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Part B. Care of older LGBTI people

General principles

- The historical pathologising of older lesbian, gay, bisexual, transgender and intersex (LGBTI) people's bodies and relationships continues to adversely affect their health and wellbeing.
- Older LGBTI people may hide their sexual orientation, gender identity or intersex status until they know they are safe; open disclosure to GPs improves health screening, targeted health promotion and therefore health and wellbeing.
- Abuse and violence among LGBTI people may be perpetrated by intimate partners, family, community members or aged care service providers.
- Mental health concerns, particularly depression and anxiety, arise from experiences of discrimination and minority stress.
- There are harmful levels of alcohol use among lesbian and bisexual women, and smoking and drug use among LGBT people.
- Social isolation and loneliness may result from being estranged from families of origin, and LGBTI communities and friends may be regarded as family.
- LGBTI people living with dementia may lose capacity for independent decision making and be vulnerable to LGBTI-phobic family members and service providers.
- Older transgender and gender-diverse people have had limited support and resources to affirm their gender. They often experience higher levels of discrimination and a greater number and severity of health issues.
- Many people with intersex variations have been stigmatised because of their bodily differences, and can have a number of health issues that relate to the variation or treatment they had in the past, and a distrust of health practitioners.
- General practitioners (GPs) have a central role in creating an inclusive environment for older LGBTI people, and doing so will promote patient health and wellbeing.

Introduction

The healthcare needs of older people who identify as lesbian, gay, bisexual, transgender and intersex (LGBTI) have largely been ignored in the healthcare system.

The launch of the National LGBTI Ageing and Aged Care Strategy (Strategy) in 2012 highlighted the discrimination and health inequalities faced by older LGBTI people.[1] The Strategy aims to promote equitable access to aged care for older LGBTI people and to support the development of LGBTI-inclusive services. The Strategy has led to:

- the rollout of LGBTI-sensitivity training for aged care services in all states and territories
- qualitative research on older LGBTI people's care needs
- capacity-building initiatives
- development of an Aged Care Diversity Framework.[2]

Concurrent reforms included an amendment to:

- the *Aged Care Act* to recognise older LGBTI people as a special needs group
- the *Sex Discrimination Act* to protect older people from discrimination in aged care on the basis of sexual orientation and gender identity.

While significant reforms have already taken place to address the many barriers and unmet needs of older LGBTI people, many continue to experience delays in accessing aged care services. This is because their historical experiences have led to a distrust of institutions, including residential aged care facilities (RACFs).[3] Many older LGBTI people fear that entering an RACF will necessitate a 'return to the closet' or hiding their relationships, bodies and care needs in order to avoid discrimination.[4] This is not surprising given the onus of responsibility was historically placed on older LGBTI people to 'straighten up' or hide their diversity and conform to the status quo.[5]

It is therefore important to recognise that many older LGBTI people place significant value on their relationship with their general practitioner (GP), particularly when they feel safe disclosing their LGBTI status and LGBTI-related healthcare needs.[4] Given the historical pathologisation of older LGBTI people in medicine, it is particularly important that GPs understand the power they have to affirm LGBTI identities and, in doing so, promote wellbeing. It is also important that GPs keep abreast of the emerging body of evidence on older LGBTI people's healthcare needs as the interest in researching older LGBTI people continues to grow.

Understanding how patients identify

There are many ways older LGBTI people might express their diverse sex, sexual orientation or gender identities:

- **Regarding sexual orientation** – People with a same-sex partner, or who are same-sex attracted, may identify as lesbian, gay or bisexual; or they might not use these terms for themselves. It is important not to assume lesbian, gay and bisexual (LGB) identity, but to regard sexual attraction, behaviour and identity as overlapping but distinct categories. Many older people will have had to conceal their sexual orientation at many stages of their lives and may not have language to discuss this. Others will be very connected with LGBTI communities and living openly as LGB.
- **Regarding gender identity** – Some older people express gender diversity while not identifying as transgender. Others identify strongly as transgender, having come out relatively recently, while others may have affirmed their gender many years ago, and not regard themselves as transgender at all.
- **Regarding intersex variations** – Most people with intersex variations do not regard intersex as an identity, but rather as a natural bodily part of themselves.

Health issues for older lesbian, gay and bisexual people

Many older people who identify as LBG have lived through a period when their only protection against heterosexist violence and discrimination was to publicly deny their sexual orientation in order to pass as 'heterosexual'.

