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A Scoping Review of Older LGBTI People's Experiences of Homecare

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Abstract

Amidst the global growth of the ageing demographic in the world, an inclusive assessment of the care needs of the older lesbian, gay, bisexual, transgender, and intersex (LGBTI) population is receiving increasing attention, especially in view of reported health inequalities for these minority groups and the position of their sexual orientations and gender identities within a predominantly heteronormative health and social system. This literature review aims to identify and analyse previous research on older LGBTI people's views, experiences, and perceptions of homecare provision. We searched the CINAHL, Medline, and PsychINFO databases and found a total of 337 records. After an eligibility assessment, 12 studies were selected, comprising 11 qualitative studies, and one mixed methods study. Under an overarching theme of fears of discrimination and of receiving suboptimal care, we further categorised our findings in the following three interlinked subthemes: (a) disclosure of gender identity and sexual orientation; (b) emerging meanings of LGBTI-competent care; and (c) recommendations for improved quality of LGBTI-friendly services. The overall surfacing outcome of our analysis of the participants' experiences described in the studies examined is an aspiration for homecare services ensuring quality of holistic, person-centred care that recognises this population's distinct set of requirements, including knowledge and consideration of their histories of inequalities and oppression. Wider awareness about the need to re-imagine more inclusive care for the LGBTI community has the potential to improve services and practices, reduce access barriers, and prevent inequalities.

Keywords

ageing; healthcare; homecare; LGBTI; prevention; scoping review

1. Introduction

With the ageing demographic growing worldwide, the specific health requirements of the older lesbian, gay, bisexual, transgender, and intersex (LGBTI) population are receiving increasing consideration, as is the need to ensure the provision of adequate care prevention for this minority group. This reflects the much wider and deeper discrimination and marginalisation experienced by the LGBTI population, in the cis-normative and heteronormative social arrangements which surround their lives and extend to all aspects of home, family, and work life.

Indeed, members of the LGBTI community face inequalities throughout their life trajectories that are harmful to their physical and mental health and have repercussions on their approach to and experience of healthcare (Zeeman et al., 2018). In comparison to the heterosexual population, sexual minority older adults tend to disproportionately suffer from several chronic health conditions, ranging from lower back and neck pain, cancer, and a weakened immune system to cardiovascular disease, such as stroke, heart attack, and angina pectoris (Fredriksen-Goldsen et al., 2017). There is also a higher prevalence of anxiety, depression, and substance use disorders among this population (Yarns et al., 2016). Older LGBTI people's encounters with health and social care services are repeatedly pervaded with experiences and perceptions of homophobia, heteronormativity, and attitudes that tend to ignore or overlook their sexuality and identity (Kneale et al., 2021; Stinchcombe et al., 2017). Studies have shown that sexual minority groups experience or perceive spaces of care as customarily privileging heterosexuality, for instance, through obliviousness to their sexual lives, use of heterosexist language or absence of non-straight cultural references during communal social activities, and by the non-acknowledgement of same-sex relationships and routine reinforcement of traditional family models (Westwood, 2016; Willis et al., 2016). While this is well documented, especially in the context of long-term, residential facilities, the preference for which is comparatively low across both the heterosexual and non-heterosexual populations (Buczak-Stec et al., 2023), it is less so for other aged and social care settings, such as homecare.

Homecare, or domiciliary, services can cover attendance to nursing and medical needs as well as assistance with personal care and housekeeping. They offer those who avail of them the advantage of being supported in their own home where they can retain a higher level of privacy, autonomy, and independence, as well as a sense of safety and security that arises from attachment to a familiar space and connection with neighbourhoods and social supports, such as family and friends (Holmberg et al., 2012; Wiles et al., 2012). Receiving care in the home is more than just benefitting from the provision of support services from an expert professional. It is also a meeting between a stranger and the domestic environment of an individual with distinct health and social care needs, and with a unique biography, the integrity of which needs to be maintained. The visit of a homecare professional to an LGBTI household entails not only knowledge of and attendance to specific health and care requirements of given members of the LGBTI community, but also respect for the variety of their ways of life and consideration of the needs that may arise from both past and present circumstances of being LGBTI.

To help illustrate the specificities of older LGBTI people's lived realities of receiving homecare support services, and contribute to expanding the attention on the need to improve health prevention measures for this population, in this scoping review we examined relevant literature through the frame of the following questions: "What are older LGBTI people's views and experiences of homecare, especially in terms of faced

disparities and inequalities?” “What are the attributes of LGBTI-congruent homecare that emerge from these views and experiences?” and “What can be learnt to build a vision of LGBTI-friendly homecare?”

