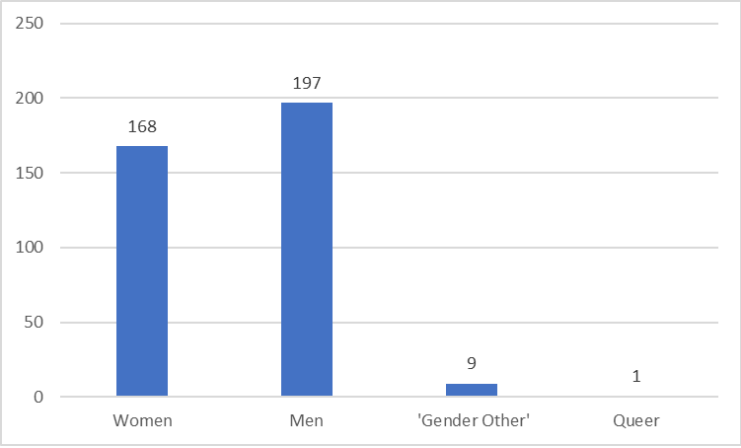

Figure 2 Overview of survey participants by gender

5.1.3. Sexuality

Question 2c asked participants to identify their sexuality in an open-ended question allowing for a free-text answer.

Again, there was a large number of unique responses, which have been categorised for analysis purposes. Of the 168 women, 149 (87%) were classified as Lesbian, 9 (5%) as Bisexual (i.e. they wholly self-identified as Bisexual), 5 (3%) as 'Woman, Other Sexuality', 3 (3%) as Queer, one as Heterosexual (% neg) and one (% neg) as Asexual. 'Woman, Other Sexuality' comprised women who identified as: 'pansexual; 'strictly lesbian-romantic, but sexually varied (the two are NOT the same thing and are NOT linked)'; still working it out'; 'I don't know, poss asexual? and 'no labels I'm just me'. Five of the nine Bisexual Women were classified as Trans, four were not.

Of the 197 men, 185 (94%) were classified as Gay, 7 (4%) as Bisexual (i.e. they wholly self-identified as Bisexual), 3 (% neg) as 'Man, Other Sexuality', one (% neg) as Queer Man, and one (% neg) as Heterosexual Man. 'Man, Other Sexuality' comprised men who identified as: 'not defining' (man); 'loose morals' (man); and' transvestite (as a self-defined sexuality). None of the seven Bisexual Men were classified as Trans.

Among the nine participants classified as 'Gender Other', their self-defined description of their 'Sexuality Other' sexualities were 'heterofluid'; 'gay' (n=2); 'lesbian' (n=2); 'I always fancy women'; 'attracted to women'; 'celibate'; 'Fluid. It's the individual not the body, but my life partner is female'. None identified as bisexual. One person ('Queer Person') identified as queer for both gender and sexuality.

5.1.4. Ethnicity

Question 2d asked participants to identify their ethnicity in an open-ended question allowing for a free-text answer.

Responses to this question were extremely varied, with some participants reporting only their ethnic group, some reporting only their nationality, and some reporting both.

In terms of ethnicity, of 375 participants 322 (86%) were classified as White; 40 (11%) were classified as Other/Unable to Categorise (this category relates to individuals who did not provide sufficient information to establish their ethnicity with

certainty, for example because they described themselves only as: ‘British’ or ‘European’); 5 (1%) were classified as Black and Minority Ethnic (BAME); and 6 (2%) were classified as ‘Mixed Heritage’. Two people declined to state their ethnicity.

5.1.5. Disability

Question 3 asked participants to give a yes/no answer to the question ‘Do you consider that you have a disability?’

Of the 375 participants 66 (18%) reported that they considered themselves to have a disability/disabilities and 309 (82%) reported that they did not consider themselves to have a disability.

5.2. Key findings

5.2.1. Living alone or with others

Question 5 asked participants to give a yes/no answer to the question ‘Are you living alone or with others?’

