Questions for older LGBTQI+ people

Afeji had never worked with a LGBTQI+ public as the explicit target of a European project. That is why the researcher got in touch with local LGBTQI+ associations. The researcher also has personal connections with LGBTQI+ community of Lille and with associations, which facilitated the initial contact and the gaining trust among a very distrustful community. As opposed to professionals, LGBTQI+ elders were interviewed individually, in order to create an atmosphere of trust and safety. However, it was complicated to conduct the interviews face-to-face and they ended up being conducted online or by phone calls. There is a will to keep in touch with these persons to involve them in the later peer-reviews (A4/PR1) and more globally in the whole dynamic of the project. **Indeed, it is important for Afeji to work** with **the targeted audience rather than working** on **and thus –** without**.** It is even more interesting as two of the interviewees are very dynamic activists. Afeji also decided to keep having interviews even though the planned activity is over to keep getting advice, recommendations about the unfolding of the project. Our relation with the association LGBTQIF (the F stands for feminist) Center of Lille, Laisse Bien Ta Gaieté LBTG (Leave your Happiness Well) among others is dear to the project.

The fact that two out of three interviewees are dynamic activists does not reflect the entire community. Not every LGBTQI+ person is that involved in the defense of the community's rights, for different reasons. These interviews deserve to be counterbalanced by others coming from a more "common" point of view.

The interviews were conducted by one researcher, voice-recorded and then summarized in a report, upon provision of informed consent. Each interview lasted one hour.

Interviewees' demographic information:

3 LGBTQI+ seniors:

- P1 is a gay cisgender man aged 63, retired since 2017, out since his 30s and currently single though he has lovers, involved in the community as an activist in many associations (AIDES[1] for 13 years) before settling at the Sisters of the Perpetual Indulgence[2] for 20 years until today. He is also close to trans activists' circles as he was involved in the Transcendence Commission and other organizations in his city of Poitiers. P1 used to be a geriatric care night worker and healthcare assistant.
- P2 is trans woman aged 69, retired since 2015, out since she is 55 years old (late transition), and currently engaged in a lesbian relationship with her partner. She is well involved in the community as an activist at the local Planned Parenthood in her city of Rennes where she, alongside with doctors and other activists, implemented a formation on the medical care of LGBTI+ people. She also co-founded the ReST (Reseau Santé Trans – Trans Health Network), a network putting safe doctors in relation with trans people and registering them on a safe list for trans people to consult. P2 used to be an engineer at France Telecom.
- P3 is a lesbian cisgender woman aged 62, retired. She is still to be interviewed as we both encountered unexpected events.

1 AIDES (AIDS/help in French) is the pioneer French association fighting against AIDS/HIV.
2 The Sisters of the Perpetual Indulgence ("the Sisters"), is a French association organized in branches all over the world, referred to as "convents".

Experience with care

- **None of the interviewees needs support in their daily activities,** they are entirely autonomous. None of them received care in a residential care home as either. **Therefore, information available is very limited.** P2 just was admitted once to the hospital. She was treated correctly but felt there was **some discomfort among the medical staff about her being trans.**
- Also, both had an experience as being the care giver. P1 was a geriatric caregiver and P2 volunteered in a residential care home for ten years out of activism principles and taste for helping older people. Though they were not receiving it, they did observe a lot about residential care and **"how little adapted it is to LGBTQI+ realities".**
- They know people who are living in a residential care home. None is LGBTQI+ though. They do not have a good image.
- The way they imagine and depict residential care homes says long about their non-conviviality for LGBTQI+ elders. **P1 talks a lot about mistreatment and abuse of elderly people he witnessed when he was working.**

Ideal care home

- The three seniors had similar ways to describe **their absolute refusal to enter a care facility.** When asked what they expected from a care facility for them to be ideal, they were straightforward and did not hesitate in their responses. They evoked both general feelings and precise examples. Concerning their specific identities, they talked about a "trained and sensitized, aware staff". **P2 especially insisted on the "tolerance" factor and stated it was not enough for her to feel safe. She said she needs a real training as she witnessed at the Planned Parenthood that goodwill does not make up for actual lack of information.** All seniors agreed that a good facility **addresses sexuality of older people, does not deny it and allows it to be expressed.** P1 underlines that if sexuality is not addressed, how can consent and safe practices be? **Well-informed on AIDS/HIV issues, he said that the first victims of such a silence policy are LGBTQI+ elders as they are seen as perverted and carriers of diseases. This could be debunked if sexuality was addressed and it would be a great service rendered to non-LGBTQI+ elders as well.** As for concrete examples, P1 and P2 highlighted **the importance of explicit and displayed possibility of access to apartments for same-sex couples, guarantee of access to hormones and more generally non-mistreatments.** Both put emphasis on the fact **that one should not have to look for this information and that they should be easily accessible to residents. These rules have to be integrated to the general functioning of facilities rather than decided case by case, most of the time with very little attention.** The label proposed in the project could play this role of **"positive signal".** Of course, seniors also evoked that if among professionals there are LGBTQI+ people, it would automatically make them feel more at ease, but that relies is on random factors for now.
- When talking about their fears, what could go wrong and the "worst case scenarios", all seniors immediately talked about **dementia and "losing their minds".** This is obviously common to all older people but in the case of LGBTQI+ people, it would mean **losing their identity, power over themselves and exposure to LGBTQI+phobic behaviors from staff – whether it is conscious or not. Stereotypes of perversion were also very present in their words. Mockery was also at the center of preoccupations as most of LGBTQI+ underwent such bullying during their lives.** P1 was victim of a very bad joke when he was a geriatric care worker. Colleagues put a zucchini on his desk as a "joke", referring to him being gay**. He was**

able to defend himself but was worried of what would happen if he was to be diminished in terms of cognitive capacities. The question of serologic status was also raised as huge stereotypes on gay men and trans people subsist especially in a context of the recent pandemic, which reactivates the panic P1 experienced among medical staff in collective institutions in the early 90s. **With the fear of contamination increases the risk of abuse, isolation and errors of treatment.**