2. Methods

These three databases were searched for records up to the third week of May 2023, with no time frame restrictions considering the potential scarcity of studies conducted on the topic explored: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, and PsycINFO. These were chosen to ensure a broad reflection of studies across the nursing, health, medicine, and psychology domains of publication. Keywords and combinations were employed consistently across the different databases and were grouped under the four themes of (a) views and experiences, (b) ageing, (c) homecare and ageing in place, and (d) LGBTI groups.

To select records for the review, we used the following inclusion criteria: peer-reviewed primary research studies published in English; studies that explored homecare experiences of LGBTI older people, among whom at least half were aged 50 and above (this age limit was chosen because older LGBTI people aged 60 or above are often a hidden population within the context of research recruitment, given their history of not disclosing their gender and sexual identities); studies that employed qualitative, quantitative, or a mixed methods approach. We excluded: studies that were not about LGBTI older groups, non-primary research articles, such as reviews, and editorials. For analysis, records were transferred onto MS Excel sheets. After duplicate removal, titles and abstracts of the records were screened for eligibility according to inclusion criteria. Eligible full-text articles were then retrieved and further evaluated, after which the final list of selected articles was examined for an in-depth analysis. We did not carry out a formal quality appraisal of the individual studies examined. With our initial research questions in mind, to reach our findings we followed a narrative synthesis approach, broadly similar to a methodology previously used in health research (Brien et al., 2010), that allowed interpretation and description of both the qualitative and quantitative data examined. For each article, specifics on study design, sample, national context, and methodology used were extracted, and descriptions of findings were summarised. An inductive analysis recognised the recurrence of elements and produced relevant clusters of topics and was followed by an integrative synthesis and assessment of its soundness across the various studies, resulting in the identification of subthemes.

Aware of the continuous and inclusive evolution of the terminology to describe the LGBTQIA+ community, to refer to it in general, in this article we chose to employ the acronym LGBTI. Our choice originates from the consideration that it might better reflect the groups familiar to and the relevant terminologies used by the community’s older generations, whose experiences and realities of diversity are at the centre of our study. Sometimes, we also use the terms “sexual minorities” or “sexual minority groups.” All care has been taken to refer to the identity groups of the studies examined with the appropriate original description terms.

3. Findings

3.1. Articles Found

A total of 337 articles were recovered: 82 through CINAHL, 123 through Medline, and 132 through PsycINFO. Following duplicate removal, titles, and abstracts of 215 records were screened for eligibility. After this assessment, 21 full-text articles were retrieved and examined. Nine articles were further excluded

because they did not examine homecare services or, in the case of studies employing quantitative methods, because it was not possible to extrapolate data on homecare services from a larger pool of data on general health, social, and aged care services. Twelve articles were ultimately selected for the review, published between 2010 and 2022 (see Figure 1). Eleven were qualitative, employing either interviews, a town hall meeting, or focus groups. One, which was also the most recent, was a mixed methods study that combined a survey and follow-up interviews. Five studies were conducted in the USA, four in Canada, one in the Netherlands, one in Wales, and one in Australia (see Table 1).

