outlook

Support for LGBTQ+ people in later life

The COVID-19 pandemic shows the importance of tailoring health care to older lesbian, gay and trans people as they age, says Trish Hafford-Letchfield.

ANN FLYNN

In 2020, during the first COVID-19 lockdown in the United Kingdom, my colleagues and I carried out a study of older people from sexual and gender minorities (LGBTQ+ people) about their experiences during the pandemic[1]. One comment from an older trans women stays with me: "I would much rather kill myself than go in a care home. I have written 'Do Not Resuscitate' on the wall above my bed so the ambulance people know what I want."

Our survey revealed many positives, including examples of informal care offered by the LGBTQ+ community to its older members. But that comment was not a one-off. Along with the findings of other studies I have led as an educator and social-work professional, it shows how far we still need to go for older LGBTQ+ people to feel confident and safe in the services we provide.

Our 2020 survey found social distancing meant that many older LGBTQ+ people had to rely on health care and public services that, in their gendered and normative fashion, were not tuned to their needs. Many advocacy organizations who adapted their services during lockdowns reported older LGBTQ+ people hiding to avoid unwanted attention from neighbours and community volunteers.

As the size of the ageing population grows, so does its diversity. In the United Kingdom, for example, more than 120,000 people over the age of 65 identify as LGBTQ+.

Older LGBTQ+ people in various countries have witnessed transformative legal, political and social changes during their lives — although it is important to remember that in 69 countries, diverse sexual and gender identities remain illegal, some with dire consequences.

In the United Kingdom, positive changes include the freedom to adopt as a same-sex couple (in 2002), the introduction of civil partnerships (2005), and the legalization of same-sex marriage (2014), alongside measures to tackle discrimination in employment, crime and health care. Today's older LGBTQ+ people came of age as homosexuality was partly decriminalized (1967). In the 1970s, many engaged in political and social movements such as radical feminism, and they lived through the global AIDS crisis in the 1980s. Even so, many older LGBTQ+ adults still face rejection from family members who refuse to accept their life choices.

Some cultivate alternative support structures, known as 'friendship families' or 'families of choice'. Maintaining these networks can become more difficult as LGBTQ+ people age, owing to the loss of roles in retirement, the death of loved ones, the onset of chronic health conditions, and threats to their independence. As a result, lesbians and gay men are more likely than the general population to live alone in their later years, without a partner or children. This deprives them of a source of support that care systems in the United Kingdom and elsewhere rely on (see page S12).

Lesbians and gay men are more likely than the general population to live alone in their later years.

Trish Hafford-Letchfield is a qualified nurse and social worker and head of the school of social work and social policy at the University of Strathclyde, Glasgow, UK.
e-mail: trish.hafford-letchfield@strath.ac.uk

Having confidence in health and social care services is important. Our 2020 review of health inequalities in LGBTQ+ ageing found evidence of poorer health and health-care provision compared with the general population, particularly with regard to cancer, dementia, palliative care and mental-health services[2].

In the United Kingdom, trans people report some of the highest rates of dissatisfaction with health care. There is, on average, a four-year wait to access gender-identity services, which is a problem for those who have waited until retirement to transition, perhaps to avoid the trauma of doing so in the public arena of a workplace, or until their children have grown up.

In 2003, the psychiatric epidemiologist Ilan Meyer coined the term 'minority stress' to refer to lifelong exposure to prejudice and discrimination[3]. Pressure to conform to stereotypical sex and gender roles, and the sanctions people face when they don't conform, can lead to increased smoking, substance use and obesity. These sources of stress often intersect with other factors arising from power and privilege around race, culture, ethnicity, dis/ability, social class and geographical location.

Adverse experiences can lead LGBTQ+ people to develop resources such as social skills, emotional resilience and political awareness. All of these can be crucial in later life as these people continue to live a diverse lifestyle, either at home or in a care setting, and we should take account of these life skills in our interactions with them.

I use education to address a growing appetite among health-care professionals to improve services for older LGBTQ+ people. In 2018, for example, alongside academic colleagues, we recruited eight LGBTQ+ older people who were trained during the study as community advisers across six sites run by a large care-home provider[4]. The advisers used their own lived experiences, expertise, patience and resilience to educate and challenge others to adopt a more person-centred approach in the face of some common responses such as "we don't have people like that in here" and "we treat everyone the same".

The project developed seven areas of good practice in LGBTQ+ inclusion in care homes: policies and procedures; consultation; risk management; end-of-life support; cultural safety; transgender-specific issues; and workforce development. Other schemes have since been designed for the LGBTQ+ community, highlighting the need for inclusive spaces and supportive environments where people can get what they expect as they age, such as respect for their relationships, accessible health care and support.

1. Hafford-Letchfield, T., Toze, M. & Westwood, S. *Health Soc. Care Commun.* https://doi.org/10.1111/hsc.13531 (2021).
2. Westwood, S. *et al. J. Epidemiol. Commun. Health* **74**, 408–411 (2020).
3. Meyer, I. H. *Psychol. Bull.* **129**, 674–697 (2003).
4. Hafford-Letchfield, T., Simpson, P., Willis, P. B. & Almack, K. *Health Soc. Care Commun.* **26**, e312–e320 (2018).