- **P1 and P2 would out themselves in a care home. P1 was out on his medical workplace so he wouldn't act any other way if he had to enter a care home. P2 said she would not have the choice as her trans identity is visible, according to her own words. The matter of** passing **for trans people is complicated because they cannot "hide".** However, **if being out in their living space is non-negotiable, the fact that staff shift so often** (in terms of recruitment and everyday shift) makes it harder because the coming-out can become permanent. They need **steadiness,** but this is a general problem of residency care work in France.
- P1 used to be a geriatric care worker and P2 volunteered at a care home and both **never heard a single set point addressing the residents' intimacy and sexuality. When addressed, it was only to condemn a sexual intercourse which occurred between two non-married residents.** They both highlighted that sexuality was considered **"over"** for people a certain age and especially if they live in a care residence. **It makes it very difficult to act on sexual health. P2 argued that the medical-social body should stop focusing sexual health on cisgender-centered procreative sexuality (smear test, STDs detection…) because it makes the general opinion believe sexuality is over once there is no longer procreation.**

Quotes

"I wouldn't last long, it would be for me the worst of the worst of the horrors"

"I've seen institutional mistreatment of older people. So, if you add my homosexuality and the fear of AIDS in medical institutions…"

"I'll never go to a home care facility"

"I want my right to indifference"

"I'd rather die than go there"

"If sexuality is not addressed, how can consent and safe practices be?"

"With the fear of contamination increases the risk of abuse, isolation and errors of treatment"

Conclusions

- They would enter a residential care home if staff were trained and facilities prepared to welcome them. It is not the very principle of residency that restrains them rather than LGBTQI+ phobia, especially in the case of late coming out like it is the case for P2. It is tangible that the identity they spent their lives to assume – and to be discriminated for – is non-negotiable in exchange for care.
- LGBTQI+ seniors have a rather precise idea of mechanisms to be implemented in order to make the facility more convivial and inclusive. An expertise exists in the community.
- Testimonies show that, contrary to what has been stated by most professionals, LGBTQI+ elders do undergo ill-treatment, mockery and discrimination when confronted with the medical body, even if it is not perceived as such by non-LGBTQI+ staff. However, these elements do not necessarily originate from a place of hatred or ill-tolerance rather than from ignorance: one of the key is training of the staff and awareness which make, most of the time, their irritating points melt.

Questions for professionals

As Afeji is both coordinator and operator of medical-social projects and facilities, we thought it would be more both convenient and relevant to interview workers within our organization. Also, Afeji usually pairs each project with a target facility to increase positive and evaluable outcome. All the professionals interviewed here were aware of the initiative though it was mostly the director who willing to participate in the project from the very beginning. It is highly important to precise this information as bias may occur in the responses of the interviewees.

The researcher also believes it encouraged reactions and discussions as it is an ice-breaker for the project. Later in the unfolding of the project, individual and informal moments will happen with professionals to know more about their opinion and practices, behind closed doors. To do so, the coordinator works on the field with them one day per week.

Information was collected through a focus group. Individual interviews were not possible as this professional sector is on a tight schedule and restricted team. Otherwise it would have meant making them work overtime while unpaid and/or impede on their break time. The focus group was conducted by one researcher, voice-recorded and then summarized in a report, upon provision of informed consent.

The focus group lasted 1 hour.

Interviewees' demographic information:

9 professionals total:

- 1 psychologist
- 2 medical-psychological assistant (MPA)
- 2 social workers
- 2 healthcare assistants
- 1 nurse
- 1 hotel agent

7 women, 2 men including one LGBTQI+ individual (Gay cisgender man). All others are heterosexual. All individuals identify as cisgender. Age is between 25 and 45 years old.
As one of the professionals is gay, biases may have occurred to maintain politeness and courtesy within the group.

Knowledge and experience about LGBTQI+ people

The focus group began by a short description of the project and its goals. The researcher decided not to precise the difference between sexual orientation and gender identity so as to see if professionals were familiar with these notions.

- Most professionals **knew the definition of sexual orientation but were more confused when it came to gender identity and intersexuation** (see Quotes – 1). Concerning the acronym itself, most professionals knew about gay, lesbian and bisexual people but were **using outdated words to qualify trans people and miscomprehension of who they are. There was little to**

no reaction when the researcher explained what intersexuation consists of. Considering the lack of information concerning trans identity, it was not possible to evoke non-binarity at this point.

- **Only two professionals personally know LGBTQI+ people** in their private lives: the psychologist and the gay MPA. Since one of the present professional in the room is gay, most logically affirmed **they had already worked with LGBTQI+ colleagues and spontaneously underlined they were tolerant** (see Quotes – 2). When it came to residents, professionals were « not sure » whether they worked with this public. The researcher asked for further information and they said **they assumed the person's orientation.** Professionals said there was no incident nor hostility with other residents. The psychologist, who works in this care home residency for only a year but has been practicing for 3 years, never encountered the coming-out of a resident.
- When asked how they would take care of LGBTQI+ residents, most professionals **seemed chocked**. **They answered they made no difference between a cis/het individual and a LGBTQI+ individual.** Following questions left them bewildered (see Quotes – 3). Therefore, they did not feel less capable of taking care of a LGBTQI+ resident. When confronted with the possibility of trauma and bad experience with medical staff, **they reacted defensively by saying that all kind of people could have experienced such thing and that it is not specific to the LGBTQI+ community.**
- When asked how they would react if a resident disclosed themselves as LGBTQI+, **some laughed. Some admitted they would not know how to react, especially if they had to decide whether to inform their colleagues or not. The common reaction was that they never thought this possibility.**
- All professionals affirmed LGBTQI+ issues were never raised during their recruitment process.

