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The Health, Social Care and Housing needs of Lesbian, Gay, Bisexual and Transgender older people: literature review

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EXECUTIVE SUMMARY

How many people?

Estimates of the lesbian, gay, bisexual and transgender (LGBT) population vary from 3 per cent to 8 per cent of the population. A recent Treasury estimate (Campbell, 2005) suggested there are about 175,000 lesbian, gay and bisexual people in Wales (or 6% of the total population). Assuming an even spread across the age range, about 65,000 people over 50 are lesbian, gay or bisexual. No similar official estimates of the transgender population are available.

Needs the same as other older citizens

Many of the health and social care needs of older people who are lesbian, gay, bisexual or transgender are likely to be the same as other older members of the community in Wales. However there are areas where the needs of these groups will be distinct.

Discrimination

Lesbian, gay, bisexual and transgender people suffer from discrimination in a number of different forms:

- **Heterosexism** is the assumption made by society that forms of sexuality other than heterosexuality are deviant. Heterosexism is institutionalised and overtly practiced by some politicians, religious figures and the mainstream media and underlies historical efforts to “heal” homosexuals.
- **Homophobia, transphobia and bi-phobia** describe the prejudice, hostility and discrimination directed at homosexual, bisexual or transgender people purely because of their sexuality.
- **Ageism**: like other older citizens, lesbian, gay, bisexual and transgender people are subjected to discrimination as a result of their age. For LGBT people, assumptions about their sexuality may compound the discrimination.

Consequences of discrimination

Punitive attitudes to sexual minorities directly impact on the quality of communication and care provided to these groups. This may include institutional discriminatory practices which exclude LGBT people from access to care, delay access to care, result in poorer quality of care when it is accessed or exclude carers from proper access to patients.

Older LGBT people may seek to conceal their sexuality as a result of guilt, shame, past experiences of discrimination or medicalised oppression such as attempts to “heal” them in earlier decades.

Supportive networks are important in maintaining self-esteem in the face of discrimination. Lesbian and gay people in particular have been found to rely on durable networks of friends.

Health and social care needs

Evidence from younger groups suggests that lesbian and gay people are more likely to drink heavily, to take drugs, to smoke and are less likely to take part in health screening and routine health care than other people. These factors are likely to contribute to higher risk of various types of cancer (cervical, lung, breast, prostate, bowel), stroke and heart disease. Lesbian women also have increased risk of certain cancers due to lower parity and the protective effects of pregnancy. Commentaries note that the emphasis on HIV/AIDS in relation to these groups is excessive. Some American studies suggest lower levels of condom use and testing among the over 50s, but note that gay men take more protective action than other groups.

Mental health is often cited as a particular concern for LGBT people. Higher rates of depression, stress, addictions and suicide have been reported in studies of discrimination. Supportive networks, including friends and family are important in maintaining good health into old age and some studies report greater life satisfaction among older LGBT people.

Housing

Research suggests that while many older LGBT people live alone, they remain part of a community of identity which includes partner and friends. The notion of “families of choice” formed by LGBT people includes partners, friends and some family members for whom these groups look to for social support. Older lesbian women in particular may have children and grandchildren with whom they remain close. In terms of residential care, there is evidence that LGBT people delay entering residential care, perhaps in expectation of institutional discrimination.

Economic disadvantage

A common misconception is that LGBT people are affluent. Institutional discrimination may affect access to benefits or pensions, where finances are shared, but the nature of the relationship is not public. Anecdotal evidence suggests that the Civil Partnerships Act has been used by many people to mitigate the effects of end of life, inheritance and retirement issues.

Carer issues

Carers of LGBT people may not provide all relevant information to professionals due to fears of discrimination. Similarly, if the cared-for individual does not disclose his or her relationship with the carer, the identity and support needs of carers will not be met. These “families of choice”, if not properly understood or not recognised may not be properly involved in their partner’s care.

Limitations of the research

There is a shortage of good quality studies of the subject area. Many of the studies address only one or two of the groups concerned. Indeed the needs of the four sub-groups, lesbians, gay men, bisexuals and transgender people may differ significantly. An unknown, but perhaps major part of the LGBT population in Wales, particularly among older people may not be willing to disclose or discuss their sexuality. Different patterns of disclosure may relate to socio-economic status and ethnicity and may vary across Welsh-speaking and non-Welsh speaking areas of Wales.

SUMMARY OF RECOMMENDATIONS

Training

Health and social practitioners and policy-makers at all levels of government should have access to on-going diversity and anti-discriminatory training.

Confidentiality

Older LGBT people may require additional assurances of confidentiality to reveal their sexuality to professionals. There is a need to raise this as an issue for policy-makers and service delivery organisations.

Recognising discrimination

Older LGBT people are not legally protected from discriminatory practices. The inherent heterosexism of public services should be recognised and addressed. Public bodies should be encouraged to audit current practice, to acknowledge this form of discrimination and begin change processes.

Recognising ‘families of choice’

One place where heterosexism can be immediately addressed is in recognising the right to define same-sex partners as next of kin and to recognise the importance of “families of choice” to LGBT people.

Support for rural/cultural outreach programmes

Older LGBT people from minority ethnic communities, language groups, certain faith groups and those who live in rural communities may be more isolated than their urban counterparts. Statutory authorities should acknowledge this deficit and seek dialogues with representatives of these communities.

LGBT older person’s advisory network

There are important and quite specialised issues raised by this research. The Assembly may well feel unprepared to address all of them. We recommend that they should convene a meeting of academic specialists to advise on policy in this area.

Need for further research

We identify an urgent need for well-designed research to address a number of issues. These include: a series of qualitative studies to investigate in greater depth the needs of LGBT older people in Wales, both collectively and with respect to other social variables including social group, ethnicity, first language and location. Secondly research that investigates heterosexist practices in institutions. There is a need for additional research to address these questions.

1. Foreword

Good medical and social care is founded on establishing a respectful and honest relationship between the service user and the practitioner. Members of various population groups have different needs, risks and expectations of health and social services. In order to communicate in a meaningful and respectful way with users, practitioners need to draw on knowledge of these factors as they impact on health wellbeing and patterns of accessing services. The health and social care needs of older lesbian, gay and bisexual people are not well understood and research in these areas is scarce and of mixed quality. A major reason for the relatively poor quality of research on the needs of these groups appears to be that funding and political and institutional motivation to examine this field has been limited. What literature exists, indicates that deep patterns of discrimination lead to marginalising the needs of these groups and impact on access to services on various levels. Some specific health risks are associated with being a lesbian, gay, bisexual or transgender older person. However data on mental health and wellbeing is politically contentious and is likely to be incomplete as older people do not readily self-identify as being lesbian, gay, bisexual or transgender. The literature also reports specific strengths associated with gay and lesbian aging.

This report will describe how evidence-based research and grey literature contributes to our understanding of each of these issues. It will conclude with recommendations for health, social care and housing policy in Wales that will enable Wales to take substantive steps towards excellence in the care and services provided to these groups.

2. Background

This literature review was commissioned by the Welsh Office for Research and Development in Health and Social Care (WORD) as part of implementing the Strategy for Older People in Wales. It also follows from a ministerial commitment to further the aims of inclusivity, equality and diversity that underlie the Strategy for Older people in Wales. In compiling this review, we have sought to address the overlapping needs of lesbian, gay, bisexual and transgender older people who belong to other minority groups such as ethnic and linguistic minorities and the disabled. Where relevant literature was not found, we have identified these areas for future research. In this way, the findings can be mainstreamed as part of the wider anti-discrimination strategy developed by the Welsh Assembly Government (WAG), in order to ensure that the rights of older lesbian, gay, bisexual and transgender older people who also belong to other minority groups are fully protected.

2.1 Project brief

The literature review was commissioned to perform a number of functions. These were:

- To map existing research on the health, social care and housing of lesbian, gay, bisexual and transgender older people.
- To provide the background for a full research exercise to be completed
- To identify priority areas for further research
- To inform policy makers of key health, social care and housing needs

2.2 Main areas of inquiry

A number of key areas were identified in the project brief. These were:

- The issues facing older lesbian, gay, bisexual and transgender people as users of care service provision
- Health and social services issues facing older lesbian, gay, bisexual and transgender people including as informal carers

- The involvement and participation of older lesbian, gay, bisexual and transgender people
- Housing issues facing older lesbian, gay, bisexual and transgender people

2.3 Inclusion criteria

Peer-reviewed papers included in this review conformed to the following inclusion criteria:

- They had been published since 1985
- They had been independently funded and subject to peer review
- They had examined either or both the health or social care needs of either, lesbian, gay, bisexual or transgender people or all of these groups
- They had used recognised qualitative or quantitative methods and validation

In the case of grey literature, the second and fourth criteria did not apply.

2.4 Searching strategy and modifications

This short literature review used a two-tiered approach including an interim presentation and evaluation of the literature to identify further themes to be explored during the last phase of the study. During both stages of the review, the themes and patterns emerging from the international, peer-reviewed literature were contextualised by a reading of UK-wide and locally produced grey literature. Grey literature was identified using web-searches and messages posted on public health and social policy mailing groups. Reports and policy statements on lesbian, gay, bisexual and transgender older people proved to be less extensive than expected. Peer-reviewed literature was identified through database searches of BNI, Pub med, CINAHL, DARE, Psychinfo. A small minority of papers identified at the interim presentation stage addressed lesbian, gay, bisexual and transgender issues specifically. Accordingly the initial inclusion criteria was expanded to include work on health and social care needs of any of the groups studied regardless of age. This step was taken where we believed findings might be informative and generalisable to older

people. Books and book chapters were also searched with 148 papers or chapters identified retrieved and 50 reviewed in full. Not all material was subject to peer review and methodological limitations of peer reviewed studies are discussed at length below (Section 3.8 on Page 27).

We had intended to draw on informal consultation with a network of organisations, bodies and researchers, due to the complexity of the issues raised by the literature review and our desire to trace these issues to work on sexual minorities as a whole, this phase of the study was not undertaken in full. Nonetheless a list of potential researchers who may be convened as an advisory group for a larger study or to develop a research network is provided as an appendix.

