Older LGBT people's experiences and concerns with healthcare professionals and services in Ireland

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Abstract

Background. The specific healthcare needs and concerns for older lesbian, gay, bisexual and transgender (LGBT) persons have not been explored to any degree within Ireland.

Aims and objectives. The aim of this paper, which is part of a larger study, is to detail older LGBT persons' usage, experiences and concerns with accessing healthcare services, disclosing their LGBT identity to professionals, preferences for care and their suggestions for improvement in services, including nursing services.

Design. A mixed methods research design combining quantitative survey and qualitative interview approaches of equal significance was used.

Methods. 144 respondents completed an 84-item questionnaire concerning their use of healthcare services, experiences and needs. The qualitative phase involved in-depth interviews where 36 participants' experiences and concerns around health services were explored more in-depth. Quantitative data were analysed using descriptive statistics. Qualitative analysis employed the constant comparative process to generate the leading themes.

Results. Only one in three participants believed that healthcare professionals have sufficient knowledge of LGBT issues, and less than half (43%) felt respected as an LGBT person by healthcare professionals. Although 26% had chosen not to reveal their LGBT status for fear of a negative response, many positive encounters of coming out to healthcare professionals were relayed in the interviews. LGBT persons have specific concerns around residential care, particularly in relation to the perception that the Irish healthcare services emanate a heteronormative culture.

Conclusions. Irish healthcare services need to reflect on how they currently engage with older LGBT persons at both an organisational and practitioner level. Consideration needs to be given to the specific concerns of ageing LGBT persons, particularly in relation to long-term residential care.

Implications for practice. Healthcare practitioners need to be knowledgeable of, and sensitive to, LGBT issues.

Key words: bisexual, gay, health care, lesbian, long-term care, mixed methods, transgender

Introduction

The importance of the expression of sexuality for people throughout the lifespan has been highlighted by authors (McAuliffe *et al.*, 2007; Nay *et al.*, 2007). However, the sexuality of older people is often ignored, overlooked or assumed to not exist (Nay *et al.*, 2007). Minority sexual orientations or gender identities, such as Lesbian, Gay, Bisexual or Transgender (LGBT), are even more overlooked with a 'notable absence of research and literature dealing with older people and non-heterosexuality' (Bauer *et al.*, 2007: 65), as most of the early research within the LG community focussed on the younger LG age group. In addition, many nursing and social care textbooks on older people fail to acknowledge the need to consider sensitive, safe and inclusive practice for LGBT people.

Healthcare services, including nursing and older people's services, have been accused of mirroring the heteronormative and ageist assumptions of society by failing to recognize LGBT identities (Eliason *et al.*, 2010; Lim & Levitt, 2011) and, more

specifically, the needs of older LGBT people (Bayliss, 2000; Hughes, 2008). Indeed, commentators within Ireland have noted that the health needs of older LGBT people have been overlooked or evenignored (Denyer *et al.*,2009). While it has been argued that healthcare professionals, including nurses, are in an ideal position to engage in conversations with older people about their sexuality, needs and concerns (McAuliffe *et al.*, 2007), international research into LGBT people's experiences of healthcare services suggest that although some advances have been made, discriminatory practices continue to exist. While some participants in various studies identify sensitive and inclusive practices, many report experiencing insensitivity, prejudice and discriminatory practices from staff, including nursing staff working in older age services (D'Augelli & Grossman, 2001; King *et al.*, 2003; Hughes, 2007; Barrett, 2008). This may be evident explicitly or implicitly through nurses' and other practitioners' heteronormative assumptions, which assumes that heterosexuality is the only sexual orientation (D'Augelli & Grossman, 2001; Knauer, 2009; Fish & Bewley, 2010). Some of the negative reactions reported by LG people include: embarrassment, rejection, hostility, suspicion, pity, condescension, ostracism, avoidance of physical contact or refusal of treatment (Butler, 2004; Johnson *et al.*, 2005; Hughes, 2007; Barrett, 2008; Hughes *et al.*, 2011). Older bisexual and transgender people are rendered even more invisible, with limited literature on their specific ageing needs and concerns (Grant *et al.*, 2010). What is available suggests that older transgender people have anxiety and fear that services will be unresponsive to or ignore of their needs (Berreth, 2003; Shipherd *et al.*, 2010). The idea of 'incon- gruent bodies' can lead to health practitioners being wary, feeling uncomfortable or even hostile towards transgender people in their care (Berreth, 2003; Shipherd *et al.*, 2010).