Making the facility LGBTQI+ friendly

- Most professionals were **clueless** when asked what could be done within their facility to enhance conviviality. The researcher made propositions to observe reactions. The proposition perceived as the most "challenging" was about the flag. Indeed, the researcher explained that even though professionals are tolerant, LGBTQI+ seniors may not be aware of that posture if there is no "signal" and suggested the idea of a rainbow flag on the website / flyers / at the reception... **Most professionals were shocked because they felt it was a community symbol and that it encouraged difference,** "as if we needed a flag to be tolerant". The gay MPA intervened by saying that for LGBTQI+ people, it represents a lot: **safety, security, guarantee they can show their partners affection without getting insulted or worse and guarantee that people are educated on the challenges they encounter.** However, after further discussions, **most professionals agreed that putting the logo of the project in the corridors / on the flyers / website could give a positive signal to LGBTQI+ elders.**
- The researcher also asked whether same-sex couples were allowed to share apartments in the facility. None of the professionals were able to answer and one recalled a gay couple who had lived at the facility a few years ago and who did not share their room. Though, the professional did not know the reason and they said they would ask later if that is allowed.
- When confronted with the coming-out of a resident and the reactions among colleagues and residents, most professionals stuck to their previous reaction: **affirming they "don't have a problem with that", they are "tolerant"** and that they do not think it would imply any further

reaction among residents and colleagues. **However, the psychologist underlined that maybe no reaction might be violent for the person who is disclosing themselves. She said it is a proof of trust to confide to a professional and if the latter does not react, it may recreate a feeling of loneliness, reject or worse.**

- When asked if LGBTQI+ elders may be suspicious to come out in a care facility, most professionals answered **they should not be, as the professional branch of medical-social is open and kind. They did not consider that it might not be a matter of professional posture but rather of personal values impeding on work and bias professionals might be unaware of.**

Quotes

« We are playing the homophobic people's game"

"What you're proposing, to treat people differently and put flags everywhere, sounds like apartheid to me"

"Having flags and external signs of acceptance is super important. It shows that in this place, we can hold our partners' hands, kiss them...without taking the risk of being beaten, insulted or worse"

"Once in Paris I touched my partner's shoulder and we got insulted."

About trans identity: "I don't understand"

When asked if they ever took care of a LGBTQI+ resident: "I'm not sure he was gay though... but we assumed he was"

When talking about LGBTQI+ people: "As people say nowadays"

"We have no power to act"

When asked how they would react about a coming-out: "It's his life, I don't mind, I wouldn't treat him no different than another resident but I don't know how I would react. I think I just wouldn't react at all." / "I don't know if I should react or not. Because if this person tells me that at that moment, maybe they felt trust in me...So maybe I should acknowledge what they're saying and offer a listening ear. But I never thought about this situation before."

"I don't have your level of competences"

Conclusions

There seems to be no blatant hostility or reject towards the LGBTQI+ community, but rather incomprehension of stakes, biases and little knowledge about the specific care these public needs. One of the most sensitive elements of this discussion is the question of differential treatment for LGBTQI+. Professionals seem to a distorted view of what "specific need" implies in terms of care and life experience. They are unaware that their interaction with medical staff is impacted by their non-heterosexual / trans / intersex experience of life and how it materially impacted their bodies and mental health. Professionals seem to sum up the situation as a matter of identity rather than lived discrimination and violence. That is why they do not seize the importance of the matter and reduce it to a question of tolerance. Also, many times the discussion shifted on sexuality and especially same-sex sexual intercourses within a facility whereas it was not the point (especially when it comes to trans and intersex people). It was interesting to observe that it is a tense point (for non-LGBTQI+ people as well, by the way).

BestCare 4LGBTQI+

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ATTACHMENT 1 - Reporting Template

Introduction

The interviews in Greece were carried out with 6 professionals and 2 Older persons identifying as LGBTQI+. We knew the interviewees and had previously worked with them on previous projects that KMOP participated in.

The collection of findings was with 2 Focus Groups following the research protocol. One with the professionals and one with the older persons identifying as LGBTQI+. One researcher conducted the Focus Groups.

Professionals

Demographic information

The focus group involved:

- 4 Social workers who are working in a residential care facility for older people
- 1 Psychologist
- 1 Nurse

All the interviewees were female.

Knowledge and experience about LGBTQI+ people

The Focus Group started with the Researcher and the professionals introducing themselves.

- All the professionals knew the meaning of LGBTQI+. One professional explained what the acronym stands for and that the term has been in use since 1990 and is an adaptation of the original LGB, which replaced the term gay about the gay community in the mid-1980s. The LGBTQI+ community refers to the gay, transgender, asexual, non-binary, gender fluid, intersex, queer, and generally anyone who is not heterosexual or does not self-identify according to their birth gender.
- Sexual orientation is someone's sexual preference. More specifically, whether they are attracted to the same sex, opposite sex, or any sex or all sexes. Gender identity is about identifying one's gender regardless of one's sexuality.
- One professional said: "I think, without being sure, that intersex is people who are born with the genitals of both sexes."
- Many of them have several friends who are gay, trans, and non-binary. These community groups have so far happened to be in their circles.
- So far, they haven't had any experience with older LGBTQI+. Or at least any of the seniors they have helped come out. They understand that it is generally tricky in Greek society, let alone for older people who anyway find it difficult for society to accept their sexuality.
- They have not yet met any older LGBTQI+ because it is difficult to admit that one is part of the LGBTQ+ community, especially at an older age. Let alone in a residential care facility.

- Physically, they don't think there are marked differences compared to other older people. The psychologist supported that they need the same physical care that a heterosexual patient needs. Where there is a difference is in psychological care. For these people, they can be more traumatised, feel excluded, and frightened at some point in their lives.
- "It is crucial to be trained to treat people who belong to the LGBTQI+ community to provide them the care they need."
- All professionals answered that they would be able to take care of LGBTQ+ older people. The difference with a non-LGBTQ+ older adult in care would possibly be to promote their positions on their rights and freedom and right to expression to inspire confidence. In addition, they would reassure them that they are in a safe space and do not intend to face any discrimination or aggression. Given that they work in a genuinely safe area, colleagues and management staff are equally open-minded, and that racist behavior would not be tolerated.
- They would be very happy that they felt comfortable sharing it with them and try to reassure them of any fear or insecurity they may have felt. All the interviewees answered that they would not reveal it to anyone.
- Unfortunately, not.