3. Discussion

The predominant theme that arose from the literature review related to the experiences and scope of discrimination and its effects on patterns of accessing services among lesbian, gay, bisexual and transgender older people. Issues closely connected to discrimination were those of the failure to acknowledge the needs of lesbian, gay, bisexual and transgender users of health and social services. Lesbian, gay, bisexual and transgender older people have particular needs for mental health services and social care which will have an impact on their physical and mental health where they are not met. These groups run particular risks in terms of their physical and mental health as a result of individual choices. Reports of rates of mental distress as a result of being 'gay' are contentious given that research has historically categorised sexual minority identities as being pathological. It is also acknowledged that poor access to health and social services has a negative impact on wellbeing and health. 'Risks' of poor health and low levels of wellbeing and social integration that are associated with being 'gay' or bisexual may relate much more closely to the acceptance of lesbian, gay and bisexual people within health and social care institutions and within society at large. Research on transgender people in this field as in others is scarce. Similar factors may however, reasonably be assumed to pertain in these cases.

This section will consider various forms and experiences of discrimination, reported patterns of access to health and social care among these groups. It will then move on to review studies of mental and physical health needs and their impact on needs for social care and housing support.

3.1 Discrimination

The key issue underlying access to health and social care among lesbian, gay, bisexual and transgender older people is that of discrimination. Past experiences of discrimination or fears of encountering further discriminatory practices, appear to contribute to health risks as lesbian, gay, bisexual and transgender older people seek to avoid routine health care and fail to claim social and housing support when it is needed. In addition, lesbian, gay, bisexual and transgender older people have been shown as

seeking to avoid the disclosure of their sexual or gender identity when they access health and social care services (MacBride-Stewart, 2001).

Heterosexism

The discrimination experienced by lesbian, gay, bisexual and transgender older people has three main dimensions. Heterosexism is an assumption made by a society as a whole that maintains that forms of sexuality other than heterosexuality are deviant or are less relevant to an individual's wellbeing, social networks or health and social care needs. This position historically underlies efforts to 'heal' homosexuals and contributes to the marginal position the needs of sexual minorities have in research and policy development in health and social care. Herek, (1986) emphasises how heterosexism marginalises other identities, in describing how it represents:

' a world view, a value system that prizes heterosexuality, assumes it is the only appropriate manifestation of love and sexuality, and devalues homosexuality and all that is not heterosexual' (Herek, 1986:25).

A later definition by Butler (2004) emphasises how heterosexism functions to stigmatise groups and identities. According to Butler, heterosexist thus represents:

'...an ideological system that denies denigrates or stigmatises any non-heterosexual form of behaviour, identity, relationship or community' (Butler, 2004:29).

Heterosexism cannot thus be regarded as a 'phobia' as can other dimensions of prejudice encountered by lesbian, gay, bisexual and transgender people. It is rather an assumption that being gay is less normal than not being gay,. The power of this assumption is that it is reflected and reproduced in social and institutional practices. Heterosexism is reported to be routinely and overtly practiced in health service policies and the practices of its staff (MacBride-Stewart, 2001). The peers of older lesbian, gay, bisexual and transgender people are thus likely to retain prejudices against sexual minorities and minority gender identities (MacBride-Stewart, 2001).

Homophobia

The second dimension of discrimination encountered by lesbian, gay and bisexual people across generations is not embedded in the structures of health and social services – and hence may be less prevalent - but is encountered on an inter-personal level. Homophobia, is the fear or hatred of homosexuals based solely on their sexual orientation. Murphy (1992) provides a definition which also describes some of the effects of homophobia:

‘The prejudice, discrimination, and hostility directed at gay men and women because of their sexual orientation. In the most overt form, homophobia results in violence ranging from sexual harassment to murder (Murphy, 1992:230).

Homophobia in a health care setting can include refusing visiting rights to partners of same-sex couples, lecturing lesbians or gay patients on the ‘evils’ of homosexuality, or refusing to provide appropriate health information relevant for lesbian, gay, bisexual or transgender patients.

Transphobia

Social prejudice directed at transgender people on the basis of their gender identity, or ‘transphobia’ is often more virulent than that directed at lesbian, gay and bisexual people (Butler, 2004; Cook-Daniels, 1997).

Bi-phobia

A specific form of discrimination that may be suffered by bisexual people is that of ‘bi-phobia’, which shared some characteristics with homophobia. Having noted that that bi-phobic assumptions and practices in society at large, seek to marginalise those who identify with more than one sexuality, Laird (2004), indicated that bisexuals were often discriminated against by lesbian and gay people as well as heterosexual members of society. Equally, some bisexuals distance themselves from gay and lesbian and transgender politics (MacBride-Stewart, 2001). Subsequently bisexual identities may come to be viewed negatively by lesbian and gay groups as being non-political.

Ageism

A further form of discrimination that older lesbian gay, bisexual and transgender people face, alongside other members of society, is that of ageism. The sexuality of older people as a whole is an

issue that arouses strong negative responses from service providers. Older people are thus reported to be viewed as asexual and expressions of sexuality are suggested to be seen by service providers as problems to be treated or managed.

These ageist assumptions are coupled with tacit presumptions of heterosexuality (for example that people have lived enduring married relationships with a person of the opposite sex) are likely to form a considerable barrier to the expression of lesbian, gay, bisexual and transgender lifestyles in institutional environments. In addition, there are implications for the increasing numbers of people who are not married, whose children come from relationships outside of the expected norm of marriage, or who are single.

Signs of affection between lesbian and gay people have been suggested to cause conflict with residential institutions and their staff (Claes & Moore, 2000). In a study of hospital nurses, the majority was reported found to believe that homosexuality was a sickness that should be cured (Jay, 1992 cited in Claes & Moore, 2000: 186). Those lesbian, gay, bisexual and transgender people who find themselves discriminated against for showing signs of affection may be doubly discriminated against, with their actions censured on the grounds of their age and on the ground of their sexual orientation or gender identity.

Effects of discrimination

Punitive attitudes to gay, lesbian, bisexual and transgender identities directly impact on the quality of communication and care provided to these groups as a whole. Lesbian and gay patients report negative reactions from health care providers. These include: embarrassment, anxiety, rejection or hostility, curiosity, pity, condescension, ostacsim, withholding treatment, detachment, avoidance of physical contact or breach of confidentiality (Brotman, Ryan & Cormier, 2003). Eliason (1996), reports that in the US, critical care settings continue to enforce policies that restrict visitors to family and husband or wife. While hospitals may make arrangements for spouses to spend the night in a patient's room, lesbian and gay people of all generations are reported to face indifference or hostility where they make the same request (Eliason, 1996). By systematically failing to extend rights to lesbian and gay people that are available to heterosexual couples without

question, these practices represent clear instances of heterosexism.

Even where direct discrimination is not intended, clinicians who are not at ease with patients who are lesbian, gay, bisexual or transgender may nonetheless withdraw information from patients that they would otherwise have provided. Where communication is not open, lesbian, gay and bisexual people may fear discrimination and may have concerns regarding confidentiality (Mays & Cochran, 2001). Similarly, a study of 107 lesbians aged 51-80, found that openness, supportive doctor-patient relationships and other forms of social support contributed to increased rates of routine mammography screening. Conversely, where openness regarding sexuality was not experienced, lesbian women tended to avoid screening (Lauver, Karon & Egan, 1999).

Some work has sought to examine homophobia from the perspective of medical practitioners. In 1985, Marthes et al surveyed members of a California country medical society and found that 40% of respondents were 'sometimes' or 'often' uncomfortable in treating homosexual patients (Cited in Claes & Moore, 2000: 188). In a nation-wide American survey of 1,121 primary care physicians, 35% indicated they were nervous when they were with homosexuals and 33% agreed with the statement that homosexuality was a threat to basic social institutions (Maguire & Bleeker, 1991, cited in Claes & Moore, 2000: 188). These attitudes appear to be reflected by other groups of health practitioners. While the American Psychiatric Association removed homosexuality from the register of mental disorders in 1973, health care providers may still consider homosexuality as a mental disorder (Harrison & Silenzio, 1996). Similarly, in Chaimowitz's (1991) study, of psychiatric teachers at a medical school, it was reported that 25% affirmed they were prejudiced against gay and lesbian people (Cited in Claes & Moore, 2000:189).

These attitudes have direct implications for the patterns of care described above. In a survey of 711 members of the American Association of Physicians for Human Rights by Schatz and O'Hanlon (1994), 67% of respondents knew of lesbian, gay and bisexual people who had received substandard medical care or had been denied care because of their sexual orientation. A large majority (88%) of respondents had overheard colleagues make pejorative remarks about lesbian, gay and bisexual patients. Two-

thirds of respondents felt that many fellow physicians would seek to jeopardise the career advancement of lesbian, gay and bisexual physicians. Similarly, a survey of its membership by the American Gay and Lesbian Medical Association found that 88% had overheard colleagues make disparaging comments about gay and lesbian patients and 67% knew of colleagues who had denied or provided less care to gay and lesbian patients. It should be noted that as respondents belonged to sexual minority professional bodies, some selection bias is expected.

3.2 Invisibility: self-imposed and socially imposed

Given that the sexuality of older people is not widely recognised, older lesbians, gays and bisexuals have been understood to be 'twice hidden' and to represent the most 'invisible of an already invisible minority' (Blando, 2001: 87). The invisibility of older lesbian, gay and bisexual people results both from individual's own efforts to conceal their sexuality and from heterosexist assumptions that function to erase the different identities and needs of these groups.

