



Pride at home

PLATINUM RAINBOW GUIDANCE FOR HOMECARE

Dr Mel Duffy, Dr Giovanni Frazzetto, Prof Anthony Staines, Prof Anne Matthews, James Geoghegan, Collette Gleeson, Claire Mooney, James O'Hagan and Sean Vail



Ollscoil Chathair
Bhaile Átha Cliath
Dublin City University



Taighde Éireann
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Chapter 1 - Introduction

The world's population is growing older, and this development is set to continue bringing with it multiple challenges. An older population is likely to have significant economic and social impact, with the United Nations suggesting that population ageing is one of the most significant megatrends with global implications (UN 2023).

The population over 65 in Ireland is 'estimated to have risen by over 40% between 2013 and 2023 (CSO 2024). In 2024 the Central Statistics Office estimates that there are 833,200 persons over the age of 65 but offered no data as to the LGBTI population (CSO 2024). There is no official estimate of the LGBTI community in Ireland however the Central Statistics Office are currently in the process of including such an item on the next full Census in 2026. Higgins et al. (2016) note that the approximate range of the LGBTI population is thought to be between 5-7%. Applying this estimation to the total estimated population of those over 65 years in Ireland $n=833,200$, means that the LGBTI population aged 65+ in Ireland ranges between 49,992-58,324 people.

To speak about LGBTI within society we need to understand sexuality and some of the discourses relating to older people. Sexuality is a broad concept, incorporating behaviour, wellbeing, health, sexual self-esteem, performance, intimate relationships and functioning. Historically the emphasis was narrowly placed on sexual response cycles, heterosexist and ageist assumptions inclusive of heteronormative behaviours. Traditionally older people were perceived as being asexual; incapable of having sex; sexually undesirable whereby beauty and physical attractiveness pertains to the young. The world looked on disdainfully at older people who displayed desires, love or jealousy as it viewed displays of sexuality with repulsion. Any displays by older people of perceived uncharacteristic sexual interactions could lead to shame, embarrassment and humiliation. While the literature points towards the benefits of maintaining a healthy intimate and sexual life amongst older people, conflicting findings have been reported in the research literature regarding staff attitudes to residents' sexuality in the nursing home setting (Monteiro, Ana, von Humboldt, Sofia and Leal, Isabel 2017 Di Napoli, Breland and



Allen, 2013 Bouman, Arcelus, and Benbow 2007). However, there is little research undertaken on the knowledge and attitudes towards sexuality of those who provide care within the home. Several variables have been identified as influencing care staff attitudes to late life sexuality including staff members age, race/ethnicity, total year of education, experience of working with older people and position in the organization (Monteiro, von Humboldt, and Leal 2017). The attitudes of carers have also been shown to influence care. In addition, participants reported more negative attitudes about interactions between same-sex couples than opposite-sex couples. Healthcare professionals found it difficult to discuss issues of sexuality when it related to older people.

Within the Irish context, legislation such as the Equality Act of 2004 which encompasses the Employment Equality Act 1998 and the Equal Status Act 2000 requires all workplaces to create a culture of diversity so that the nine grounds identified: gender, marital status, sexual orientation, religion, age, disability, race and member of the Travelling community, where discrimination is illegal are fully integrated into organisational culture. The Act also requires all members of an organisation to adhere to it. It could be suggested that within this requirement is the recommendation that LGBTI people in their own home should be able to express their sexuality as in the case of this project the workplace is the home of the person the care is being provided for.



Chapter 2 - Methodology

2.1 Introduction

This was an interdisciplinary project that examined the lived experience of older LGBTI dwelling in the community and their support circle of homecare in Ireland from lay and professional perspectives. The study, adopted a PPI approach, aligns with national public health policy - which is deemed to be 'population based', emphasizing the 'personal and collective responsibility' in protecting the health of individuals and society (Department of Health 2015). It was inclusive of Public & Patient Involvement (PPI) with PPI members drawn from the older LGBTI community which fulfilled the LGBTI community principle of 'nothing about us, without us'. PPI members represented different perspectives namely nursing care provision to older individuals, personal experience as a member of the LGBTI community, and experience in providing home care to LGBTI individuals.

The inclusion of key stakeholder groups in researching the lived experience of community dwelling older LGBT people from lay and professional perspectives further consolidates the strategic aim of creating 'an environment where every individual and sector of society can play their part in achieving a healthy Ireland'. The research also embraced the goal of population health research 'of promoting health and wellbeing' by hearing the experiences of community dwelling older LGBT individuals, thus reflecting an empowerment approach to health promotion. Through hearing the voices of all stakeholders, a comprehensive understanding of the provision of homecare in Ireland emerged. Thus, we reinforce the goal of undertaking robust research to enable the development of appropriate educational instruments, policies and guidelines that results in better outcomes for all stakeholders. The quantitative, qualitative and educational resource aspects of this project were co-designed and guided by PPI participants, working with the researchers.

2.2 Aims and objectives

The study aims were threefold:

1. Identify the homecare experiences of community dwelling older LGBTI individuals and their support circle.
2. Uncover the knowledge and attitudes of professional caregivers providing homecare services to community dwelling older LGBTI people and their support circle.
3. Co-develop an educational tool kit that will lead to improved practice and quality of homecare services received by community dwelling older LGBTI people.

2.3 Central research questions


This research is underpinned by two central research questions. The first question asks what are the lived experiences of community dwelling older LGBTI people and their support circle of receiving home care support services. From this four further research questions emerge which will enable us to answer the main question.

1. How do older LGBTI people living in the community and their support circle experience homecare?
2. How do they describe that experience?
3. How do they interpret that experience?
4. What meanings do older LGBTI people, and their support circle give to that experience?

2.4 Methodology

The project engaged with mixed methods. The methodology chosen for the first part of the study is from the qualitative framework namely hermeneutic phenomenology (Dibley et al. 2020) which enables us to obtain an understanding of community dwelling older LGBTI individual's experiences of homecare. What a community dwelling older lesbian, gay, bisexual, transgender and intersex individual says is happening in his/her/their world is happening as they/he/she experiences and live it:

It is in the co-disclosure of the shared world that issues of voice, reflexivity, identity, and understanding reveal themselves (Kavanagh 2006 p.25)



It is through the voices of community dwelling older lesbian, gay, bisexual, transgender and intersex people that we can begin to understand their experiences of receiving homecare services.

In summary, phenomenology is concerned with finding and analysing the meanings that human beings confer on their social experiences, events and concrete objects (Jones 2003). Phenomenology is concerned with how individuals experience, describe, interpret and understand the phenomenon under investigation (Bergum 1989). Phenomenology also strives to investigate the way that meaning is constructed collectively, socially and culturally (Duffy and Ní Mhuirthile 2024); thus, describing and interpreting ‘the meaning of the lived experiences for several individuals about a concept or the phenomenon’ (Creswell 1998). Families and social institutions such as health care in this instance the provision of home care have a key role in the transmission of key cultural and ideological ideas and values. For these reasons, as a methodological approach phenomenology is particularly suited to the overall aim and objectives of this research which seeks to explore the meanings and understandings that community dwelling older LGBTI people give to their experiences of either receiving home care.

The use of a phenomenological approach will enable an examination of the general meanings and understandings that all participants give to the phenomena of homecare. It is a particularly suitable methodology for analysing the data emerging from the one-to-one interviews undertaken during this research. As an approach it enables reflection and interpretation of the way the construction of reality may be similar, or different, to that of other individuals experiencing the same situation

The work environment of the homecare provider is a unique space. The home is the private sphere of the community dwelling older lesbian, gay, bisexual, transgender and intersex people. However, for the homecare provider it is the workplace. It is here we may find a clash between the public and private spheres.

2.5 Gathering interview data and Ethics

This research required two samples: community dwelling older lesbian, gay, bisexual, transgender and intersex people and a survey of homecare providers. The first sample will be reviewed first.

Lee (1999) informs us that when one undertakes sensitive research, it has implications at every point of the research process. He argues that threats to the person can come in the form of intrusion into an individual's life and social space; it can take many forms, from the perception of, to actual reality of, physical threat (Lee 1993). These are considerations that lesbian, gay, bisexual, transgender and intersex individuals take into account when deciding whether to participate in a study. In this study lesbian, gay, bisexual, transgender and intersex individuals were self-selecting.

Ethical approval was received from Dublin City University Research Ethics Committee. The criteria for inclusion in the study were: 1) being 50 and over and community dwelling individuals identifying as LGBTI and 2) being, or having been, in receipt of homecare support services in the Republic of Ireland. We offered participants a €50 One4All voucher as compensation for their time in taking part in the research¹. No distinction was made between homecare support services that covered attendance to nursing and medical needs, and assistance with personal care and housekeeping, as long as they were provided by formal health care providers and not friends or family members.

The recruitment was carried out in two main phases. First, a call for participation, along with a description of the study, was disseminated via social media networks such as Facebook and X and through mailing lists of homecare agencies, as facilitated by some of the authors who are representatives of the Public & Patient Involvement. At a later

¹ Compensating study participants is a common practice with practical advantages with regard to reaching respondents from a wider scale of socio-economic backgrounds, especially in times of precarity, crises and widespread increasing costs of living. The introduction of compensation payments, for instance, for time-defined participation like interviews, enables more successful recruitment procedures, respects the participants' time, values their 'lived experiences' as expertise, and avoids the risk of a slanted representation of the realities examined by not collecting data exclusively from groups that are more privileged. More broadly, it contributes to making research more inclusive (Warnock, MacNeil Taylor and Horton 2021).

stage, a web page dedicated to the study was created and the links to the study shared again across the channels mentioned above. Posters about the study were printed and shared across several LGBTI organisations, such as Outhouse, and social locations in Dublin, such as bars and cafes. Participants contacted the first author by email or by text message and subsequently, according to scheduling and availability, interviews were arranged at a suitable time.

Each step of the sampling and data gathering requires the researcher to take steps to protect their participants and to disguise the identities of the lesbian, gay, bisexual, transgender and intersex individual's so pseudonyms were used. Fourteen participants took part in the one-to-one interviews. The average age was 54.78 years, with the youngest participant being 51 years old and the oldest 63 years. The gender and sexual identities of the group are divided as follows: 7 lesbian women, 3 bisexual women, 2 bisexual men, 1 gay man, and 1 transgender woman. Nine reported living in urban areas, and three in rural areas. One participant reported living in a suburban area, and another in a semi-urban area. Table 1; gives the pseudonyms of individuals who participated in the one-to-one interviews by age, sexual orientation which indicates male or female, and years receiving homecare services.

Data gathering took place between August 2022 and September 2022. A mobile phone was purchased for the sole purpose of the study, as a mode of contact that no one else had access to. All elected to be interviewed through zoom and transcribed verbatim. The transcriber signed a confidentiality agreement.


Table 1: Name, sexual orientation, gender identity, urban or rural by year of receiving homecare services

	Name of participant	Age (age range)	Gender identity and Sexual Orientation	Urban / Rural	Time in homecare (years)
1	Ardan	63 (60-64)	bisexual man	rural	5
2	Aithne	51 (50-54)	bisexual woman	urban	few

3	Bain	55 (55-59)	bisexual man	urban	3
4	Gobnet	55 (55-59)	transgender woman	urban	3
5	Myrna	53 (50-54)	bisexual woman	rural	few
6	Ultan	62 (60-64)	gay man	urban	3
7	Keavy	61 (60-61)	lesbian woman	urban	2
8	Grania	54 (50-54)	lesbian woman	urban	2
9	Saraid	62 (60-64)	lesbian woman	urban	1
10	Sive	57 (55-59)	bisexual woman	rural	6
11	Ena	62 (60-64)	lesbian woman	urban	3
12	Murna	63 (60-64)	lesbian woman	urban	1
13	Talulla	61 (60-64)	lesbian woman	urban	1.6
14	Ornat	63 (60-64)	lesbian woman	urban	1.5

The interviewing approach used an unstructured technique that sought to centre the participant and focus on their narrative. Participants were singularly interviewed. The interviewer has a minimal role, other than to ask one broad question, and then provide any follow up comments or non-leading questions as required to show engagement in the narrative and keep it broadly on track. The starting interview statement is:

- Can you please describe your experience of homecare?




Dinkins (2005) points out that the interviewer is the instrument through which data is collected. The initial contact between the potential participant and the interviewer created the space to provide details about the study and what we would like them to talk about. In this LGBTI people would think about and reflect upon their experiences in their own time and space prior to the interview. It also acted as a buffer zone for potential participants to remove themselves from the study if they wished.

During the course of the interview, further questions arose from the information the interviewees imparted. These questions acted like prompts to enable the individual to develop their own story. They are not used in every case. The questions are:

1. Would you like to expand on x?
2. May I ask if you would like to speak further about x?
3. May I ask if you would mind telling us about the good times?
4. Do you mind if I ask, when you made a complaint were you satisfied with the response?
5. Do you mind me asking how that made you feel?
6. Can I ask what you mean by feeling strange?
7. How do you adapt to a stranger coming into your home?
8. Can I ask you what is the overall impact of you receiving homecare?
9. What kind of reception do you get when you tell them?
10. How much information about you as a person would you give people?

Through interviews, the voices of older community dwelling LGBTI people can be heard, offering insight into their 'ideas, thoughts, and memories in their own words, rather than in the words of the researcher' (Reinharz 1992 p.19)

As each interview was undertaken by Zoom, each participant received by email a consent form and plain language statement prior to the interview (Appendix A). The consent form was signed by the interviewer upon the agreement with the participant which was




recorded. Each participant retained the signed consent form, which clearly states that they can remove themselves from the study at any stage.