"I think it has something to do with the fact that we haven't had, at least openly, LGBTQ+ people. But we should be prepared in case."

Making the facility LGBTQI+ friendly

- One Social Worker supported that: "The first step, I think, would require training seminars for employees and administrative staff. This is because we must ensure that care and health professionals know different gender identities and sexualities and can address patients by whatever pronouns they are asked."
- Workers must act in a person-centered way and therefore show respect to all patients and not discriminate. Also, care facilities should not accept any form of discrimination or criticism from other residents. Finally, those residents from the LGBTQ+ community would feel much safer speaking and expressing themselves as they wish if they knew that staff is specially trained to care for and protect them within the facilities.
- The nurse supported that: "I think the most challenging part would be managing the opposition of the other residents, as we are talking about older people who are usually more entrenched in their views and find it difficult to accept anything that was not acceptable in their time or that they do not understand."
- They answered that that depends on the people in the residential care facility. The most important thing is for the professionals to prepare every resident properly and be there to answer any questions they may have.
- Definitely. It's still difficult for the community. When you have experienced social exclusion or rejection from family members, the job market, etc., how do you feel comfortable being an older person in a closed space where you live to talk about it? But they think that with time, the situation improves, and they are encouraged to be themselves.

Older persons

Demographic information

The focus group involved two women in the LGBTQI+ community who are a couple, and they have been together for more than twenty-five years. The one woman (P1) is 65 years old; the other woman (P2) is 80, and both are in retirement.

Experience with care

- For now, neither P1 nor P2 needs support for their daily activities.
- No, they have no experience receiving care for themselves in a residential care service.
- P1 has an experience with her father living in residential care for almost a year before passing. P1's father had Alzheimer's, and it was necessary to have him somewhere safe with professional care. It was difficult for P1 as they have heard many stories of mistreating patience in this kind of care. "You have to be in contact all the time with the staff of the residential care to see if they are looking after him and to find out if he is okay. I used to visit him every day, but the visiting hours were specific, and I could not see him when I wanted except at certain times. When you take care of your person yourself, you feel safe, but when someone else does it for you, you feel insecure, and you are in a constant state of anxiety.

Ideal care home

- The most important of all is that the care home has good workers who look after and care for the older adults who live there correctly and with care. To treat them as different personalities and to know each one's needs and above all with respect. P2 also pointed out that the facilities that exist in Greece are not good or welcoming for the people staying. They are more reminiscent of hospitals, with rooms that divide them; Many are without a garden, which is essential.
- What would make us feel comfortable in a residential care home is for the staff to show that they care and for us to feel secure that they will take care of us. Also, it is important that a space is clean and that each tenant has their own space.
- We don't think there's anything to be ashamed of. There is nothing else to think about as long as there is the right staff and training. Also, the other older people must be respectful and receptive.
- Yes. It's a way of life not to hide who you are, and we always follow that.
- In itself, sexuality in old age is relatively marginalized. The specific needs are not calculated for people of the third age, let alone for people who are LGBTQI+. Professionals must be trained to recognize and be able to care for the needs of this type of older adult. Professionals should be sensitized about intimacy and sexuality, ensuring the rights and protection of vulnerable people.

"I don't think only the older LGBTQI+ should be treated differently. Every person is different, and every person has different needs and needs a different kind of care. Treating everyone equally runs the risk of reinforcing inequality and failing to meet sex, sexuality, intimacy, and more needs".

Conclusions

Although based on a small sample, the conclusions depict a part of the reality and some older LGBTQI+ needs.

- Most professionals have no experience nor are trained in caring for the older LGBTQI+ community.
- The professionals caring for older people should be trained to recognize every need.
- Older people's needs are often put aside.
- An essential factor in addressing the issues is to recognize that older adults may still want to be sexually active or intimate.
- Raising issues of sexuality and intimacy can be difficult for both care home residents and professionals, but there needs to be appropriate training for professionals to know how to manage such issues.

ATTACHMENT 1 - Reporting template

Introduction

In Italy data were collected following the research protocol as follows:

- Older persons identifying as LGBTQI+: we used a convenience-sampling, recruiting persons with whom we were previously in touch with because of personal connections or involvement in previous projects. Data were collected through in-person interviews. Interviews were conducted by a researcher, recorded and then summarised in a report, upon provision of informed consent.
- **Professionals**: we used a convenience-sampling, recruiting persons with whom we were previously in touch with because of personal connections or involvement in previous projects. Data were collected through a focus group + 1 interview with a professional unable to attend the focus group but willing to be involved in the research. The focus group was conducted by two researchers, recorded and then summarised in a report, upon provision of informed consent. The same procedure was followed for the interview, which was conducted by a single researcher.

Older persons

Demographic information

- P1 and P2 are a lesbian couple of, respectively, 67 and 70 years old. Currently retired, one worked as an architect and the other as Italian literature professor in a junior high- school. They both received an academic education and come from the upper-middle class. They have been a couple for over 15 years but only few years ago they formalized their relationship in a civil union. P1 and P2 both had experience with care as their mothers were taken care first at home and then in (two different) residential care facilities.
- P3 is a trans-woman aged 62. She lived with her mother till her mother died, and after that she realised, she perceived herself as a woman and started her transitioning. Using her own words, she's aware of herself and "even if the awareness, sometimes, hurts I want to play with it as much as I can".
- P4 is a gay man aged 71, now he is retired, he used to be craftsman, a well-known and praised framer. What gives meaning to his days, in his own words, that gives "taste to his days" is to help a guy from a non-EU country with bureaucratic issues in order to get a visa to finally stay regularly and freely in Italy, learn Italian and get some training. "This helped him and helped me to feel still useful and... praised"

Experience with care

- Experiences are mixed – some have none (P3) for some were very positive, creating a "positive prejudice" (P1), for others more negative (P2, P4), creating a general sense of fear and angst when thinking that they might need such a service in the future.