The Stonewall riots in New York in 1969 are usually assumed to mark the inception of the gay liberation movement. Homosexuality had an ambiguous legal status in the UK until 2000, when the Sexual Offences (Amendment) Act 2000, lowered the age of consent for gay men to 16 in line with the provision for heterosexual sex (The Stationery Office, 2000). The age of consent for lesbians is not specifically mentioned in the Act, which refers to homosexual sex, but does not mention female partners (The Stationery Office, 2000). While progress towards equal legal recognition for gay, lesbian and bisexual sexual practices has been slow, during the 1970s, the political and legal climate in which lesbian, gay and bisexual people conducted their social lives began to change. In 1973, homosexuality was removed from the list of mental disorders known as the DSM (Diagnostic and Statistical Manual of Mental Disorders) by the American Psychiatric Association (APA). Nonetheless, the term, 'ego-dystonic' was used to describe homosexuals in the US until 1989 (D'Augelli, Grossman, Hershberger & O'Connell, 2001). The categories of 'Gender identity disorder' and 'Sexual disorders not otherwise specified' are still included in the current version - the DSM-IV. In 1994, the committee overseeing the categorisation of disorders for replaced the diagnosis of transsexualism with

'Gender identity disorder'. This condition can be diagnosed as 'Gender Identity Disorder of Childhood, Adolescence, or Adulthood' and is known to be used as a psychiatric diagnosis for gay and lesbian youth.

Historically, health professionals have been involved in 'healing' homosexuals through means such as electroshock therapy and aversion therapy (Brotman, Ryan & Cormier, 2003; Daley, 1998).

Kochman (1997), notes that prior to the APA revision of the status of homosexuality, social services in the US had also defined homosexuality as a disorder. Social services had thus also sought to 'convert' lesbian, gay and bisexual clients to heterosexuality through referring them to medical treatments (Kochman, 1997). Nonetheless, in 1977, the US-based, National Association of Social Workers (NASW) adopted a counter-discriminatory policy directed at lesbians, gays and bisexual clients (Butler, 2004). The organisation maintains and updates its policy on the equality of lesbian, gay and bisexual clients. It provides no guidance on the rights of transgender clients however and content on older lesbians, gays and bisexuals is not in evidence (Hooyman & Kiyak, 2002).

A further classification system, - the ICD (International Statistical Classification of Diseases and Related Health Problems) is closely aligned to the DSM but is produced by the World Health Organisation. This retained homosexuality until it was removed in 1992 in the current edition (the ICD-10). The ICD-10 retains five different diagnoses for gender identity disorder: Transsexualism, Dual-role transvestism, Gender identity disorder of childhood, Other gender identity disorders, and Gender identity disorder, unspecified.

West (2004), in her study of transsexuals in Brighton and Hove reports that much of the client groups dissatisfactions with the service provision were linked with the supposition that gender dysphoria is linked to mental illness.

Parks (1999) describes the effects of this oppressive social and institutional atmosphere by recounting the life-histories of older American lesbian women. A participant who was aged 82 described how she had sought to draw attention away from her sexuality:

'I would never go out and broadcast it or flaunt it because I'm from an era when you did not do that. I had to hide it so long, for many years when I worked, that now it is second nature' (Parks, 1999, cited in Orel, 2004: 62)

Many lesbian and gay people during this period sought to lead an apparently heterosexual lifestyle that might include marriage and childrearing (Herdt & Beeler, 1998). Individuals within this group recall how they feared isolation and stigmatisation were they to disclose their sexuality to families, friends or health care providers. It is worth noting that the effects of the Stonewall riots in New York in 1969 on the self-perceptions and confidence of lesbian, gay, bisexual and transgender people are unlikely to have reached Wales until some time later and in all probability, will have been assimilated at different rates and in different ways across urban and rural localities, communities and ethnic and language groups in Wales (3.1). Considerable variation in the experiences of lesbian, gay and bisexual people aged over 50 can thus be expected in Wales.

We can be more certain that lesbian, gay and bisexual people in Wales who are now aged over 70 may have experienced enforced medical interventions or have endured direct discrimination from health and social services practitioners as a result of the pathologising of their sexuality (Chamberland, 1996; Kaufman & Raphael, 1996). Similar patterns of medicalised oppression can be expected to have been experienced by transgender older people. Accordingly, there is no reason to suppose that these experiences or the consequent lack of trust that follows from them are not shared by lesbian, gay, bisexual and transgender older people in Wales. Caution is likely to have been particularly salient for these groups (Friend, 1996). Lesbians, gays and bisexuals of what are termed the 'pre-liberation' generation are reported to focus more on remaining in the relative safety of family and social environments and institutions such as schools, universities and workplaces with which they are familiar (Appelby & Anastas, 1998; Demczuk, 1998). They are less likely to access health service or to identify themselves as being gay or lesbian when they do access these services (Harrison & Silenzio, 1996; Owen, 1996; Risdon, 1998; Robertson, 1998). Low levels of early access to services have compromised specific outreach efforts directed at lesbian, gay and bisexual groups as a whole (Jacobs, Rasmussen, &

Hohman, 1999, Conolly, 1996). As is the case above, in the absence of specific research, we have assumed that similar patterns exist among transgender older people. Nonetheless, we note that for transsexuals who have sought medical reassignment of their sex will have had direct and ongoing contact with health and psychiatric services as hormonal treatments or genital surgery are only allowed following a psychiatric diagnosis.

Furthermore, while older gay, lesbian and bisexual people may have previously disclosed their sexuality to others – including health and social care providers, they may feel the need to hide it from the point where they require access to older people's health services in order to avoid discrimination. Similarly, transgender people may seek to hide their identity. A potential reason for this pattern of behaviour may be that homophobia, transphobia bi-phobia, and heterosexism are seen by lesbian, gay, bisexual and transgender older people to be prevalent in elderly care systems. These perceptions have been suggested to be founded on observations of services that have developed insensitive and heterosexist policies and practices because of a historical lack of scrutiny of the equality policies (Brotman, Ryan & Cormier, 2003). This suggestion is supported by a number of studies that report the concerns of older lesbian and gay people relating to discrimination in accessing health and social services (Harrison, 1996; Quam & Whitford, 1992; Deevey, 1991; Kehoe, 1986). Heterosexism and specific forms of discrimination in elderly care may also be allowed to continue unscrutinised where policy makers make ageist assumptions that sexuality and gender identities are not important identifications for older people. Secondly, voluntary care and shared housing may expose older lesbian, gay, bisexual and transgender people to being in close and continual contact with other residents contemporaries who hold discriminatory attitudes that they could previously avoid (Gold, Skinner & Hinchy, 1999; Daley, 1998; Krauss Whitbourne et al., 1996; Peterson & Bricker-Jenkins, 1996).

The onset of disability in later life may contribute to a much greater risk of the involuntary 'outing' of lesbian, gay, bisexual and transgender people by care providers. Crises that accompany the diagnosis of life-threatening disease or gradual onset of disability expose a person's domestic arrangements or living circumstances in ways that would not occur otherwise (Price, 2005). Lesbian, gay and bisexual lifestyles and relationships may be exposed and

judged by those providing care or treatment or who visit the home to perform an assessment. For lesbian, gay and bisexual people who have spent a lifetime hiding their sexuality, the inability to manage professionals' knowledge of their sexuality is likely to be a real cause for concern. Harrison (1996), reports that even routine care is avoided by lesbian and gay people who fear exposure of their sexuality. Older sexual minority people are also anxious about completing official documents that require information about next of kin (Rankow, 1995, Price, 2005).

As suggested above, an underlying cause of the invisibility of lesbian, gay and bisexual older people is an institutional bias against recognising their identities and the differences or diversity they may represent. Physicians learn how to care for patients in medical schools that assume a generalised patient who is heterosexual and they receive little education concerning sexuality (Claes & Moore, 2000). McMahon (2003), estimates that US medical school devote on average 1 hour per year to teaching issues around sexuality and homosexuality, and often under the topic of illness, deviance, or abnormal psychology. Reviews of medical texts reveal scant - or no - information on lesbian health issues (McMahon, 2003). Issues pertaining to gay men arise predominantly in the context of HIV/AIDS and other sexually transmitted diseases. Schwanberg's (1990) review of 59 articles on homosexuality in medical publications found that over 61% expressed negative perceptions of lesbians and gay men – particularly those with AIDS. Smith (1992) suggests that a shift from neutral to negative perceptions of lesbian and gay people as a whole occurred around the peak of the AIDS pandemic in Europe, North America and Australasia. As a result of the invisibility of gay, lesbian, bisexual and transgender older people, these groups are likely to be further marginalised in health and social care provision. The UK-based report, *Opening Doors: Working with older Lesbians and Gay men* (Smith & Calvert, 2001), describes some myths that are cited by service providers as reasons not to provide services for lesbian, gay, bisexual and transgender groups.

Firstly, service providers report that there are no lesbian, gay, bisexual and transgender users in their area. This is unlikely in view of the population estimate discussed above. The majority of older lesbian, gay, bisexual and transgender people do not conform to stereotypes as they are likely to have avoided

disclosure earlier in life. Secondly, service providers claim to provide a passive policy of equality and hence justify not responding to particular needs. Work on the inclusion of ethnic minority groups shows that this 'colour-blind' approach tends to replicate inequality (Bradby, 2003). A final myth concerning the needs of older lesbian, gay, bisexual and transgender people is that as no individual user has specifically asked for their needs to be met, these needs do not exist. Given the extensive work that now reports high rates of non-disclosure among older lesbian, gay and bisexual people, it would appear reasonable to conclude that needs for care that takes account of gay and lesbian, bisexual or transgender identity exist where they are not voiced by a specific individual.

A specific pattern of avoiding recognising the presence of lesbian, gay, bisexual and transgender users in the health care systems is suggested by an early study conducted in the United States (Smith, Johnson & Guenther, 1985). US-based medical schools are reported to train physicians to address sexual orientation in an open manner. Nonetheless, this survey study of study of 2000 lesbians reported that only 9% had been asked about their sexual orientation by their GP (Smith, Johnson & Guenther, 1985). Anecdotal evidence of lesbian and gay couples being separated in residential care because of lack of awareness of their relationship or a failure to acknowledge it is offered by Brotman (Brotman, Ryan & Cormier, 2003).