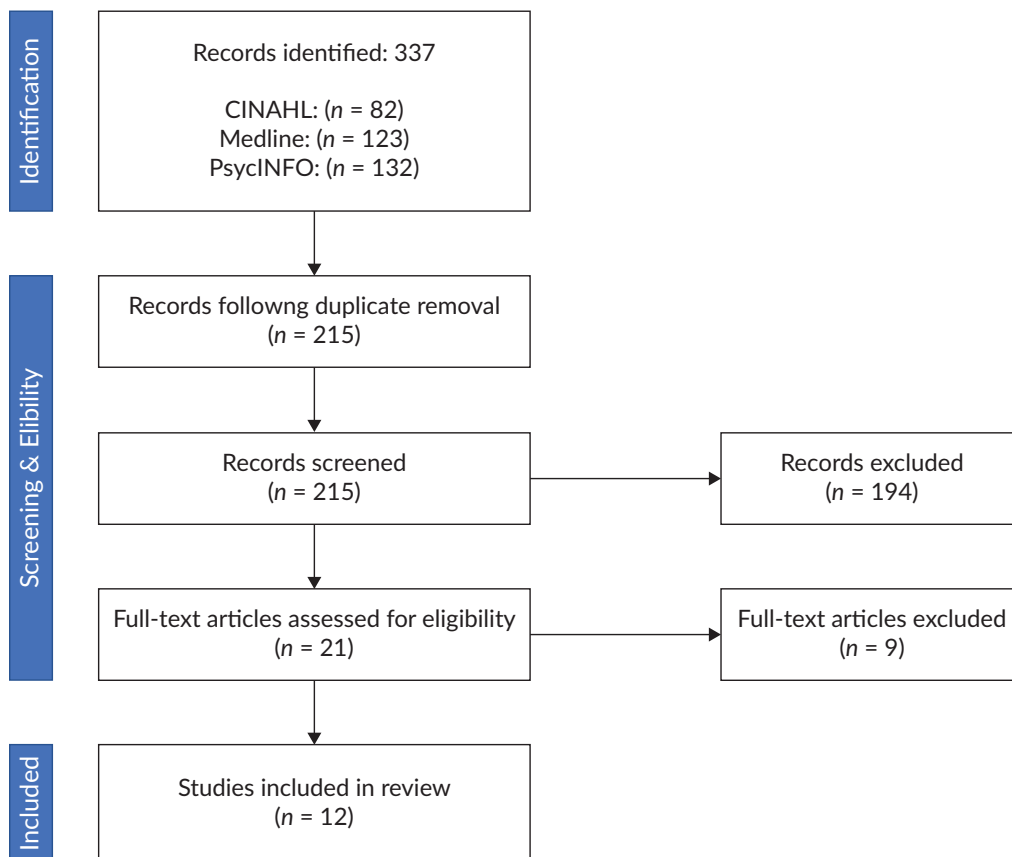


Figure 1. Flow diagram of search and selection of articles.

3.2. Fears of Discrimination and of Receiving Suboptimal Quality of Care

Through an analysis of the selected studies, the prevalent theme among older LGBTI people’s views and experiences of accessing and receiving homecare services is a fear of discrimination, homophobic mistreatment, and poor quality of care, which was often rooted in incidents of stigma and prejudice this generation faced in the past, at a time when many of them might have had to live their identities in secret and endure attitudes of intolerance and periods of social exclusion. This is exemplified by a community-dwelling participant (sexual identity and gender unspecified) in the least recent of the studies examined:

I’m afraid to have a stranger in my home, someone who may be very anti-gay, and then what if they find out about my life and now they’re in my home regularly, and could somehow take advantage or mistreat me? (Stein et al., 2010, p. 429)

Table 1. Summary of articles included in the review.

No.	Author(s)	Sample summary	Research design	Themes
1	Boggs et al. (2017)	<p>No. of participants = 73</p> <p>Demographics only available for interview participants ($n = 29$; participants could indicate more than one option)</p> <p>16 lesbians; 2 bisexuals; 1 straight; 9 gays; 2 transgenders; 1 queer; 20 females; 9 males (participants could indicate more than one option)</p> <p>Age range 40–79</p> <p>8 white; 1 Hispanic; 1 African American ($n = 10$)</p> <p>Context: USA</p>	Qualitative (focus groups, town hall, interviews)	Fear or experience of discrimination; support and community
2	Butler (2018)	<p>No. of participants = 20</p> <p>20 lesbian women</p> <p>Age range 66–86</p> <p>All primary participants identified as white</p> <p>Context: USA</p> <p>6 additional participants were informal caregivers, age range 62–76</p>	Qualitative (interviews)	Fear or experience of discrimination; quality of care; support and community
3	Butler (2017)	<p>No. of participants = 20</p> <p>20 lesbian women</p> <p>Age range 66–86</p> <p>All primary participants identified as white</p> <p>Context: USA</p> <p>11 additional participants were 6 informal caregivers, age range = 62–76 and 5 homecare workers, age range = 44–69</p>	Qualitative (interviews)	Fear or experience of discrimination; identity disclosure; quality of care; support and community
4	Dunkle (2018)	<p>No. of participants = 31</p> <p>16 lesbian women, 15 gay men</p> <p>Age range 54–80</p> <p>87% white; 3.2% Asian; no other races represented; no participant reported being Hispanic or Latino; race not indicated by three participants.</p> <p>Context: USA</p>	Qualitative (focus groups)	Fear or experience of discrimination; identity disclosure; support and community
5	Furlotte et al. (2016)	<p>No. of participants = 12 couples (4 male same-sex couples and 8 female same-sex couples); 1 partner identified as transgender.</p> <p>Age range 39–75</p> <p>The majority of participants identified as white, Caucasian, Anglo-Saxon, European background; one participant identified as Chinese-Canadian</p> <p>Context: Canada</p>	Qualitative (interviews)	Fear or experience of discrimination; identity disclosure; quality of care

Table 1. (Cont.) Summary of articles included in the review.