- General "resignation" to the idea that, not having children, they would most probably end up in a residential care facility, which is in any cases perceived as a better option that staying at home with the support of a care worker. This is considered more invasive from a privacy point of view as well as riskier.
- The lack of freedom, the need to ask permission for everything and being subjected to a schedule decided by someone-else, while understandable, was striking when approaching a residential care facility for the first time
- The fact that people employed in a facility are professionals and skilled in their job is perceived as reassuring and somehow mitigating the violation of intimacy which is inherently connected with the need of personal care.
- There is the perception that residents are considered as "asexual": there is no consideration about their sexual needs and neither spaces for intimacy.

Quotes:

"I really regret that I ended up deciding to admit my mother to a residential care facility, you really feel at the mercy of the staff, compelled by the schedule of others. I can't think about myself in such a place, it is very hurtful for me when I think about it" P2

"I think I will end up in a residential care facility. It's just me and my partner, we don't have children, so I think it is quite inevitable. I have always thought it's like going to the hospital: nobody likes it, but if it is necessary you just do it. I see a nursing home as a machine, but I am a technician and for me machines are reassuring". P1

"I hate the idea that someone who is not a professional touch me – I have been in hospital for surgery and it really made the difference for me to be helped in personal care by professional nurses. It alleviated the shame" P1

"When you get older, you have more free time and you have a sort of growth in relation to your sexuality, maybe not in performance but in willing and in desire to prove new experience" P4

"I know people do not aspect this, me too – when I was younger- I didn't believe that, but that it. As you get older you push forward the time when you say << well, I'm too old to do this>>. Because sex make you feel good at every age, but most in seniority: it gives you a good reason to carry on. My 93 years old uncle smile at me when he says to me << However, every once in a while, I still manage to do it>> P4

Ideal care home

- There is a perception of being in the mercy of staff and a general sense of unsafety and fear for one-self, especially in case of diminished cognitive capacities.
- The presence of an "ombudsman", someone external from the nursing home with monitoring responsibilities, together with a broad use of video-cameras, would make them feel safer.
- Maintaining their cognitive capacity is considered of paramount importance to keep their identity and safety while in residential care as well as to be able to preserve autonomy in as much (even if tiny) choices as possible; choices consistent to own personality.
- P1 and P2 agree that they would not conceal their sexual orientation and the fact of being a

couple if entering a care facility, but at the same time they would not tell everyone as they think it is something private and somehow that people might consider it a bit "pathetic" since they are older persons. On the other hand, they think that being two older ladies their lifestyle might be considered "less threatening" by those who are against LGBTQI+ as they live a very "normal" life.

- P3 would not have problems to reveal herself, but only if she had the feeling that those who run and work in the care home had not prejudices o bias in order to not be segregated.
- P4 said he would not worry disclosing to the staff, he worries he could be stigmatized by other residents. So, he would like to find a residential facility ready to address cases of discrimination towards residents.
- Staff should be selected seeking workers who has empathic competencies and human approach
- They would inform the management and trust that they will inform those who need to be informed to provide adequate care.
- They consider it protective for themselves if the management is aware.
- There is a wish for a more flexible service provision, where the service is less standardized and more tailor-made to the needs of guests, provided in smaller groups gathered by the same specific interests, attitudes, etc...
- P3 desire an elder care residence in which the focus is not only medical or strictly on caring but more holistic, open to the help of peer support workers, for example, as in her opinion those knowing care-needs out of experience can be more helpful than professionals.
- All respondents mention their will to share the room with their partners (either partners they had before entering care or partners they found in the residence) in order to live that situation in private way but still not under covered
- The availability of space for intimacy is considered very important. For example, being able to close the door of the room, if they wish to have a sexual intercourse, but also for other reasons, such as for example to pray or just to stay on their own for a while. A participant also mentions the desire to have some adornment of their taste and maybe some music or some flowers
- There is agreement on the need of a private place in which to live own sentimental and sexual lives in privacy, intimacy, dignity even if sexuality is not perceived as "straight".
- While they are aware that practicing sex might expose them to some risks, they prioritize their self-determination over safety.
- A collateral service should be for residents to be supported to set their own living will or advanced care planning, with the right formality of law maybe with a public officer that periodically goes to care residential home and receives those wills [or maybe with a list of public notaries, with agreed calmed down rate, editor note's], in order to make them enforceable in protection of their will, even in case they would lose their cognitive capacities.

Quotes:

"I would speak openly about my relationship with A. I have learned to say it, or sort of. I live a normal life and I think this is reassuring. I don't have to put on the sign, but whoever needs to know must know (the manager, for example) so that there is no doubt that we are a couple and need to be treated as such. I would not ask to keep it confidential at all costs, I

would say "I tell you because I need this: you manage it". I just have to figure out who is the right person to tell about it in the organization." P1

"I wouldn't say it to the four winds, I fear it risks being pathetic. I am old but I don't feel like that, I have to think that I am old. The heart does not age, neither do desires. However, when I see other older gay couples, I have to remember to myself that for me it is legitimate, because sometimes seen from the outside I perceive it as pathetic and anaesthetic" P2

"The fact that we are older persons, I think is reassuring even for those who see the thing [being LGBTQI+] differently [she refers to people who discriminate against LGBTQI+]. As an older person, one is perceived in a less threatening and normalized way. You don't show anything that worries others. The fact that for the others you are old, protects you." P1

"According to my sexual desire, I would like to be penetrated by a woman and to do that I need some "special toys". I would like not be stigmatized or judged or talked-about by the staff because of that" P3

"If I had to die while making love, I'd sign every disclaimer / limitation of liability paper to those who run the residential care home" P4

Professionals

Demographic information

The focus group involved:

- 4 residential care facility coordinators
- 2 social worker coordinating home-care services
- 3 psychologists (1 working in community services for people with dementia and 2 working in residential care facilities)

All female.