Some writers suggest that anticipated fear of discrimina- tion may lead to mistrust and

the poor uptake of healthcare services and thus impact upon the quality of life of older LGBT people (McFarland & Sanders, 2003; Shankle *et al.*, 2003; Jackson *et al.*, 2008). This is especially worrying in the light of the fact that recent research has shown relatively high levels of poor health among LGB older adults, including diabetes and depression (Frediksen-Goldsen *et al.*, 2012), as well as high incidence of mental health issues for older LGBT people (McCann *et al.*, 2013).

Within Ireland, the current generation of older LGBT people grew up in a strongly conservative culture in which issues around sex and sexuality, even 'normative heterosex- uality', were considered off-limits for discussion, brushed aside and hidden (Higgins *et al.*, 2009). In addition, it was a time when sexual orientations other than heterosexuality were pathologised, stigmatised and criminalised (Higgins *et al.*, 2009). Indeed, homosexual acts between consenting male adults of 17 years or more were only decriminalised in Ireland in 1993. Today, even in the face of what appears to be positive advances towards equality for LGBT people in Ireland, with the passing of the Civil Partnership Act allowing same-sex couples to have their partnerships legally recognised (Ireland Department of Justice Equality & Law Reform, 2009), the everyday acceptance of LGBT people may continue to have shortcomings. Irish research highlights that LGBT people of all age groups are still subjected to ongoing prejudice and discrimination in all areas of life (Equality Authority, 2002; Layte *et al.*, 2006; Norman *et al.*, 2006; Gibbons *et al.*, 2007; Mayock *et al.*, 2009). Support for older LGBT people has been identified as one of the top 10 priorities for the Irish LGBT community (Denyer *et al.*, 2009). This paper reports on findings from a larger study conducted with older LGBT people in Ireland (Higgins *et al.*, 2011). Findings presented here specifically relate to the sample's experiences and concerns with accessing healthcare services,

disclosing LGBT identity and preferences for care and service provision as they age.

Method

Aim

The overall aim of the study (Higgins *et al.*, 2011) was to examine the lives and needs of LGBT people aged 55 and over living in Ireland in order to make policy, service and practice recommendations that address positive ageing and the full participation and inclusion of older LGBT people in Ireland. The specific aim of this paper is to detail older LGBT persons' usage, experiences and concerns with accessing healthcare services, disclosing their LGBT identity to profes- sionals, preferences for care and their suggestions for improvement in services, including nursing services. While people over 55 years of age may not identify as 'older', this term has been used throughout the paper for the ease of reporting.

Design

A mixed methods research study was conducted involving a survey and in-depth interviews with a sample of LGBT people over 55 years of age living in Ireland.

Data collection instruments

Surveys have advantages over other methods of data collection in that they are inexpensive, easily administered and do not require as much effort as in-depth individual interviews. The survey method is particularly appropriate in obtaining data from potential participants located within a wide geographical area and from those who may wish to remain completely anonymous to researchers. In an attempt to reach as many people as possible and to achieve a high response rate, an 84-item

survey was developed. It could be completed online, via post or email, or by telephone.

The research team and research advisory group considered a number survey tools when developing the survey. Some questions were adapted from existing instruments used in research on LGBT issues and others were designed by the research team in conjunction with the research advisory group. The full survey is available for use with permission from the research team (Higgins *et al.*, 2011).

Content validity of the survey was assessed by a research advisory group, comprised of people from voluntary bodies and state agencies who had expertise on LGBT issues, older LGBT issues and older people's issues. The survey was piloted with nine LGBT people aged over 55 who lived in Ireland to test for face validity. Overall, their feedback was very positive, and only minor changes were made to the draft following their comments. Questions on participants' use of various healthcare services, their openness to nurses and other practitioners about their LGBT identity and their preference for health care, which are the focus of this paper, were addressed through a number of five-point Likert scale-type questions. Participants were also asked through two open-ended questions what they felt LGBT and older people's organisations could do to make life better for older LGBT people within Ireland.

The interviews allowed for a more, in-depth exploration of participants' experiences as an older LGBT person within Ireland. Due to time constraints, data collection for the surveys and interviews were conducted simultaneously; consequently, the interview schedule was developed indepen- dently of survey findings. However, the open-ended questions asked within the interviews did reflect issues addressed within the survey on participants' health and their engagement with healthcare services and professionals, including services accessed, experiences, concerns and recommendations for improvement.

