Title: “Going Back in the Closet”: Addressing Discrimination against Sexual and Gender Minority Residents in Long-term Services and Supports by Providing Culturally Responsive Care

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Abstract

Sexual and gender minority (SGM) older adults face discrimination in long-term services and supports (LTSS). Yet, SGM older adults use LTSS disproportionately higher relative to their non-SGM counterparts. The discrimination is compounded by existing disparities, resulting in worse health outcomes and well-being for SGM older adults. Guided by the socioecological model, we posit that training LTSS staff in SGM responsive care and implementing SGM anti-discrimination policies will improve care. Considering accessibility and turnover challenges, training should be online, interactive, and easily accessible. Studies that assess interventions for SGM responsive care are needed to guide policy and practice.

Keywords: Sexual and gender minority, discrimination, long-term services and supports, education, training

Key Points:

• Sexual and gender minorities are more likely to use long-term services and supports
• Sexual and gender minorities in long-term services and supports face discrimination
• Training staff in responsive care will reduce this discrimination
• Online training may be most effective and sustainable
Introduction

Sexual and gender minorities (SGM) include lesbian, gay, bisexual, and transgender (LGBT) individuals, as well as people whose gender identity and/or sexual orientation is something other than cisgender and/or heterosexual. SGM older adults disproportionately need residential long-term services and supports (LTSS), but they experience documented health disparities and discrimination in LTSS facilities, (Diverse Elders Coalition, 2017) especially in rural settings (Austin, 2013; Bell et al., 2010; Butler & Hope, 1999; Caceres et al., 2019; Knochel et al., 2012; Lee & Quam, 2013). If solutions to these discriminatory practices are not addressed, disparities will widen as the number of SGM older adults is rapidly increasing. By 2030, 20% of the US population will be aged 65+ (U.S. Census Bureau, 2018). Adults aged 85+ (the group most often needing LTSS) will more than double from seven million in 2020 to 15 million in 2040 (Urban Institute, 2019). About 2.7 million (or 2.4%) of adults aged 50+ in the US currently identify as SGM (Fredriksen-Goldsen et al., 2018), a figure projected to increase to five million by 2060 (Fredriksen-Goldsen, 2016; Fredriksen-Goldsen & Kim, 2017b). A similar number may not publicly identify as SGM but meet the definition of SGM based on self-identity, attraction, expression and/or behavior, making the true estimate approximately twice those cited (Fredriksen-Goldsen, 2016; Fredriksen-Goldsen & Kim, 2017a).

Despite the increase in the proportion of SGM older adults and their need for formal LTSS, systematic knowledge development on initiatives to promote culturally responsive care has been slow to develop. There has been growing literature on the barriers faced by SGM older adults anticipating to use formal LTSS and the reasons for these barriers, based on discrimination against SGM people by residents and staff. Yet, there has been little progress on how to work toward systems change to better meet the needs of SGM older adults who use LTSS. Therefore, this
commentary reviews the research on current needs of SGM older adults and their reported experiences in using formal LTSS. We describe a proposed intervention of LTSS staff training in SGM sensitive care as one way to address current disparities, with implication for social policy to address existing gaps in care for this growing but often invisible population of SGM older adults. We also engage a socioecological framework to help further understanding of the systematic issue of discrimination towards SGM and where better staff training could mitigate this problem.

Existing Health Disparities among SGM Older Adults

For SGM older adults, the increased utilization of formal LTSS is compounded by the many documented health disparities among SGM older adults compared to non-SGM older adults. SGM adults aged 50+, compared to their heterosexual and cisgender counterparts, are disproportionately more likely to have disabling chronic, physical, mental, and cognitive health conditions (Graham et al., 2011). For sexual minority (SM) men and women, physical conditions include low back pain, neck pain, weakened immune system, stroke, heart attack, asthma and arthritis (Fredriksen-Goldsen & Kim, 2017a, 2017b). They are also more likely to have poor general health, mental distress, disability, sleep difficulties, and to smoke than heterosexual peers (Fredriksen-Goldsen & Kim, 2017a; Gonzales & Henning-Smith, 2015). Gender minority (GM) older adults experience poorer general health, more disability and mental distress associated with elevated rates of victimization, discrimination and lack of access to appropriate care (Fredriksen-Goldsen et al., 2013). Over 50% of persons living with HIV in the US are aged 50+ (d'Vinci Interactive, 2016), with SM men and transgender women more likely to be aging with HIV compared to their heterosexual and cisgender counterparts (Centers for Disease Control and Prevention, 2019). SM women experience higher rates of alcohol-related problems than heterosexual women (Fredriksen-Goldsen & Kim, 2017a). For SGM people, lifetime
victimization and internalized stigma is associated with both disability and depression
(Fredriksen-Goldsen et al., 2012). SGM individuals are at significant elevated risk for depression and suicidality compared to their cisgender and heterosexual counterparts (Graham et al., 2011).