As can be seen from Figure 4 below, of the 375 participants 190 (51%) said they lived alone and 185 (49%) said they lived with others. Among the women, 89 of 168 (53%) said they lived alone and 79 (47%) said they lived with others. Among the men, 96 of 197 (49%) said they lived alone and 101 (51%) said they lived with others. Of 9 participants classified as 'Gender Other', 4 said they lived alone and 5 said they lived with others. The Queer person said they lived alone.

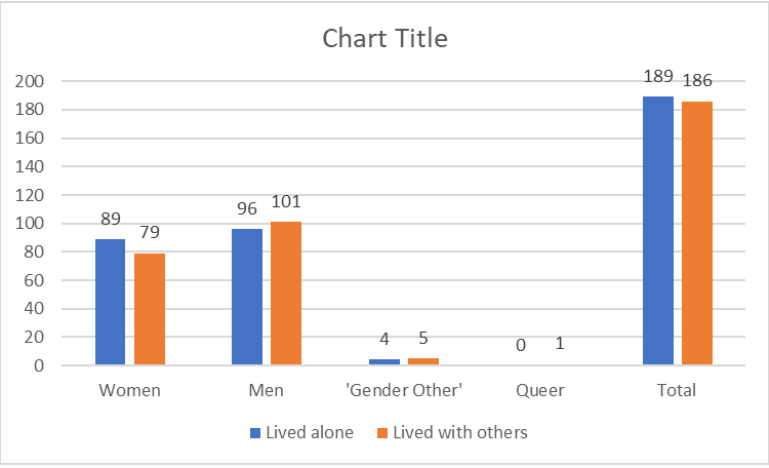

Figure 3 Participants who lived alone/with others

The 79 women who lived with others, described the people they lived with as: wife (n=27); spouse (n=6); civil partner (n=12); partner (n=24); wife and children(n=1); wife/civil partner/partner within a women's co-housing community (n=3); sister (n=2); mother (n=1); adult children (n=1); house-sharers (n=1); and 'love of my life' (n=1).

The 101 men who said they lived with others described the people they lived with as: civil partner (n=27); partner (n=25); husband (n=21); spouse (n=6); 'husband and houseboy' (n=1); wife (gay man); wife and children (heterosexual man, self-identified transvestite) (n=1); 'elderly parent' (n=1); mother (n=1); father (n=1); father and son (n=1); son (n=1); daughter (n=1); teenage family member after death of parents (n=1); 'older parent' (n=1); 'family' (not specified) (n=1); 'gay friend' (n=1); landlords/lodgers/landlords and lodgers (n=4); 'ex-lover, friend, lodger' (n=1); 'husband & LGBT+ lodger' (n=1); 'husband and live-in house manager' (n=1); '24/7 carers' (n=1); and estranged 'civil partner, in process of breaking up' (n=1).

The 'Gender Other' participants who said they lived with others described them as: civil partner (n=3); wife (n=1); and 'platonic housemates' (n=1). The 'Queer Person' with a queer gender and sexuality identity said they lived alone.

The ten participants who did not identify with the gender they were assigned at birth and who said they lived with others, described the people they lived with as: husband (n=2); wife (n=3); spouse (n=1); partner (n=2); mother (n=1); 'platonic housemates' (n=1).

5.2.2. Emergency contact

Question 7 asked participants to give a yes/no answer to the question 'Do you have someone you can call upon in an emergency?'

Of the 375 participants 336 (90%) said they had someone that they could call on in an emergency and 39 (10%) said they did not.

Out of the 79 participants classified as Woman who lived with someone else, 75 (95%) said they had someone they could call on in an emergency and 4 (5%) said they did not. Out of the 89 participants classified as Woman who lived alone, 73 (82%) said they had someone they could call on in an emergency and 16 (17%) said they did not have anyone to call.

Out of the 101 participants classified as 'Man' who lived with someone else, 94 (93%) said they had someone they could call on in an emergency and 7 (7%) said they did not. Out of the 96 participants classified as 'Man' who lived alone, 85 (89%) said they had someone they could call on in an emergency and 11 (12%) said they did not.

Of the nine participants classified as 'Gender Other', all five of those who lived with someone had someone they could call on in an emergency and three of the four who lived alone, the latter citing a son (n=1); brother (n=1); and friends (n=1). The 'Queer Person' with a queer gender and sexuality identity, who lived alone, said they had a friend they could call on in an emergency.