Recruitment and data collection

To participate in the study, a person needed to be over 55 years of age, living in the Republic of Ireland and identify as LGBT. Assuming that approximately 10% of the 55 and over population of 874 891 within Ireland is LGBT, this leaves a study population of 87 498 (Government of Ireland, 2007a). From the outset, the study team anticipated chal- lenges in recruiting an adequate number of participants in the light of the low response rate (5%; n = 58) from older LGBT people (50+) in an Irish study (Mayock *et al.*, 2009). Furthermore, the researchers were conscious of the number of authors who highlighted the inherent difficulties in accessing this population due to the invisibility of LGBT identities in society and LGBT people's fears of discrimination should they disclose their LGBT identity (McFarland & Sanders, 2003; Shankle *et al.*, 2003; Grossman & Hollib- augh, 2008). In rural communities in Ireland, LGBT people over 55 years of age may be invisible to LGBT organisations having chosen to remain silent about their LGBT identity as a self-preservation mechanism (Health Service Executive, 2009). In order to maximise the number of people who were informed of the study, convenience sampling was used to increase the response rate of hard-to-reach populations (D'Augelli & Grossman, 2001; Hughes, 2009). In addition, a multipronged recruitment approach was employed. The study was advertised in a variety of ways, including older people and LGBT websites, print media and national events. The survey was available to complete either online, via post or email, or over the telephone. At the end of the survey, each participant was asked if they would be interested in partic- ipating in an interview. If they were, they were asked to send in their information separately and they were then contacted by a researcher to arrange the interview. All participants who volunteered to participate in an interview by the cut-off date were contacted in order to arrange an interview. All interviews were audio recorded

and most lasted 60–90 minutes.

Ethical considerations

Ethical approval to conduct the study was received from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. To protect the confidentiality of participants, all electronic data files were password protected and stored in accordance with national data protection acts. All hard copy data were stored in locked cabinets within the researchers' office.

Data analyses

Survey and interview data were analysed independently of each other. Quantitative survey data were analysed by two members of the research team primarily using descriptive statistics generated from PASW version 18.0 (SPSS Inc. Chicago, Illinois, USA). Cross-tabulations were generated to examine patterns in responses between different groups of respondents (e.g. lesbian, gay, bisexual, transgender); however, as response groups were so small, no statistically significant findings were identified. The textual survey data were entered into a Microsoft Excel spreadsheet and thematically analysed by two members of the research team.

All interview recordings were transcribed verbatim and entered into NVivo version 8 (QSR International Pty Ltd. Cheshire, United Kingdom). Following open coding of the first four interviews by two members of the research team, a coding guide was developed inductively from the data, while keeping in mind the overall aims of the research. The coding framework was then used by the two researchers to code the remaining transcripts. While the coding framework provided some structure and rigour to the analytical process, it was sufficiently flexible to enable any new concepts and codes to be incorporated into the analytical process. Following the initial phase

of coding, both researchers used the constant comparative process to compare and collapse codes into higher order themes or categories.

Triangulation across data collection methods (survey and interviews) was used to cross-check and affirm the reliability of the data. In addition, the use of two researchers to analyse the qualitative data helped to enhance credibility and trustworthiness of the study.

Participants

In total, 144 people completed the survey (78% responded online; 21% through post; and <1% through email) and 36 people participated in the interviews.

Results

Use of health services

Almost 90% of the survey sample was using at least one of the health services listed (see Table 2). The greatest numbers were seeing a General Practitioner (GP) (87%), dentist (64%) and a medical specialist or consultant (43%). Smaller proportions were using sexual health services (9%) and psychological or counselling services (6%). The proportion- ally high use of medical specialists or consultants (43%) was not surprising as just under half of the survey participants (47%; n = 64) reported that they had a physical health condition. Of the 64 participants who responded to the question on medication, over three quarters (77%; n = 49) were on medication for their physical health condition. Many of the health problems reported reflected the age profile of the participants.

Experiences of healthcare provision and interaction with professionals including nurses

The survey had mixed findings, with less than half of the sample (43%; n = 51)

reporting that they felt respected as an LGBT person by health professionals. Table 3 provides further details on the sample's views on healthcare profes- sionals. Similarly, within the interviews, there were mixed views about experiences. Several participants discussed positive stories of 'coming out' as an LGBT person to healthcare practitioners and positive experiences of health- care providers' attitudes to their same-sex partner which suggests that the attitudes and reactions of nurses and other healthcare professionals towards LGBT people may be changing:

> It [sexual orientation] wasn't an issue. I didn't feel it made any difference to her [GP]. (lesbian female, 58 years of age)
>
> I've been seeing the consultant every 6 weeks since I had this [names medical condition] and [names partner] comes in with me and she accepts that completely. That's not a problem. He's my partner and that's that. No problem. (gay male, 66 years of age).