Knowledge and experience about LGBTQI+ people

- The session started with a short explanation of the acronym LGBTIQ+ and the difference between sexual orientation and gender identity (using the "Gender Unicorn") as not all participants were familiar with the terms.
- None of the participant has ever met older LGBTIQ+ persons in the framework of their services. One had a volunteering experiences in "Gender camps" for older LGBTIQ+ persons while another worked with an informal carer of an older person, she was supporting that was in the process of transitioning from male to female.
- Because of this lack of direct experiences, the conversation focused more on the issue of sexuality of older persons in residential care services and how this is (not) dealt with. Participants agreed that there is a stigma around sexuality of older persons in general and obviously this includes LGBTIQ+ as well. The topic is neither part of the training of care professionals nor explored when individual care plans are drafted.
- It is basically neglected both because it is not considered that relevant for older persons but

also because professionals are afraid that asking would create expectations that then could not be met. For example, it is difficult to create space for intimacy for couples as in their facilities there are mostly double or triple rooms in facilities.

- A participant mention that any gesture which has a sexual nature (masturbation, but also trying to touch other residents or the staff) this is immediately labelled as disinhibition instead of investigating if that's a sexual impulse that has to be expressed. It is not addressed at all.
- One of the participants mentions the fact that it is important that those having a coordinating role raise, if needed, issues related with management of sexuality-related issues during team meetings with care professionals. Indeed, in her opinion this "gives the permission" to them to raise their concern and uncover a taboo-topic.
- Another talks about staff being LGBTI and that sometimes they are excluded or criticised by other colleagues as well as by residents. So she was wondering how it would be in case of older residents, if they would be well accepted or excluded.

Quotes:

"My impression is that sexuality in residential care is totally neglected: we talk a lot about how we strive to make our guests feel good, but how can we achieve this if we forget such an important thing?"

"I don't perceive this as an issue for my context at the moment, since no one of our guests has ever disclosed as such. Of course, this doesn't mean that there are not LGBTIs but – maybe it is a cultural issue – no one felt like talking about it. This is probably because sexuality in residential care facility is not in the agenda"

"We do have cases of [straight] older couples who are expressing the need to have sex and we as well have many cases of masturbation, but for my staff this is still a taboo, so no wonder we haven't made the step forward to talk about LGB sexuality or transsexual older persons, which is even more difficult to face"

"I thought that maybe I have never met older LGBTIs in my work because they came from a cultural context where you were not used to say that or even the homosexuality was latent. Maybe some of them just decided to get married and have a family to conform to the norm of their cultural context. But it might be that emerging dementia is the chance to brought it out."

Making the facility LGBTQI+ friendly

- Participants discussed about the fact the needs related with sexuality should be discussed with the older person when he/she/they enters the care facility, same as they do in relation to other issues such as personal care, hobbies etc.
- This would give the opportunity to users to express their concerns or needs if they wish to, although it would be important to think carefully how to ask these questions not to invade their personal space and not to convey the message that they are obliged to respond if they don't want to.
- It is raised the topic of how these issues can be managed while respecting privacy rules, and the conclusion to which the group came is that older persons should be given the opportunity to provide this information only if they wish to and to decide to whom they should be disclosed.

- The need to provide training and supervision to staff in relation to sexuality of older persons is considered useful, as it would help them dealing with cases, should they happen.
- It is also discussed to which extent and how it should be explored the attitude, bias and prejudices of staff towards older LGBTI. On the other hand, professionalism of staff should be able to overcome this.
- Participants discussed about how the way the care facility is, from an architectonic point of view, has an impact: indeed, many said that they only have shared rooms and often bathrooms shared among more rooms, so that providing spaces for intimacy would be really difficult.

Quotes:

"One of the topics I raised with my staff is in relation with the fact that we give for granted that we should separate rooms based on gender, but is this really the case that everyone feels more at ease with people of the same gender?"

"Modesty is an important issue for residents but also for care workers. When I interview new staff [for a job position] I usually ask how they feel in providing personal care to someone of the opposite sex because I can understand that the care recipient can feel if he/she is touched or treated with contempt. So, I am thinking that I should do the same in relation with possible LGBT clients."

"Once I was managing a case in which I needed to find a home care worker for an older lady whose carers (the daughter) was about to leave for Thailand to receive a sex-reassignment surgery. I was totally not at ease with the care-worker as I couldn't be explicit to respect the privacy of the family but, at the same time, I was worried that once she understood the actual situation, she might not react well. On the other hand, I understand that I never had to claim in a service "I am heterosexual" because everyone assumes that. But that's not the case for everyone".

"Sometimes I wonder if dedicated residential care facilities might be a solution. Sometimes I think they end up being a ghetto, but on the other hand I think that maybe LGBTI persons never feel safe in the community and therefore it is like they are living in a ghetto all of the time".

Conclusions

What we can conclude from this small-scale research is that

- On one hand older LGBTIs have some concern about their possible future in a residential care facility but that these concerns are more related to a general perception of lack of autonomy rather that specifically in relation to the expression of their sexuality. They call for a person-centred care approach which is also inclusive and respectful of this aspect of their life.
- On the other hand, professionals have had very little or no experience with older LGBTI persons so far, so it's difficult for them to think about specific needs or solution. They tend to include the issue under the broader topic of "sexuality in residential care" which they recognize as being very much neglected and taboo. Some of the reasons mentioned are stigma at societal level, lack of training of professionals, challenges to deal with the topic while respecting confidentiality / privacy obligations.