2.6 Gathering survey data and ethics

An on-line survey to assess the attitudes of homecare providers to LGBT individuals and their care. The goal of survey research is to accurately measure particular constructs within a sample of people who represent the population of interest. This study will use a cross-sectional, correlational design which involves collecting data from a sample of individuals at a single point in time, to determine the degree of the relationship between variables for the possibility of making predictions based upon these relationships. An on-line questionnaire will be administered to a national sample of healthcare professionals (nurses and care staff) providing home care to older LGBT people using the ZOHO® survey platform. ZOHO® is a secure platform and is compliant with EU GDPR regulations. A link to the survey (and associated information) will be forwarded to potential participants via the homecare company's employees email lists. The survey will be anonymous, and no data by which respondents can be identified will be recorded.

A researcher co-designed questionnaire with the PPI panel will be used to collect background demographic data from homecare personnel and explore their experiences of caring for people from the LGBT community. This will include variables identified in previous research as influencing attitudes towards LGBT people including age, gender, sexual orientation, religion, nationality, previous education, and knowing someone (friend or acquaintance) from the LGBT community. It will also ask respondents to indicate their level of comfort with providing general and intimate care to LGBT people.

In addition, several standardised validated research instruments will be used to explore homecare staff attitudes towards gay, lesbian and transgender people. Attitudes towards gay and lesbian people will be measured using the *Attitudes Towards Lesbians and Gay Men Scale*. This scale consists of 20 different statements, 10 about gay men (ATG subscale) and 10 about lesbian women (ATL subscale). Respondents indicate their level of agreement or disagreement with scale statements on a 5-point Likert scale. A second



instrument *The Modern Homonegativity Scale* will be used to assess more subtle discriminatory behaviours towards LGBT individuals. This 24 item scale consists of two 12-item subscales (one for gay men and one for lesbian women) and measures contemporary negative attitudes toward gay men and lesbian women.

Attitudes towards transgender people will be measured using the *Attitudes Towards Transgender Men and Women Scale* [ATTMW], a 24-item scale consisting of two non-identical 12-item subscales which independently assess attitudes toward transgender men and transgender women. This scale will be supplemented with 5 items from the *Global Attitudes Toward Transgender People* survey exploring more general attitudes towards transgender people.

These instruments will provide a description on staff attitudes to LGBT individuals and allow discrimination between attitudes towards gay men, lesbian women, transgender men, and transgender women. Correlations between the demographic variables and scale scores will be explored to identify any factors which impact these attitudes.

2.7 Data analysis

All interviews took place on zoom and permission was granted by each participant to be recorded. The recordings were subsequently transcribed verbatim. These transcripts formed the basis of the data analysis, by spending time with the data listening to each participant describe their experiences. The analysis sits within the central aspects of the practice of hermeneutic phenomenology in particular the hermeneutic circle:

Analysis [it] is a continuous circular and reflective process where themes emerge, and the researcher returns to the data and starts to re-read it. (Dibley et al 2020 p.127)

The themes that emerge gives order to the data and enables the research writing.

Chapter 3 – Literature Review

A literature review was conducted to map the state of the art in the field of homecare and identify across international contexts issues salient to homecare for the LGBTI population. The literature review was published, and we insert the published chapter below.

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REVIEW

Open Access Journal

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

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Abstract

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

Keywords

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

1. Introduction

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

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

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

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

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

2. Methods

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

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

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

3. Findings

3.1. Articles Found

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

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

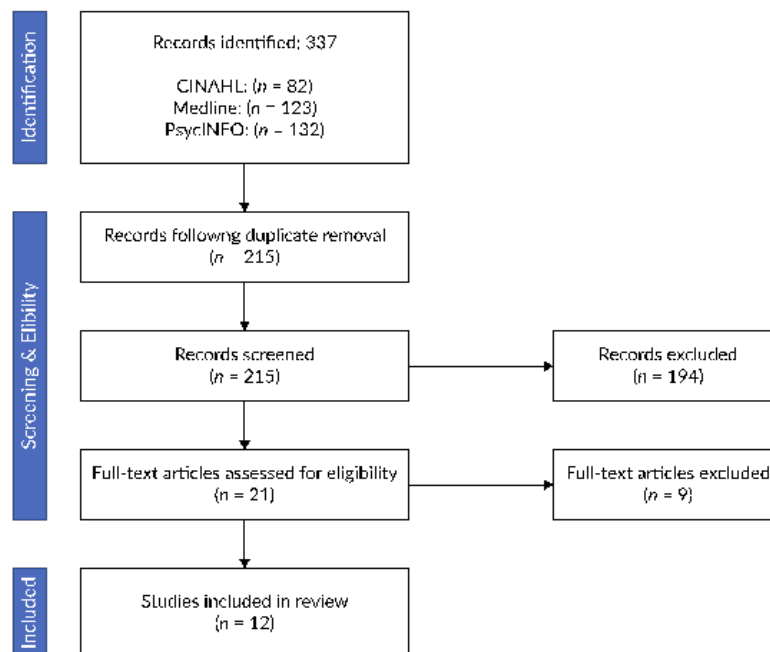


Figure 1. Flow diagram of search and selection of articles.

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

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

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

Table 1. Summary of articles included in the review.

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

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

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

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

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

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

3.2.1. Disclosure of Gender Identity and Sexual Orientation

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

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

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

Over 30% of respondents to a survey indicated revealing their identity to care workers, with the disclosure almost invariably enhancing the quality of their interaction (Hoekstra-Pijpers, 2022). For many users in another study, not being able to be out to providers meant a preference for not accessing the services (Dunkle, 2018). A male gay participant based his choice of coming out on his status as a survivor of the HIV/AIDS pandemic:

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

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

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

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

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

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

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

3.2.2. Meanings of LGBTI-Competent Homecare

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

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

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

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

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

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

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

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

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

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

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

3.2.3. Recommendations for Improved Quality of LGBTI-Friendly Services

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

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

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

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

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

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

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

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

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

4. Conclusions

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

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

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

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

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

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

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

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

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Conflict of Interests

The authors declare no conflict of interest.

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



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Collette Gleeson is the managing director of Comfort Keepers Homecare Ireland & Evaluation Training and a board director of Home and Community Care Ireland. With over 20 years of experience across the public, not-for-profit, and private sectors in hospital, home, palliative, and disability services, Collette has dedicated her professional life to providing person-centred services through the lens of quality and value-based people leadership. She is deeply passionate about the important role health and social care services play in all our lives and has focused on contributing at a local, national, and international level to the development of services, governance, digital transformation, and people development to advance the sector in the delivery of choice and to help shape the future of services. She holds an MBA in technology and management, a BA in HR, and diplomas in risk management and coaching.



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



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


Chapter 4 - Being in one's home

Traditionally we viewed the workplace as something outside the home, people went to their place of work. COVID was to change the world of work. The division between work and home became intertwined, the office culture pre 2020 has disappeared and business are finding it difficult to reimagine that space. This may have been the first time for many individuals when the private and public spheres hurtled into each other. This difference for people who require homecare, remote working during COVID 19 did not require the private sphere being breached by managers of the workplace. This is different to the experience of homecare. Within this study we argue that work and home can become contested spaces The home becomes the workplace for homecare providers which results in a collision of public and private spheres and multiple meaning(s). This collision may be more important for older LGBTI people, already members of a minority as well as the wider community. Jacobson (2015) suggests that:

We are essentially supported in who we are, in how we think and feel, in what we do by the places and things that surround us (Jacobson 2015 p.32).

LGBTI people give meaning to those things that encircle them fostering their becoming as either lesbian, gay, bisexual, transgender or intersex. The meanings that things hold may reflect how they see themselves such as emblems representing who they are such as: rainbow flag; lesbian flag, gay flag, bisexual flag, transgender flag or intersex flag; pins and indeed photographs that suggest a life well lived. Flags not only represent who a person is but also community membership.

During a lifetime, work gives meaning to LGBTI people. Markowe (1996) had pointed towards work as places where identities are negotiated as both the private life and public lives may overlap. Work and identity can overlap thus providing a coherent sense of accomplishment (Clunis et al. 2005). Through work we encounter the Other giving us a sense of who we are in society and the communities we interact with (Morgan 1999). Layte et al (2006) consider that:



Sexual orientation, identity and expression do not occur in a neutral environment where sexual identity ... is a simple matter of individual choice. Quite the opposite; homosexuality is still widely stigmatized and homosexual identity can come at a great cost to individual's (Layte et al 2006 p.123).

Through his work on unearthing the past of the LGBTQ community, Kerrigan (2024) suggests there are clear illustrations of how work in and of itself in Ireland could be a site of prejudice and discrimination. He further guides us through legislation which was enacted to create equality, diversity and inclusion in the workplace and indeed the change in the constitution in 2015 embraced the existence of same-sex union thus legalising marriage and in the same year the implementation of the Gender Recognition Act. However, Kerrigan points out that two years later TENI in their survey:

found that 55 percent of transgender and gender-diverse people experienced problems at work, which included unfair dismissal, and denial of promotion and discrimination based on their gender identity (Kerrigan 2024 p. 161).

While the workplace theoretically must adhere to legislation to create a safe environment, it may not always be experienced in practice by those it set out to protect. However, TENI's results illustrated that one's identity can lead to great personal cost and by extension cost to a community who understand that being themselves may lead to great social and personal costs.

This chapter examines the collision between home and workplace and the social and personal costs incurred by older LGBTI people once carers enter the home. Finally, this chapter divides into four section: the first deals with what it means to age in place or to live at home; the second uncovers what meaning(s) and understanding(s) community dwelling older LGBTI people give to a stranger arriving into the home; thirdly, this study unravels whether a community dwelling older LGBTI person risks coming out to their homecare provider and finally coming to terms with homecare.


4.1 Ageing in place or living at home

The language surrounding being older and living in the community has changed over time. Europe's policy of 'ageing in place' has existed for the last two decades (Martinsen, Norlyk and Gramstad 2023). This policy resulted in older people living as long as possible within their own homes and community. Pani-Harreman et al (2020) reported that out of 34 studies consulted in their scoping review on 'ageing in place' only two articles had developed their own definition of the concept. They conveyed that Grimmer et al (2015) perceived ageing in place as residing as long as possible in one's own home prior to needing nursing home care. Horner and Boldy (2008) definition was more positive as it incorporated living independently and the needs of the older person being met in the community for as long as possible (Pani-Harreman et al 2020). The paradigm includes:

not only staying in one's own home but also includes remaining in a stable and known environment where people feel that they belong (Pani-Harreman et al 2020 p.2050).

Living in one's own place or home has a positive sense of belonging, knowing one's environment, neighbours, built on memories of a lifetime and feelings of safety. It is familiar, knowable and social networks have been created over the years. Kelly et al (2024) argues for homecare that is built upon the principles of a rights-based approach to the care that is provided which places the focus on human rights.

From an LGBT perspective the meaning of ageing in place is directly related to the economic strength of countries that studies were carried out in, coupled with the health and social policies that are put in place (Hoekstra-Pijpers 2022). Duffy and Ní Mhuirthile (2024 p.6) note "few are asked in a medical setting to reveal who they are from their perspective". At the same time, older LGBTI live with the memory of discrimination throughout their lives (Zeeman 2018), particularly any form of discrimination or prejudices that they received while in healthcare settings. It is well documented how past experiences inform current situations making many older LGBTI very wary. Many older LGBTI live with the memory of being immoral, criminal and needing psychiatric intervention. The immorality derived out of the Catholic churches being the 'arbiter of



public morality in all spheres of human behaviour, particularly sexual conduct” (Cooney 1999 p.277) while homosexuality was decriminalised in Ireland in 1993 (Rose 1994).

The traditional model of understanding homosexuality within the healthcare profession, derived from the cause and treatment paradigm thus rendering homosexuality as in need of psychiatric care. Conrad had viewed the medicalisation of everyday life as:


Defining behaviour as a medical problem or illness and mandating the medical profession to provide some treatment for it (Conrad 1975 p.12).

Later he intimated that the process of medicalisation begins with a definition:

in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it (Conrad 1992 p.211).

Once a behaviour is labelled as ‘a social problem’, for example homosexuality, it begins its journey of being considered from a medical standpoint resulting in a new medical model of homosexuality, rather than the definition from a criminal or immoral model. The model of homosexuality older people grew up with was threefold: a sin (immoral), a crime (criminalisation) and illness/disease (psychiatry). Medical treatments became the new form of punishment and social control (Conrad and Schneider 1980) so that the medical profession became Influential in defining identity and sexuality (Martin 1993), which in turn permeated cultural norms. The medical profession defined homosexuality and then produced ‘treatment’ and ‘cures’. This placed them in the position of power, resulting in the perception that they were the best group to deal with the ‘social problem’.

The home was and is the place where one feels most comfortable in being oneself. Home is the place where a person can be oneself and those who enter the home are invited people who are known to those who reside there. Kagan (2022) questions the concept of ageing in place, probing the nature of the hypothesis that links support and care insinuating that we may be infantilising older people. If support and care is considered as need based from both ends of the life cycle we negate the fact that throughout life we



may need support and care. Supporting people to live in the right place is a lifelong pursuit (Kagan 2022). This does not relate only to growing old but also as the public debates at present centre on the fitness of place for people under the age of 65 with disabilities being placed in nursing homes. This is due to the lack of places that facilitate the needs of people. Therefore, independent living for people with disabilities may not be a reality. Older people may also find themselves situated in similar multifactorial arguments (Lebrusán and Gómez 2022) that are considered around an older person's ability to remain at home.