Of the 28 participants who did not identify with the gender they were assigned at birth, nine of the ten participants who lived with others, said they had someone that they could call on in an emergency. Among the eighteen participants who did not identify with the gender they were assigned at birth, who lived alone, 12 (67%) said they had someone that they could call on in an emergency, while 6 (33%) said they did not.

5.2.3. Top concerns about COVID-19

Question 6 asked participants 'What are your top 3 concerns about how you are currently affected by Covid19?' with a free-text box for responses

Women

Among the 168 women participants, three women stated, in response to this question, that they had no concerns, while 165 women (98%) identified multiple wide-ranging concerns. The most frequently articulated concerns were as follows:

- Anxiety/fear of contracting and/or dying from COVID-19 (46%)
- Missing seeing/being with family and/or friends (34%)
- Loneliness/social isolation/feeling alone (26%)
- Anxiety/fear of a loved-one (spouse/partner; children; grandchildren; close friends) contracting and/or dying from COVID-19 (14%)
- Lack of physical contact/ physical affection/ hugs (9%)

Nine women expressed concerns for ageing parents, with various physical ailments and/or cognitive impairments, and/or dying friends, whom they could not see or support during lockdown. Three women in relationships with partners with whom they were not co-habiting, referred to their distress at being separated from one another. Two women reported that their relationships had ended during the lockdown, one was with a long-term cohabiting partner, and this woman stated that she was struggling to cope.

Seven women had been bereaved during lockdown (two reported that their partners had died; two that one/both of their parents had died and they had not been able to see them before they had died; one woman said two friends had died; one woman, who lived alone, said her dog had died). Two said they had been unable to attend loved-ones funerals.

Three women said that they had had COVID and one reported experiencing ongoing symptoms of post-viral fatigue.

Several trans women participants made particular reference to trans-specific issues. One trans woman, mid-transitioning, has had gender affirmation surgeries cancelled during the lockdown, and said that her already fragile mental health has deteriorated as a consequence. Another trans woman, post-transitioning, was concerned that routine medical monitoring of her gender affirmation interventions was not taking place, and that as a result felt vulnerable (to undetected health risks and/or misaligned interventions not being modified). A trans woman, transitioning, still living with her wife (who she had married when legally a man) spoke of tensions in the relationship and feeling desperately alone and unable to be herself at home. A trans woman, post-transitioning, a healthcare worker, had been moved teams and was experiencing transphobia in her new team. For each of these individuals, COVID-19 and the lockdown had exacerbated previous trans-related concerns and risk issues.

Men

Among the 197 men participants, five said they had no concerns, while the remaining 192 (97%) reported multiple concerns, the most common of which were:

- Anxiety/fear of contracting and/or dying from COVID-19 (36%)
- Fear of partner/spouse contracting and/or dying from COVID-19 (36%)

- Loss of social and leisure activities (22%)
- Loneliness and social isolation (15%)
- Being unable to see family and/or close friends (10%)
- Not being able to have intimate physical/sexual contact, go to gay saunas, gyms, sex clubs, and teashops and/or meet men for sex (6%)
- Concern about impact on mental health (5%)
- Not being able to access routine healthcare, scheduled operation etc. (5%)

Eight men expressed dissatisfaction with the government's handling of the crisis. Seven men referred to missing general physical contact and/or hugs. Six men were concerned about boredom. Four men were concerned that they were unable to get a haircut. Two men said they had had COVID and both reported still experiencing residual symptoms. One man's partner had had COVID, and he had been unable to be tested to see if he had it too. Two men had been bereaved shortly before the COVID outbreak (one man's father had died, the other man's partner had died) and both reported that being separated from their friends and/or family was making it more difficult to cope with their bereavements.

Four men were concerned about not being able to see their non-cohabiting partners. Two men reported being distressed by being unable to visit their ageing mothers each with care and support needs. One man was concerned about being unable to see an ageing parent in a care homes, and two men were distressed by being unable to see their husbands who were in care homes.