No.	Author(s)	Sample summary	Research design	Themes
6	Grigorovich (2016)	<p>No. of participants = 16</p> <p>7 lesbians; 2 lesbians/queers; 1 lesbian/queer/dyke; 1 bisexual; 4 gays; 1 woman-loving-woman</p> <p>Age range 55–72</p> <p>No race/ethnicity data available</p> <p>Context: Canada</p>	Qualitative (interviews)	Fear or experience of discrimination; quality of care
7	Grigorovich (2015a)	<p>No. of participants = 16</p> <p>7 lesbians; 2 lesbians/queers; 1 lesbian/queer/dyke; 1 bisexual; 4 gays; 1 women-loving-woman/femme</p> <p>Age range 55–72</p> <p>Ethnicity/race (self-identification, open-ended category): Jewish (2); Anglo-Irish (1); Dutch (1); English German (1); Chinese/South Asian/Caribbean/Caucasian (1); French Canadian (1); English Canadian (1); Hungarian/English (1); Welsh (1); British (1); Scottish/Irish (1); English/Irish (1); French Acadian/Aboriginal (Micmac) (1); Aboriginal (1); Aboriginal (Dene) (1)</p> <p>Context: Canada</p>	Qualitative (interviews)	Fear or experience of discrimination; identity disclosure
8	Grigorovich (2015b)	<p>Number of participants = 16</p> <p>7 lesbians; 2 lesbians/queers; 1 lesbian/queer/dyke; 1 bisexual; 4 gays; 1 woman-loving-woman</p> <p>Age range 55–72</p> <p>12 identified as having a White European background; 1 participant identified as a woman of colour; 3 participants identified as Aboriginal</p> <p>Context: Canada</p>	Qualitative (interviews)	Fear or experience of discrimination; quality of care; support and community
9	Hoekstra-Pijpers (2022)	<p>No. of participants = 115 (survey); 10 (follow-up interviews)</p> <p>Age range 68–88 (interviews)</p> <p>3 lesbians; 2 bisexuals; 5 gays</p> <p>No race/ethnicity data available</p> <p>Context: Netherlands</p>	Quantitative and qualitative (survey and follow-up interviews)	Fear or experience of discrimination; identity disclosure; support and community
10	Stein et al. (2010)	<p>No. of participants = 16</p> <p>Age range = 60–84</p> <p>4 lesbian women, 12 gay men</p> <p>Age range 60–84</p> <p>14 participants were white; 2 were African American</p> <p>Context: USA</p>	Qualitative (focus groups)	Fear or experience of discrimination; identity disclosure; support and community

Table 1. (Cont.) Summary of articles included in the review.

No.	Author(s)	Sample summary	Research design	Themes
11	Waling et al. (2019)	<p>No. of participants = 33</p> <hr/> <p>19 lesbian women, 14 gay men</p> <hr/> <p>Age range 60–80</p> <hr/> <p>As mentioned in the “Discussion” section of the article (p. 1258): “Most participants were of Anglo-Celtic background”</p> <hr/> <p>Context: Australia</p>	Qualitative (interviews)	Fear or experience of discrimination; quality of care; support and community
12	Willis et al. (2018)	<p>No. of participants = 29</p> <hr/> <p>19 lesbian women (some also identified as gay); 9 gay men; 1 participant identified as a “cross-dressing” bisexual male</p> <hr/> <p>Age range 50–76</p> <hr/> <p>All participants were white (26 of British descent)</p> <hr/> <p>Context: Wales</p>	Qualitative (interviews)	Fear or experience of discrimination; meaning of home; support and community

Within this overarching theme, we further identified the following three subthemes, through which we structured the review in an attempt to illustrate a comprehensive picture of the elements making up the vision and experience of homecare emerging across the studies examined: disclosure of gender identity and sexual orientation, emerging meanings of LGBTI-competent care, and recommendations for improved quality of LGBTI-friendly services.

3.2.1. Disclosure of Gender Identity and Sexual Orientation

Deciding to reveal one’s gender identity and sexual orientation to care providers surfaces as a common and meaningful step along the experience of receiving homecare support as an LGBTI person.

For most LGBTI people, the choice of this type of disclosure is a dilemma faced constantly. Within the specific framework of accessing healthcare, the consequences associated with coming out are assessed against the risk that the revelation may result in the receiving of low-quality care or jeopardise the establishment of a relationship of openness and trust with the care worker.

Across the studies examined, the range of choices spanned from viewing disclosure as a useful or essential condition for care, or only necessary according to given circumstances and in case of medical relevance, to deciding to avoid it completely (Butler, 2017; Dunkle, 2018; Furlotte et al., 2016; Grigorovich, 2015a; Hoekstra-Pijpers, 2022; Willis et al., 2018).