SGM older adults living in rural areas experience more structural barriers to care and more health disparities (Austin, 2013; Bell et al., 2010; Butler & Hope, 1999; Caceres et al., 2019; Knochel et al., 2012; Lee & Quam, 2013).

Additionally, SGM older adults are at increased risk for cognitive impairment (Hsieh et al., 2020; Liu et al., 2020) and Alzheimer’s Disease and Related Dementia (AD/ADRD) (Alzheimer's Association, 2020; Flatt, 2020; Flatt et al., 2019; Flatt et al., 2018; Perales-Puchalt et al., 2019; Rosenwohl-Mack et al., 2020). An estimated 240,000 to 400,000 SGM older adults have cognitive impairment (Fredriksen-Goldsen et al., 2018), 121,000 are diagnosed with Alzheimer’s (Fredriksen-Goldsen et al., 2018), and 350,000 have AD/ADRD (Flatt, 2020).

Cognitive difficulties are higher among SGM who are African American, Hispanic, HIV-positive, transgender, and male, which reflects the intersectional considerations of AD/ADRD (Dragon et al., 2017; Fredriksen-Goldsen et al., 2018). The cost of care of SGM with AD/ADRD is in excess of $17 billion per annum (Fredriksen-Goldsen et al., 2018). SGM with AD/ADRD require unique care and services (e.g., gender care of transgender patients with ADRD) (Scharaga et al., 2020). Without training, LTSS staff may view SGM residents as postsexual, and assess their intimate relationships as “deviant and inherently risky” (Cook et al., 2017).

**Discrimination in Healthcare**

Discrimination against SGM in medical care is common. Ross et al. (2021) have found reports of discrimination in medical treatment of older adults to be high. For instance, an online survey study of 193 gay, bisexual, and transgender prostate cancer patients (67% of whom were 60+
years) found that almost half (46%) reported at least one item on the Everyday Discrimination Scale in Medical Settings (Peek et al., 2011). 43% reported that the provider did not listen, 25% that they were talked down to, 20% that they received poorer care, 19% that the provider acted superior, and 10% that the provider appeared afraid of them. Of those who attributed the discrimination to an aspect of themselves, about half (9%) said it was because of sexual orientation, 4% to age, 2% to gender, 2% appearance, and 1% to race. The rest wrote in comments attributing it to going in as a gay couple, being gender non-conforming, or to the provider being arrogant, a jerk, or too pushed for time (Ross et al., 2021).

**High Rates of Discrimination in Formal LTSS**

This discrimination against SGM individuals is also a problem in LTSS facilities, where SGM residents fear discrimination from staff and other residents (S. Butler, 2017; S. S. Butler, 2017; Gabrielson, 2011; Johnson et al., 2005; Lowers, 2017; Putney et al., 2018; Stein et al., 2010). Having less social and familial support than non-SGM peers (Kurdek, 2001, 2004, 2005; Smith et al., 2007), and being less likely to have children or a partner (Gates, 2014), SGM older adults are more likely to rely on formal caregivers (Fredriksen-Goldsen et al., 2011), or to just “go it alone” (Capistrant, Torres, Merengwa et al., 2016; Capistrant, Torres, Mitteldorf et al., 2016). Nursing homes are seen as heteronormative, isolating, dangerous environments, forcing many SGM residents to conceal their identities (Clark et al., 2010; Hash & Netting, 2007; Lowers, 2017; Smith et al., 2010). A recent national survey regarding SGM in LTSS documented 853 instances of mistreatment (Justice in Aging, 2015). Of 289 LTSS staff, 85% felt SGM were not safe coming out (Justice in Aging, 2015). Most (89% of 649) residents and staff predicted staff would refuse basic care to SGM residents, while 77% predicted other residents would isolate an SGM resident (Justice in Aging, 2015). Research highlights the plight of SGM older
adults and their vulnerability to elder abuse (Gross, 2007; Justice in Aging, 2015; Winsor, 2017).

Staff in one nursing home refused to bathe a resident because they did not want to touch “the
lesbian” (Cahill & South, 2002). In another, two male residents were separated and one
transferred to a psychiatric facility for having consensual sex (Cahill & South, 2002). One in four
lesbians report discrimination from home care workers (attributed to religious bigotry) (S. S.
Butler, 2017). Gender minority older adults fear LTSS staff are not trained to meet their medical
needs (e.g., hormone use) (Lowers, 2017). Also, 14% of transgender people in a national survey
reported being denied service, experiencing harassment, and experiencing physical attacks from
LTSS staff for being a gender minority (James et al., 2016).