Queer and gender non-binary participants

Among the nine gender non-binary participants five were concerned about not being able to spend time with family and friends, five were concerned about getting infected and/or infecting others and four expressed strong dissatisfaction with the government's handling of the crisis (NB participants gave multiple answers). The queer-identifying person was concerned about contracting and possibly dying from COVID-19 and of the impact of the lockdown on their ability to participate in voluntary activities for charities.

5.2.4. Health and wellbeing

Question 4 asked participants to give a yes/no answer to the question 'Do you have any serious health conditions?'

A can be seen from Figure 4 below, the 375 participants N=173 (46%) said they considered themselves to have a serious health condition and N=202 (54%) did not consider themselves to have a serious health condition.

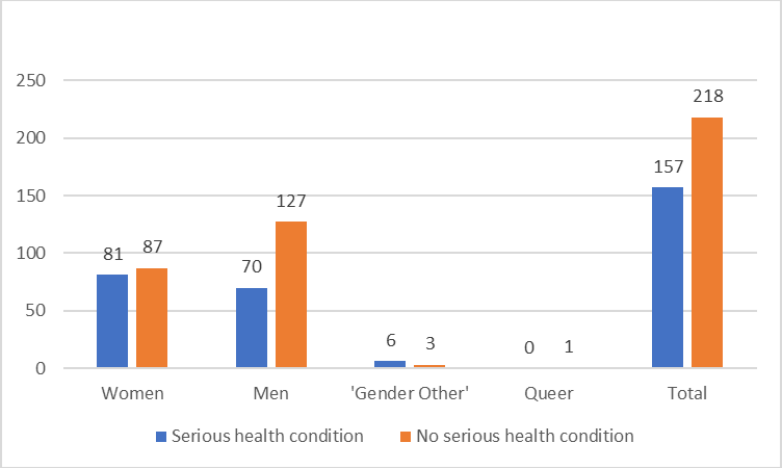

Figure 4 Participant profiles by health status

Among the women, N= 81 out of 168 (48%) participants said they had a serious health condition. Among the men, N=70 of 197 (36%) participants said they had a serious health condition. N= 6 out of 9 (60%) participants classified as 'Gender Other' said they had a serious health condition. The 'Queer Person' with a queer gender (and sexuality) identity did not consider themself to have a serious health condition. Of the 27 participants who did not identify with the gender they were assigned at birth, 16 (60%) considered themselves to have a serious health condition.

N=44 (12%) of all the participants said they had 'Shielded' status. Among the women participants, N=22 out of 168 (13%) said they had 'Shielded' status. Among the men, N=22 out of 197 (11%) also said they had 'Shielded' status. Of 10 participants classified as 'Gender, Other', none said they had 'Shielded' status. The 'Queer Person' with a queer gender (and sexuality) identity did not state that they had Shielded status. Of the 28 participants who did not identify with the gender they were assigned at birth, 3(11%) said they had 'Shielded' status.

5.2.5. Impact of lockdown upon health and wellbeing

Participants were asked about the impact of COVID-19 on their physical and mental health, completing a 5-point Likert scale (A lot better; Slightly better; Neither better nor worse; Slightly worse; A lot worse) for their physical health (Question 14) and their mental health (Question 15) respectively.

In terms of their physical health, the whole sample (n=375) responded as follows:

- A lot better, N=18 (5%)
- Slightly better, N=69 (18%)
- No change, N=174 (46%)
- Slightly worse, N=92 (25%)
- A lot worse, N=22 (6%)

Overall, almost half (46%) reported no change in their physical health, while those who did report a change in their physical health comprised 26% (n=87) who thought it had improved (slightly or a lot better) and 30% (n=114) who thought it had got worse (slightly or a lot worse).