However, homecare facilitates remaining in the home. For older community dwelling LGBT people this can present challenges. They may find homecare to be full of the unknown and unknowable and some of our participants maintained a performance of being heterosexual, but crucially they tried to prevent a '*discovery*' of their identity that might discredit them.

Wherever he goes his behaviour will falsely confirm for the other that they are in the company of what in effect they demand but may discover they haven't obtained, namely, a heterosexual [mentally untainted] person like themselves (Goffman 1963 p.58).

While Goffman maintains that when we are different, we go out of our way to appear acceptable within society. The home may present a different situation as Young (2005 p.155) suggests that in modern societies:

... an important aspect of the value of privacy is the ability to have a dwelling space of one's own, to which a person is able to control access, and in which one lives among the things that help support the narrative of one's life

Having a private space of one's own suggests that one can control who enters this domain. However, the need for home support calls this into question. The literature review uncovered that there is little written or researched about the experiences of LGBTI of homecare both nationally and internationally. Young claims that the home can help to 'support the narrative of one's life' (Young 2005 p.155) and this study reveals how the



narrative of the life of community dwelling older LGBTI people is maintained in the face of homecare.

Some participants in this project spoke about what it was like having a stranger enter their home. Their home reflects who they are and how they created it to make them feel comfortable in their own place. They understand it, it is theirs and those who enter are usually invited and are people they are comfortable with. It is familiar and knowable. As Plummer points out:


Through interaction he builds up commitments, perspectives, 'world-taken-for-granted views' and stable self-conception all of which lend a precious stability to his social world (1975 p.40)

This can be interrupted when an individual seeks homecare if they do not fit the expected normative frame of thinking. Once a person is in need of homecare, they have no control over who enters their home. They open themselves to the other or to being othered through a stranger, albeit an invited stranger as a home care worker, entering their home. We normally invite those we want into our home, but this is a different invitation as it is one necessary for health needs and it is to team of unfamiliar people not an individual.

4.2 A stranger in the home

The subject matter of this chapter is the meanings and understanding that older LGBTI people give to receiving homecare. A person learns meanings through socialisation (Mead 1934), s/he/they not only become a subject but also, to co-habitate in society with other, s/he/they must become an inter-subject, thus seeing her/him/themselves as other see her/him/they. In so doing, an individual integrates the values, belief systems and norms of their particular society, enabling her/him/them to occupy a position within a society. All participants in our study know how to be in Irish society and how to present themselves in public:

Self-presentation is a term that indicates conscious and unconscious strategies for controlling or managing how one is perceived by others in terms of both appearance and comportment (Dolezal 2015 p.237).



Community dwelling older LGBTI people understand the concept of self-presentation within a world that demands what they are not, heterosexual people.


The home, however, is private, a place where we can be who we are and as Goffman suggests, the place to recharge, not to perform, rather a place to be ourselves. The home is one place that members of the LGBTI community feel they do not have to perform in the world. It is their safe space to be. The home is private, a place where we can be whoever we are and as Goffman suggests, the place we can recharge, the place where we are not performing rather a place to be ourselves. People who enter the home are normally known, friends and family, but at times they are health care providers who we may not know.

Bain, a 55-year-old bisexual man, articulates what it is like having a stranger enter your home, even though they are invited as a homecare provider:

Well at first you know you don't really actually how should I put it, you don't actually communicate fully with a stranger at first, and it gets naturally better and better and now ok you actually know ok each other.

Bain indicates that in the situation of having a stranger, a homecare provider, enter your home you do not know each other but both know why they are there. Ardan, a 63-year-old bisexual man speaks in a similar vein:

It's like this unprepared moment and you are unsure of how to relate to this stranger, you don't know the best way to communicate with this stranger. You find it really difficult to navigate on your first experience. I remember a couple of times when I had new people sent to my home. I was really uncomfortable because I didn't know the background of the person that was sent to me and I really found it difficult to kind of socialise with this person. Because the person is a stranger to me, and the person is a stranger to me, the individual must have had some information on me that would have helped them to work better, they must have



had some pre-knowledge about my attitude, my personality, what I looked like as a person. Having a stranger is, a total stranger is really mind boggling, it is a time you need to try as much as possible to make the best decisions to work with others and to ensure that you get the level of support that you need.


Additionally, Ardan voices the 'unprepared moment', namely, how to prepare for this person even though knowing that this stranger will be arriving at the home. We know the expected ways of communication, but Arden speaks of being unprepared and consequently not sure how to communicate.

Also, Ardan is aware that the home care provider has pre-knowledge of him while he does not have the privilege of knowing anything about the homecare provider prior to their meeting. He is vulnerable wondering what the other knows about him but as the client wants to make the relationship work so that he can get the best possible outcome. Saraid, a 62-year-old lesbian makes similar sentiments when she notes:

It is having someone come around your house and you don't know them, and you haven't yet disclosed your details to them, they know little about you, so anxiety is created but with time it kind of makes you feel relieved when you get to know them personally.

Bain, Ardan and Saraid find themselves occupying the space of the unknown within their own home where they feel uncomfortable emerges. The taken-for-grantedness of knowing who enters your home is gone. Communication and getting to know each other becomes important in traversing that void.

However, as Saraid indicates, one must 'come out' and trust that the other person will be receptive. Bain, Ardan and Saraid also experience minority stress which can be the result of "negative impact on health and well-being caused by a stigmatised social context," (Mayock et al 2009 p.16).



Overall, within this study it was the social interaction with a stranger in their home which caused their initial stress and wondering what was known and unknown about them. they did not know how to act within their own space, the home.

4.3 Taking risks-- Coming out to your homecare provider


The progression of acknowledging who you are is the act of coming out, in particular, coming out to the self, which is the initial aspect of the process. It is also worth noting there is no comparable process for heterosexuals. Coming out is a precarious affair whereby LGBTI people choose when, where and to whom they relate their sexuality. It involves making decisions on whether to disclose or not to disclose, based upon whether it is safe to do so or not, resulting in the process being fraught with the unexpected, from social acceptability to rejection. However, for LGBTI people:

Coming out can be ecstatic release, joyful abandonment, passionate embracing, sexual surging, a plunging into new consciousness, a journey of discovery (Moane 1995 p.86).

Coming out is not a singular activity but requires indicating one's sexuality time and again. This process is continuously navigated by all members of the LGBTI community, young or old. We have noted the era in which older LGBTI people lived in. In their day-to-day lives, LGBTI people know how to act, react and behave within society, having developed what Draucker (1999 p.361) called 'everyday skilful coping'.

These everyday skills of coping become normal ways of being that enable them to negotiate the world in which they live. This can get called into question when a stranger arrives in the home particularly if your identity is uncovered. Gobnet, a 55-year-old transgender woman, tells her story:

I thought I was being discriminated against by some of their service providers because of my gender. Because I was identifying as a transgender. So why I am saying that is because I noticed that in some kind of way that particular staff, the way they cared for me actually changed after she realised that I was a transgender. Because she wasn't in charge of my discretion and all of that and it was long that



she knew I was a transgender, so I was alone when she started caring for me, that was after some conversation she realised that I was a transgender, you know. So, I could notice from the reaction in her face that I wasn't receiving a quality care anymore.

Gobnet's care changed once her identity was revealed. It was not that something was said, rather, it was the body language, the knowing, the look, the understanding that Gobnet brings to her situations from years of experience. The nuances of prejudice and discrimination are understood in both what can and cannot be said.


Gobnet's worth, value and understanding of who she is in the world was undermined:

It is only through being object that we can be given a value, assigned a worth, some 'thing' that can be assessed (Howard 2002 p.59)

Gobnet understood that she was not measured in accordance with her own community but the general heterosexual community, the community of her assessor, the homecare provider. Such judgment disrupts the sense of self, the taken-for-granted knowledge of knowing who I am. However, Gobnet did not allow herself to become an object of this judgement, as she reported the incident and took back her sense of self. Gobnet took control of her own needs by demanding a change of personnel. She sought someone who would care for her as she presented herself. She cannot be other than who she is which requires acceptance, indeed demands acceptance:

I didn't really want to have a problem with someone that wasn't comfortable with me. So, what I did was I requested for a change of person, so I didn't want to continue with her anymore, I let them understand that I was a transgender and I needed someone who can accept me that way, someone who would be able to provide me with quality care and respect my values or gender or anything like that [Gobnet].

For Gobnet having her needs met as a transgender woman cannot be taken-for-granted, the ability to speak to one's needs is not something every person can do but Gobnet used



her knowledge developed over the years not to accept substandard care or care with a negative attitude. Being transgender challenges the perceptions of homecare providers. The relationship may start out well but subsequent knowledge can lead to a decline in care, as exemplified by Gobnet's experience.

When a person is dependent on care it means:

...that one needs to accept receiving help from caregivers in various intimate situations such as bathing, dressing, going to the toilet, etc (Martinsen, Norlyk and Gramstad 2022 p.388).

While a person is required to learn how to negotiate accepting care, caregivers, equally, need to provide care in a 'safe, efficient, and high-quality care across all health and social care services' (Kelly et al 2024 p.1-2). High quality care is not merely an action but is inclusive of recognising the person receiving the care. As Gobnet found, being oneself is never easy when there is a dependent relationship particularly healthcare. She had to take control of her sense of self which she had built over years rather than allowing others to undermine the very foundations of her being.


Similarly, Myrna, a 53-year-old lesbian woman took control to remove the sense of being judged:

Sometimes just having a conversation they just go ahead to conclude without asking me so that's the fact they have already judged me based on my sexuality.

Myrna has experienced homecare providers who have judged her based on her sexuality. While she tries to negate how others view her, she cannot control the outcome so that being open about who she is may not necessarily led to the desired positive outcome. Myrna indicates why she reveals the self:

I do it that way so that you have the option of whether to proceed or not.

Consequently, she is protecting herself, taking back power and making a clear decision who can and cannot assist her:



You have the option that if you want to go ahead and work with me, if you can deal with me or not, I just kind of make it like a brief story about me, that way you can, ok so for instance you already have background information on this person. You've already known half the things about this person. So you know how to treat [Myrna].


By coming out Myrna takes back control over who enters her house and cares for her. This strategy, while forcing Myrna to come out, allows her to feel safe and know that the person who continues with her care, stays because s/he/they are comfortable with her.

There is an underlying assumption that healthcare workers are aware of LGBTI people and understand how to meet their needs. There is also an assumption that healthcare workers practice from an inclusive standpoint. However, Keavy, a 61-year-old lesbian woman made the choice to divulge her sexual identity and not hide who she is to obtain better healthcare:

I would say you shouldn't feel uncomfortable, it should be something you disclose, it will create a connection with the person and he or she will know what exactly your needs are.

Keavy considers that by being open about who you are a connection can be made and developed. Likewise, Myrna understands that if a caregiver cannot countenance working with a lesbian woman, the person should have the choice not to. Keavy, on the other hand, works from the premise that she should not be uncomfortable about who she is. Both are saying in their own respective ways that it is not me but you who should change. Indeed, Grania, a 54-year-old lesbian woman finds communication can transcend discrimination:

I believe communication is one of the key factors people might not understand. I try to communicate and when I communicate, I find that there are things that I thought would be, but they are not exactly the way I thought them to be... for instance what I mean when I don't understand their dos and don'ts most times, I don't understand how they perceive things, their notions or their perceptions about something, their perceptions about my reactions to a particular thing. I want to have



a conversation with them, but I find out that it wasn't exactly like this. That maybe they are doing this thing not to get me used to the uncomfortable lifestyle. There are several conversations that I would be having, and I'd be like ok this is not to get at me, this is just to make me feel stronger.

She tries to negate misunderstandings and correct first impressions particularly if she perceives that they may be wrong.

While some of our participants did come out to their health care providers, others weighed up what information they would allow the homecare provider to have about them personally. Within the literature, past experiences of health care will inform present and future interactions. Sive, a 57-year-old bisexual woman, illustrates how fear informs what may or may not be said:


You [a caregiver] try to ask me questions and I tell you, and you use questions about myself to judge my personality. That is crossing boundaries.

While this is how Sive makes a conjecture of what might happen the possibility, for her is all too real and she has preconceived ideas of where to draw the boundaries. Her past experiences may inform her present interactions with home care providers:

I am concerned about the discrimination and negative attitudes after getting to know me, am I supposed to hide my sexuality orientation? Oh, yes, I guess I am supposed to.

The fear of judgement and discrimination causes Sive to take the position of silence. if she reveals herself it may lead to prejudice and discrimination.

Holmberg, Valmari and Lundgren (2012) consider that when nursing or care support professionals enter the home the professionals and the occupants of the home have a set of expectations of what is going to happen. Patient-centred care suggests that the client should be met with dignity and respect. However, if heteronormativity is not challenged in caregiving, then dignity and respect of those who are not heterosexual



cannot be implemented. If Otherness is not recognised, inequality will continue to permeate all aspects of health and social care (Sherriff et al 2019). The conundrum for participants is that hiding oneself may not be possible in the intimacy of care in the home.

4.4 Coming to terms with homecare


To accept strangers in the form of homecare providers into the home indicates that the person to some extent recognises that they cannot live their daily life without assistance:

Becoming dependent on homecare in old age is a radical life change that requires complex adaptation (Martinsen, Norlyk and Gramstad 2022 p.388).