However, almost one in four survey participants (23%) reported that they had received poor quality of treatment when using healthcare services in Ireland and, of those, more than half (54%; n = 16) considered their negative experience to be related to being LGBT. Within the interviews, a number of participants spoke of negative or inappropriate interac- tions with a variety of healthcare practitioners, including nurses:.

> [Names partner] had to have [names major surgery] about a year ago. I went in with her and then when I went back afterwards, the nurse said, 'Who are you with?' and I said her name and she said, 'Do you want to wait here?' and I said, 'No, I want to sit by her bed. I'm her partner,' and the nurse visibly got a shock that I was so open with it, but I thought: 'I'm not going to pretend.' (lesbian female, 58 years

of age)

Concerns about coming out to healthcare providers

Revealing oneself as an LGBT person is rarely easy and involves an appraisal of potential reactions, support avail- able, trust, power relationships, confidentiality and attitudes of nurses and other healthcare professionals (Gibbons *et al.*, 2007). Within the surveys, it was found that while 61% (*n* = 61) were out to either some or all of their healthcare providers, 26% (*n* = 30) were not out to any of their healthcare providers. While 44% (*n* = 56) were of the view that it was not necessary for health professionals to know about their LGBT identity, over 20% (*n* = 28) reported that they would not reveal their LGBT identity to a healthcare professional for fear of a negative reaction (see Table 3). This fear of disclosure was reiterated within the interviews:

All the doctors I had in [capital city in another country] were gay .. . This doctor I have now [in Ireland] .. . I don't know what would happen if I ever picked up an STD? I would die having to tell the doctor. I don't know what I'd do. So I wouldn't feel comfortable here [Ireland] at all. (gay male, 60 years of age)

No, I wouldn't [tell the GP about being a lesbian]. It's a lady doctor, but I wouldn't tell her because … I don't think I'd be able to tell her. I just couldn't. I don't think she would understand. (lesbian female, 59 years of age)

Concerns about nurses and other healthcare practitioners' knowledge base

While most of the survey and interview participants did not report experiencing discrimination because of their LGBT identity, the majority believed that healthcare staff was not knowledgeable about LGBT issues. Within the survey, just 41% (*n* = 33) agreed that healthcare professionals have sufficient knowledge about LGBT issues (see Table

3). The presumption of heterosexuality and the use of heterosexist language by health practitioners were viewed as reinforcing the invisibility of LGBT people, making it difficult for people to come out for fear of stigmatisation and discrimination. In addition, participants suggested that not only did healthcare staff consider all older people as asexual but also they were not well informed on LGBT sexuality and identity:

If the health service is not homophobic, I would think a very large percentage of the workers are not particularly well-informed or intuitive about gay ageing people's rights. (gay male, 59 years of age)

In particular, interview participants spoke of an acute lack of knowledge among nurses and healthcare practitioners when they came into contact with people who were transitioning genders:.

One of the big issues is they [practitioners] don't know the issues, can't deal with them, have never been trained to deal with them .. . So there is a massive gap. (bisexual transgender female, 62 years of age)

Concerns about accessing residential care

Not surprisingly, survey and interview participants expressed a strong preference for living in their own home as they aged (M = 6.5, SD = 1.4), followed by living in a house with other LGBT people (M = 4.5, SD = 1.8). The least preferred option was to live in a nursing home (M = 1.9, SD = 1.3), with many expressing concerns around needing to move to residential care facilities. Survey participants feared that should they require residential care they might be forced *'back into the closet'* or finding themselves 'entrapped in a heterosexual world' where their 'sexuality [would] not be taken seriously or respected'. Interview participants expressed similar concerns:

Your sexual orientation wouldn't be accepted and recognised [within a nursing home]. (lesbian female, 55 years of age)

For a small number of interview participants who were in same-sex relationships, there was a real concern that their same-sex partners would be rejected and that the role of their partner, in respect to their care, would not be recognised. For the transgender participants, the fear of loss of self was palpable as participants spoke of fearing that they 'may not be able to fully express [the] self.. .as a transgendered person' and not be able to 'live as the person I am'. One survey participant wrote of being 'unsure how I will continue to cross-dress when my freedom and mobility decrease'.