Over 80% of respondents to a survey indicated revealing their identity to care workers, with the disclosure almost invariably enhancing the quality of their interaction (Hoekstra-Pijpers, 2022). For many users in another study, not being able to be out to providers meant a preference for not accessing the services (Dunkle, 2018). A male gay participant based his choice of coming out on his status as a survivor of the HIV/AIDS pandemic:

In my mid-30s I lost all of my friends to AIDS. Every. Last. One. Of. Them. And I had a large circle of friends. I think at this point, and pardon my language, I basically said fuck it. This is who I am. I'm a survivor. God knows why. And I'm gonna live a proud and open life. (Dunkle, 2018, p. 446)

In one study that included the disclosure experience of older lesbians, including lesbian couples, one partner in a couple summarised their decision to reveal their sexual orientation and relationship status by affirming the unwillingness to put up with intolerance: "I set boundaries, when they first come into the house or on the phone, saying up front that we were a lesbian couple and that we did not want anybody saying anything negative" (Butler, 2017, p. 387).

The middle option of disclosing one's identity if it came up or according to circumstances, often resided in the idea that one's sexual identity was not considered relevant for the caregiver-user rapport, and there was no need to make it known (Butler, 2017; Furlotte et al., 2016). In some cases, this position hinged on the participant's relationship status, with singlehood, though not unvaryingly, being a reason not to disclose one's identity (Butler, 2017; Grigorovich, 2015a).

The choice not to disclose sexual orientation involved having to "pass" and often consisted of deliberate actions of "straightening up" or "de-gaying" the home, by hiding clues that might give identity away, such as putting away items like books, DVDs, or Pride symbols (Butler, 2017; Furlotte et al., 2016; Willis et al., 2018).

Concealing or disclosing one's identity surfaced as a component of an "expenditure of energy" involved in navigating a heteronormative healthcare system, with the effort comprising in general having to keep a degree of alertness for slight or discrimination, to monitor and tame negative or uncomfortable reactions, as well as having to always teach or appease others (Furlotte et al., 2016; Grigorovich, 2015a). A participant stated:

You learn to bury your feelings and honour theirs in the hope that they'll meet you halfway. It becomes your job and yours alone to explain, ignore, to forgive over and over again....You're always the one who has to, you know, soften the corners, make things right. (Furlotte et al., 2016, p. 439)

Some have argued that the search for and implementation of common procedures in healthcare to facilitate the disclosure of gender identities and sexual orientations, could be guided by whether it provides users with a range of capabilities, in other words, enables or impedes their attainment of a wide-ranging health, including plain medical benefits, emotional health, and bodily autonomy (Toze et al., 2020).

3.2.2. Meanings of LGBTI-Competent Homecare

Overall, the emerging meaning of homecare that is congruent to LGBTI older people entailed the recognition of the needs arising from the vulnerabilities and challenges of belonging to a sexual minority.

In a study investigating the meanings attributed to home, rurality, and place among a group of older lesbian, gay, and bisexual participants, concerns were expressed at the possibility of receiving homecare support, particularly in relation to the unknown views and mindsets of the visiting care professional, with the home being considered as a safe and affirmative space where to be able to express their identities (Willis et al., 2018).

Described as being in line with principles of the feminist ethic of care, the following attributes were recognised as ensuring quality of care in a study conducted among a group of participants predominantly identifying as lesbian women: attentive and responsive, competent, and actively enabling comfort (Grigorovich, 2016). As voiced by both participants who received medical support, personal care and housekeeping assistance, attentive care meant that it was focused and tailored to their specific needs, it was carried out according to their requirements and preserved their autonomy by engaging them in the decision-making. The participants described receiving care as a vulnerable condition and considered the providers' responsiveness to their feedback and readiness to involve them in the direction of the care provision as mitigating their feelings of vulnerability.

Providing competent care bore a dual connotation. On one hand, care professionals needed to show knowledge, preparedness, and technical expertise in carrying out their job. On the other, they also needed to offer emotional and relational competence, which, given the isolation endured by many of the participants through ill health or disability, would also work as a form of social support. A 57-year-old participant stated:

Well to me, there's two kinds of homecare. There's the physical care that you get when you get the help in the shower, the laundry is done for you, the housecleaning. And the other type of care is how the caregiver relates to you as a human being, as a person, and how caring they are of you. Quality homecare is somebody I can get along with, who treats me as a "normal" human being, treats me with respect, treats me with understanding and caring. (Grigorovich, 2016, p. 112)

The experience of homecare required providers to guarantee users' comfort, while also showing their own in delivering assistance. The participants' description of comfort included being at ease with an outsider coming into their home and performing care but extended specifically to feeling safe amid fears of discrimination or mistreatment in relation to their sexuality. Not only did the participants want reassurance that the providers did not show ostensible homophobia, but they also wanted providers to withhold judgments about their identities, recognise the realities of their households, such as partnerships and family, and display sensitivity towards their history of oppression.