It is important to remember that homosexuality was not removed from the *Diagnostic and statistical manual of mental disorders* (DSM) until 1973, and disclosure could result in enforced 'cure' treatments (eg electroconvulsive therapy, lysergic acid diethylamide, psychotherapy).[6] Disclosure could also result in incarceration, criminal prosecution or the loss of family, friends and employment.[4] Older LGB people's senses of self and place in society were shaped by their experiences of institutionalised discrimination.[5]

There are several health issues that are more prevalent in older LGB people than their heterosexual counterparts. GPs should be aware of the heightened risk for several conditions that result from experiences of discrimination and marginalisation, as well as specific lifestyle factors.

Abuse and violence

Experiences of violence among older LGB people can arise in multiple situations, including:

- family violence as children, adolescents or adults
- intimate partner abuse (refer to Part B. Abuse of older people)
- workplace violence
- random abuse from strangers.

The effect of structural stigma is also significant, from societal barriers to full social inclusion (eg marriage inequality). For example, LGB Australians who lived in regions with a higher proportion of 'No' voters in the same-sex marriage plebiscite had worse life satisfaction, mental health and overall health than their counterparts who live in more affirming areas.[7]

Bisexual people are even more likely to have experienced violence than gay and lesbian people; this is thought to be related to ostracisation from both the gay and lesbian, and heterosexual communities.[8]

More information on the appropriate identification and response in clinical practice to patients experiencing abuse and violence is available in The Royal Australian College of General Practitioners' (RACGP's) *Abuse and violence: Working with our patients in general practice*.

Mental health concerns

Mental health concerns, particularly depression and anxiety, are of significant concern among older LGB people. Mental health issues among older LGB people relate to lifelong and repeated experiences of discrimination, which has been termed 'minority stress'.[9] Minority stress is even more likely in more conservative social settings (eg rural, outer urban locations).[10] Bisexual people have a higher prevalence of serious mental health problems than gay and lesbian people, which is in part related to poverty, lack of social connection and violence experiences.[11,12]

Alcohol misuse

Lesbian, bisexual and queer women are more likely than their heterosexual counterparts to:[13]

- drink alcohol at harmful levels
- have initiated drinking at a younger age
- persist with heavy drinking to an older age.

More information on reducing the risk of alcohol-related harm is available at the National Health and Medical Research Council's (NHMRC's) *Australian guidelines to reduce health risks from drinking alcohol*.

Smoking

LGB people are more likely to smoke and less likely to respond to mainstream health promotion initiatives for smoking cessation than their heterosexual counterparts. GPs should therefore consider more personalised approaches to encourage smoking cessation.[14,15]

More information on the smoking cessation is available in the RACGP's *Supporting smoking cessation: A guide for health professionals*.

Drug misuse

LGB people are more likely than their heterosexual counterparts to use illicit drugs, and to continue using illicit drugs at an older age.[14]

Alcohol misuse and illicit drug use in older gay and bisexual men who are human immunodeficiency virus (HIV) positive is particularly prevalent and affects their general health and wellbeing.[16]

Cardiovascular and diabetes

Midlife and older lesbian and bisexual women have higher risk factors for cardiovascular diseases,[17] which relate to their lifestyle factors (eg smoking, drug misuse, obesity, lower likelihood of pregnancy, reduced access to health screening).[18]

Gay and bisexual men are also more likely to develop diabetes.[19] Older gay and bisexual men with HIV have a higher chance of developing neuropathy, heart disease and diabetes than gay and bisexual men without HIV.[16]

An emerging theory suggests the physical role of persistent minority stress leads to a 'cascade of health-relevant events'.[20] This cascade can include repeated social stressors that create a high level of vigilance, resulting in psychological and physiological stress responses (eg immune system responses) and leading to altered health behaviours and risk taking.

More information on the early identification and optimal management of people with type 2 diabetes is available in the RACGP's *General practice management of type 2 diabetes*.

More information on the management and prevention of cardiovascular diseases is available in the RACGP's *Guidelines for preventive activities in general practice*.

Cancer risk

There is a higher prevalence of risk factors for cancer among LGB people, including smoking, alcohol misuse, obesity, stress and reduced cancer screening practices.[21] Seven common cancer sites that need particular attention for LGB people include:

- anal
- breast
- uterine
- cervical
- prostate
- colorectal
- lung.

The incidence of anal human papilloma virus (HPV) infection among gay men and other men who have sex with men is higher than their heterosexual counterparts, and even higher for those who are HIV-positive. However, there is no current anal cancer incidence data.[22]

More information on the prevention, diagnosis and treatment of various cancers is available on the Cancer Council Australia's Wiki page.

