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

58 **Introduction**

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

75 Despite the increase in the proportion of SGM older adults and their need for formal LTSS,
76 systematic knowledge development on initiatives to promote culturally responsive care has been
77 slow to develop. There has been growing literature on the barriers faced by SGM older adults
78 anticipating to use formal LTSS and the reasons for these barriers, based on discrimination against
79 SGM people by residents and staff. Yet, there has been little progress on how to work toward
80 systems change to better meet the needs of SGM older adults who use LTSS. Therefore, this

81 commentary reviews the research on current needs of SGM older adults and their reported
82 experiences in using formal LTSS. We describe a proposed intervention of LTSS staff training in
83 SGM sensitive care as one way to address current disparities, with implication for social policy to
84 address existing gaps in care for this growing but often invisible population of SGM older adults.
85 We also engage a socioecological framework to help further understanding of the systematic issue
86 of discrimination towards SGM and where better staff training could mitigate this problem.

87 **Existing Health Disparities among SGM Older Adults**

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

104 victimization and internalized stigma is associated with both disability and depression
105 (Fredriksen-Goldsen et al., 2012). SGM individuals are at significant elevated risk for depression
106 and suicidality compared to their cisgender and heterosexual counterparts (Graham et al., 2011).
107 SGM older adults living in rural areas experience more structural barriers to care and more
108 health disparities (Austin, 2013; Bell et al., 2010; Butler & Hope, 1999; Caceres et al., 2019;
109 Knochel et al., 2012; Lee & Quam, 2013).

110 Additionally, SGM older adults are at increased risk for cognitive impairment (Hsieh et
111 al., 2020; Liu et al., 2020) and Alzheimer's Disease and Related Dementia (AD/ADRD)
112 (Alzheimer's Association, 2020; Flatt, 2020; Flatt et al., 2019; Flatt et al., 2018; Perales-Puchalt
113 et al., 2019; Rosenwohl-Mack et al., 2020). An estimated 240,000 to 400,000 SGM older adults
114 have cognitive impairment (Fredriksen-Goldsen et al., 2018), 121,000 are diagnosed with
115 Alzheimer's (Fredriksen-Goldsen et al., 2018), and 350,000 have AD/ADRD (Flatt, 2020).
116 Cognitive difficulties are higher among SGM who are African American, Hispanic, HIV-
117 positive, transgender, and male, which reflects the intersectional considerations of AD/ADRD
118 (Dragon et al., 2017; Fredriksen-Goldsen et al., 2018). The cost of care of SGM with AD/ADRD
119 is in excess of $17 billion per annum (Fredriksen-Goldsen et al., 2018). SGM with AD/ADRD
120 require unique care and services (e.g., gender care of transgender patients with ADRD)
121 (Scharaga et al., 2020). Without training, LTSS staff may view SGM residents as postsexual, and
122 assess their intimate relationships as "deviant and inherently risky" (Cook et al., 2017).

123 **Discrimination in Healthcare**

124 Discrimination against SGM in medical care is common. Ross et al. (2021) have found reports of
125 discrimination in medical treatment of older adults to be high. For instance, an online survey
126 study of 193 gay, bisexual, and transgender prostate cancer patients (67% of whom were 60+

127 years) found that almost half (46%) reported at least one item on the *Everyday Discrimination*
128 *Scale in Medical Settings* (Peek et al., 2011). 43% reported that the provider did not listen, 25%
129 that they were talked down to, 20% that they received poorer care, 19% that the provider acted
130 superior, and 10% that the provider appeared afraid of them. Of those who attributed the
131 discrimination to an aspect of themselves, about half (9%) said it was because of sexual
132 orientation, 4% to age, 2% to gender, 2% appearance, and 1% to race. The rest wrote in
133 comments attributing it to *going in as a gay couple, being gender non-conforming,* or to the
134 provider being *arrogant, a jerk,* or *too pushed for time* (Ross et al., 2021).

135 **High Rates of Discrimination in Formal LTSS**

136 This discrimination against SGM individuals is also a problem in LTSS facilities, where
137 SGM residents fear discrimination from staff and other residents (S. Butler, 2017; S. S. Butler,
138 2017; Gabrielson, 2011; Johnson et al., 2005; Lowers, 2017; Putney et al., 2018; Stein et al.,
139 2010). Having less social and familial support than non-SGM peers (Kurdek, 2001, 2004, 2005;
140 Smith et al., 2007), and being less likely to have children or a partner (Gates, 2014), SGM older
141 adults are more likely to rely on formal caregivers (Fredriksen-Goldsen et al., 2011), or to just
142 "go it alone" (Capistrant, Torres, Merengwa et al., 2016; Capistrant, Torres, Mitteldorf et al.,
143 2016). Nursing homes are seen as heteronormative, isolating, dangerous environments, forcing
144 many SGM residents to conceal their identities (Clark et al., 2010; Hash & Netting, 2007;
145 Lowers, 2017; Smith et al., 2010). A recent national survey regarding SGM in LTSS documented
146 853 instances of mistreatment (Justice in Aging, 2015). Of 289 LTSS staff, 85% felt SGM were
147 not safe coming out (Justice in Aging, 2015). Most (89% of 649) residents and staff predicted
148 staff would refuse basic care to SGM residents, while 77% predicted other residents would
149 isolate an SGM resident (Justice in Aging, 2015). Research highlights the plight of SGM older

150 adults and their vulnerability to elder abuse (Gross, 2007; Justice in Aging, 2015; Winsor, 2017).
151 Staff in one nursing home refused to bathe a resident because they did not want to touch "the
152 lesbian" (Cahill & South, 2002). In another, two male residents were separated and one
153 transferred to a psychiatric facility for having consensual sex (Cahill & South, 2002). One in four
154 lesbians report discrimination from home care workers (attributed to religious bigotry) (S. S.
155 Butler, 2017). Gender minority older adults fear LTSS staff are not trained to meet their medical
156 needs (e.g., hormone use) (Lowers, 2017). Also, 14% of transgender people in a national survey
157 reported being denied service, experiencing harassment, and experiencing physical attacks from
158 LTSS staff for being a gender minority (James et al., 2016).