On the other hand, a few participants worried that their decision to 'remain in the closet' would not be protected as they aged. One survey participant described his 'fear of being discovered after a lifetime of being in the closet, as people would not understand or forgive what they would perceive as betrayal'. This fear was also expressed by one of the interview participants who spoke of destroying, in the recent past, some of his short story writings that referred to gay issues for fear that on his death his family might discover them, put 'two and two together' and be 'landed with his legacy' *(gay male, 70 years of age).*

Similar to other older people in Irish society (Treacy *et al.* 2005), the participants in this study also worried about loneliness and isolation. Just over 30% (n = 38) of the survey participants agreed or strongly agreed with the statement that 'I feel more lonely as I am getting older'. Loneliness was a particular concern for interview participants who lived in rural areas or for those who had not come out or were not connected into the LGBT community. A number of partic- ipants spoke of their fears of being alone within residential

care with no external person to visit them:

.. …….Being alone in a nursing home and not being visited and that kind of thing, I think who would visit me? .. . It is a concern. (lesbian female, 58 years of age)

Recommendations for staff and service development

Both survey and interview participants were asked to provide recommendations for healthcare services to better support older LGBT people. They highlighted several major priority areas for development within older age services. They recommended that nurses and other healthcare practitioners, 'be consciously aware that the person they are talking to may not be heterosexual' (*survey participant*) and not 'assume that if people are married and have children they are heterosexual' *(survey participant).* It was considered of great importance that staff should consciously 'acknowledge the rights and existence of same-sex partners in decision-making and caring processes' *(survey participant).* In addition, participants highlighted the importance of promoting and advertising residential services that were LGBT-friendly.

Participants felt that education for nursing and other staff was essential and that managers should ensure that staff had the necessary knowledge and skills to provide an inclusive and sensitive service. In addition, several of the lesbian female interview participants expressed a preference to have female or lesbian healthcare provider and emphasised the need for real choice within the services, while a small number of gay men identified the need for more gay doctors as they felt that they would be less embarrassed talking about issues and that they would not have to engage in detailed explanations.

The lack of services, including counselling, medical care and information on

transgender issues, was viewed as a major priority for those who were confronting gender identity issues:.

There's no help, especially when you live in the back of the beyond. There's no one going to come and tell you about it. You just have to go and find out for yourself but where do you go? There are no services.. . (lesbian transgender female, 55 years of age)

Discussion

Older lesbian, gay, bisexual and transgender people in Ireland have grown up, lived through and survived the criminalisation and pathologisation of their identity. Considering this context, it is hardly surprising that a percentage of the participants (26%) in this study had not revealed their LGBT identity to their healthcare practitioners and will continue to hide their LGBT identity for fear of discrimination or anti-LGBT bias. Interestingly, this proportion of participants who were not out as LGBT to their healthcare provider (26%) is relatively similar to the 21% of older LGBT adults in a USA study (Fredriksen- Goldsen *et al.*, 2011). The decision not to come out can have consequences for the type and quality of healthcare received or may lead to the mistaken assumption among nurses and other healthcare professionals that LGBT people do not use existing services. Future research should explore how healthcare practitioners view their own practice with LGBT people, the challenges and the ways in which they believe it can be improved.

Despite the vast majority of participants indicating that they are engaging with healthcare services for a variety of health conditions and not experiencing discrimination, some interview participants painted a picture of health services that are not responsive or sensitive to the specific needs of LGBT people (Jackson *et al.*,

2008). Nurses therefore need to be aware of the historical context of older LGBT people's lives and the fears that their life history may engender. Knowing about life circumstances may help nurses to be sensitive to older LGBT anxieties and more conscious of the need to create a safe and supportive care context where LGBT people can be open about their LGBT identity. Nurses also need to review nursing documentation history-taking questions, information leaflets and language to ensure that their interactions do not reinforce heterosexual assumptions and are inclusive of LGBT people and their families.