This chapter illustrates the WHO move towards the concept of the ‘living in place’ model for older people through their older friendly cities. We have seen that older people prefer to live at home rather than move into a nursing home. Home provides a sense of self, independence and dignity of being. However, illness disrupts an individual’s life and renders some older people becoming dependent on others. This can be a short time need or long-term dependency which takes time to come to accept. As Martinsen, Norlyk and Gramstad (2022) suggest it is a complex situation but one which requires a life change.

As humans we are born dependent but learn independence and from some people as we get older, we may move once again to dependence. However, unlike being a child there is a loss of independence that requires negotiation. Prior to requiring homecare all participants had achieved ‘successful ageing’ with a good quality of life (Layte, Sexton and Savva 2013), which, however, can remove the reality of the deterioration that inevitably is part of growing older (Martinsen, Norlyk and Gramstad 2022). Growing old is celebrated within a society more so if that equals being independent but becoming dependent is constructed in a very different way at times as it can be considered as burdensome upon society.

Charmaz’s (1997) suggests that the experiences of people with chronic illness includes a loss of the person that had been. While Charmaz articulates that in her experience of



chronic illness, Grainia on the other hand conveys loss of the self as a by-product of homecare as she experiences to receive the homecare, she needs she becomes other than herself. She loses herself to obtain adequate care.

totally a different person. You become a different person entirely, you can never be yourself...

Grainia indicates that she becomes a person who can somehow navigate the new situation she finds herself in. Aithne considered that she consciously changes:

I would be so cold. I wouldn't even be able to be open. I would have lost the sense of feeling open. I can't be open.

For Aithne there is a sense of loss of becoming someone she does not want to be and, because she changes, she loses the ability to be herself around certain homecare providers.


All our participants learnt they had to come to terms with their situations and employed different mechanisms to accomplish that. We have seen that Grainia and Aithne both decided that the best way forward was to protect themselves which left them with an empty feeling.

To achieve a sense of being in this new state of dependence Ultan advises being patient with the homecare provider and giving time to this new situation:

... we had to understand each other and to talk to each other, how to give each other much time to make sure we are related, we are familiar, and we are friendly.

For Ultan a friendship ultimately had to develop for the dependency to work. These aspects of a working relationship take time to create a relationship whereby each can be at ease with the other.

Mead (1934) indicates that the first language we learn as babies is body language. How an individual enters our home, the sound of their voice and the movement of their bodies may tell us more than the person realises. Communication arrives in many forms and our



participants are subtly reading the interactions around them. Charmaz (1997 p.2) suggests living with illness means 'overcoming stigmatizing judgements, intrusive questions, and feelings of diminished worth'. But as seen in this section, community dwelling older LGBTI people have various strategies in place to enable them to rise above these situations and create some successful outcomes, while for others a resignation that being closeted is best.

4.5 In summary

Older community dwelling LGBTI people live within the comfort of their home where they live their lives without intrusive questioning. Illness disrupts their comfort. It may require them seeking help to continue living in the community. When they decide to accept help, they are then committing themselves to a stranger entering their home. This is when their lives become disrupted as decisions are made about disclosing gender or sexuality or coming out. Some participants came to terms with the situation they found themselves in as the healthcare provider could be given access to their clients' bodies, cares and worries. This is the sharing of life being lived and is the optimal situation for community living older LGBTI people.

Chapter 5 Survey findings

5.1 Survey response quality

Despite several strategies used to reach out to the community of home care staff, it proved very difficult to recruit a reasonable number of people to look at the survey, and, of those who did access the survey, just over half consented to take part.

Other work such as Garnett and Northwood (2022) on reaching out to marginalised populations has shown the challenges of doing this and made some constructive suggestions for responding to these (Ellard-Gray 2015).

Common elements in this body of work include supporting participants in accessing the instruments required, building and developing trust and relationships over time with participants, and working with participants to develop ideas for priorities.

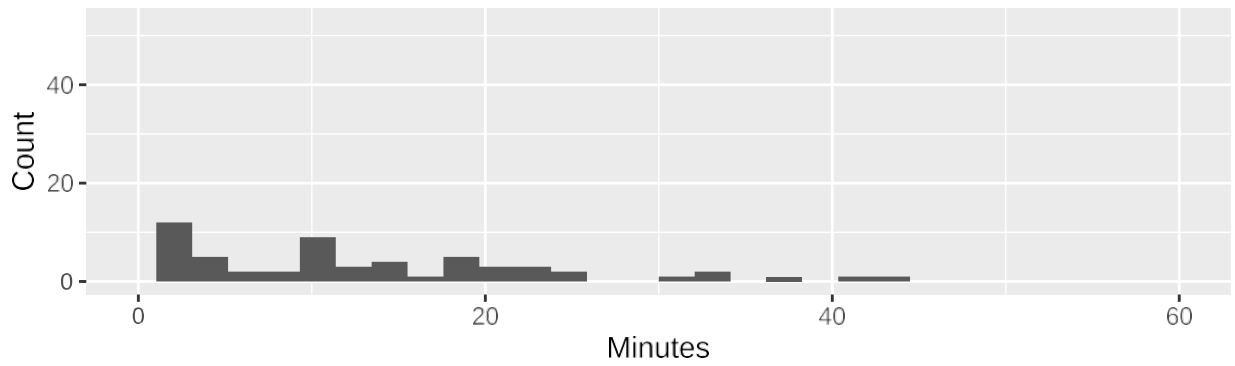
Few of the problems identified in work on home care staff in 2016 (Smith 2025) have been resolved. Although little definitive data are available, many Irish home care workers are migrants, with limited power in Irish society. The recent requirements for formal training for home care workers may be beneficial, in as much as the identity of this group of workers may be made stronger.

5.1.2 Duration

In gauging survey responses, it's important to see how long users took to respond to the survey. Those who fill in the survey in a under a minute have probably not taken the time to read the questions and consider answers

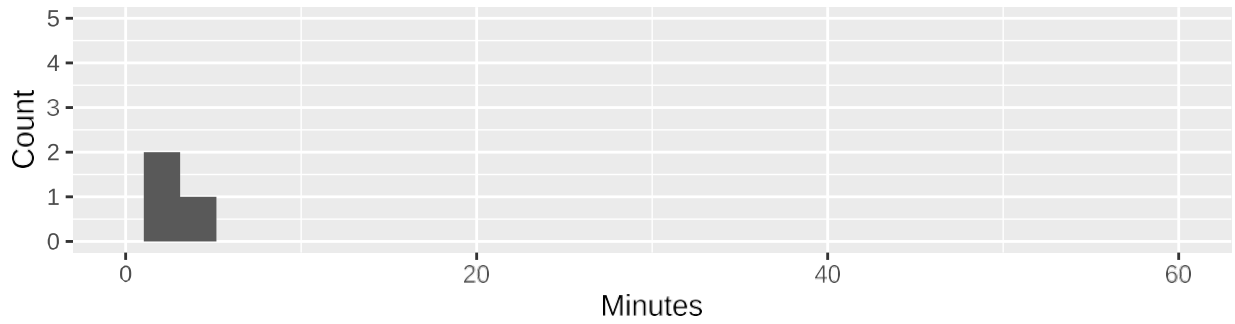


Original survey



Revised survey

Consent given

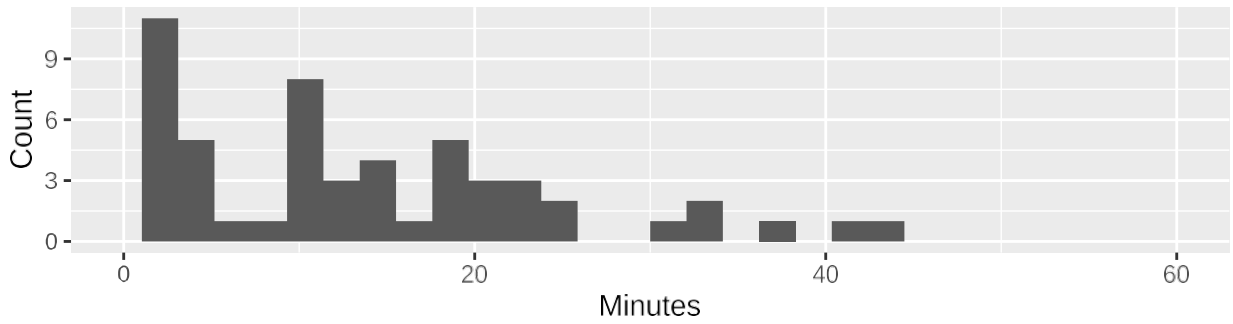


Looking only at those who agreed to take part, by giving consent when they initially accessed the survey, about of those who opened the survey, the picture is a little different. However, some people still spent implausibly short times filling in the questionnaire.



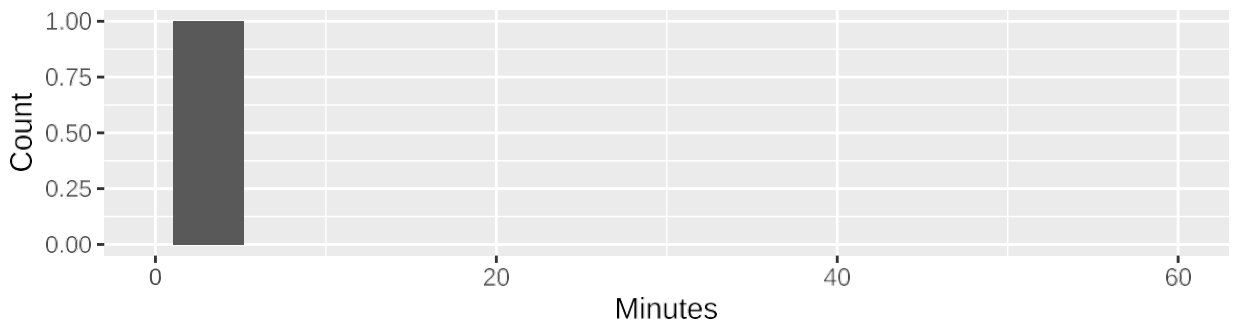
Original survey

Consent given



Revised survey

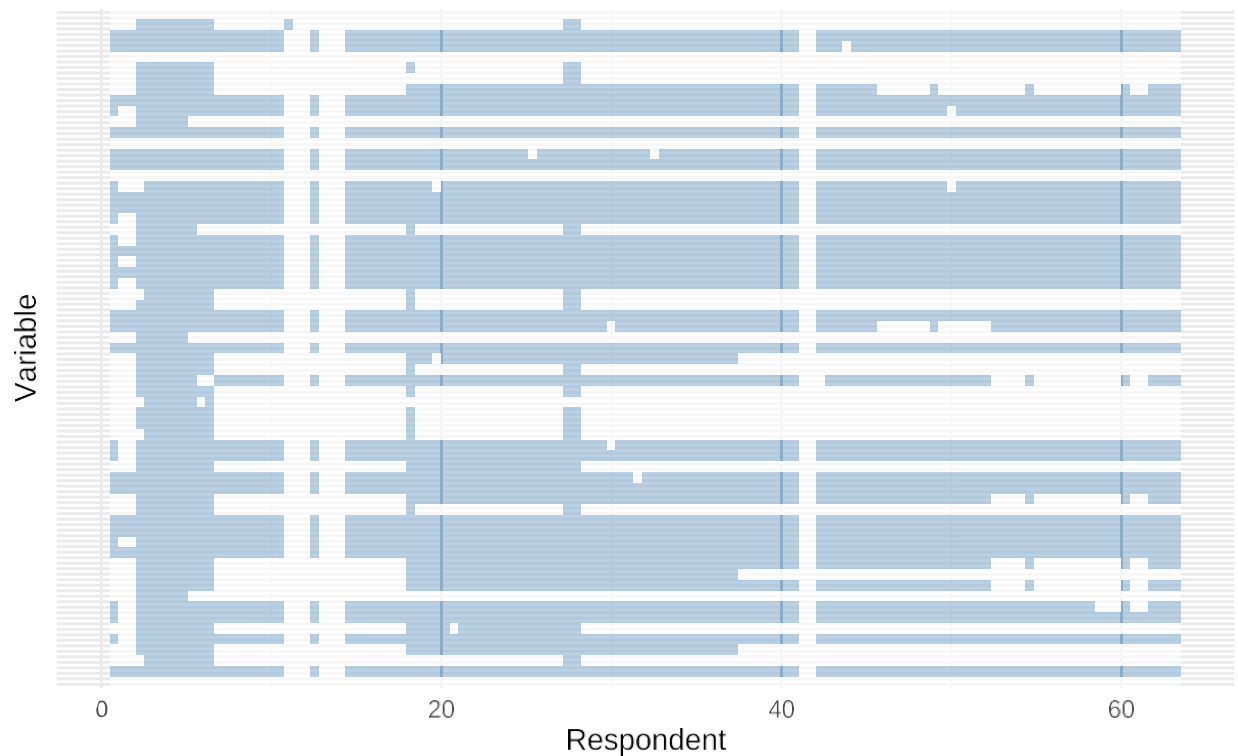
Consent given



5.1.3 Missing Values

It is important to know how many people replied to each section of the questionnaire. While 63 people gave consent to take part, for many questions fewer people responded. Some individuals who consented, responded to very few questions.

Responses and missing values by variable
White boxes show missing data




On this graph, each column represents a person, and each row represents an item, that is a single question. The rows are presented in groups of questions corresponding to the sections of the questionnaire. The pattern of missing values shown indicates both a sizeable number of missing values, and a strong tendency to miss out certain blocks of the questionnaire completely.