Obtaining estimates of the present and projected lesbian, gay, bisexual and transgender population has been problematic for two reasons. Firstly, sexual orientation as a research variable has not been measured in almost all major gerontological survey including the UK and US Census (Barranti & Cohen, 2000). Since 2000, the US Census includes a question on sexual orientation that may enable lesbians, gays and bisexual people to self-identify. However, as transgender is not included as a census category, transgender people are not included in the following estimates. A second reason for the relative unreliability of population data on lesbian, gay, bisexual and transgender people is that pervasive homophobic and heterosexist attitudes in society together with ageist attitudes to the sexuality of older people are likely to discourage older members of these groups from self-identifying (Orel, 2004). Accordingly, no firm data on the size of the older lesbian, gay and bisexual population in the Wales or the UK is

available. Estimations of the size of these groups are founded on estimates of the overall lesbian, gay and transgender population made in the United States. These have ranges from 1% to 10% of the general population (Barranti & Cohen, 2000; D'Augelli & Patterson, 1995; Kochman, 1997). Orel (2004) notes that The National Gay and Lesbian Taskforce, a US government organisation, recommend the use of a conservative range of 3-8% to estimate the older lesbian, gay and bisexual population in the US. As Butler (2004) suggests, this is likely to be an underestimate due to the disinclination of lesbian, gay and bisexual people to self-identity in completing census forms or surveys (Butler, 2004: 31).

Estimates of the UK population of gay and lesbian people vary between 545,000 – 872,000 (Manthorpe and Price, 2003; Ward, 2000). If the 3- 8% estimate advocated by the US-based National Lesbian and Gay Taskforce is used in Wales, given the 2001 census figure for Wales (2,903,085), the potential population would range between around 87,000 and 230,000. There is no reason to suppose that there are fewer lesbians, gays and bisexuals among older people. Estimates of the size of the transgender population are not currently available. Many will have partners, family or friends to provide care. Professionals are unlikely to know who carers are and what their relationship with the person care for is. It is thus probable that needs for support among lesbian, gay, bisexual and transgender carers are underestimated and thus not met (Manthorpe and Price, 2003; Ward, 2000).

3.3 Health needs of Lesbian and Gay older people

Data on younger lesbian and gay people suggests that both groups are more likely to abuse alcohol and smoke and to take fewer screening tests than heterosexuals (Harrison, 1996; Zeidenstein, 1990). Nonetheless, these findings are not consistent and few studies have been conducted with gay and lesbian youth (MacBride-Stewart, 2001). Where screening is not undertaken, patterns of later diagnosis are proven to lead to higher mortality rates for cervical cancer (Sasieni, Adams & Cuzick, 2003). By extension, given the lower rates of attendance at screening, older lesbian and gay people as a whole may therefore be assumed to be at higher risk of contracting lung cancer, colon cancer, breast cancer, cervical cancer and stroke. As suggested above, due to negative experiences with care providers – or fears of these – lesbian and gay people at all stages of life often chose not to seek

routine care and hence are unlikely to present early with the symptoms of cancer (Claes & Moore; 2000 Eliason, 1996).

The US-based, Women's Health Initiative study of 93,311 women aged 50-79 analysed the characteristics, risk factors, health related behaviours and screening practices of heterosexuals, bisexuals, women who had always been lesbians, women who had become lesbians later in life and women who abstained from sex (Valanis, Bowen, Bassford et al. 2000). Sexual identity does not necessarily predict sexual behaviour. Most lesbians have a history of sexual intercourse with men (Hughes & Evans, 2003). Accordingly, lesbian women may well run similar health risks with regard to HPV, STD and HIV as heterosexual women. These risks will be exacerbated by a tendency among lesbian women and service providers to assume that they do not require regular screening tests. Nonetheless, human papillomavirus virus (HPV), is strongly associated with cervical cancer and genital warts is likely to infect lesbian women as 1 in 5 women who have HPV have never had sexual intercourse with a man (Hughes & Evans, 2003). Although uncommon, female to female transmission of HIV is also reported (Hughes & Evans, 2003). Rates of female-to-female HIV infection are likely to be significantly higher because the issue is under-researched. Most, notably, the major means of categorising HIV do not include female-to-female transmission (O'Sullivan & Parmar, 1992). High risk behaviours such as drug use and unprotected sex with bisexual or heterosexual men are likely to contribute to the prevalence of HIV infection among lesbian women (Hughes & Evans, 2003).

Rates of drug and alcohol abuse have been reported to be higher among older lesbian women than their heterosexual peers. This finding is similar to those found by surveys of younger lesbian and bisexual women (Valanis, Bowen, Bassford et al. 2000). Nonetheless, these claims have been contested where similar populations of women are interviewed (Welch, Howden-Chapman & Collings, 1998) Lesbian women of all ages are reported in US-based reviews to have a higher body mass, and have been reported to have diets lacking in fruit and vegetables (Valanis, Bowen, Bassford et al. 2000). A key issue among lesbian and bisexual women may be exercise, as the US evidence indicates that where their diets were similar in fat content, 2-7% more lesbian and bisexual women surveyed were obese than their heterosexual peers (Valanis, Bowen, Bassford et al. 2000).

Lesbian women have lower parity than heterosexual women. Those who do have children tend to do so after age 30 (Hughes & Evans, 2003). Prolonged exposure of breast tissue to oestrogens is likely to make it more prone to carcinogenic changes. Additionally, the oral contraceptive, pregnancy, miscarriage, abortion and birth all protect against ovarian cancer. These protective factors are less pronounced in the case of lesbian women. All in all, lesbian women of all ages have increased risks of: breast, ovarian, endometrial, lung and colon cancer. This finding is supported by the US-based Women's Health Initiative Study which reports that 2-6% of self-identified lesbians had received a diagnosis of cancer. The study also reports that the bisexual group had a higher rate of breast cancer (8.4%) than all other women. Life-long lesbians and those who had previously been heterosexual had higher rates of breast cancer than their heterosexual peers (Valanis, Bowen, Bassford et al. 2000). Possible additional reasons suggested for these high rates are higher consumption of alcohol and lower rates of mammography and cervical screening among most lesbian and bisexual groups (Valanis, Bowen, Bassford et al. 2000). A further barrier to providing adequate health care for lesbian clients is the myth of lesbian immunity to HIV and certain cancers (Edwards & Thin, 1990; Johnson, Smith & Guenther, 1987). Similarly, given lifestyle factors such as higher rates of smoking, drinking and obesity and poorer diet contribute to a higher risk of cardiovascular disease (Hughes & Evans, 2003).

Hart & Flowers (2001) note that few studies address risks of cancer, coronary heart disease or non HIV psychiatric morbidity among gay men.

A number of commentaries on the health and social care needs of older lesbian, gay, bisexual and transgender people have noted that the emphasis on HIV/AIDS in younger LGBT groups is excessive (Butler, 2004; Orel, 2004; Claes & Moore, 2000). Nonetheless, AIDS in older people remains a problem with 10% of people aged over 65 world-wide diagnosed with AIDS according to the US-based Centres for Disease Control and Prevention (Centres for Disease Control and Prevention HIV/AIDS surveillance reports, 2002).

Sexual contact has become the major cause of infection among Americans aged over 65. Two cross-sectional US-based surveys of 2673 Americans aged over 50 reported that older people used fewer preventive measures (condoms and testing) than younger people (Stall & Catania, 1994). Conversely, the small subset of actively gay or bisexual men in the study reported high rates of condom use (9% only never used them, 52% always used them). Similarly, 60% had been tested for HIV (Stall & Catania, 1994).

The focus on alcohol, breast cancer and sexual health needs in the literature we identified should be regarded with some caution. Given the preponderance of studies of these areas and the lack of studies of lesbian, gay, bisexual and transgender health, illness and service user experiences in other fields, it appears that non-heterosexual groups are systematically excluded from much health and social services research. We have also noted an element of censure in some of the literature on alcohol, diet and sexual health among these groups that would appear to confirm that heterosexism is an issue in determining research priorities for lesbian, gay, bisexual and transgender people.

We were unable to identify any material relating to the health needs of bisexual or transgender older people.

3.4 Mental Health Needs of Lesbian, Gay, Bisexual and Transgender older people

Mental Health needs are often cited as a particular concern of lesbian, gay, bisexual and transgender people in general. Nonetheless the history of the pathologisation of sexual minorities and other gender identities may bias research towards an assumption that these groups suffer from higher rates of mental distress (Mirowsky & Ross, 1999). Studies of heterosexual older people have found that the sense of impending illness and actual experiences of illness and dependence coupled with lower income, isolation and loneliness increase rates of depression and suicide and contribute to poorer mental health among older people in general (Hughes & Evans, 2003).

Nonetheless while social stereotypes may influence the way in which research questions are framed, higher rates of depression among lesbian, gay, bisexual and transgender people are routinely reported in the literature. Managing long-term stigma in the form of

heterosexism and homophobia is believed to contribute to higher risks of depression and suicide, addictions and substance abuse (Russell & Joyner, 2001; Rothblum, 1994; Bradford & Ryan, 1989; Gillow & Davis, 1987). As discussed above, lesbian, gay and bisexual older people who began their social lives prior to the period of gay liberation, suffered the effects of a lack of social acceptance on a personal, institutional and societal level (Brotman, Ryan & Cormier, 2003). The few empirical studies that have explored the effects of discrimination have found higher rates of depression, stress, addictions and suicide among lesbian, gay and bisexual older people who have maintained their lives in the semblance of heterosexual expectations imposed on them by society (Brotman, Ryan & Cormier, 2003; Bradford, Ryan & Rothblum, 1994; Gillow & Davis, 1987).

A study of predominantly professional, healthy older gay men conducted by Shippy, Cantor & Brennan (2004), reported that a large minority (30%) described feelings of depression and a high level of unmet emotional need. The Women's Health Initiative study found that 15-17% of lesbians had been depressed compared with 11% of heterosexual women (Valanis, Bowen, Bassford et al., 2000). Studies of older lesbian, gay and bisexual people also appear to confirm these findings. A survey performed on 416 lesbian, gay and bisexual adults aged between 60-91 reports that gay men experienced negative feelings about being gay, tended to over-use alcohol and had suicidal feelings (D'Augelli, Grossman, Hershberger & O'Connell, 2001). Many of this group associated these experiences with reactions to their sexual orientation (D'Augelli, Grossman, Hershberger & O'Connell, 2001). Conversely, good mental health was associated with higher self-esteem, a sense of social integration and more people being aware of their sexual orientation.