The need for building a reciprocal feeling of comfort between users and providers was similarly illustrated by participants in another study, conducted with older lesbian and gay couples who were asked to communicate their opinions about the prospect of utilising homecare services or entering a long-term care facility (Furlotte et al., 2016). Participants voiced their preference for providers who, besides not expressing prejudice, could also understand users' reservations about obtaining care from a non-LGBTI person and showed regard for their ways of life, while behaving toward them with a genuine approach that signalled acceptance inconspicuously. Among the participants' views in this study was also the articulation of a contrast between wanting to be cared for like any other user while in parallel being seen as a lesbian or gay person with distinctive needs, in search for what belied that uniqueness:

In some ways, I'm tempted to say that the answer is "no," that we don't need anything different. Except I think there is something wrong with a "no" because the context is different....There might be nuances that need smoothing or that they need to work on. (Furlotte et al., 2016, p. 440)

Qualities such as maturity, the ability to listen, dependability, and competence counted for the establishment of good relationships between care recipients and homecare workers in another study conducted with a group of lesbian women participants, some of whom also developed friendships with their care workers outside the professional connection (Butler, 2017, 2018). Some, but not all, members of the same cohort expressed the preference to be cared for by other lesbians (Butler, 2017), as did some women in another study, with one motivation being:

I'd like to have [younger] lesbians...just to know that the people who were caring for you, you had the same connection with them that we have with all our lesbian friends, you know, just that you don't have to explain yourself. (Willis et al., 2018, p. 913)

Overall, the data suggest that many of the features of homecare advocated by the participants align with attributes of homecare also wished for by non-LGBTI groups, namely qualities of a holistic, person-centred dimension of care that acknowledges the individuality, dignity, and autonomy of the older person, and that is also based on respect, trust, and communication (Högländer et al., 2019; Holmberg et al., 2012; Sundler et al., 2020). In addition, however, these studies jot a picture of an LGBTI-congruent care that guarantees equality through difference, by emphasising the necessity for the care to recognise the totality of the distinct lived realities of sexual minority older adults, including, for instance, the acknowledgement of their histories of social exclusion.

3.2.3. Recommendations for Improved Quality of LGBTI-Friendly Services

Common among the recommendations for the creation, or strengthening, of LGBTI-inclusive home support services, was the need to ensure adequate training for health workers and care providers.

In one study, participants voiced the need for improved training across all levels of healthcare, and the importance of service providers taking responsibility to educate themselves about the LGBTI community and acknowledge that users' past experiences of maltreatment result in loss of trust (Dunkle, 2018). Better education was regarded as a prerequisite for leadership in reaching LGBTI older people and creating welcoming environments, as expressed by a gay male participant:

I don't believe we should have to do all of the work. We've been talking about doctors here...all these highly educated people....I don't understand why they don't understand the umbrella is this big [extends arms wide] not this big [shortens arm extension]. (Dunkle, 2018, p. 448)

Training was considered essential considering the vulnerability that homecare entails and, as expressed throughout the studies, how traumatic it would be to experience homophobic attitudes or mistreatment. A lesbian female participant expressed this necessity:

They have to be educated to come into a lesbian home and feel comfortable. These people that come into your home must be educated in diversity. I would call ahead and ask and if they are not open to serving the lesbian community, I'd say no thank you. (Dunkle, 2018, p. 448)

The adoption of adequate language and terminology that, for instance, did not assume heterosexuality and acknowledged non-traditional support circles surfaced as a relevant facilitator for the attainment of a quality of care that is comfortable for both caregivers and homecare recipients (Grigorovich, 2016; Hoekstra-Pijpers, 2022). Thirty-eight percent of respondents to a survey conducted in the most recent of the studies thought that the language employed to address them, or the questions they were posed by the caregivers, did not adequately apply to their circumstances. Among them, more than half envisaged being more receptive if the care workers used wordings that were more neutral (Hoekstra-Pijpers, 2022). Within the context of language and terminology employed, participants also lamented the lack of diversity and inclusivity in forms and documents, such as the absence of options to indicate sexual orientations or mentions of partners other than legal spouses (Dunkle, 2018).