Not surprisingly, similar to other studies involving non- LGBT older people (O'Hanlon *et al.*, 2005; Croucher, 2008) and LGBT people (Neville & Henrickson, 2010), the survey participants' most preferred option older age accommodation in this study was to live in their own homes. The least preferred option was to live in a nursing home. However, if the participants had to live in a nursing home, in keeping with other studies (Jones & Nystrom, 2002; Orel, 2004; Hash & Netting, 2007), participants expressed a preference to live in an exclusively LGBT residential care facility, which would be sensitive to their needs. While none of the participants were currently living on old-age residential services, they had significant anticipated fears pertaining to a perception that some nurses and healthcare practitioners viewed older people as asexual, lacked knowledge of LGBT issues and held anti- LGBT biases. For a small number of interview participants who were in same-sex relationships, there was a real concern that their partner would be rejected and that the role of their partner in respect to their care would not be recognised. Older transgender people also expressed anxiety, fear and resentment about the lack of knowledge among healthcare staff and lack of services that are responsive to their needs. Consequently, there is an urgent need for what Lim and Levitt (2011: 11) call

‘scholarly discourse’ within the nursing curriculum on the needs of older LGBT people, with specific emphasis on transgender people. Professional bodies with responsibility for guiding and accrediting education curricula for nurses have an important role to play in promoting the needs of older LGBT people and should include older LGBT issues as one of their criteria for accreditation. In addition, nursing organisations and groups need to respond to Keepnews’ (2011) call to support public policy proposals that promote LGBT health and reduce health disparities for this group of people.

Hinrichs and Vacha-Hasse (2010: 786) state that: ‘LTC (long-term care) facilities need to be updated to include gay affirmative practices. Although long-term care facilities are often well equipped to care for a resident’s medical and health-related needs, needs of intimacy or sexuality may be virtually ignored regardless of sexual orientation’. Phillips and Marks (2008), in their analysis of advertising brochures for older age care facilities in Australia, highlighted how the dominance of the ‘heterosexual norm’, which fail to recognise or value difference, marginalises the identities of LGBT people and operates as ‘silencing mechanisms’, thus exacer- bating social exclusion. Nurses working in older age services, and particularly residential service, are in an ideal position to review service philosophy, mission statements and policies to ensure that they are inclusive of LGBT people and that imagery and publicity material used within services presents positive imagery and helps increase the visibility of older LGBT people. Organisations with responsibility for setting and monitoring standards for residential services need to include older LGBT issues as one of their criteria for approval.

While research involving older people indicates that regardless of sexual orientation or gender identity, many experience loneliness and isolation and fear isolation as they age

(Victor *et al.*, 2000; Morgan *et al.*, 2008) and the risks for older LGBT people are increased for a number of reasons. Existing research affirms the view that older LGBT people have significantly less traditional forms of support when compared to the heterosexual older population. They are more likely to live alone, be non-partnered, not have children and lack a family member to call on in a time of need (Brookdale Center on Aging of Hunter College & Senior Action in a Gay Environment, 1999). This was also true for the participants in this study. The proportion of survey participants who were single (43%) was much greater than the 15% reported for the entire population over 55 years in Ireland in the 2006 Census (Government of Ireland, 2007b). Although not directly comparable, the high rate of solitary living (46%) contrasts sharply with the 29% of over 65-year- old people who reported living alone in the 2006 Irish Census (Government of Ireland, 2007b). In view of this, nurses need to be conscious of the potential for isolation and loneliness among this group and make every effort to assist the person to build networks with the community, including the LGBT community.

Limitations

While this study highlights important results from both the surveys and interviews, the findings must be considered in the light of the following limitations. Although the sample could be considered an informed group as a high number reported using healthcare services and were therefore in a position to comment on experiences of discrimination, the survey sample size of 144 only reaches a 95% confidence level with a

+/—9% confidence interval. Certain groups are under-repre- sented including women; people over 70; bisexual and transgender people; and people living in nursing home/

residential care. Future research should continue to explore the best methods for recruiting larger and more diverse samples of LGBT people over 55 years of age. Furthermore, people self-selected to participate in the study and self- identified as LGBT; in other words, they actively volunteered to participate in the research which might bias the results towards people who are more secure in their LGBT identity. It must also be acknowledged that the recruitment strategy may have resulted in people with reading difficulties and people not familiar with technology being unable to participate.

Conclusion

Internationally, there is an agreement that older LGBT people are a 'doubly invisible group'; hence, research that has specifically addressed their lives, needs and aspirations is sparse. Although older LGBT people are not a homogeneous group, using mixed methods, this study contributes empirical evidence on the fears and challenges faced by older LGBT people in relation to healthcare delivery, and in particular, the anticipated fears they have regarding residential care. These findings highlight the need for a comprehensive approach that incorporates the inclusion of LGBT issues in education for nurses and other practitioners, as well as a review of policy, practice and information materials. Without this, there is a real risk that this group of people, who have historically experienced discrimination, will face further discrimination as they enter older age.

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Conflicts of interest

No conflict of interest has been declared by the authors.

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