Retiring from previous paid employment may represent a challenge for lesbian, gay, bisexual and transgender who tend to give work a more central place in their lives than heterosexual people. Quam & Whitford (1992), found that among lesbian and gay older people, adjustment to later life depends largely of acceptance of ageing, the maintenance of high life satisfaction and being active in the gay and lesbian community. Nonetheless, lesbian and gay older people often feel marginalised from the gay and lesbian community. Lesbian, gay and bisexual communities are in no way immune to ageism. Indeed, in many ways, gay and –

to some extent - lesbian communities may value youthfulness more highly (Brotman, Ryan & Cormier, 2003). Examples of ageist practices within lesbian, gay, bisexual and transgender communities are described by Cahill et al:

'Manifestations of ageism within the GLBT community (a variation of LGBT) include beauty standards that privilege youth, the exclusion of old people from community discussions, and the absence of senior issues from the mainstream GLBT agenda' (Cahill et al, 2000: 18 in Butler, 2004:32).

Where gay male groups extol youth, fitness and sexual prowess, older gay men, who have previously identified with these values, may lose self-esteem as they age and need to re-define themselves and their relation to their community (Claes & Moore, 2000). Reid (1995) suggests that the generational divide reflects greater political activism within the lesbian and gay communities between the late 1960s and 1990s. Accordingly, the focus on community-based HIV/AIDS care and support during the 1980s has not been matched by initiatives in the care of older people who may be perceived as having contributed less to the community than their younger peers (Slusher, Mayer & Dunkle, 1996).

Isolation is likely to be a major threat to the wellbeing of older lesbian and gay people placing individuals at higher risk of self-neglect, decreased quality of life, and increased mortality (Herdt, Beeler & Rawls, 1997; Peterson & Bricker- Jenkins, 1996; Quam & Whitford, 1992). Gay men across generations are particularly vulnerable to mental health problems and gay men appear to have significantly higher rates of psychological distress and attempted suicide than heterosexual men (Hart & Flowers, 2001).

Conversely, many lesbian and gay older people have developed adaptive means of coping with the physiological changes and social marginalisation that tend to be contingent on ageing. Family and community support has been found to be instrumental in facilitating happy and healthy aging in lesbians, gay, bisexual and transgender people. Research on the social integration of older gay men reports mixed findings. Porter, Russell & Sullivan (2004), describe the relative isolation and vulnerability of two self-identified older gay men in a deprived area of Sydney. Lipman (1986) nonetheless notes that lesbian and gay people have more friends than heterosexuals of the same age. These friends tend also to be

gay or lesbian and form what have been termed 'families of choice' (Weston, 1991). Similarly, Shippy, Cantor & Brennan's survey research among 711 gay men living in New York (2004), found that the extent of support networks among older gay men is similar to that of heterosexuals but that networks are composed mostly of friends and siblings rather than children and parents. Support networks consisting of lesbian and gay friends have been assumed to be lifelong (Weston, 1991). Issues such as mobility and access to tolerant or supportive public spaces as lesbian and gay people age may nonetheless impact on the durability and sustainability of 'families of choice'. We will consider how rural location may also affect the nature of support networks below (3.2).

More widely, the extent and capacities of the support networks constructed by lesbian and gay older people have been related to their level of comfort with their own sexuality, their experiences of discrimination and access to a wider lesbian or gay community (Patterson, 2000; Barranti, 1998). Positive aspects of gay and lesbian ageing have been widely described (Butler, 2004; Healy, 2002; Butler & Hope, 1999). Following the example of Barranti and Cohen, Butler (2004) describes specific factors that are likely to support the health and wellbeing of older lesbian and gay people. These factors include:

- Coping skills developed in the process of accepting their sexuality that may be transferred to the changing identity that is contingent on aging.
- Skills in managing society's perception of inferior difference represented by homosexuality may be used to compensate against ageism. Orel reports that among the participants in her study, those who had publicly avowed their sexuality developed coping strategies that they used to combat the effects of ageism (Quam & Whitford, 1992).
- 'Families of choice' may provide extensive support when needed
- Lesbian and gay older people are likely to be more prepared to be flexible in their gender roles than heterosexual people and will thus experience less difficulty in adjusting to changing gender roles as they age (adapted from Butler, 2004:34).

Given the presence of these factors, a number of studies report that older gay and lesbian people report greater life satisfaction, lower levels of self criticism and fewer psychosomatic problems (Barranti & Cohen, 2000; Humphreys & Quam, 1998; Kimmel, 1995; Adelman, 1990; Friend, 1990; Berger & Kelly, 1986).

An additional factor in the wellbeing of older lesbian, gay and bisexual people is suggested by as Butler (2004) who remarks that older people in these groups may have disclosed their sexual identity later in life and hence may have avoided much of the overt homophobic policies and treatments supported by health and social services. Nonetheless, the impact of heterosexism and invisibility on people who suppressed their sexuality or gender identity would appear likely to have outweighed any benefits gained from avoiding direct discrimination.

Laird and Aston (2003), conducted research in order to identify issues of particular relevance to transgender people of all age groups They identified the most significant health related issues for male to female (MTF) transsexuals as being those of alcohol abuse, suicidal feelings, continuous anxiety concerning gender issues and disgust with body parts. Key areas of concern for female to male (FTM) transsexuals included anxiety, fear of other people's judgements, suicidal feelings and – prior to surgery – experiences of distress about body parts. Self harm and depression were also significant patterns of behaviour among both groups of transgender people as were judgements concerning their sexual practices and biological gender/sex.

No material relating specifically to the mental health needs of bisexual older people was found in our literature search.

3.5 Housing and Welfare

Older lesbian and gay people are more likely to live alone than are their heterosexual peers (Cahill et al, 2001). A survey conducted in New York, found that 65% of a sample of 253 lesbian and gay older people lived alone (Brookdale Centre, 1999). This is twice the rate for heterosexual older people. A second study, cited by Butler (2004) found that 75% of lesbian and gay older people in the Los Angeles area reported living alone (Rosenfeld, 1999, cited in Butler, 2004:31). The distinction between living alone and being lonely is indicated by Butler. The widely held negative view of older

lesbian and gay people as being isolated has been refuted. Older lesbians and gays have been shown to be no less lonely than heterosexual older people or younger lesbians and gays (Cahill et al, 2001). Given that lesbian, gay and bisexual people form 'families of choice' these groups have been suggested to be better prepared to face ageing and the crises of declining health (Butler, 2004; Barranti & Cohen, 2000). Assumptions should thus not be made that lesbian and gay people who live alone do not have partners. As Cahill et al. (2001) note, US-based surveys have shown that 40-60% of gay men and 45-80% of lesbian women have long-term partners at any one time.

Older people in general are concerned about the loss of their independence. For lesbian and gay people who have experienced discrimination or imposed treatment regimes from health care providers, dependence on social care or institutionalisation are perceived as a real threat (Taylor & Robertson, 1994; Claes & Moore, 2000). Given these conditions, older lesbian and gay people are reported to delay entering residential care (Claes & Moore, 2000). Abuse and neglect in nursing homes affects a large minority of residents. A survey by Pilemer and Moore (1989) cited by Claes and Moore (2000: 189) revealed that 36% of nursing home workers had seen other staff members physically or psychologically abusing residents. These potential problems would appear to be compounded for lesbian, gay and bisexual residents by homophobia or the threat of involuntary disclosure of their sexuality. Discrimination against gay and lesbian older people in residential setting may also include threats of involuntary 'outing', neglect and physical and sexual assault (Bybee, 1991; Stevens & Hall, 1988, Bradford & Ryan, 1987). As transgender people form a still more invisible minority, it may be assumed that these factors are potentially more salient for these groups. Transgender people are thus likely to be further marginalised and potentially more vulnerable to abuse in residential care than are lesbian, gay and bisexual older people.

3.6 Financial deprivation

An issue compounding the effects of social exclusion is likely to be that of relative poverty as lesbian, gay, bisexual and transgender people as a whole have poor rates of benefit uptake. A potential reason for this been suggested to relate to health and social care practitioners being unaware that their client has a partner when

filling benefit forms (Age Concern, 2000). Similarly, lesbian, gay, bisexual and transgender people may prefer not to claim benefit for a partner where their relationship is not public (Age Concern, 2000). In rural areas, lesbian, gay, bisexual and transgender couples may live separately but be financially inter-dependent. Accordingly, where one member of the couple needs care, the financial effects on the other may be great, but remain unrecognised (Age Concern, 2000).

Where partnerships are recognised by service providers, decisions on whether to recognise jointly owned property remain discretionary, leading to wide variations across local authorities in assessing financial contributions to care (Price, 2005). This situation would appear to offer little security or reassurance to older people who are facing the need to enter residential care. The provisions of the Civil Registration Act (2004) cover some aspects of the financial and legal status of lesbian or gay couples.

Anecdotal evidence suggests that the majority of couples choosing a civil partnership are in their 50s and 60s and do so in order to ensure that care-giving arrangements are in place and to address some end of life issues. Nonetheless, a small minority of gay and lesbian people have thus far registered for Civil Partnership. In England and Wales by 31 January 2006 same sex couples formed 3,648 civil partnerships (General Register Office, 2006).

Public sector pension schemes often don't recognise a lesbian or gay partner as a beneficiary and lesbian and gay couples will pay more capital gains tax than married homosexual couples and will not have access to the married couples' tax allowance (Price, 2005). Lesbians report greater financial concerns especially where they are divorced or widowed as is more likely to be the case for older women and those who have 'come out' later in life (Price, 2005). It is also worth noting that two older gay men will generally have a higher socio-economic status than two older lesbians due to lifelong differences in earning between men and women (Price, 2005).

3.7 Carers

The emphasis placed on the biological family as primary care givers in health and social literature over the past 10 years may have further marginalised the experiences of gay, lesbian, bisexual and transgender older people and their 'families of choice'. Carers

of a gay, lesbian, bisexual or transgender person may not choose to confide all relevant information to professionals due to fears of discrimination. Similarly, where the individual cared for does not seek to disclose his or her relationship with the carer, the identity and support needs of carers will not be met.