REPORT
PR1 - Interviews with 55+ LGBTQI+ in Portugal

Introduction

The interviews happened in the professional or domestic contexts of the interviewees. They were conducted by two interviewers allowing interviewees to answer the questions freely (semi-structured interviews), ensuring that the themes and questions were addressed. The recruitment of the participants was very hard and it was really difficult to guarantee the 3 interviews. The contacts were made, in a first phase, via e-mail to some public figures and associations dedicated to LGBTQI+. The few responses arose via e-mail, recognizing the inability to help and recognizing that it is a group (the older ones) difficult to identify. In a second phase, we insisted with the e-mail and started to contact the different associations by phone, once again we faced many difficulties with representatives of the associations reinforcing the difficulty in reaching the older population for one main reason: it is a generation that faced a conservative Portuguese context (lived childhood and youth in a fascist regime) and consequently lived its life discreetly. However, one representative in one association helped and gave us two email contacts. After several email contacts and a reinforcement of help to the person who provided the contacts, we managed to get one of the people to answer and scheduled the interview. After the interview, the interviewee undertook to contact the person who had not yet answered (knowing that he had also been contacted and to know who is the person) and helped find a third person, which she did the next day. The interviews were carried out between July 28th and August 5th, 2022 and were audio recorded by both interviewers, for transcription purposes. Firstly, the main idea of the project was explained, and informed consents were signed in duplicate.

Demographic information

Participant 1 (P1) - 60 years old; female; lesbian - degree in medicine, specialized in pulmonology; doctor – pulmonology and researcher; single, living alone; no children; currently without a partner;

Participant 2 (P2) - 66 years old; male; gay - master in medicine, specialized in pathologic anatomy; retired (doctor - pathologic anatomy); single, living alone; no children; currently without a partner;

Participant 3 (P3) - 59 years old; female; lesbian – no information about education; retired (bank worker); single, living alone; no children; currently without a partner.

Experience with care

- All the interviewees are autonomous, live alone, don´t have children or partner, did not need or actually need care in everyday life.
- All interviewees had experience with other people in need of care, 2 of them with family members (P1 e P3) and another one with acquaintances (P2);
- P1 and P2 had a relatively good experience with residential care, recognizing its importance although P1 disagrees with some of the rules (routines), and P3 considers that experience as

bad, considering the structure and care conditions; P2 experience was with a residential care in the Netherlands, and was impressed with the conditions and respect for privacy;

- None of them imagines to live in a residential home as the ones that exists in Portugal nowadays, at least the ones they know or heard about.

> *P1 - he [her father] began to go only during the week [to the residential care], still came on weekends (...). He reacted a little badly when he went but after some time it was him who wanted to stay, because although the residential care service was not luxurious had interesting conditions, he was in a wheelchair and they had various activities, they wrote on the computer, put music (...). He at first stayed in a room alone, then he himself asked to stay in a room with another gentleman with whom he had a good relationship (...).*
>
> *P1- I usually say that if you don't have some money to pay for a home, you're screwed (...) My father was an insurance professional, retired at the top of his career, was a director of an insurance company, had a good pension and I can tell that we spent his entire pension to pay for the residential care service and we still had to put on the diapers, for the drugs and for all that stuff (...).*
>
> *P2 - my stepmother is Dutch and I went there for a few months and one of my father's maids was in a residential care home and we visited her and I think to myself - I didn't bother! - because it was a T0's (apartments), each one of the residents had a T0, lived in a T0, if someone needed, on the first floor had laundry, had restaurant, had kitchen, if it wasn't feel alright called and someone will bring food, and this way, kept the individuality.*
>
> *P3 - my other grandmother was here in Porto but I confess that when I went there (to the residential home) I felt a very depressing environment, a woman waiting for death and nothing else. (...) The space was not pleasant, it ended up closing... smells (...) I never saw mistreat anyone but I felt that people were a little abandoned.*
>
> *P3- I confess that when I went there, I felt a very depressing atmosphere. A woman waiting to die and nothing else.*

Ideal residential care

- All participants idealise residential care as a community of friends living in independent homes/suites, with respect for privacy and intimacy, helping each other, and relying on external help when needed;
- P1 underlines the relation with nature and pets, with an open space outside;
- P2 refers that this solution needs to be prepared from the present moment, but acknowledges the formal challenges and inheritance issues that may arise, suggesting for the group of friends to create a cooperative;
- Although all of them have the same ideal and sometimes speak about that with friends, P3 mentions that she doesn't think much about that;
- P1 and P3 don't agree with residential care exclusive for LGBTQI+ people and don't imagine living in such a solution. They consider this as a form of discrimination and retrocession; P2 considers this solution to have some advantages, but it could be a problem in small cities. He sees himself living in a solution like that.

P1 - live in community, with a little privacy (...) each of us can have a room or a living area where can be alone or accompanied by someone, where you can have a meal or feel like staying at night eating a soup and drinking tea and not having to have great meals. Having a nearby structure, a large room, where I can live together, I can play cards with friends, watch a movie together, and have a kitchen where I can go, I really like to cook (...). With open space because I like nature, if there could be a pool it would be fantastic (...). Above all, the issue of animals was very interesting although I understand that it may be complex.

P1- I think that the more the communities closed among themselves off, the less accepted they will be. (...) I think it is a part of us that should be lived with serenity without anyone hurting us (...), but we don't have to be only with people that also... [with the same sexual orientation] I think this is very poor, isn't it? I wouldn't like to live my oldness as poor as that.

P2- that example from the Netherlands... it didn't have to be so refined, but to have guarantees of some independence and some privacy. That's something that bothers me, that someone messes with my privacy. It's true that there's a physical dependency because we deteriorate and perhaps one day someone will have to bathe me... If it ever has to be...

P2- My mother is 84 years old, lives alone in her house, I have her key, but before I enter, I ring the bell.