5.2 Introduction

A total of 122 people accessed the survey. Of these 63 gave consent to take part.

5.2.1 Demography and personal details

The rate of missing responses in this section was low, with most people completing every question.



Most who gave job titles were health care assistants, home support workers, or home care workers. There was wide range of experience, and 1 in 3 had worked 6 to 10 years in the sector, but 1 in 3 had less than two years' experience. There was a wide span of ages, and most worked in urban areas.

All who responded reported giving personal care to clients. Almost 40% cared for 5 to 7 clients daily, but a substantial number (1 in 4) had smaller caseloads. However, 18% cared for more than 7 clients a day. Most who responded (85%) were female. 62% self-described as heterosexual.

The commonest qualification reported was a FETAC/NVQ Level 5 (73%). The large majority (88%) reported no specific training on working with older LGBTI clients.

5.2.2 Work with LGBTI clients

Few had experience of giving care to people known to be members of the LGBTI community (5 (9%) rarely, and 2 (4%) regularly). However, many (16(30%)) did not know if they had such experience, suggesting the possibility that not all the LGBTI people involved were out to their carers.

A more detailed question was asked in the next section of the questionnaire. Respondents were asked if they had cared for people like this in their work, three times, once specifically for gay men, once for lesbian women, and once for transgender people. The differences between these two sets of responses are of interest. In each of the first three tables, the first column is people who said they did not provide care for that group of people at work, and the second column is those who said they did provide such care at work. The rows are those who said, 'Don't know', 'Never', 'Rarely' and 'Regularly', respectively to the question "How often have you provided



homecare to members of the LGBTI community?”

Looking at the individual responses to the same set of questions and ignoring those who did not give any positive responses, the individual responses from these 8 people show that few ‘Regularly’ gave care at work to people from the LGBTI community. Those who reported ‘Rarely’ giving such care, in general did not report giving care to members of one of the three specific groups included here

5.2.3 Familiarity

We asked a series of questions about familiarity with gay men, lesbians and transgender people. About 30% reported gay personal friends, or lesbian friends. Far fewer reported knowing transgender people.

For the questions, respondents were asked to choose as many responses as applied from :- * I rarely or never encounter people like this * I have seen people like this but do not know them personally * I have acquaintances like this * I have personal friends/family like this * I am like this myself * I have cared for people like this in my work * Don’t know

Table 1: Home care provision and Care for Gay men

	No	Work
Don’t Know	14	1
Never	30	0
Rarely	3	2
Regularly	0	1

Table 2: Home care provision and Care for Lesbian women

	No	Work
Don't Know	10	0
Never	24	0
Rarely	2	2
Regularly	0	1

Table 3: Home care provision and Care for transgender people

	No	Work
Don't Know	10	0
Never	21	0
Rarely	3	1
Regularly	0	1

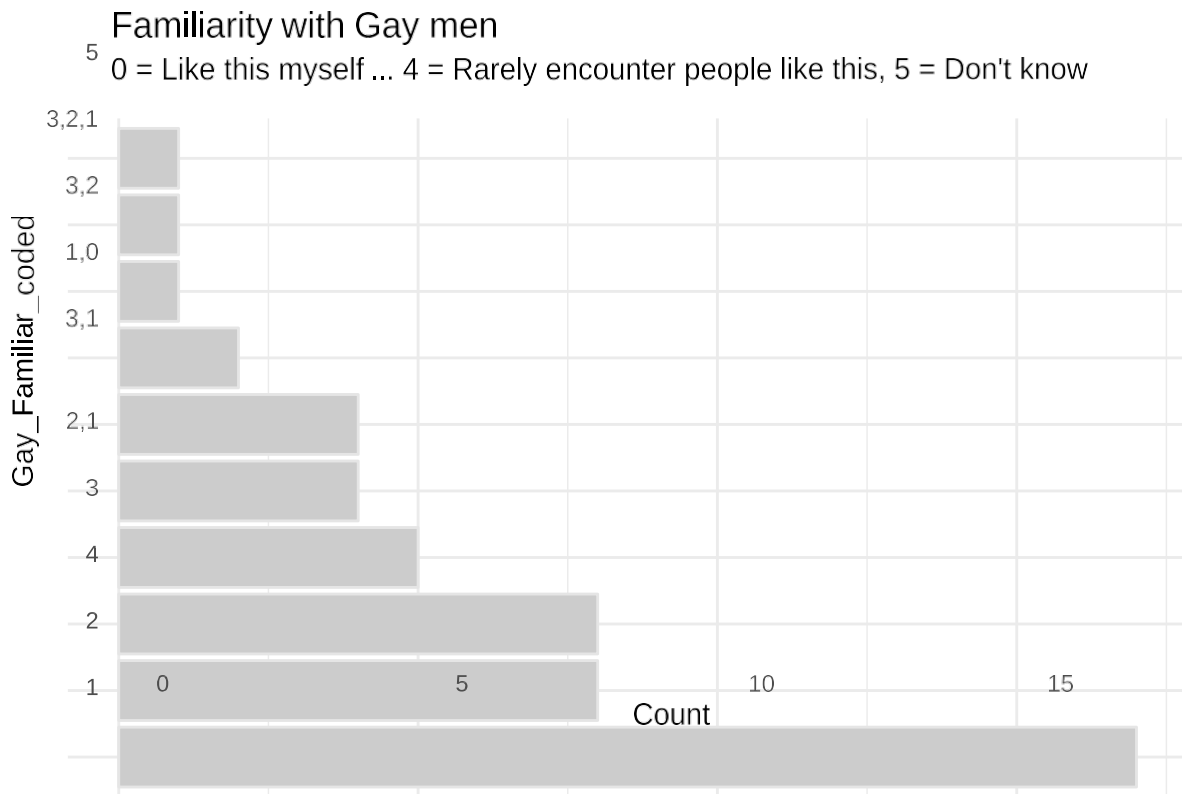
Table 4: Individual reported experience of providing care to LGBTI people

Homecare_LGBTI_rc	Gay_Care	Lesbian_Care	Trans_Care
Regularly	Work	Work	Work
Regularly	NA	NA	NA
Rarely	No	No	No
Rarely	No	No	No
Rarely	No	NA	NA
Rarely	Work	Work	No
Rarely	Work	Work	Work
Don't Know	Work	No	No

These were recoded as follows * 0 I am like this myself * 1 I have personal friends/family like this * 2 I have acquaintances like this * 3 I have seen people like this but do not know them personally * 4 I rarely or never encounter people like this * 5 Don't know

The final response, which relates only to care settings, was coded separately * Work I have cared for people like this in my work

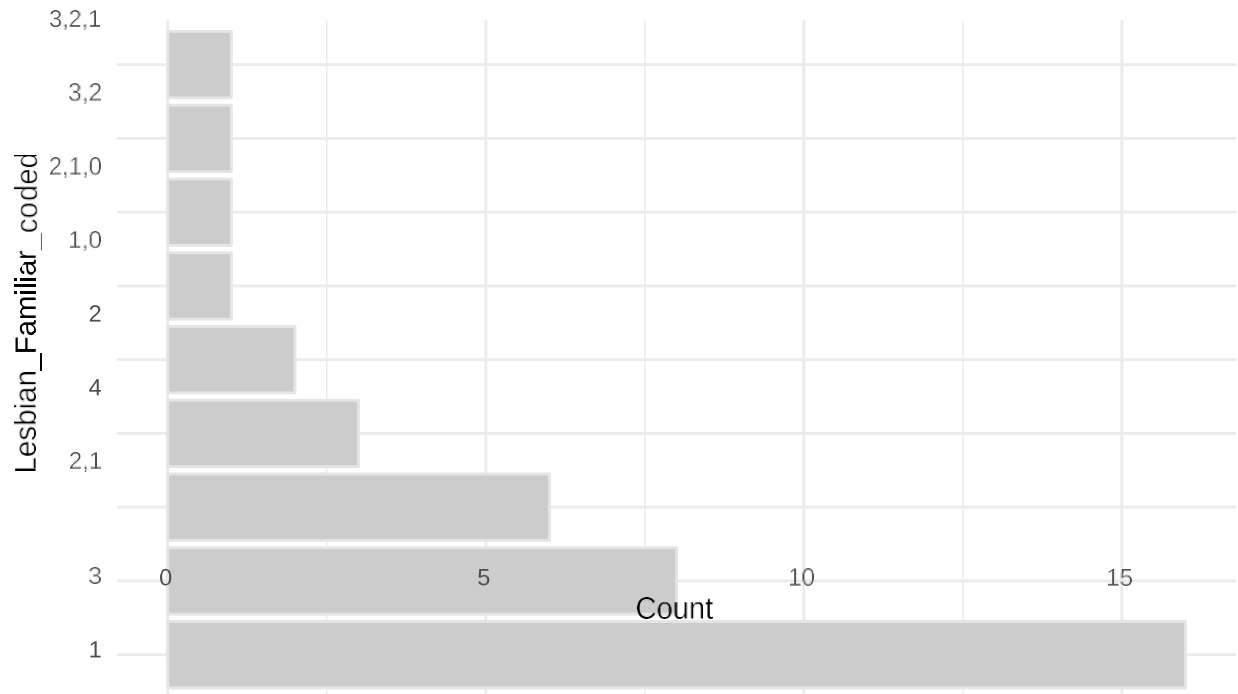
For gay men, most people either had gay people in their family and friends, or among their acquaintances. Seven said they rarely met gay men. Only two were gay men themselves.



For Lesbian women, only two respondents described themselves as such. Most knew lesbian women either in their family and friend group, or as acquaintances. Three said they rarely met lesbian women.

Familiarity with Lesbian women

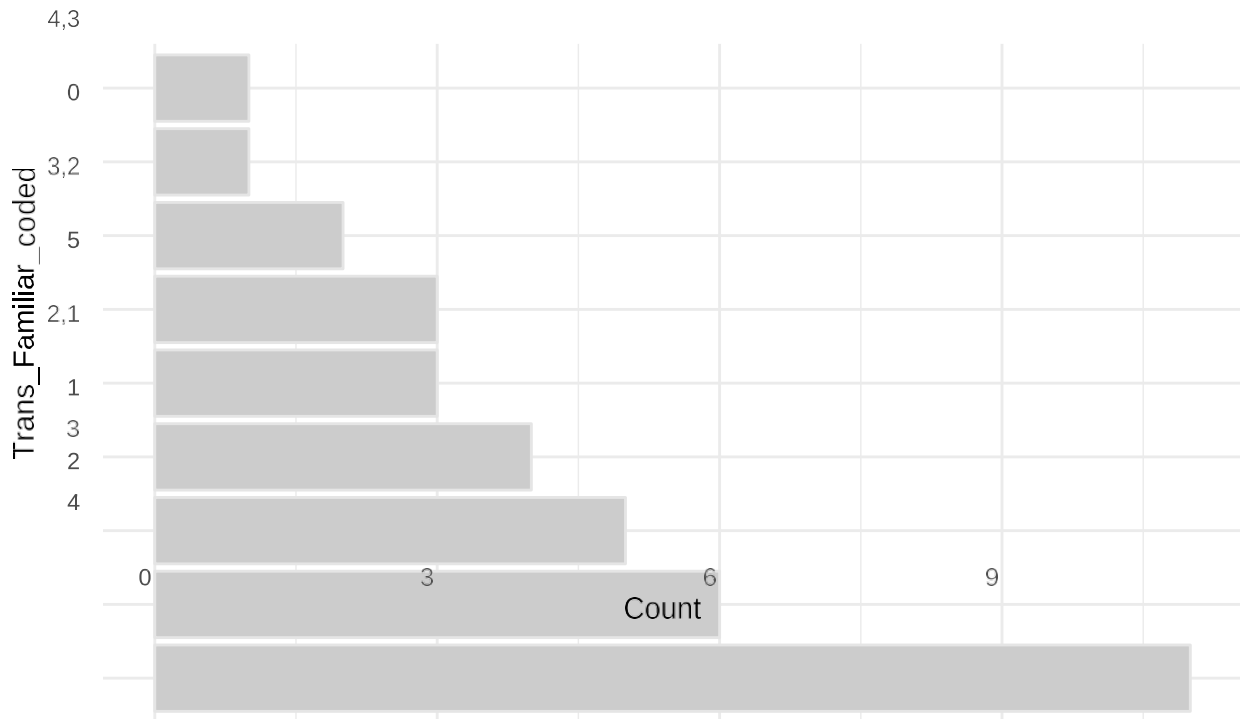
0 = Like this myself ... 4 = Rarely encounter people like this, 5 = Don't know



For transgender people, the picture was quite different. The largest single group of respondents, 12 people, said they rarely encountered transgender people. One respondent was transgender, and 10 had transgender friends, family, or acquaintances.