Disability

LGB people aged ≥50 years are more likely to have a disability (refer to Part B. Disability in aged care).[19] A recent review and study of the experiences of LGBTI Australians living with a disability found that they were disproportionately likely to:[23]

- have experienced abuse and violence
- be less able to express their gender and sexual identities because of constraints from carers and living arrangements
- have found it difficult to connect with LGBTI communities.

Isolation and loneliness

Older LGB people are more likely to be single and live in relative isolation in their community because of a long-term inclination to conceal their lifestyle to avoid negative attitudes.[24] They are also more likely to be estranged from their family of origin, and less likely to have children themselves. However, many single LGB people are actually well connected to their chosen community and can have a close-knit group of friends who they regard as family.[25]

Dementia and abuse of older people

Older LGB people living with dementia face particular challenges related to their decreased capacity for independent decision making (refer to Part A. Dementia). Family members and service providers who do not respect same-sex relationships may restrict the older person from access to intimate partners, and take actions to undermine or override decision making by intimate partners.[5]

In addition, the myth that older LGB people with dementia will 'become straight' may result in a lack of support for LGBTI community connections and fail to create LGBTI-inclusive dementia services.[26]

Homelessness

LGBT Australians are two to three times more likely to experience homelessness during their lifetime than their heterosexual counterparts.[27]

For young LGBT people, this is particularly due to family rejection and violence; however, for older LGBT people, it is more related to:

- discrimination in the workplace
- loss of employment
- poverty
- difficulty accessing housing support.

Human immunodeficiency virus

Ageing with HIV is increasingly common, as the use of effective antiretroviral medications has become widespread. Most gay and bisexual men with HIV are able to live healthy lives into older age, and specific health promotion messaging is starting to focus on this population group.[28] However, long-term HIV infection can increase the risk for dementia, specific cancers and general immune dysfunction.[29]

Carers

LGB people are more likely to be a carer for a member of their family of origin, partner or friend. Many LGB people rely more heavily on their domestic partner to be their carer, particularly if they are reluctant to access health services.[25]

Equally, the role of same-sex partners is emerging as important to positive survivorship after cancer.[30]

Disclosure

Open disclosure about LGB status to a GP has been found to improve health and wellbeing via more comprehensive exploration of health risk factors and more tailored health promotion. For example, open disclosure can increase cervical screening[31] and improve access to alcohol treatments.[32] The lack of identification and disclosure of LGB people in general practice is a major barrier to inclusive care, as this perpetuates misbeliefs that silence is the preferred option for LGB people.[33]

LGB patients, especially older people, can be reluctant to openly discuss their sexual identity and behaviour because of fears of negative attitudes and previous negative experiences. GPs can encourage disclosure by discussing sexual orientation when it is relevant to the presenting issue, and as part of a comprehensive social and contextual history. This discussion should be framed as a normal set of questions that provide an important context for care, rather than a stigmatised or embarrassing discussion. Documentation of sexual orientation in the patient's medical record is essential to ending health inequalities.[34]

Health issues for older transgender and gender diverse people

Older transgender and gender diverse (TGD) people continue to be pathologised, where the term 'gender dysphoria' is still listed in DSM-5. By contrast, the release of the 11th edition of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11) in 2019 has depathologised TGD status by listing it in the sexual health chapter as 'gender incongruence'.

Older people who experienced gender incongruence in their earlier years often lacked the information, support and resources to affirm their gender.[35] Consequently, an increasing number of people are affirming their gender in their old age. This has resulted in a unique set of issues related to family conflict and the capacity of RACFs to provide gender affirmation care (eg hormones).[35] Despite these obstacles, affirmation can be a positive experience given the right environment and support from the community and healthcare providers (eg GPs).

TGD people face many of the health issues listed for LGB people above, but in even greater numbers and severity. TGD people's experience of discrimination tend to be more prevalent and extreme because of a poor understanding of transgender identities and high levels of transphobia.

Cisgenderism is common, which is defined as invalidation of a person's own understanding of their gender and body.[36] This can manifest as misgendering (ie using the wrong pronoun or name) or pathologising the experience of being transgender.

Some transgender people desire medical treatments to affirm their gender (eg hormones), speech therapy or surgery; while others do not. This chapter will not include details of medical gender affirmation care; besides affirmation care, there is a range of particular health issues for older TGD people.[37]

Long-term hormone use

There is little evidence yet about the effects of cross-sex hormones for older transgender people; however, there is some evidence that:[37]

- transgender women who are aged ≥50 years and have taken oestrogen for longer than five years are at risk for breast cancer, and should have regular breast screening[38]
- transgender women on oestrogen are likely to have a lower risk of prostate cancer than cisgender men
- oestrogen or testosterone use can both increase lipids and depression in susceptible people
- transgender men on testosterone may develop vaginal atrophy and may find speculum examination uncomfortable; however, it is important to note that they still need regular cervical screening.