Other suggestions centred around strategies for care providers to signal the inclusivity of their services, through the increase of visibility and representation, which was also seen as a way to reach people not open about their sexuality (Dunkle, 2018). These included, for instance, the establishment of a reliable resource centre dedicated to LGBTI ageing, lists of LGBTI-friendly providers and services available, or the use of Pride symbols, such as rainbow flags and stickers, or images of non-heterosexual couples on services brochures and advertisements (Boggs et al., 2017; Dunkle, 2018). A female lesbian participant stated: “If I were sitting in a waiting room and filling out a form that acknowledged me, and seeing a reflection on the wall of our senior community, [it] makes a difference—creates a welcoming environment” (Dunkle, 2018, p. 449).

Finally, another common experience described by ageing LGBTI participants across several of the studies examined was the need to specifically connect with, or receive support from, other older LGBTI people and have access to safe environments and neighbourhood or other community activities (Boggs et al., 2017; Furlotte et al., 2016; Hoekstra-Pijpers, 2022; Waling et al., 2019; Willis et al., 2018). A sense of belonging to community is of significance to older people’s experience of identity and lifestyle (Phillipson, 2007). Sexual minority groups are more likely to live on their own and to have friends at the core of their social and support circles (Brennan-Ing et al., 2014). In one study, not being able to consistently rely on family or friends for help was described as a factor impacting the choice to access or the circumstances of complementing homecare support (Grigorovich, 2015b).

A female lesbian participant from one of the studies expressed how mutual support among the gay community resided in an exercised habit of having to rely on each other to build strength in the face of adversity: “Historically we’ve all taken care of ourselves, going back even to pre-AIDS. It’s always been us that’s taking care of us” (Dunkle, 2018, p. 449). Participation in LGBTI community events and activities, however, was not experienced homogeneously. In the most recent of the studies examined (Hoekstra-Pijpers, 2022), around 75% of survey respondents (especially those open about their sexuality) participated in community activities. Among those who did not, meeting too few people their contemporaries, and fear of ageist attitudes were the motivations for not attending for 40% and 20% of them respectively. Participants in another study showed ambivalence about how welcome they felt in their community, with some expressing they did not feel at ease either with younger members of the community or with their heterosexual peers (Boggs et al., 2017).

4. Conclusions

The purpose of this review was to identify in the available literature aspects of homecare salient to the views, perceptions, and experiences of older LGBTI adults.

Overall, the outcome of our analysis points to converging narratives of perceived or endured inequalities vis a vis the position of this group's sexual identities and orientations within a largely heteronormative social care system. While not all study participants' views and experiences of homecare examined in this review were negative, as observed elsewhere (Smith & Wright, 2021), the predominant theme among them was a lingering fear associated with risks of homophobia, discrimination, and intolerance that would compromise the preservation of their identity as well as the quality of care received.

Our findings comprise descriptions of identity disclosure dilemmas, states of vigilance in anticipation of slight or mistreatment, language and communication inadequacies, as well as calls for an inclusive care environment and connection to a supportive community. Taken altogether, these accounts outline receiving home support as a complex and not always unproblematic dimension with potentially non-negligible effects on this population's course of health. The cultural distress paradigm proposes that the delivery of care that is not congruent to patients' unique perception of what the obtained care should entail elicits a detrimental response with physiological and behavioural manifestations (also related to the experience of an imbalanced power dynamics in the patient-provider rapport), that may aggravate illness, impede healing, compromise access to and utilisation of health services, and cause allostatic load (DeWilde & Burton, 2017). According to this model, therefore, to avoid any of these damaging consequences, it is necessary within the context of LGBTI-specific health and social care to take into consideration this group's own accounts of what constitutes a regimen of care that fits their requirements.

The meaning of what constitutes LGBTI-congruent care emerging from our analysis of the existing literature comprises properties of person-centred care that align with experiences observed in the non-LGBTI population. These include the safeguarding of an older person's dignity, autonomy, and independence, and the establishment of a rapport of trust, respect, and good communication with the caregiver (Hoeglander et al., 2019; Holmberg et al., 2012; Sundler et al., 2020). However, what transpires as specific to the sexual minority experience among the narratives examined is an aspiration for the attainment of a delicate balance between being treated as everyone else and being recognised as individuals with a distinctive set of requirements that includes knowledge and consideration of their histories of invisibility and inequality. The experiences described in the studies reviewed point to the vital need for better training for healthcare workers, and to the necessity for shifts in organisational culture among homecare providers towards inclusion and diversity. A recent integrative review of research on healthcare workers' perceptions of sexual minority adults has found that 70% of participants in the studies examined expressed feelings of unpreparedness to care for this population and demands for better training (May & Crist, 2023). An evolving discourse in health and social care education is suggesting a need to move beyond cultural competence and toward the attainment of "cultural humility." Some of the motivations for advocating such a shift are premised on the view of cultural competence as primarily "content-oriented" and focused on advancing a carer's knowledge, self-confidence, and efficacy when interacting with diverse groups of care recipients (Lekas et al., 2020). This approach poses the risk of operating with a meaning of culture that is stagnant, places the authority of its definition on the providers, and assumes a series of fixed perceptions shared by a