In terms of their mental health, the whole sample (n=375) responded as follows:

- A lot better, N=6 (2%)
- Slightly better, N=26 (7%)
- No change, N=161 (43%)
- Slightly worse, N=145 (39%)
- A lot worse, N=37 (10%)

Overall, just over two-fifths (43%) reported no change in their mental health, while those who reported a change in their mental health comprised 9% (n=32) who thought it had improved (slightly or a lot better) and almost half of the sample, 49% (n=182) who thought it had got worse (slightly or a lot worse)

There is, then, a marked difference in the self-reported impact of the impact of COVID-19 on the participants' physical and mental health. As can be seen in Figure 5 overleaf, participants reported greater, and more negative, changes to their mental health compared to their physical health in association with COVID-19.

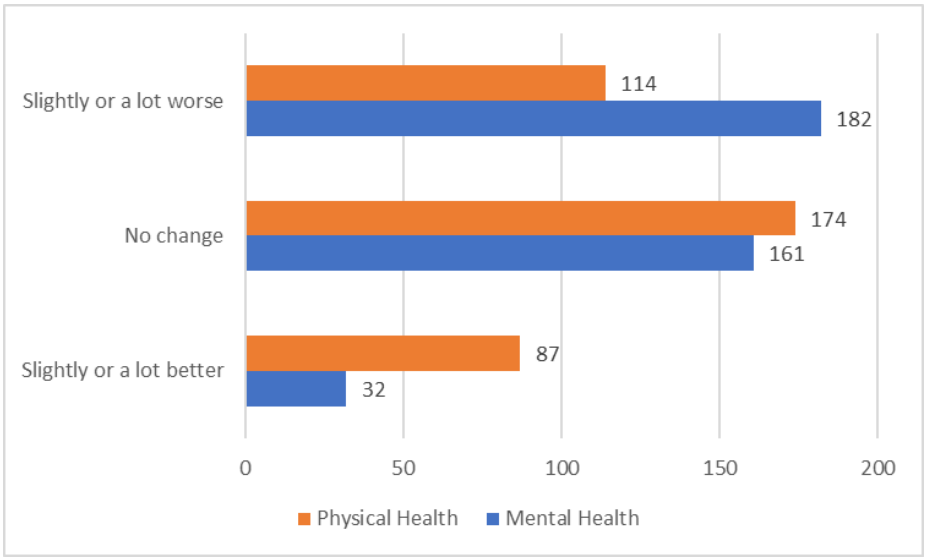

Figure 5 Changes to physical and mental health during COVID-19 lockdown

5.2.6. Coping strategies

Question 17 asked participants 'What strategies are you using to cope with social isolation due to COVID-19?' with a free-text box for answers.

The following were the most commonly identified coping strategies:

- Increased time on old/new hobbies (gardening/ allotment; writing; painting; drawing; photography; local history; new languages; singing; playing a musical instrument; baking; cooking; jigsaws; puzzles; games; online courses; virtual tours of art galleries and museums; home improvements) (57%)
- Maintained/increased daily exercise (walking, cycling, running, swimming in the sea, indoor exercise, online fitness classes, dancing, Pilates, yoga, tai chi, Zumba (30%)
- Increased use of social media (including FaceTime, Facebook Messenger, Jamulus, Skype, Twitter, WhatsApp, and Zoom,) to connect with personal/social networks (19%)
- Increased contact with personal network by telephone (13%)
- Reading more (14%)
- Watching more television, YouTube, films on Amazon and/or Netflix (12%)
- Creating and maintaining a routine (7%)
- Meditation, prayer and/or positive thinking (5%)
- Keeping busy (4%)

Eleven participants stated they were ‘just getting on with it’ without specifying any strategies in particular. Several participants who were still working and reported not feeling isolated. 28 respondents (7%) who were not at work stated that they did not feel isolated, and were enjoying increased time at home, either by themselves, or with their spouse/partner.

Eight participants stated that they already felt isolated pre-COVID and had not developed any new coping strategies. Ten other participants reported that they did not have any coping strategies. Ten other participants described increased use of alcohol. Five participants described taking psychiatric medication as a coping strategy.