159 Structural anti-SGM prejudice and stigma contributes to negative experiences faced by
160 SGM older adults. Many LTSS are affiliated with conservative religious denominations, and/or
161 staffed by persons with religious beliefs, who may view SGM individuals as problematic (Cook
162 et al., 2018). Multiple contemporary literature reviews have found a positive association between
163 higher religiosity and negative attitudes towards LGBTQ+ people, especially among self-
164 identified Christians and Muslims (Campbell et al., 2019; Westwood, 2022). About 60% of
165 LTSS workers are from communities of color, and around 25% were born overseas.[64] Over 80%
166 have less than a college degree and lower acceptance of sexual orientation diversity (PHI
167 (formerly Paraprofessional Healthcare Institute), 2019). The LTSS workforce disproportionately
168 draws its staff from Africa and the Caribbean, two regions of the world where laws criminalizing
169 same-sex behavior and severe social stigma against SGM people are still commonplace
170 (Hagopian et al., 2017). Hence, there is a need for staff training interventions to address current
171 attitudes, knowledge, and skills about SGM care.

172 **The Promise of LTSS Staff Training in SGM Responsive Care**

173 Lack of knowledge and training on SGM health is a critical problem in LTSS. Nationally,
174 76% of nursing home directors report no training in SGM responsive care (Bell et al., 2010). and
175 less than one-third of LTSS staff ever receive any training in SGM care (Bell et al., 2010;
176 Dickey, 2013; Smith et al., 2018). Negative staff attitudes toward SGM older adults are prevalent
177 and highly problematic (Ahrendt et al., 2017; Fairchild et al., 1996; Hinrichs & Vacha-Haase,
178 2010). Most studies had two key recommendations: SGM-inclusive and welcoming facilities to
179 improve treatment of SGM residents (Caceres et al., 2019) and specific staff training in
180 providing responsive care to SGM older adults (Bell et al., 2010; Dickey, 2013; Donaldson &
181 Vacha-Haase, 2016; Fairchild et al., 1996; Hinrichs & Vacha-Haase, 2010; Smith et al., 2018).
182 In assisted living and nursing homes, as many as two-thirds of residents have ADRD and up to
183 90% have cognitive decline (Gaugler et al., 2014; Zimmerman et al., 2014). As these cognitive
184 issues introduce unique challenges for care, it is important that training on SGM sensitive care
185 should also include training on care for SGM residents with ADRD. Staff training should seek to
186 influence the interpersonal interactions between LTSS staff and residents as well as the
187 intrapersonal attitudes and knowledge of the staff themselves. Combined with instituting SGM-
188 affirming policies, which would influence organizational factors, such as implementing SOGI
189 data collection on intake forms, every domain of the socioecological model can be acted upon.

190 **Practical Considerations for LTSS Environments**

191 Another practical consideration for training curricula is the fact that the LTSS industry
192 has a high degree of staff turnover and work force instability (Castle et al., 2007; Stone, 2017;
193 Sullivan et al., 2018). This creates a need for on-going, accessible training. As states mandate
194 training, stakeholders need to know what effects training has on SGM responsive care. Often,
195 online training is preferred by trainees because it is more convenient, accessible, scalable, has

196 high fidelity, and is tailorable and learner driven (Andersson & Titov, 2014; Carrard et al., 2011;
197 Griffiths et al., 2006; Norman et al., 2007; Paxton et al., 2007; Wantland et al., 2004). During the
198 COVID-19 pandemic, it has often been the only option. However, many online trainings are sub-
199 optimal because the curriculum was not designed to maximize the strengths of online learning
200 (Allen, 2003; Gurak & Lannon, 2003). From an efficacy standpoint, most staff training programs
201 only assess effects on staff. Further research should assess effects of service delivery across and
202 between different types of agencies, management, and staff, and effects on SGM residents'
203 quality of care and sense of safety and belonging.

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

205 Applying a socioecological model can help better understand factors at the individual,
206 social, community, and policy levels to address to SGM discrimination in LTSS facilities (see
207 Figure 1).[78] From a *public policy level*, nondiscrimination and SGM affirming polices can help
208 protect SGM patients. *Institutional level* considerations such as welcoming cues, inclusive forms
209 that ask about sexual orientation and gender identity (SOGI), and ongoing training on SGM
210 responsive care can also serve to protect SGM patients. At the *interpersonal level*, inclusive
211 language, partner/chosen family inclusion, and modeling of respect for residents' SGM status all
212 affect SGM residents' experiences in LTSS contexts. Lastly, the *intrapersonal level* contains
213 aspects such as the LTSS staffs' attitudes, knowledge, and skills as they relate to SGM residents.
214 Training LTSS staff in SGM responsive care as well as instituting SGM inclusive and SOGI
215 nondiscrimination policies would cover all four aforementioned areas of the socioecological
216 model and could improve the health and safety of SGM older adults in LTSS.

217 **Conclusion**

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

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