given social group, potentially generating stereotypes and disregarding issues of intersectionality. By contrast, cultural humility is considered “process-oriented” and based on a care provider’s self-reflexivity and willingness to create a provider–recipient rapport that is power-balanced, an enduring commitment to learning, and respect for care recipients’ own expertise of their cultural and social circumstances (Lekas et al., 2020).

Improving health prevention for any given vulnerable group involves not regarding it as a homogenous entity, but accumulating diverse knowledge of their specific health needs. Studies in geographical gerontology underline the value for health professionals in granting places of care, including homes, similar diversified attention. A home should not be considered as a mere “container,” but as a multi-faceted and evolving, social process, inseparable from how it is understood and experienced by its occupiers, and from a variety of contexts, including a historical one (Wiles, 2005). Older LGBTI people’s sexualities are inherently linked to their homes, which they can edify as safe spaces (Gorman-Murray et al., 2022). By way of an example, a study conducted with older gay men living in London showed how participants can display their identities through materialities that in subtle, or more overt ways, reflect how they see themselves and would like to be seen and can work to queer heteronormativity and challenge oppression (Pilkey, 2014). The narratives from our analysis suggest a similar ambition for the safeguarding of this nuanced dimension and a desire for equality.

This review presents several limitations. The small number of studies recovered through our search reveals a scarcity of research in this field, but at the same time undermines the breadth and soundness of the interpretations and conclusions derived. Another limitation of our study is the absence of a formal appraisal of the quality of the studies examined, which affects the significance and applicability of the findings (Brien et al., 2010; Grant & Booth, 2009). Furthermore, our findings are relative to groups that are in large part white, Western, and English-speaking. The experiences of homecare discussed, therefore, are representative of a homogenous section of the population and do not reflect those of other racial and ethnic minorities, or other groups vulnerable to prejudice or intolerance, which may be dissimilar. They also do not reflect the realities of older people living in national contexts with limited or absent rights for LGBTI individuals, for whom access to, and experience of, health and social care services may be significantly compromised. An important limitation of this study is that it does not include homecare experiences of transgender and intersex individuals, who, we acknowledge, present unique health and social care needs that are distinct from those of cis members of the LGBTI community. It would be important if future studies in this field could shed light on how the groups not represented in this review experience homecare.

Despite the limitations listed above, our work has the potential to contribute to promoting awareness about the need to envision a more holistic and inclusive quality of health and social care for LGBTI older adults and to prevent inequalities.

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Conflict of Interests

The authors declare no conflict of interest.

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Anthony Staines started as a neonatal paediatrician and then moved into public health and academic epidemiology. After an MSc in epidemiology at the London School and a PhD in spatial epidemiology in Leeds, he worked at Imperial with SAHSU. Anthony moved back to Dublin in 1997 to University College Dublin and set about developing research activity in public health. He moved to Dublin City University as first chair of Health Systems in 2007. He is the Deputy Director of the Centre for Integrated Care. His main focus is on the uses of health information systems.



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James O'Hagan is a podcaster, writer, and activist passionate about giving voice to marginalised communities and exploring intersectional identities. He has recently been writing about fatness, fat acceptance, and anti-fat bias, and his work as an LGBTQI+ activist with LGBT Ireland, the national support service for LGBTQI+ people in Ireland, focuses on ensuring older members of the LGBTQ+ community are supported and enabled to flourish and enjoy inclusive, healthy and fulfilling lives as part of their communities.



Sean Vail grew up in the heyday of LGBT+ culture, born in 1959 on the Canadian/American border. From Dallas to Hollywood and LA to Boston, America was the place to be gay in the 70s and 80s. Sean moved to Bantry, West Cork in 1991 to join his family businesses. Moving to Bantry was like going back to 1950 America where tolerance and acceptance of LGBT+ people hadn't developed yet. Now retired from physical therapy, Sean focuses much of his time on psychosocial issues within marginalised communities and continues to develop opportunities for the over-60s rural LGBT+ population.