6. Discussion

The findings from this rapid scoping online survey of 375 LGBT+ older people provided a mixed picture. The general picture from the survey is that older LGBT+ people in the UK, not surprisingly, had a wide variety of social networks and relationships as evidenced in previous research (Heaphy, Yip and Thompson, 2004; Guasp, 2011). Slightly over half (51%) of the sample lived alone (a lower proportion than suggested in other studies) (Brennan-Ing et al., 2014, Lottmann and King, 2020, Guasp, 2011). Of these, some participants reported experiencing loneliness and isolation, and for them the COVID-19 lockdown often either made little difference to an already isolated life, or compounded that isolation, placing pressures on fragile social support networks (Green, 2016). Some reported feeling fearful of getting sick and no-one knowing/no-one being there to support them. More men than women come under this 'category'. However, many people who lived alone did not report being lonely, instead describing either a diverse range of social networks and/or being comfortable with their own company. Several were in ‘living apart together’ partnerships, some in new non-cohabiting relationships, some lived alone by choice and valued doing so, and some had extensive social networks comprising family of origin and friends (Green, 2016; Wilkens, 2016). It appears that living alone in and of itself is not a cause for loneliness, but rather the reasons for, and circumstance of living alone.

By contrast, many of the respondents were in cohabiting couples, some with limited social support networks. Respondents in this situation sometimes expressed

concerns or vulnerabilities around the possibility of both partners becoming sick at the same time. Others (in significant numbers), single or coupled, have strong networks of family (including children and grandchildren, siblings, etc.) and friends and their primary source of stress is worrying about their loved-ones' health and not being able to see them. These were strong indicators of coping strategies and resilience to the environmental conditions (see Orel and Fruhauf, 2015 and Bower et al, 2021). There were particularly rich descriptions of utilising technologies to foster and maintain contact with loved ones and peers (see Mock et al, 2020).

Some people, especially single older cis gay men, appear to be very reliant on organised older LGBT+ support much of which appears to have gone online. Others, with stronger personal networks, less so. Several gay men reporting platonic cohabiting friendships with other gay men some of whom were also their lodgers. All participants, but especially those who lived alone emphasised the importance of having or acquiring IT skills for online social networking to mitigate loneliness and isolation (Mock et al, 2020).

Sadly, several people described bereavements during the COVID-19 lockdown, including two who lost partners. Several have spoken of being unable to be with parents (in hospital/care homes) when they died while many more have spoken of the challenging of supporting a parent/bereaved parent with memory loss at a distance. Some provided care to ailing partners and/or family members and are describing the challenges of being a lone carer without respite or support during the lockdown.

Many respondents described previously full and fulfilling lives with lots of social activities with family, friends and/or special interest groups, are not directly associated with their sexual and gender identity (sports, hobbies, the arts). The frustration was about not being able to travel, visit loved ones, go out for meals, go to usual events, and generally have the same level of *fun* they were used to.

Some participants also identified benefits from COVID-19. These were around issues such as having more time to spend with partners and loved ones, more time to spend on hobbies and interests, and being able to take life at a slower pace.

5.2.7. LGBT+ ageing and experiences of lockdown

Some people saw their sexualities and/or gender identities as being relevant to COVID. Older trans and gender non-conforming (TGNC) people in particular have described lower levels of social support, greater biological family rejection, higher levels of disability, physical and mental health problems, and more concerns about care should they need it. By contrast, several gay men and lesbians were explicit in saying that they thought identifying as L/G/B &/or T was irrelevant to the COVID-19 crisis and that they objected to being singled out with what they perceived to be a victim narrative. Unsurprisingly, these were the individuals who were most likely to report being socially integrated, having a strong social support network, and being physically and mentally well. However, other participants, who lived alone, were less well integrated and/or had greater health concerns spoke of terror, despair, misery and desperate loneliness, which they directly attributed to a minority sexuality and/or gender identity (Westwood et al, 2020; Kneale et al, 2020). It is this great diversity of narratives which was, perhaps, the most striking feature of the survey's findings. It makes it difficult, in fact impossible, to generalise in relation to the whole sample, or indeed extrapolate to other older LGBT+ people living in the UK, other than to comment on their heterogeneity. It does, however, highlight the substantial diversity of experience within older LGBT+ populations in the UK, and emphasise the importance of policy makers and service providers engaging with LGBT+ communities to understand and plan for their needs in later life.