Structural anti-SGM prejudice and stigma contributes to negative experiences faced by
SGM older adults. Many LTSS are affiliated with conservative religious denominations, and/or
staffed by persons with religious beliefs, who may view SGM individuals as problematic (Cook
et al., 2018). Multiple contemporary literature reviews have found a positive association between
higher religiosity and negative attitudes towards LGBTQ+ people, especially among self-
identified Christians and Muslims (Campbell et al., 2019; Westwood, 2022). About 60% of
LTSS workers are from communities of color, and around 25% were born overseas. Over 80%
have less than a college degree and lower acceptance of sexual orientation diversity (PHI
(formerly Paraprofessional Healthcare Institute), 2019). The LTSS workforce disproportionately
draws its staff from Africa and the Caribbean, two regions of the world where laws criminalizing
same-sex behavior and severe social stigma against SGM people are still commonplace
(Hagopian et al., 2017). Hence, there is a need for staff training interventions to address current
attitudes, knowledge, and skills about SGM care.

The Promise of LTSS Staff Training in SGM Responsive Care
Lack of knowledge and training on SGM health is a critical problem in LTSS. Nationally, 76% of nursing home directors report no training in SGM responsive care (Bell et al., 2010) and less than one-third of LTSS staff ever receive any training in SGM care (Bell et al., 2010; Dickey, 2013; Smith et al., 2018). Negative staff attitudes toward SGM older adults are prevalent and highly problematic (Ahrendt et al., 2017; Fairchild et al., 1996; Hinrichs & Vacha-Haase, 2010). Most studies had two key recommendations: SGM-inclusive and welcoming facilities to improve treatment of SGM residents (Caceres et al., 2019) and specific staff training in providing responsive care to SGM older adults (Bell et al., 2010; Dickey, 2013; Donaldson & Vacha-Haase, 2016; Fairchild et al., 1996; Hinrichs & Vacha-Haase, 2010; Smith et al., 2018).

In assisted living and nursing homes, as many as two-thirds of residents have ADRD and up to 90% have cognitive decline (Gaugler et al., 2014; Zimmerman et al., 2014). As these cognitive issues introduce unique challenges for care, it is important that training on SGM sensitive care should also include training on care for SGM residents with ADRD. Staff training should seek to influence the interpersonal interactions between LTSS staff and residents as well as the intrapersonal attitudes and knowledge of the staff themselves. Combined with instituting SGM-affirming policies, which would influence organizational factors, such as implementing SOGI data collection on intake forms, every domain of the socioecological model can be acted upon.

**Practical Considerations for LTSS Environments**

Another practical consideration for training curricula is the fact that the LTSS industry has a high degree of staff turnover and work force instability (Castle et al., 2007; Stone, 2017; Sullivan et al., 2018). This creates a need for on-going, accessible training. As states mandate training, stakeholders need to know what effects training has on SGM responsive care. Often, online training is preferred by trainees because it is more convenient, accessible, scalable, has
high fidelity, and is tailorable and learner driven (Andersson & Titov, 2014; Carrard et al., 2011; Griffiths et al., 2006; Norman et al., 2007; Paxton et al., 2007; Wantland et al., 2004). During the COVID-19 pandemic, it has often been the only option. However, many online trainings are suboptimal because the curriculum was not designed to maximize the strengths of online learning (Allen, 2003; Gurak & Lannon, 2003). From an efficacy standpoint, most staff training programs only assess effects on staff. Further research should assess effects of service delivery across and between different types of agencies, management, and staff, and effects on SGM residents’ quality of care and sense of safety and belonging.

Socioecological Model of SGM-Responsive Care-Based Areas to Intervene

Applying a socioecological model can help better understand factors at the individual, social, community, and policy levels to address SGM discrimination in LTSS facilities (see Figure 1). From a public policy level, nondiscrimination and SGM affirming policies can help protect SGM patients. Institutional level considerations such as welcoming cues, inclusive forms that ask about sexual orientation and gender identity (SOGI), and ongoing training on SGM responsive care can also serve to protect SGM patients. At the interpersonal level, inclusive language, partner/chosen family inclusion, and modeling of respect for residents’ SGM status all affect SGM residents’ experiences in LTSS contexts. Lastly, the intrapersonal level contains aspects such as the LTSS staffs’ attitudes, knowledge, and skills as they relate to SGM residents. Training LTSS staff in SGM responsive care as well as instituting SGM inclusive and SOGI nondiscrimination policies would cover all four aforementioned areas of the socioecological model and could improve the health and safety of SGM older adults in LTSS.

Conclusion
SGM individuals are more likely to need formal residential LTSS as they age. Combined with an increasing number of SGM-identified older adults, there is a large need for research to evaluate how to improve care for SGM people in LTSS. Current research shows many SGM people experiencing discrimination in healthcare and LTSS settings. Further research should consider strategies informed by the socioecological model to reduce discrimination and improve the health and wellbeing of SGM residents in LTSS contexts. With some states passing legislation on training that prohibits harassment based on sexual and gender identity and orientation in varying settings (Nader, 2017), similar initiatives are greatly needed in LTSS. These strategies include implementing SGM-affirming and SOGI nondiscrimination policies, as well as SGM-responsive training for LTSS staff.

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