Hormone replacement therapy for transgender people is often regarded as lifesaving and life affirming. There may be instances when treatment is maintained when it would otherwise be contraindicated. For example, in the context of past venous thromboembolism, oestrogen may be maintained after all of the potential side effects are carefully discussed with the patient. Likewise, polypharmacy may be an issue and may require review of the use of hormones. However, the patient's relative need to continue hormones may mean that other drugs that are less important should be stopped first.[39]

Mental health

TGD Australians have high levels of depression, anxiety and suicidal ideation (refer to Part A. Mental health).[40] There is increasing evidence that TGD people are more likely to have autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD).[37]

Economic disadvantage

TGD people are more likely to be unemployed or underemployed because of transphobia in the workplace.[41] This can be associated with high levels of homelessness and restricts the capacity of older TGD people to access treatments to affirm their gender identity.

Isolation and abuse of older people

Estrangement from family and difficulty finding an intimate partner are more likely to be experienced by older TGD people than their older LGB or heterosexual counterparts. This can be particularly difficult once care needs increase, as family can be required to be more involved and be dismissive of the person's transgender status.

Adult children may restrict gender expression by prohibiting the TGD person from presenting in their affirmed gender when in contact with grandchildren, at family events or in public spaces.[35]

Dementia

There is an unsubstantiated view that TGD people who develop dementia would 'revert' to their gender ascribed at birth. However, it is more likely that TGD people with dementia lose their capacity to assert their gender identity with transphobic family members and service providers who restrict their gender expression.[42] These changes in gender expression may be misinterpreted as a consequence of brain changes, rather than social restrictions.[35]

Lack of understanding

Many TGD people resent needing to educate their healthcare provider about transgender issues and call for improved training.

Health issues for older people with intersex variations

Intersex is defined in a recent Victorian Government resource paper as 'an umbrella term for people born with congenital, atypical sex traits. The variations may be chromosomal, hormonal and/or anatomical in nature'.[43] Common intersex variations include:

- Klinefelter syndrome (47XXY)
- Turner syndrome (eg 45X)
- congenital adrenal hyperplasia
- androgen insensitivity syndrome.

Sexual orientation for people with intersex variations is as variable as the rest of the population; in a large Australian study, only 48% of people with intersex variations identified as heterosexual.[44] The majority of people with intersex variations do not 'identify' as intersex, and some identify as TGD.

Most people with intersex variations regard themselves as healthy; however, many have also had negative experiences with the healthcare system.[44] These negative experiences include:

- multiple genital surgeries as infants or children
- informed late or not at all of their intersex status
- being assigned a gender that may not match their affirmed gender.

For example, significant distress can arise when infertility leads to a diagnosis of an intersex variation.

Many people with intersex variations have been stigmatised because of their bodily differences, and some have experienced voyeurism, misgendering and pathologisation within the healthcare system. This often leads to mistrust of healthcare providers, and reduced access to health promotion and regular care.

A brief case study illustrates the significant effect this can have on a person as they age, where they have to relive old trauma when re-entering the healthcare system, and have heightened concern about a lack of autonomy and privacy in an RACF.[45]

Older people with intersex variations can have a number of health issues that relate directly to the variation or treatment they had in the past:

- Reduced bone density or osteoporosis
- Long-term sex hormone treatment – this can have effects on cardiovascular risk factors, metabolic syndrome, insulin resistance, weight and joint issues, although these are poorly researched
- Mental health – there is little information available about the mental health of intersex people; however, the largest study of Australian people with intersex variations found that 42% had thought about self-harm and 26% had engaged in self-harm.[44] There is some evidence that they suffer increased anxiety and depression related to experiences of secrecy, stigma, discrimination, family rejection, difficulty forming intimate relationships or fertility issues
- Learning difficulties – some people with certain intersex variations can have learning difficulties, behavioural issues or ADHD
- Cancer risk – this can be higher for some variations, particularly of gonadal tissue, but also lymphomas and breast cancer
- Autoimmune conditions – intersex people may be more likely to have autoimmune conditions (eg coeliac disease, hypothyroidism and rheumatoid arthritis

Assessment and management strategies to promote LGBTI wellbeing

It is important to use a strengths-based approach to LGBTI health. It can be easy to focus on the health inequalities of older LGBTI people, but a positive and affirming approach to LGBTI lives is critical to providing a positive healthcare experience. This includes focusing on resilience as a key determinant of positive health.[46] Resilience-building strategies include:[47]