7. Conclusion

Initially intended to be a small scoping study, this project has produced a much larger dataset offering insights into the lives of older LGBT+ people in the UK, both in relation to COVID-19 and more broadly. We have identified that older LGBT+ people live diverse lives, informed by their intersection with a wide range of social locations, cutting across the social spectrum. This in turn informs their experiences of COVID-19 and of related lockdowns. No single narrative can encompass the full range of their lived experiences, issues and concerns. The richness of the data obtained through the survey has also provided a window into a wider description of older LGBT+ people's lives, living situation, social networks and instrumental support. Many of

these were followed up in the subsequent qualitative study not reported here but where there was potential application to enhancing our understanding of wider ageing and its impact on LGBT+ lives (El-Zerbi, 209)

The diversity of older LGBT+ populations has implications beyond the current context of COVID-19 and lockdown restrictions. Many participants described diverse, active social networks, which they could and did call upon for support in the lockdown period. Many also described effective coping strategies for dealing with the challenges of lockdown. However, the study also identified LGBT+ older people who were facing significantly greater challenges, for example those who had experienced family estrangement, had concerns about accessing services, and/or were experiencing isolation even prior to lockdown. This suggests that there is a need for ongoing work to support LGBT+ people in developing robust and resilient social networks throughout their lifecourse.

However other projects have identified challenges faced by LGBT people and voluntary sector organisations both before and during in the COVID-19 period (Colgan et al, 2014; Consortium, 2020). Moreover, Opening Doors London, the largest older LGBT+ support organisation in the UK, recently reported on a survey of its members in regard to COVID-19 (Opening Doors London, 2020). That report found higher levels of loneliness, isolation and mental distress among respondents than we found in our study. This is most likely because Opening Doors' survey was of those people in receipt of its excellent support, whereas our survey included both those who needed (and some who accessed) formal support and those who did not.

The research team will be drawing on a range of data from this research project in relation to future knowledge exchange and publications. These should enable more in-depth reporting on; a) older lesbians, b) older gay men, c) older bisexual people and d) older trans and gender non-conforming individuals, and other broader issues identified within this study (e.g. ethnic identity, sexuality and gender identities and methodological issues)

Subsequent publications will also address the in-depth qualitative interviews conducted with both experts by practice (i.e. those providing support to older LGBT+

people) and experts by experience (i.e. older LGBT+ people themselves). We expect to report on comparative findings with other international partners who have also engaged with adapting the project methodologies.

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APPENDIX ONE

SURVEY QUESTIONNAIRE

OLDER LGBT+ & COVID-19 SURVEY (Westwood, Hafford-Letchfield and Toze, 2020)

You have reached the website of the survey for the research project 'Covid-19 emergency measures and their impact on older lesbian, gay, bisexual and trans+[i] (LGBT+) people in the UK: a rapid response review.'

The project is being run jointly by Dr Sue Westwood, University of York, Professor Trish Hafford-Letchfield, University of Strathclyde, and Dr Michael Toze, University of Lincoln. It has been approved by the ELMPS Ethics Committee at the University of York.

The purpose of this study is to take a 'temperature check' of how older LGBT+ people in the UK are impacted by Covid-19 mandatory social isolation, and to understand the coping strategies they are using to manage their situations. The findings from this study will be used to inform organisations developing responses to support them being more inclusive and sensitive as well as to highlight any gaps or needs for specialist support services.

Please proceed with this survey if you identify as lesbian, gay, bisexual, trans+ (transgender and gender non-conforming) aged 60 and over living in the United Kingdom.

The survey contains questions about how you are currently affected by Covid-19. It is completely anonymous and the results will be seen only by the members of the research team.

At the end of the survey, there is a list of organisations which can provide you with information, advice and support, if you should need it.

At the end of the survey you will be asked if you are interested in taking part in a more in-depth interview which will give you a chance to expand on some of the areas you wish to share. This interview will take place either by telephone, Skype, Zoom or WhatsApp, whatever you prefer. If you wish to take part in this aspect of the process, you will be asked to provide your email address or telephone number so we can contact you. If you are not, you do not need to provide any contact details.