Children of a lesbian, gay or bisexual older person that have been born from a previous heterosexual relationship may have a troubled relationship with their parent because of their sexuality (Price, 2005). These children may find themselves perceived as distant or uncaring by professionals when the onset of disability obliges them to take on a role of carer after potentially years of family rupture (Price, 2005). Members of the biological families of lesbian and gay older people may show animosity towards their social networks and seek to obscure their relative's sexual orientation (Barranti & Cohen, 2000). Similar issues are likely to pertain in the case of families of transgender people. Friends or partners of lesbian and gay older people report having great difficulty in obtaining information concerning the person whom they have cared for when they are taken into hospital (Price, 2005). Members of 'families of choice' also note that insufficient recognition is granted to them in terms of visiting, decision making, and caring for their friend or partner (Ryan, Hamel, & Cho, 1998; Turner & Catania, 1997; Irving, Bor, & Catalan, 1995).

As has been suggested above in the discussion of mental health needs (Section 3.4, Page 23), the friends and siblings of lesbian and gay men who form their 'families of choice' will tend to belong to the same generation as the person cared for. They may thus be affected by illness and disability that compromise their capacity as carers.

3.8 Limitations of the research literature

There has been increasing interest in researching the needs of lesbian, gay, bisexual and transgender groups. Nonetheless, as Cahill and his co-authors note in their seminal report on lesbian, gay, bisexual and transgender groups in the US (Cahill et al, 2001), serious limitations decrease the value of much research in the area. The majority of research addresses the experiences of gay men. Considerably fewer studies address the perceptions and concerns of lesbians with still fewer studies exploring the experiences of bisexual and transgender people. The majority of

studies are based on small samples that are skewed towards white, middle-class, male groups. It is important to note that recruiting older lesbian, gay, bisexual and transgender groups to research is complicated by social stigma that is likely to be experienced differently depending on the cultural, economic and generational location of the individual. The term, 'gay' is meaningful in a primarily Anglo-European or 'Western' context. Accordingly, people from diverse cultures and groups may be 'gay' but do not use the term to describe their life or their lifestyles. Nonetheless, studies that do not reflect the racial, cultural and economic diversity of lesbian, gay, bisexual and transgender groups are likely to misrepresent and to silence the needs of much of those groups. By focusing on more affluent white men, they are also likely to consolidate prejudices regarding the composition of the lesbian, gay, bisexual and transgender population that have been used by legislators to oppose anti-discrimination laws and appropriate services (Butler, 2004).

A second issue relates to the historical and political framework within which research is performed. The disciplinary field of Gay and Lesbian Studies highlights the importance of promoting the rights of gays and lesbians, and latterly, bisexuals and transgender people (MacBride-Stewart, 2001). In the area of health this is believed to be best achieved by generating research into health issues and the education of health professionals (MacBride-Stewart, 2001). Yet despite an increase in the volume of research about health concerns of gays and lesbians since the 1970s, there has been little change in the reported experiences (MacBride-Stewart, 2001).

During the 1990s Queer Studies emerged as a new theoretical framework concerned with addressing the uncertainties of sexual identity, arguing that sexual identity is neither fixed nor inherent (MacBride-Stewart, 2001). Queer Studies argues that the ongoing discrimination of lesbian, gay, bisexual and transgender people is a consequence of the normative dominance of heterosexuality and associated views about family, marriage and wellbeing (MacBride-Stewart, 2001). This approach has led to new work in the area of health that strives to disaggregate representations of deviance from the experiences and identities they purport to describe, and to situate the process of labelling individuals as either transgender or gay or lesbian or bisexual, within processes of social power (MacBride-Stewart, 2001). Thus the emphasis is shifted from the

individual, to a focus on the complex processes by which gay and lesbian, transgender and bisexual health needs get hidden, simplified, avoided, over-generalised or associated with deviance at the level of the institutional and interpersonal relationship between the health profession and its clients (Lance & Tanesini, 2005; Hall, 2003; MacBride-Stewart, 2001; Sedgewick, 1991).

Thirdly, most research on older lesbian and gay people has recruited those for whom sexual orientation was an important aspect of their public and private identities. Accordingly, most studies are not representative of the needs and experiences of those who have not publicly disclosed their sexuality.

As Meyer (2001) comments lesbian, gay, bisexual and transgender people are:

'...diverse in the degree to which their LGBT identities are central to their self-definition, their level of affiliation with other LGBT people, and their rejection or acceptance of societal stereotypes and prejudice (Meyer, 2001: 856 cited in Butler, 2004: 29).

Orel (2004) who interviewed a range of participants some of whom had not disclosed their sexuality to others, found that the needs of those who were 'in the closet' differed considerably from those of who publicly self-identified as lesbian or gay.

While family relationships were important to all participants, Orel reports an increased anxiety concerning the quality and sustainability of those relationships among those who remained, 'in the closet' (Orel, 2004).

Butler, (2004), sums up the limitations of existing research on lesbian, gay, bisexual and transgender groups by citing a comment by Herdt, Beeler and Rawls (1997):

'...in the case of older bisexuals, lesbians and gays, the combination of poor research literature, clinical samples, and dated historical narratives from prior generations has had the effect of making this population appear more homogenous than it is, undercutting diversity in life-course experiences (Herdt, Beeler and Rawls, 1997: 234 cited in Butler, 2004:29-30).

As gay, lesbian, bisexual and transgender people may not choose to disclose their identity even where anonymity or confidentiality is

assured, this issue is likely to impact on all surveys of these groups. A particular example is provided by the women's health initiative study (Valanis, Bowen, Bassford et al., 2000), the self-reporting of sexual orientation appears to have limited the power of the study as only 1306 women identified themselves as lesbian – while the US national average is believed to be between 2-8% (Orel, 2004). Around 2.8% of the sample preferred not to disclose their sexuality.

Hart and Flowers (2001) maintain that because gay men have been defined medically in terms of their sexuality rather than other aspects of their lifestyles or health behaviours they have been ill served by general health research. Pervasive homophobia and heterosexism at the level of legislation, social policy and daily experience, represent a structure of inequality that has negative consequences on the health for the gay population. Similarly, MacBride-Stewart (2001) asserts that while research on lesbian health is still attempting to paint a picture of lesbian health, its frameworks are limited for such an analysis and it remains uncritical of the assumptions underlying the research approach.

Finally, research on sexual minority and transgender issues often rests on anecdote and undeclared assumptions. Claes & Moore (2000), report that older lesbian and gay people tend to have no children. However, surveys point to the fact that a significant minority of lesbians in particular have had children by heterosexual relationships prior to 'coming out' (Brotman, Ryan & Cormier, 2003). Many more are having children within their lesbian relationships or as sole lesbian parents in arrangements that frequently include gay men as fathers. Claes & Moore (2000) suggest that support and care from them as they age. This assumption would appear to be contestable a survey performed on 233 gay men in New York did not find nieces or nephews represented a source of care and support for older gay men (Shippy, Cantor & Brennan, 2004).

A second example is also provided by Claes & Moore (2000). They maintain that older lesbians adjust better to ageing because they are less concerned with maintaining a highly feminised or youthful appearance and link this to an assumption of higher rates of mental health than those for older women as a whole. This picture would appear to contrast with findings on higher rates of depression among lesbian women across generations and may

point to further limitations in that research. Price (2005) conducted an interview survey with lesbians and reported that the lesbian community valued youthful looks as much as the gay male community.

3.9 Conclusions

Although it is likely that the older lesbian, gay, bisexual and transgender population is growing at the same rate as that of older people in general, the needs and experiences of these groups have been unknown and disregarded by the majority of health and social care institutions and bodies. Reflecting this bias, research on the health and social care needs of older people does not reflect the full spectrum of sexualities and gender identities to which these groups subscribe. Current practices in health and social care will, at best, marginalise the needs of older lesbian, gay, bisexual and transgender groups. Given the historical role of health and social care in suppressing these identities, the lack of knowledge of sexual minority needs may serve to preserve discrimination and inequality of care.

International and UK grey literature reports widespread concerns about heterosexism and the systemic discrimination among older lesbian, gay, bisexual and transgender people become aware of the need to access care. Older people are reported to be more vulnerable to homophobia, bi-phobia and transphobia from individual peers and health and social care workers within institutional settings such as residential care and hospitals. People who have previously been open about their sexuality are thus reported to perceive it necessary to step back into the closet in order to access the care and support they need. Bisexual and transgender older people in particular may feel vulnerable to being out-ed against their will where a practitioners to fail to protect their confidentiality. Despite their much greater need for health and social care services, lesbian, gay and bisexual older people contact services considerably less frequently than the population at large. Where older lesbian, gay and bisexual people develop disability or degenerative conditions, their health, safety and security are likely to be jeopardised by these patterns of late presentation. Research on patterns of accessing health and social care among older transgender people was not identified by this review. However, it may be assumed that similar issues pertain

and may be more salient in the case of transgender people who are a more invisible and hence less supported minority.

The invisibility of lesbian, gay, bisexual and transgender older people in health, social care and housing settings thus has two dimensions. It is imposed through the heterosexist practices of institutions. However, it is also a consequence of the belief that individual lesbian, gay, bisexual and transgender older people can seek to avoid struggling against heterosexism and individual prejudice by non disclosure of their sexuality. Where these groups are invisible, service providers are able to overlook their needs. This pattern is thus likely to further entrench heterosexism in institutions and individual prejudice. Lesbian, gay, bisexual and transgender people as a whole have been suggested to be less likely to complain about the quality or appropriateness of services because of fears of being out-ed against their will. Given these life-long patterns of avoiding health and social services older lesbian, gay and bisexual people appear likely to continue to avoid disclosing their sexual identity to health and social services contributing to systemic failures to meet the needs of these groups and to address the specific health risks that they share. A vicious circle will thus continue to reinforce discrimination against these groups where measures are not taken to address heterosexism, homophobia, bi-phobia and transphobia within institutions and to convince all users of health and social care that these steps have been taken. Census data on sexual minorities is likely to underestimate the extent of this group and does not enable transgender people to self-report. Estimates of the extent of sexual minority communities in Wales thus vary between around 90,000 and over 200,000 people. No estimate of the extent of the transgender population is offered.