- social connectedness
  - LGBTI communities – LGBTI community social connectedness is found to enhance resilience, particularly in the context of rejection by family of origin or other social groups.[48] Disclosure of LGBTI status can enable connection to communities.[49] However, it is important not to assume that LGBTI people want to connect with the LGBTI community. Some transgender people may identify as heterosexual, and many people with intersex variations do not perceive this as an ‘identity’ and do not need to connect with intersex communities
  - mainstream communities – connection to enable integration of multiple identities might include Christian LGBTI people finding affirming congregations[50]
- self-care – assistance and counselling to overcome internalised homophobia, biphobia, lesbophobia, transphobia or intersexphobia can be extremely helpful at any age

- self-advocacy – one of the central strategies here is encouragement to develop an advance care plan. This not only enables discussion about future healthcare desires, but also importantly directs professionals to understand who should be involved in healthcare decisions and who is the patient's power of attorney or nominated decision maker[51]
- accessing LGBTI-inclusive professionals.

Providing LGBTI-inclusive care

GPs have a central role in creating a positive and inclusive environment for older LGBTI people in their general practices and those in RACFs. GPs should also be advocates for finding inclusive and affirming referral networks (ie medical specialists, allied health providers, in-home care, RACFs).

Rainbow Health Victoria has developed a set of National Standards for LGBTI-inclusive services, and organisations can be externally accredited against the Standards to achieve a Rainbow Tick.[52]

Standard 1. Organisational capability

Documenting a statement of commitment to LGBTI inclusivity can be a useful starting point to guide your general practice. The next steps involve embedding LGBTI inclusivity across organisational systems, including quality management.

Standard 2. Workforce development

It is important that reception and clinical staff are trained to:

- use inclusive language
- avoid using titles
- use the gender pronoun and name that is desired by the patient.

Clinical staff also need training in cultural safety and effective communication with LGBTI patients, including how to safely facilitate disclosure. Staff should also have knowledge about the contributing factors, treatment and strategies for dealing with discrimination, and respect for strategies that individuals have successfully employed themselves.[53]

Standard 3. Consumer participation

Working with older LGBTI patients and their representatives is important to identify their needs and improve the provision of LGBTI-inclusive services. Older LGBTI people who feel safe talking about their needs are invaluable sources of information.

Standard 4. Welcoming and accessible organisation

Displaying messages of welcome (eg posters, rainbow flag) can communicate to LGBTI patients that they are welcome to disclose their LGBTI identities and care needs without fear of discrimination. Staff training, policies and protocols need to be in place before communicating to older LGBTI patients that it is safe to disclose.

Standard 5. Disclosure and documentation

Make sure language on assessment forms and other documentation is LGBTI inclusive to help with communicating with older LGBTI people that the service is LGBTI inclusive. Developing a policy on LGBTI disclosure and documentation is important to ensure staff understand what information can be gathered (and from whom), and how this information can be used. This includes enabling documentation of LGBTI status in the medical record, with the patient's permission. Following disclosure, GP support can include:[36]

- validation of sexual orientation and gender identity
- support for gender affirmation
- identifying the patient's chosen carer and next of kin, and ensuring these relationships are respected
- guidance on how to inform relatives and friends of diverse sexual or gender identities
- access to LGBTI peer support
- assistance with administrative changes (eg gender or name change on the birth certificate or other documents).

Standard 6. Culturally safe and acceptable services

Cultural safety is an important starting point to creating an inclusive environment in general practice. For LGBTI people, this involves:[42]

- understanding their histories of discrimination, marginalisation or violence
- focusing on confidentiality
- being prepared to address staff values and beliefs that could affect service delivery.

Cultural safety also involves advocating for the needs of older LGBTI patients, their partners and carers within the healthcare system, including making referrals to LGBTI-inclusive services. There are growing numbers of health and aged care services that are developing LGBTI-inclusive services.

An excellent example has been the work of Bolton Clarke (formerly the Royal District Nursing Service), which has used a co-design method to develop a TGD inclusion component of their diversity framework and conducted training, including case studies, for their staff.[53]

Conclusion

GPs can provide affirming and LGBTI-inclusive care by understanding the importance of acknowledging LGBTI status as a demographic fact in patients' lives. Seeking clarification of the following will enable best practice:

- How individuals identify themselves – this enables appropriate use of terminology in conversation and medical record.
- Whether LGBTI status is relevant to the social history – ie same-sex partner, connection with LGBTI communities, chosen family.
- Whether LGBTI status is relevant to the medical history – ie physical or mental health effects of discrimination, medical transgender affirmation care, cancer risk factors (eg screening history).

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