Familiarity with Transgender people

0 = Like this myself ... 4 = Rarely encounter people like this, 5 = Don't know



5.2.4 homosexual/Gay Men

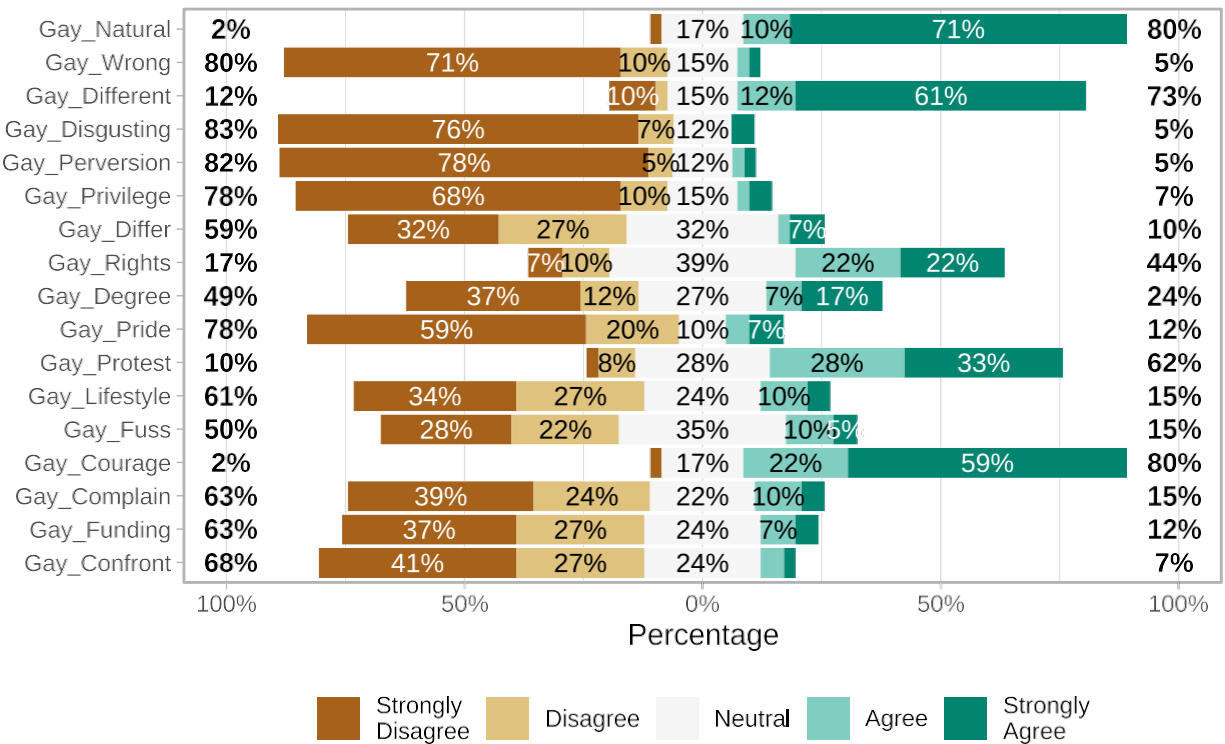
For both gay men, and lesbian women, a common set of questions were asked. Each was scored from 1 - Strongly disagree to 5 - Strongly agree.

A total of 51 people gave substantially complete responses to the questions on gay men. In contrast 39 responded to the questions about Lesbian women, and 35 to the questions about transgender people.

For gay men, the questions covered attitudes to male homosexuality, gay rights, and the process of securing them, and attitudes to higher education about Gay and Lesbian studies, and to Gay Pride. The large majority of respondents were supportive of the community, and of a rights-based approach.

Gay men

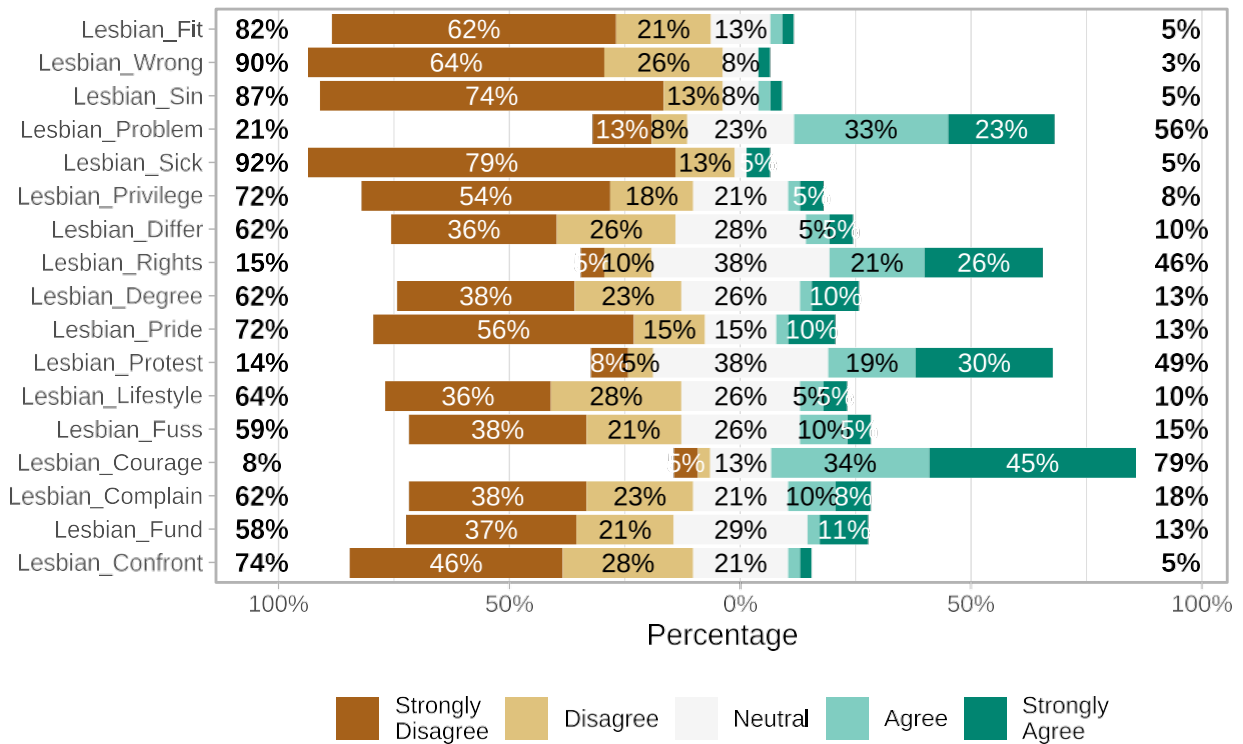
(N = 51 respondents)



5.2.4 Lesbian women

For lesbian women, the questions covered the morality of female homosexuality, lesbian rights, and the process of securing them, and attitudes to higher education about Gay and Lesbian studies, and to Gay Pride. Most respondents were supportive of this community, and also of a rights-based approach.

Lesbian women
(N = 39 respondents)



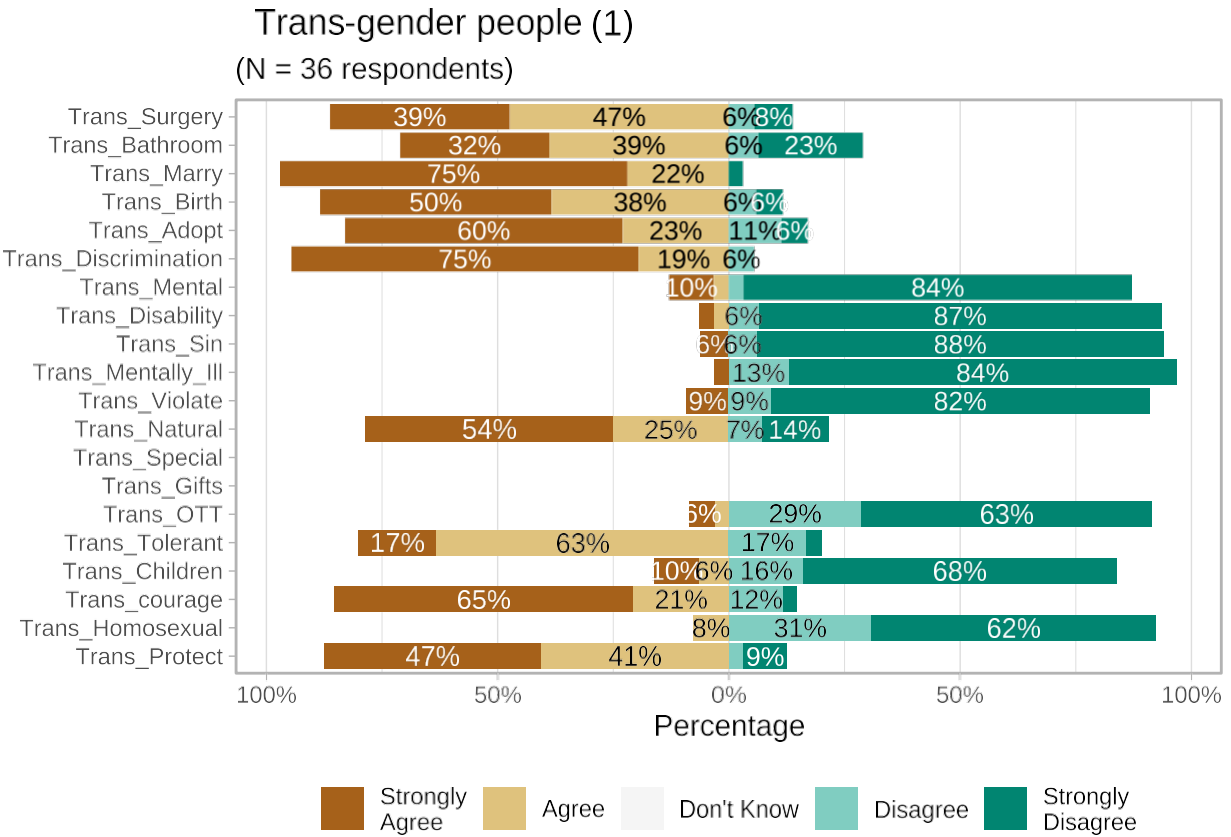
5.2.5 Transgender people

There are two sets of questions relating to trans-gender people.

The first set asked respondents to assess their agreement or otherwise with a set of statements about transgender people on a scale of “Strongly agree”, “Somewhat agree”, “Somewhat disagree”, “Strongly disagree” and “Don’t know”. These questions were somewhat similar to those asked about Gay men and Lesbian women.

Overall the responses were supportive of the expressed desires of the transgender community. Almost no-one answered ‘Don’t know’ to any of these questions. No-one responded to the two adjacent items ‘Transgender people have special place in society’ and ‘Transgender people have unique

spiritual gifts’.



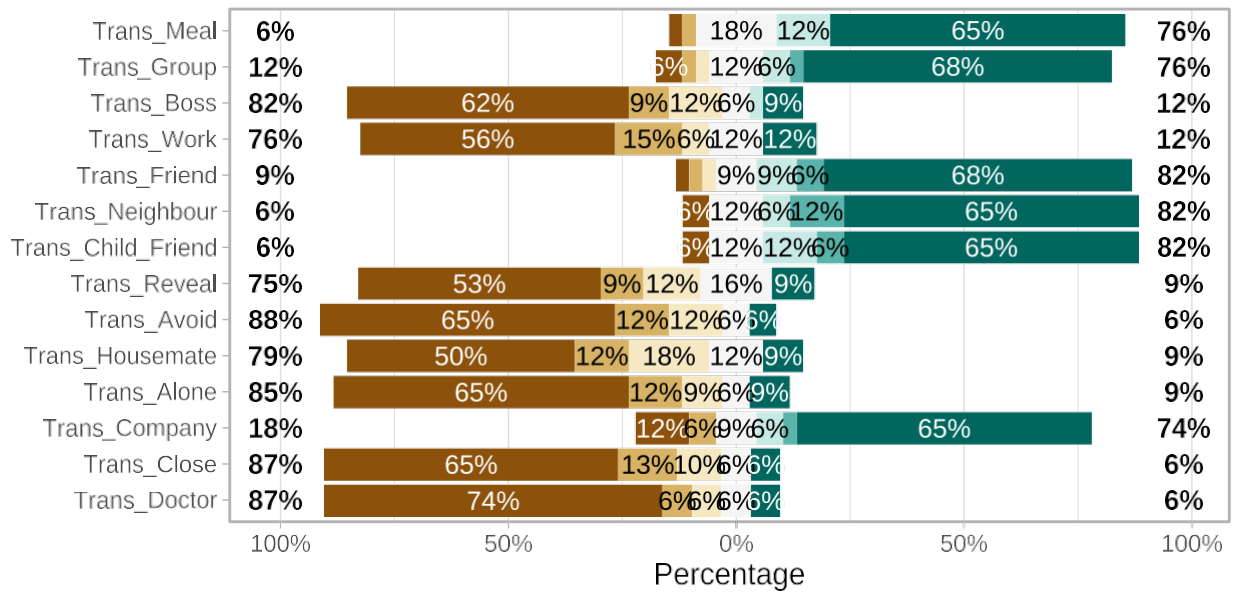
The second set of questions were scored from 1 ‘Strongly disagree’ to 7 ‘Strongly agree’ and focused on the respondents perspective to transgender people in various social settings. Examples include ‘If my child brought home a transgender friend, I would be comfortable having that person into my home’ and ‘If someone I knew revealed to me that they were transgender, I would probably no longer be as close to that person’.

Again, respondents were broadly supportive of social interactions with trans-gender people.

For clarity, two separate graphics are provided, one for the first half of the items, and one for the second half.