You will also be asked if you would like to receive a report on the project's findings. Again, if you are, you will be asked to provide your email address so we can contact you with a link to the report. If you are not, you do not need to provide your email address.

If you have any questions/concerns about the survey, please contact Dr Sue Westwood: sue.westwood@york.ac.uk.

Thank you for participating in the survey. Your participation indicates that you agree to the above information.

[Screening questions (tick box): *I am aged 60 and over; I identify as lesbian, gay, bisexual, lesbian and/or trans (transgender and gender non-conforming); I live in the United Kingdom*. All three must be ticket in order to proceed]

1. How old are you? [Select box]

60-64

65-69

70-74

75-79

80-84

85-89

90-94

95-99

100+

2. How would you describe your
    a. Sex/gender [Single line free text answer]
    b. Is your sex/gender the same you were assigned at birth? [Y/N]
    c. Sexuality [Single line free text answer]
    d. Ethnicity [Single line free text answer]

3. Do you consider that you have a disability? Yes/No.
    3.1. If Yes,
        3.1.1. If yes, please describe

    [Multiple line free text answer]

4. Do you have any significant health conditions? Yes/No.
    4.1. If yes,
        4.1.1. Please describe

        [Multiple line free text answer]

        4.1.2. Do you come under the 'Shielded' category according to Covid-19 regulations, due to your health condition? [Yes, No, Don't know]

5. Are you living alone or with others? [Alone/with others]

    5.1. If ‘living with others’

        5.1.1. If living with others, what best describes their relationship to you?

        [Multiple line free text answer]

6. What are your top 3 concerns about how you are currently affected by Covid19? [Multiple line free text answer]
7. Do you have someone you can call upon in an emergency? [Y/N]

    7.1. If yes

        7.1.1. If you have someone you can call upon in an emergency, what is that person’s relationship to you (e.g. friend, neighbour, brother, sister, etc.)

        [Multiple line free text answer]

8. How are you getting essential food, household supplies and medication?

[Multiple line free text answer]

9. What are your usual support networks?

[Multiple line free text answer]

10. How are your support networks affected by mandatory isolation?
[Multiple line free text answer]

11. How are you maintaining connections with your support networks?
[Multiple line free text answer]

12. What challenges if any, are you experiencing in maintaining connections with your support networks?
[Multiple line free text answer]

13. Have your support networks changed due to Covid-19 regulations (e.g. are people who are not normally supportive, such as estranged biological family members/ alienated ex-partners, now providing support)? If so, in what way?
[Multiple line free text answer]

14. What do you think about your PHYSICAL health and wellbeing during mandatory social isolation? [5-point scale – a lot better; slightly better; no difference; slightly worse; a lot worse].

15. What do you think about your MENTAL health and wellbeing during mandatory social isolation? [5-point scale – a lot better; slightly better; no difference; slightly worse; a lot worse].

16. Do you provide support to others? [Y/N]

    16.1. If yes

        16.1.1. If you provide support to other(s) what is your relationship(s) to them?

    [Multiple line free text answer]

        16.1.2. If you provide support to other(s) how is mandatory isolation affecting how you now provide that support?

    [Multiple line free text answer]

17. What strategies are you using to cope with social isolation due to COVID-19?
    [Multiple line free text answer]

18. Do you think you have any unmet needs due to COVID-19? [Y/N]

    18.1. If Yes

        18.1.1. If yes, what are those unmet needs?
        [Multiple line free text answer]

        18.1.2. If yes, how would you like those unmet needs to be met?
        [Multiple line free text answer]

        18.1.3. If yes, who would you like to meet those unmet needs?
        [Multiple line free text answer]

ANY OTHER ISSUES:

19. Is there anything else you would like us to know and/or think we should address in relation to older LGBT+ people and Covid-19

    [Multiple line free text answer]

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Would you like to receive a copy of the project's findings in its final report? If so, please provide your email address (which will only be used to send you the report):

*****

Would you be interested in being interviewed as part of this project? If so, please provide your email address and we will send you more information:

*****

Question numbers used for admin only, not used in actual online survey. Progress bar used to show % of completion. Compulsory completion of all questions.

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