Research on the health and social care needs of sexual minority people has a number of limitations – notably relating to groups studies and sample size (see below). Despite these limitations, a consensus is beginning to emerge regarding the health, health related behaviours and screening behaviour of lesbian and gay older people. As bisexuals experience the risks and benefits of homosexual and heterosexual groups, their physical health needs are not easily quantifiable. Some patterns are nonetheless shared across sexual minority and transgender groups. For example, some research has suggested that younger lesbian, gay, bisexual and transgender people are more likely to abuse alcohol and drugs

and are more likely to smoke. Among lesbian and gay people low levels of access to routine health checks – either voluntary or not – is likely to contribute to higher rates of some conditions: notably colon cancer, cervical and breast cancer and stroke. Similarly, higher rates of smoking, alcohol and drug use and poorer diet throughout life contribute to increased risks of cardiovascular disease and stroke. Rates of HIV and AIDS transmitted by sexual contact are reported to have rises among people aged over 65 in the United States. Nonetheless, the majority of older gay and bisexual men report practicing safe sex and attending screening programmes.

Experiences of coping with life-long stigma or with the effects of hiding one's sexuality or gender identity are likely to contribute to higher risks of mental distress, depression, self harm, mental illness and suicide among older lesbian, gay, bisexual and transgender people as among younger members of the same groups. Some debate exists around the extent to which older lesbian, gay, bisexual and transgender people are supported by 'families of choice' consisting of friends and partners. Retiring from work is likely to be more challenging for lesbian, gay, bisexual and transgender people who do not have families and whose 'families of choice' are limited or were mostly based in the workplace (Price, 2005). The isolating effects of heterosexism, homophobia, bi-phobia and transphobia are also likely to be compounded by the effects of ageism that exists within lesbian and gay communities and that serves to isolate older people from a crucial source of support. Work reviewed here also describes the positive potential of lesbian, gay, bisexual and transgender identities in adjusting to the changing gender roles and social marginalisation that accompany ageing. Some survey-based studies also emphasise that gay and lesbian older people who are integrated in their communities have positive perceptions of ageing. In summary, then, the negative social effects of ageing have important similarities to the social norms that render gay or lesbian or bisexual or transgender identities and people invisible in society. Accordingly, lesbian, gay, bisexual and transgender people are suggested to adapt better to the social conditions of aging. We note that personal acceptance of aging among lesbian, gay, bisexual and transgender people, is likely to involve different issues.

Older lesbian and gay people are more likely to live alone than other older people. A minority that is considerably larger than that in heterosexual groups, which may mean that there may not be an immediate source of assistance in an emergency. Nonetheless, as suggested above, most lesbian and gay older people may not be isolated in a traditional sense because they may have 'families of choice' or partners who do not live with them. Older lesbian women were more likely to have partners than gay men of the same generation. Entering residential care is a particular concern for older lesbian and gay people due to concerns with discrimination. Abuse is suffered by a large minority of all older people in care, however lesbian and gay groups appear to be potentially more vulnerable than others. Bisexual and transgender older people are likely to be more marginal as they will be a smaller group within residential care and thus may have more acute concerns about discrimination, abuse and harassment.

Financial deprivation impacts of the health and wellbeing of older lesbian, gay, bisexual and transgender people. While popular stereotypes focus on relatively affluent gay men, transgender people and sexual minorities who are entitled to benefits, have low rates of benefit uptake. Local authorities vary in their policies towards recognising commonly-owned property when a gay or lesbian person enters residential care, accordingly the other member of the couple may lose the home where she or he still lives. The Civil Partnership Act (2004) standardises many financial and legal issues however the rate of uptake of civil partnership by age is not yet known.

The carers of older lesbian, gay, bisexual and transgender people may be blood-family members or members of 'families of choice'. Much work in social care assumes that children will care for parents who become dependent. However in the case of sexual minority and transgender parents, conflicts arising from sexuality or gender identity may continue to disrupt the family relationship and limit children's capacities to care appropriately for their parents. Members of 'families of choice' who care for older lesbian, gay, bisexual and transgender people may seek to avoid disclosing their sexual or gender identity and that of the person cared for. Patterns of non-disclosure are likely to limit the appropriateness of health and social care support offered both to the person cared for and the carer. As friends and partners will tend to belong to the same generation as the older person, they

are likely to age at a similar rate thus limiting their capacities as carers. Animosity between families of origin and members of 'families of choice' as well as health care providers has led to friends and partners being denied access and information on older lesbian, gay, bisexual and transgender people in hospital and residential care. In many cases, these significant others are also excluded from end of life decision making.

Research on lesbian, gay, bisexual and transgender people has a number of limitations. Qualitative interview work tends to report the experiences of people who are comfortable with reporting their sexuality or gender identity for research purposes, while survey samples may consist only of individuals prepared to self identify as being transgender or belonging to a sexual minority. Given the continuing impact of heterosexism, homophobia, bi-phobia and transphobia, it is inevitable that many lesbian, gay, bisexual and transgender people will not self-identify. Certainly there are much more substantial issues about how to contact lesbian, gay and bisexual and transgender people given evidence that it is difficult to access a general population of health services users because they often report offence at being assumed to be 'gay'.

Consequently, much research on transgender, bisexual, lesbian and gay focuses only on the experiences of educated, white men whose social position enables them to feel more secure about publicly identifying their sexuality. The challenges inherent in the research with these populations nonetheless serves to obscure the needs of the diversity of lesbian, gay, transgender and bisexual people and other cultural and social gay groups. A second limitation relating to research on lesbian, gay, bisexual and transgender issues is that of institutional bias that also privileges the experiences of white, educated gay men above other bisexual, lesbian, gay and transgender people. Institutional factors determine priorities for research and have led to a focus on mental health needs, HIV/AIDS, breast cancer and alcohol abuse only that have been criticised for pathologising and blaming gay, lesbian, transgender and bisexual groups of all ages. Finally, given the embedded relationship of researchers to the topic, assumptions are made in the literature that contradict existing knowledge and appear to be based on individual belief and experience.

Commentators from outside the lesbian, gay, bisexual and transgender communities have also suggested bias originating in the researchers embeddedness within these sexual minorities. However as with most community perspectives on research,

research carried out by and for a particular set of communities can also represent important insights and perspectives that would otherwise be missed in the assessment of the research material. Examples quoted above relate to highlight insights related to knowledge and assumptions about gay 'families of choice' and beliefs that the lesbian community did not extol young in the same way as is prevalent in many gay male groups.

4. Areas for further research

Factors that are likely to have a major effect on the health, social care and housing needs of all lesbian, gay, bisexual and transgender older people in Wales are: cultural difference, class and language group, rural locality, disability, domestic violence and the role of institutions. This section will consider the foundation of research that exists in these areas.

4.1 Culture

Culture and language define the expressions of sexuality and gender identity that are considered normal, acceptable and healthy. The experience of living with a sexual minority identity or a transgender identity is thus defined by culture and language. The health social care and housing needs of lesbian, gay, bisexual and transgender older people of different cultures are likely to vary widely. A potential for discrimination exists where the needs of lesbian, gay, bisexual and transgender people from majority cultures are taken to be definitive.

The variation in experiences of sexual minority status and ways in which ethnic minority status may interact with this, have begun to be examined in research in the UK and elsewhere. Bhugra, researching experiences of coming out among younger South Asian origin men in the UK found that the readiness of young men to avow and disclose their sexuality depended on the strength of their support network within which the family and community leader had a major role (1997). Gilley and Co-cke (2005) report that Native American cultures have marginalised gay men but describe the positive effects of programmes to include gay men in community-based men's societies. These steps were taken by Native American communities in order to protect gay members from risky health behaviour such as drinking, drug taking and unprotected sex that were perceived to follow from attending gay bars outside the community. Nahas' (2004) case study of a Muslim gay men's organisation in the Netherlands illustrates how appropriate social support needs to draw on transnational faith and cultural links as well as forming alliances with care providers. The Safra project, a UK-based lesbian, bisexual and transgender organisation for Muslim women offers on-line support to individuals who prefer to identify with fellow-Muslims (Safra Project, 2002).

More ambivalently, Graziano (2005), reports on intra-community cultural sanctions and violence used against Black South African gays and lesbians in 5 townships. His interview study also describes how these groups are challenging and expanding what it means to be a Black South African through openly identifying as being gay or lesbian.

Work in the US on ethnicity and health behaviour reports risky sexual health practices among older minority ethnic men and black lesbian and bisexual women (Jimenez, 2003). Nonetheless, as participants belonged mostly to lower socio-economic and educational groups, it is likely that these behaviours are at least partly accounted for by lower educational attainment and lower income. Given the early stage of research in the field and the status of authors as champions of their community and lesbian, gay, transgender and bisexual issues, the work reviewed here is descriptive and potentially for many important reasons, including the attempt to affront ongoing discrimination, may be biased towards producing a positive image of both minority groups and the ways in which they interact.

We found no studies addressing the relationship between culture, ethnicity or sexuality or gender identity that related to older lesbian, gay, bisexual or transgender people. Similarly, no foundation of studies on the effects of class or minority language status (such as Welsh) on the health and social care needs of these groups was identified.

4.2 Rural Locality

As culturally-defined concepts, developing a sexual and gender identity requires that an individual find a reference group. Most research on self-identified lesbian, gay, bisexual and transgender people of all ages focuses on towns or suburban environments. Nonetheless, an Australian pilot study (McCarthy, 2000) reports how, despite high levels of invisibility, threats and occasional violence, rural lesbians developed small informal networks of family and friends which provided support and enabled them to express their sexuality. Lindhorst (1997), describes how lesbians and gays in rural parts of Canada are more likely to suffer from discrimination from social workers while Mancoske (1997) reports on increasing rates of HIV infection among gays and lesbians in the Canadian countryside through risky sexual practices. A

Canadian book by Riordan (1998) describes the various reasons gay and lesbian women live in rural areas and traces how these groups negotiated gender identities through their relationships with the environments. These identifications, behaviours and patterns of establishing social support may well map onto different patterns of accessing health care but the research is yet to be undertaken.