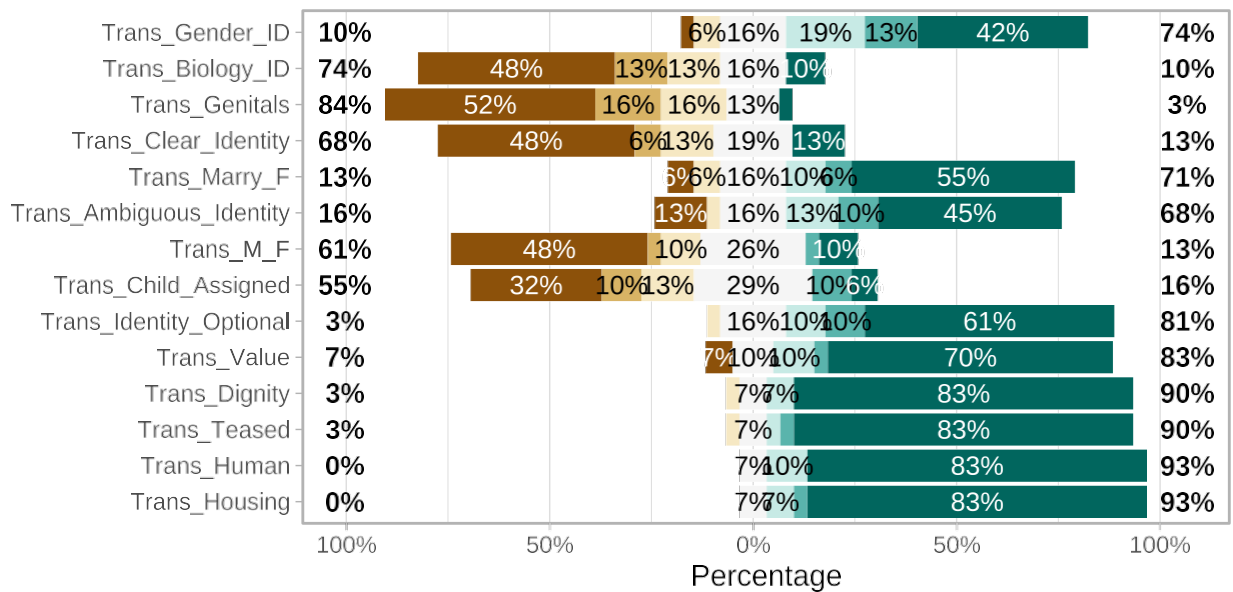
Trans-gender people (2a)

(N = 35 respondents)



Trans-gender people (2b)

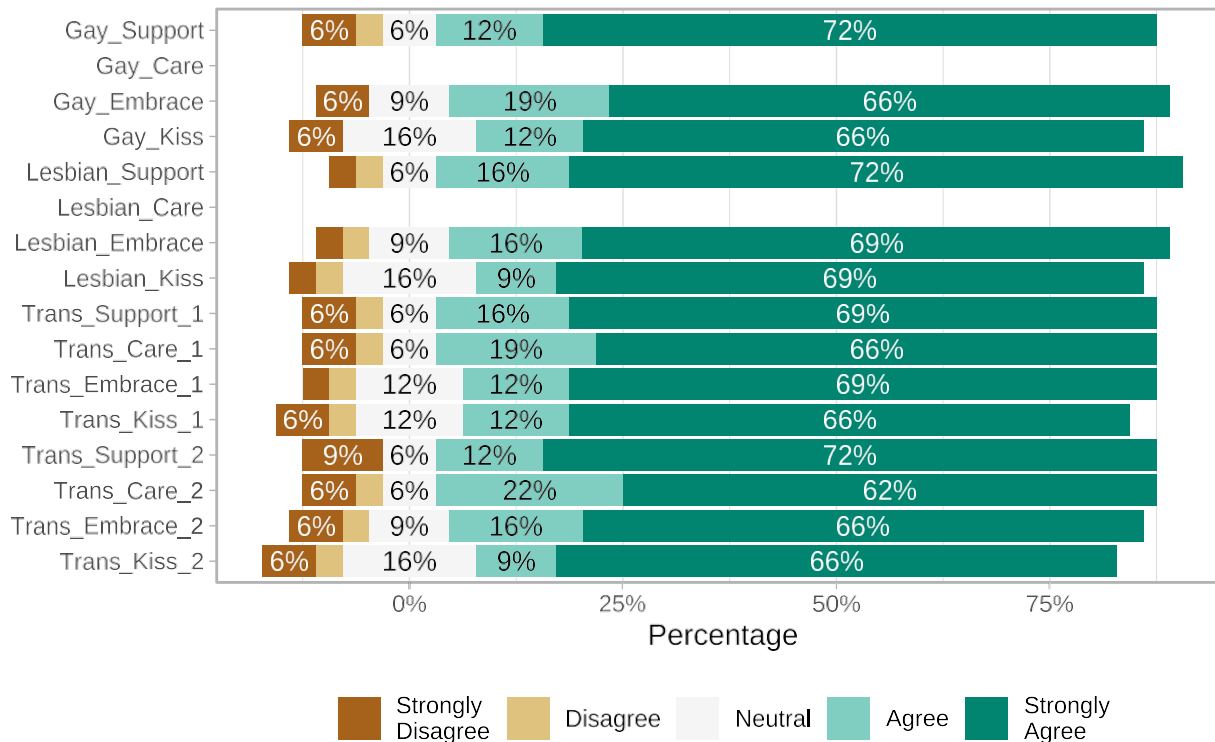
(N = 35 respondents)



5.3 Personal experience of care for LGBTI people

Personal experience of caring for LGBTI people

(N = 39 respondents)



5.3.1 Challenges

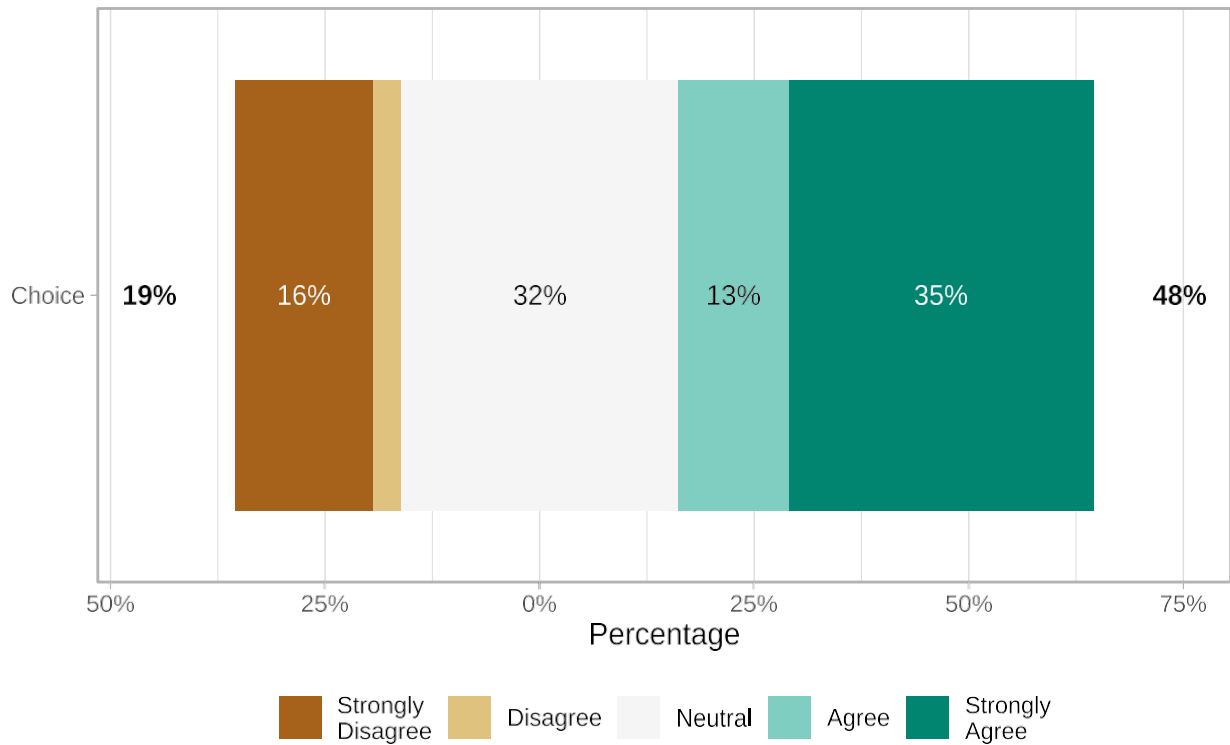
There were two further questions asked.

The first asked about choices for staff - specifically for agreement about the statement *'Home care staff should have a choice about whether they want to care for clients who are gay*

/ lesbian / transgender'.

Staff should be able to choose whether or not to care for LGBTI clients.

(N = 31 respondents)



Many respondents (10 of 31) were neutral about this question, 15 agreed, and 6 disagreed.

The second asked 'What, if any, do you consider the main challenges of providing homecare for people from the LGBTI community?'. the individual responses are shown in this table.

A broad interpretation of these comments would focus on ideas of equity or respect, and apprehension.

5.4 Conclusions

5.4.1 Strengths and weaknesses

The strengths of this work are that it is the first study of the

attitudes of home care staff to care for older LGBTIQ+ people in Ireland, these attitudes are positive, with very little expressed prejudice towards the community. It also shows that few home care workers are consciously aware of giving care to member of the community. This may reflect real experience, or that members of the community are hiding their sexuality from their home carers. Older members of the community may have had the experience of being closeted for many years and may continue this in aspects of their lives today.

The weaknesses are the low participation rate. It is unclear exactly how many home carers there are working for private service providers, but a reasonable estimate is over 5,000. Of these 122 looked at the survey, and 63 filled in at least part of it. There were sections, notably those dealing with transgender people, which were especially poorly completed. This may reflect wither the length of the questionnaire, or the relatively low saliency of transgender issues in the lives of the respondents. It is also possible that had resources been available to provide the questionnaire and, especially, the explanatory notes in multiple languages, this might have increased uptake.

Challenges

Using the correct pronouns on all legal documents of notes, people not feeling respected in their own ho	Cultural and religious differences
None though some of the older generations are guarded/afraid to be open regards their orientation I think fear of the unknown is the biggest issue.	
Once a carer meets and gets to know a client I don't th	Your values and upbringing
I think many people would be apprehensive, even though I myself wouldn't. I also think a lot of people	Nothing. They are the same as everyone else
People not understanding that everybody has the right to be who they are regardless of their preferenc	No challenges really, you treat everyone the same and equal
None, all the same	
There may be a stigma about it, I don't know but it would be a challenge,	

a change in normality. I sup No reason

1- if the carer isn't educated or open about gender and sexualities, it can cause problems for anyone in the main challenges are misconceptions.

People are all the same no matter what sexual orientation the None, every individual has freedom of choices within self's

Choice given to Carer if they want to assist

provide care best for everyone. That they might not be comfortable with my presence

Personally, I do not have issues but I think education and awareness to avoid social bias is the key and i The main challenges are people's bias towards these communities and lack of understanding of their spe

5.5 Overall Conclusions

There was a high level of support for, and positivity towards the LGBTIQ+ community in these responses. Few carers felt that there would be any issues for them in providing care to older members of the community.

Future work in this file might benefit from more of a focus on co-creation of instruments with potential participants and community members to ensure that salient issues were covered, and that instruments were shorter. In addition, provision by funders of adequate resources to prepare multiple translations of instruments would be advantageous.

Chapter 6 Educational Resource

The third component of our project aimed at developing an innovative educational resource intended to train health and social care providers, volunteers and other professionals in the homecare sector to deliver inclusive, person-centred homecare for older LGBTI people.

Chronologically, this was the last segment of the project so that the content of the educational resource could be guided and informed by the findings of the first two.

The need for improved training at all levels of health and social care was voiced prominently among the experiences of homecare provision examined in our scoping review (Duffy et al., 2024) and efforts are being made internationally to potentiate it through the creation of different kinds of teaching material (Yu et al., 2023; Dionisi et al., 2020).

The ideation of our course was based on the following three main starting objectives. First, we planned to produce a course that was accessible in terms of content and language, and also freely available online so that it could reach the widest possible number of interested learners. For that reason, we opted for the creation of a Massive Open Online Course (MOOC) that is [now/soon going to be] available through the platform Future Learn. Second, we wanted the material covered to be effective in providing a balanced combination of theoretical knowledge (in topics such as nursing and care, sociology of health, and LGBTI studies) and practical tools (guidelines, situational vignettes, assessment quizzes) that could be applied within the distinct experience of delivering care to older members of the LGBTI community in the context of their homes. Third, while wishing for the course to be available internationally and transferable across different national health contexts, we also wanted it to reflect the specific realities of homecare in Ireland, and to present as background the evolution of acceptance and integration into Irish society of sexual minorities.


6.1 Structure and development of themes

Knowledge acquired through carrying out both the scoping review and through the phenomenology-based interviews with study participants, linked with insights from our team's PPI members, led us to select the themes for the course.

The overarching premise of our selection was the consideration that a homecare visit is the balanced encounter between the expertise of a care provider and the domestic reality of a care receiver with specific health and social care needs, but essentially consists in the arrival of a stranger into the private space of an individual. Homecare is therefore a vulnerable experience involving an unknown person gaining access to a space that, in the case of an LGBTI household, is also the repository of a sexual minority identity, with a history and lived experience of isolation, prejudice, and discrimination. For our course, we aspired to dissect, map, and illustrate the components and dynamics of this encounter, and address the relevant conceptual, linguistic and terminological, and emotional tools necessary to navigate it with competence, comfort, and confidence.


The course was entitled PRIDE at HOME, for Platinum Rainbow Guide for Homecaree. It runs for three weeks, and each week carries two lessons, or topics, in turn divided into a series of activities consisting of texts, articles and definitions, alongside videos, audio recordings, and infographics.

After a welcoming introduction that outlines the objectives and general theme of the course, and lists its authors as well as the institutions and funding bodies that made its realisation possible, Week 1 concentrates on the two interconnected motivations justifying the need for an educational resource of this kind: the state, past and present, of the health inequalities faced by the LGBTI population, and the necessity to define, build, and promote a more inclusive, and LGBTI-congruent person-centred care. The first topic introduces the definitions of minority stress and heteronormativity considered useful for a care provider who encounters, especially for the first time, non-heterosexual identities. This topic includes stories and



testimonials from known Irish LGBTI personalities and advocates, such as Edmund Lynch (1947-2023) and former president Mary MacAleese, who recount the hardships this community has faced over the years, the progress achieved up to now, and the needs and challenges that remain to be addressed, not least in the domain of health and social care. It also includes a detailed chronology, from the 19th century to the present day, of main milestones in the history of LGBTI rights in Ireland, illustrated through an interactive timeline. The second topic in Week 1 introduces the general principles of person-centred care and drawing from the experience of various participants in our study, situates them within the specific context of the LGBTI population, emphasising the home as a space to safeguard where everyone has the right to be themselves and express who they are.

Week 2 moves on to cover information that a homecare worker may find useful when navigating questions of sexuality, diversity, and representation. The first topic includes the definitions of gender and sex assigned at birth, as well as gender identity and expression, and sexual orientation. It also lists the meaning of each of the letters making up the abbreviation LGBTQIA+, which is constantly evolving to be inclusive of everyone who wants to be a part of the community. Finally, this section underlines that older people continue to be sexual beings, and that while sexuality does play a role as age advances, it is also only one component of a much broader and variegated sense of what it means to be LGBTI, including perspectives on family, relationships, and belonging, and in general ways of experiencing the world and society. The other topic in this middle week centres on ways that an historically invisible population can be made visible by care providers, for instance, by cherishing and displaying in their offices and company's advertising material, the inclusive rainbow flag, or by making sure, through the employment of suitable language in both verbal interactions and in forms and documentation, of recognising same-sex relationships and the plurality of non-traditional family arrangements.



Week 3 addresses a central aspect of older LGBTI people’s experience of homecare (or indeed of any health and social care), and that is deciding whether or not to reveal their gender and sexual identity to care providers. Infused with the lived experience of a PPI member and of some of our study participants, this topic delves into the spectrum of choices surrounding the decision—from not disclosing to disclosing upfront or gradually—and the underlying motivations, which mostly pertain to the anticipated repercussions the sharing of this information may end up having on the quality of care received, or how it might in general compromise the trust of the care rapport. Special attention is dedicated to the emotions, such as fear and shame, that pervade episodes of coming out, on the part of both the care provider and care receiver. The final week also offers a list of recommendations and guidelines that summarise the main take-home messages from all the topics covered and invites learners to stay committed to learning.

6.2 Practical meaning and assessment

At the end of each topic, we included a section entitled “What does this mean in practice?” that had the purpose of summarising the content covered and translating it into bullet-point, practical examples, advice, and guidelines aimed to situate it within real-life scenarios of a homecare visit. By way of a few examples, in the context of reminding learners of the history of social exclusion endured by older LGBTI people, one practical advice is to “Do some time travel in your head and try to imagine what it must have felt like to live as an LGBTI person during that time”. In the context of acknowledging same sex relationships and the diversity of family realities in the LGBTI community when inquiring about personal information, the practical advice is “Instead of habitually asking clients to provide names of their ‘next of kin’, ask a more open and generic question, such as ‘who would you rather we contacted in an emergency?’”. To make this information easier to refer to and remember, these practical guidelines are presented in infographics tables.

The final section of each topic consisted in an assessment. We chose the form of a short multiple-choice quiz that asked learners to select the right or true answer from a list of options. Learners cannot proceed to the next topic unless they have passed each assessment, which they can take more than once.

WEEK 1	
WELCOME 1.1 Welcome to the course 1.2 Who developed this?	
INEQUALITIES FACED BY OLDER LGBTI PEOPLE 1.3 Inequalities faced by older LGBTI people 1.4 Older LGBTI People in Ireland 1.5 A Couple of Definitions 1.6 Milestones in the History of LGBTI Rights in Ireland 1.7 What does this mean in practice? 1.8 What have you learned?	PERSON-CENTRED HOMECARE 1.9 Person-Centred Homecare 1.10 A framework for person-centred care 1.11 Why is person-centred care specifically important in homecare? 1.12 What does this mean in practice? 1.13 What have you learned?
WEEK 2	
SEX AND GENDER 2.1 Sex and Gender 2.2 Sex is Not the Same as Gender 2.3 LGBTQIA+, What Does It All Mean? 2.4 Sexuality and Intimacy in Older Age 2.5 What does this mean in practice? 2.6 What have you learned?	IN/VISIBILITY 2.7 In/Visibility 2.8 Symbols 2.9 Inclusive Language 2.10 What does this mean in practice? 2.11 What have you learned?
WEEK 3	
DISCLOSURE OF GENDER IDENTITY AND SEXUAL ORIENTATION 3.1 Disclosure of Gender Identity and Sexual Orientation 3.2 Choices 3.3 Shame 3.4 What does this mean in practice? 3.5 What have you learned?	SUMMARY AND MAIN RECOMMENDATIONS 3.6 Acknowledgements 3.7 Additional Resources 3.8 Summary and Main Recommendations


Table of the course schedule with topics and list of activities.

6.3 Final considerations

PRIDE at Home is an educational resource free and available to everyone with an interest or a profession related to or intersecting the health and social care of LGBTI minorities.

We believe it is innovative in its scope because it mixes theory and practical examples to help navigate real-life situations. In our opinion, one intrinsic value to PRIDE at Home is its embeddedness in themes that, in addition to finding correspondence in wider literature from other contexts, as also evinced in our scoping review (Duffy et al., 2024), have specifically emerged from the analysis of interviews with participants in our study, which, through a hermeneutic approach, sought to explore the lived experiences of older LGBTI individuals at the receiving end of home support services in Ireland. The participants' narratives have oriented our choice of salient topics as well as the structure of the course and are included in the teaching material. Moreover, PRIDE is also informed through Public & Patient Involvement of members of the LGBTI community who, in addition to bringing with them direct experience of accessing health and social care, carry expertise and background in its provision—such as a background in geriatric nursing, psychotherapy, mental health, health education, and healthcare management.

Issues of prejudice, discrimination, and lack of competence around the experience of older LGBTI individuals in health and social care settings are common across contexts and national realities. However, we believe that training and education initiatives in each national context benefit from illustrating to those who learn the specific experience of this minority group where the care takes place. That is why our course is rich with stories and testimonials, from our cohort of participants, but also from known Irish LGBTI personalities and advocates who tell of the hardships this community has encountered over the years, the progress achieved up to now, and the needs and challenges that remain to be addressed.



That said, this same distinctive feature of the course is also in part a limitation. The small size of the sample of interviewees in our study weakens the extensiveness of the interpretations and conclusions of the study findings. The sample was also not homogeneously representative of all groups of the LGBTI community. For instance, no intersex individuals participated in the study, and only one participant identifying as transgender took part. We acknowledge that these groups present unique health and social needs that are distinct from those of cis members of the LGBTI community.


The course is not an unmodifiable entity, but a resource that can be updated and expanded as knowledge on the realities of homecare for the LGBTI population increases. We hope that it can be an inspiration for the creation of other resources in other contexts, in the shared purpose of improving the inclusiveness of care services destined for sexual minority groups, so that they are treated as everyone else and at the same time recognised as individuals with a distinctive set of needs that includes awareness and consideration of their histories of invisibility and inequality.

Chapter 7 - Conclusions

The aim of this novel project was to examine: i) the lived experience of older LGBTI People dwelling in the community, and their support circle of homecare; ii) uncover the knowledge and attitudes of homecare professionals of LGBTI people, and iii) develop an educational resource, that will lead to improved practice and quality of homecare services received by community dwelling older LGBTI people. This was a mixed methods study. The qualitative aspect of the study sits within a rich vein of research whereby we 'always question the way we experience the world, to want to know the world in which we live as human beings' (van Manen 1999 p.5). Within this study the lived experience of older LGBTI People dwelling in the community, and their support circle of homecare was explored, how they constructed and gave meaning to the situation they found themselves in. The survey aspect of this study was to unearth the attitudes of homecare providers of the LGBTI community they cared of. Finally, the third part of the study was to develop an educational resource for homecare providers.

The following is the list of findings from the qualitative aspect of the study:

1. This study provides some understanding to the level of care provided to older community dwelling LGBTI community.
2. Older members of the community prefer to age in place and remain in their own homes.
3. All participants spoke of their personal struggle in having to seek homecare
4. Many older members of the LGBTI community find it difficult to have strangers enter their home. Home is their safe space and when a stranger enters the home they do not know what to expect. Their security is challenged.
5. Not have access to the knowledge the home care provider has about them prior to entering their home renders some older members of the community on the defensive side resulting in them negotiating their stance prior to engaging with the provider.

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6. All members of the LGBTI community regardless of age know that 'coming out' is an ongoing activity. An older LGBTI person takes risks when they decide to 'come out' to their health care provider.
 7. All members of the LGBTI community grow up learning how to read the body language of those around them. It is not what is being said rather the unsaid. Transgender members of the community are more aware of this and are at greater risk for discrimination if their identity is revealed.
 8. All participants in this study spoke about coming to terms with needing homecare. It creates a dependency on others either on a short, medium or long term thus requiring good community and a relationship of trust.

The findings from the quantitative aspect of the report are:

1. In hindsight the survey was too long. It would have benefitted from a deeper engagement with homecare providers and with the members of the PPI team. However time mitigated against this.
2. The response rate was poor despite several strategies undertaken to recruit.
3. The majority of respondents suggested limited knowledge of the community or indeed of having provided care for members of the community.
4. There would appear to be little knowledge on transgender people.

The third aspect of the report was the development of the educational resource.

PRIDE at Home -Platinum Rainbow Guidance for Home Care

1. The educational resource was developed from both sets of data.
2. PRIDE at Home is an educational resource free and available to everyone with an interest or a profession related to or intersecting the health and social care of LGBTI minorities

3. The educational resource is a MOOC – Massive Open Online Course. It sits on the FutureLearn Platform.

<https://www.futurelearn.com/courses/pride-at-home-platinum-rainbow-guidance-for-home-carers>

4. The programme is a 3 week, 6 topics programme.

In conclusion this report provides an insight into the experiences of older community dwelling LGBTI people in Ireland. It provides an insight into the attitudes of homecare providers towards older members of the LGBTI community. Bringing both sets of data together PRIDE at Home was developed to enable those working with sexual minorities to care without discrimination or preconceived ideas about LGBTI people. Those who undertake the programme will learn to practice from a human right, open minded framework thus embracing the person they meet in their own home. Our logo speaks to this with the caring hands embracing the rainbow home.

Recommendations for practice

The following are a list of recommendations for health care practitioners who work with members of the LGBTI community. These recommendations are taken from the PRIDE at Home MOOC

- Show openness

Even if you think that the sexuality of your clients does not or should not influence the way you provide care to them, remember that while sexuality does play a role in older age, it is also not the only component of what it means to be LGBTI.

Show openness to discussing or addressing topics and issues you may be unfamiliar with such as sexuality, gender identity, and sexual orientation. Older LGBTI folks have been invisible for too long. They just want, as part of the care, to be fully recognised for who they are.

- Be mindful of history

Always do some history math and fit the age of your client within a larger timeframe. Remember that anyone who is aged 50 or older spent some part of their adult life fearing that their sexual orientation could get them into trouble. Show kindness and provide reassurance through your words and behaviour that you are aware of this and that you empathise with them.

- Be prepared to listen

While your job as a homecare worker may be paced by practical tasks, tight schedules, and deadlines, please make sure to listen to clients' stories and complaints. Make space for concerns that matter to them—for instance, having their experiences of inequalities and discrimination acknowledged--, and show compassion and understanding to build a valuable relationship that will be rewarding in the long term.

- Develop emotional skills

If you encounter a client whose gender identity/expression or sexual orientation is not one you have encountered in the past, do your best not to act surprised or show discomfort. If you experience discomfort, be aware of the possibility that what you are feeling may be rooted in shame. Take a moment to understand and rationalise it, and try to go past it, reminding yourself that your client doesn't deserve your shame. If you like, express honestly in simple words that this is something new to you, but that you are not making any judgments and you are fully ready to learn more about it.

- Avoid assumptions and stereotypes

You can't tell someone's gender identity or sexual orientation by the way they look, speak, or behave. Even if you think you know what gender they identify with, do not assume your idea is correct. Equally, if a client tells you that they are in a relationship, do not assume the gender of their partner.


- Use inclusive language

Make sure you use inclusive language to make LGBTI people feel seen. For instance, use the word "partner" or "spouse" instead of "husband" or "wife", unless that is how they themselves identify their significant other or the expression "contact person" instead of "next of kin".

- Acknowledge and respect pronouns

Keep in mind that the way people describe themselves in the LGBTQIA+ community changes regularly. Listen to the words your clients prefer to use to call themselves and follow those accordingly. If you are unsure about what pronouns to use with a new client, ask them what they prefer on your first visit.

- Ensure representations



Signal your acceptance of LGBTI folks by wearing a rainbow badge. Ask your organisation to use symbols, such as the rainbow and progress flags, in the ways they present or publicise their services to potential customers and their families or support circles.

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