4.3 Disabilities

Early work on disability and sexual identity sought to counter myths regarding the asexuality of disabled people (McAllan & Ditillo, 1994). It sought to encourage practitioners to reflect on their own practices and defined practical steps with regard to inclusive language in taking medical histories that practitioners could take in interacting with these groups. A recent study examines mental health needs associated with taking on a lesbian identity among younger disabled women (O'Toole & Brown, 2003). This work emphasises the autonomy of disabled, lesbian women by describing how members of this group developed their own strategies and resources to meet their mental health needs within the lesbian community and outside it. As older people and their carers find themselves potentially facing reduced mobility and various kinds of disability, studies of the strategies taken to cope with disablement, mental distress and relationships with services are particularly needed for older lesbian, gay, bisexual and transgender people.

A further issue that is not widely address by policy or research is that of domestic violence within lesbian and gay relationships. Anecdotal evidence suggests that domestic violence networks often have policies on violence within lesbian couples as lesbians were involved in the establishment of these centers, policies supporting lesbian women in situations of abuse are seldom widely-known or put into practice. Nonetheless gay, lesbian and bisexual older people in common with heterosexual older people suffer a range of verbal and physical violent and intimidating acts from their partners or from formal or informal carers. These include physical abuse, financial exploitation or the threat of harm or intimidation (Gentry, 1992; Hanson, 1996). As is the case above, the assumption is made that these issues also pertain in the case of transgender older people.

4.4 Institutions and heterosexism

As suggested above, the role of institutions in establishing sexual and gender norms and in defining other sexualities and gender identities as being deviant is likely to be of key importance for older lesbian, gay, bisexual and transgender people. Recent work has begun to raise questions about systemic discrimination against sexual and gender minorities in institutions as part of social processes that establish 'normal' sexual and gender behaviour in society (MacBride-Stewart, 2001). This scoping review found no primary research involving interviews with individuals and groups or observation within health and social care institutions. However, as indicated below, we believe that this literature does exist and should be the subject of further research in Wales (Hall, 2003; Lance & Tanesini, 2005; MacBride-Stewart, 2001; Sedgewick, 1991).

5. Research Questions for Wales

- What health and social care needs do older bisexual and transgender people in Wales have?
- What is the role of cultural identity and belonging to a language group in the health and social care needs of lesbian, gay, bisexual and transgender older people?
- How do the needs of lesbian, gay, bisexual and transgender older people differ across groups as well as differ from the general population of older people?
- What is the impact of urban/rural location on the health and social care needs of lesbian, gay, bisexual and transgender older people?
- In what ways might health and social care institutions assume and impose heterosexuality and fixed gender identities on lesbian, gay, bisexual and transgender older people in Wales?
- Given the tendency to seek to avoid disclosure of sexual and gender identity that is prevalent among older people, how might public bodies encourage older lesbian, gay, bisexual and transgender people to participate in forming inclusive policies?

6. Policy Recommendations

The work reviewed above has a number of policy implications for health, social care and housing services in Wales. This Section will set out priority areas for policy. These include: training practitioners, ensuring confidentiality and inclusive documentation, providing codes of conduct and modes of redress regarding the various forms of discrimination suffered by older sexual and gender minority people and recognising the validity and the rights of 'families of choice' in institutions, other care settings and in the home. Further key areas that need to be addressed by health and social care organisations in Wales relate to supporting existing rural and cultural outreach schemes that cater for the needs of sexual and gender minorities and conducting research on the need of older lesbian, gay, bisexual and transgender people with minority cultural groups and with groups from socio-economically deprived areas. A final key policy area for Wales relates to researching the role of health, social care and housing institutions in combating or consolidating heterosexism and other forms of discrimination.

6.1 Training

The central issue concerning the care of older lesbian, gay, bisexual and transgender people is one of access. By training health and social care practitioners and health service managers to be inclusive, care providers may encourage members of these groups to present more readily for routine care and screening and may provide more suitable and supportive long term care.

Health and social care practitioners or managers may be empathetic or may themselves belong to sexual or gender minorities. Nonetheless, their training is unlikely to have prepared them to discuss and manage care issues for lesbian, gay, bisexual and transgender people and their carers. Regardless of their own sexual and gender identity, practitioners and managers need to examine their own perceptions of ageing as this will influence their relationships with older lesbian, gay, bisexual and transgender people (Price, 2005). Practitioners and managers also need to be made aware that carers and colleagues may belong to sexual or gender minorities. In order to provide a safe and inclusive environment, the additional needs of these groups – for example with regard to confidentiality – should be described in training. Where practitioners and managers are trained to explain to

lesbian, gay, bisexual and transgender older people that information concerning their sexuality or lifestyle may be relevant to discussions of health risks, care options and potential social community support needs, these groups may feel more ready to disclose potentially important information. Where the service user is not prepared to put this information in writing, practitioners should be prepared to use oral discussion. However this also requires health service practitioners and managers to be fully trained to be able to answer questions relevant to discussions of health risks, care options and potential social community support needs.

In order to develop their own strategies of providing inclusive care, practitioners and managers be enabled to access updated information on best practice in the care of sexual minorities and transgender older people in the voluntary and public sectors. On-going diversity training could also be used to keep practitioners and managers abreast of legislative reform in this field.

6.2 Confidentiality and inclusive documentation

Older lesbian, gay, bisexual and transgender people are likely to have dealt with discrimination for much of their adult lives. The desire to hide one's sexuality and gender identity has remained an important mechanism for dealing with discrimination for these groups. Many individuals remain circumspect about providing information on their sexuality for fear of the consequences of disclosure. Patients and service users as a whole should be informed who will read their records and how they could be used. Older gay, lesbian, bisexual and transgender people may need additional reassurances of confidentiality. Genuine fears regarding confidentiality may also deter older lesbian gay and bisexual people from completing documents asking for the identity of their partners, carers or those close to them. Inclusive documentation asking questions such as: 'who is your partner or primary carer', should thus be provided as part of the older person's needs assessment. Where confidentiality is assured and inclusive documentation is provided, older lesbian, gay, bisexual and transgender people will be provided with a safe and non-confrontational environment within which they can be encouraged to disclose their sexuality and gender identity.

6.3 Recognising homophobia, bi-phobia, transphobia and heterosexism as categories of discrimination

While European and UK human rights legislation theoretically covers issues of sexuality older lesbian, gay, bisexual and transgender people have no specific legal protection when faced with discriminatory actions within Welsh health and social care institutions. Gay and lesbian, bisexual and transgender people deserve to use services that they feel belong equally to them. They should also be enabled to feel that practitioners and managers are accountable for their behaviour within the care setting. Older lesbian, gay, bisexual and transgender people appear to be particularly vulnerable to abuse, neglect and harassment in residential care facilities and hospitals. Homophobia, bi-phobia and transphobia should thus be recognised as a form of abuse as it is in other institutions. Guidelines reporting this change need to be circulated in order to protect older lesbian, bisexual, gay and transgender people from harassment and intimidation in residential care.

Heterosexism is a more prevalent form of discrimination experienced by lesbian, bisexual gay and transgender people and has deep implications for the kind of health and social care provision that is available to members of these groups. We perceive that there is a need to recognise heterosexism, rather than just homophobia as a set of discriminatory practices within older care services to provide the impetus for organisations and institutions to adapt their services to respond to the needs of lesbian, bisexual, gay and transgender people and to respond proactively against threats of homophobic, bi-phobic or transphobic discrimination against older lesbian, gay, bisexual and transgender people.

6.4 Recognising ‘families of choice’

An example of a specific means through which service providers might address heterosexism in the care of older people is in encouraging palliative care specialists to consider that patients may have same-sex partners whom they wish to appoint as a surrogate decision-maker. Service providers should consider how to build trust with the partner of a sick, dying or deceased lesbian, gay, bisexual or transgender person so that grief counselling might be extended to them. Hospitals, nursing homes, in-patient hospice programs, retirement homes, assisted living facilities and adult

daycare programmes should be aware of how homophobic, heterosexist and ageist attitudes may converge to sanction any forms of affection or love-making between lesbian, gay, bisexual and transgender residents, or residents and visitors. Also, managers of these institutions and critical care facilities should be aware that policies that restrict visitors to “family-of-origin” deprive lesbian, gay, bisexual and transgender residents of a crucial source of support and may contribute to stress and anxiety.

6.5 Support for rural/cultural outreach programmes

Older lesbian, gay, bisexual and transgender people belonging to minority ethnic or faith groups and those living in rural areas are likely to be more isolated than in metropolitan areas. Where community-based older people’s programmes exist in rural areas, they should be encouraged to address the potential needs of older people who also belong to sexual and gender minorities.

Developing dialogues with minority ethnic and faith groups around the nature of family and access issues among all older people is likely to have important potential benefits for these groups.

Community-based programmes are not in themselves sufficient to meet the social support and health related needs of older lesbian, gay, bisexual and transgender people. These programmes need to be properly evaluated and where they are effective, efficient and appropriate; they need to receive recurrent funding so they can develop over time. A co-ordinating and advisory role might also be played by a lesbian, gay, bisexual and transgender older person’s convenor to be integrated with the team administering the older people’s strategy in Wales. Notably they could work within existing rural ‘gay’ or ‘queer’ networks such as the Swansea Lesbian newsletter or other rural gay, lesbian, bisexual and transgender networks.

6.6 In-depth interview research with well-defined groups

As suggested above, the needs and experiences of older lesbians, gay, bisexuals and transgender people will vary across cultural and linguistic groups and minority groups have tended to be absent from existing research. A series of small-scale qualitative interview studies addressing the questions identified above (section 4) and targeting well-defined minority and majority cultural

and language groups in Wales and those with disabilities is thus recommended.

6.7 Research on institutions and heterosexism

A powerful means by which sexual and gender minorities are marginalised is through the heterosexist norms and practices of institutions. The belief that heterosexuality is preferred, and the expectation of traditional gender identity in experiences of health and social care among older lesbian, gay, bisexual and transgender people has not been addressed separately from issues of homophobia. We propose that a valuable and innovative programme of research should examine how health and social care institutions, structures such as needs assessments, guidelines for visiting and end of life policies and practices such as medical history taking are experienced by these groups in Wales.

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