P2- [Homes exclusively for LGBTI people] Had many advantages. At this moment, at least in big cities, I don't think so. In smaller cities, it would be the bogeyman, jungle, there are some creatures stuck there. Lisbon, Porto and cities with some dimension, I think that at this moment it would be a good option. I could [choose a home of this kind].

P3- I have a group of friends we talk about it all the time and the ideal thing for us would be to get a piece of land and some houses and be there together to help each other. That's the only image I have in relation to old age, that's it.

P3- [About residential care exclusively for LGBTQI+ people] Now that's discrimination!

Minimal requirements for Badge of Excellence/ How to make institutions more inclusive

- All participants agree with training for staff and with the need to create better awareness in all steps of the hierarchy, but specially in the higher instances;
- P2 also consider important to introduce a complaints book, to explicitly acknowledge their inclusiveness in internal documents;
- P3 underlines the importance of putting people talking and thinking about concrete and possible scenarios that may emerge and solutions to deal with them.

P1- In the residential care there is always a technical direction. It has to start there, that technical direction has to have these ideals in mind. What for? To supervise and to introduce, to encourage the day-to-day life and practice of the people who are there to be along these lines, isn't it? And this has to be discussed, right? (...) If the technical direction, the people in charge of the home, do not have this ideal, it will be difficult for the rest to happen down here, because there is no such concern. So, of course, there must be training, there must be conversation about this issue, there must be guidance on this issue (...) There

must be this type of involvement of the structure and if the structure is imbued with this thought, then it can also reach the residents. And if there are difficulties of the residents, they can be mediators of those difficulties.

P2- The first thing would be to make sure that all staff would have training, including the organizations that there are homosexuals, bisexuals... get them there, show them that these people exist, that they are as normal as you are and have every right to be here and be treated equally. Because people don't like what they don't know. Or even worse, they have in their heads those prejudices of the crazy queer people that appear in the humour sketches, on television or in magazines. That also exists, yes, but the majority of the group are normal people (I don't like the term normal). These are people who don't go around throwing flowers... No, they go around living their lives and people probably have this idea, these stereotypes and show them that there are other types of people and that they can be your son.

P3- Question them about it. If in a practical case, or several practical cases, are they going to discriminate? Are they going to have a different procedure? It doesn't make sense. It's a bit like putting them up against the wall. Speaking out. Obliged to talk about it. See how open they are to that openness. Sometimes it's us who create that discrimination, isn't it. Me for example. By not talking. If I did, I might speak naturally, but I don't. And maybe it's a bit like working with them, raising awareness of issues, practical cases.

Relevant additional information

- P3 refers to the connections of residential care with Catholic Church and the obstacles that may arise from this

  P3- A large part of these institutions is linked to the Catholic Church and this is a stumbling block, as are the people, including the residents. But perhaps it's a matter of insisting pedagogically, especially with the hierarchies. Maybe the people who live there listen to us better or more, but this involves the Catholic Church a lot. And then they undermine it a little bit, they don't let us progress as we want.

Conclusions

- All of them reject the residential care options that are available nowadays in the Portuguese context;
- All of them prefers a solution with friends, resembling to a community, with respect for independence, privacy and intimacy;
- Only one of the participants agrees with the possibility of a LGBTQI+ residential care;
- All of them agrees that training and debate are crucial to start introduce changes about inclusiveness in residential care;
- They also refer the importance that the structure and the top of hierarchies are challenging and should be addressed in relation to these issues as a priority.

Porto, 17 of August, 2022
Hélder Ferraz & Maria João Azevedo

REPORT
PR1 - Interviews with Professionals in Portugal

Introduction

Several professionals had been contacted and agreed to participate in the interviews, but due to several reasons like holidays or work-related contingencies, their interviews were postponed until the beginning of September. Professionals from the researchers' network of contacts were contacted and these professionals subsequently suggested other colleagues. Participants were contacted by phone. Considering the time of year when the interviews were carried out made recruitment difficult, due to the large number of activities carried out in the summer in the institutions, on the other hand due to the holiday period, which meant that professionals were unavailable.

In total 5 professionals were interviewed between the 4th of August and 6th of September. The first interview occurred online, via zoom and all the others were face-to-face, in the institution where the participants work, except one that occurred in a public place. Interviews were conducted by two interviewers allowing interviewees to answer the questions freely (semi-structured interviews), ensuring that the themes and questions were addressed. Interviews were audio recorded by both interviewers, for transcription purposes. Firstly, the main idea of the project was explained, and informed consents were signed in duplicate.

Demographic information

Participant 1 (P1)- 35 years old; female; heterosexual; degree in Gerontology, Master in Gerontology and Management in Social Equipments; works as a Gerontologist and Socio-cultural Animator in a group of 3 residential care homes.

Participant 2 (P2)- 31 years old; female; heterosexual; degree in Social Work; works as a Social Worker and Coordinator in a residential care home for very depend old people.

Participant 3 (P3)- 34 years old; female; heterosexual; married; degree in Socio-cultural Animation; works as a Social-cultural Animator in a residential care home.

Participant 4 (P4)- 46 years old; female; heterosexual; degree in Social Work; works as a Social Worker in a long-term care unit, and as previous worked in several services related with the young age and ageing (e.g. residential care, home care) in the same institution

Participant 5 (P5)- 45 years old; female; heterosexual; degree in Social Work; works in a long-term care facility; previously worked in in the area of domestic violence, childhood and old age

Knowledge and experience about LGBTQI+ people

- All interviewees have an idea about the meaning of LGBTQI+, but recognise that they lack full knowledge about it; none of the participants know what I and Intersex means
- P1, P4 and P5 doesn't know what QI+ means; P3 doesn't know what I means;
- All interviewees, except one (P4), have an idea of the difference between sexual orientation and gender identity, identifying the first o ne as related to how people relates sexually with others and sexual identity relates to how people feel about themselves related to gender;

- Only 2 participants (in 5) didn´t have contact with LGBTQI+ people in their private and professional daily life;
- No assumed LGBTQI+ people living in the institutions where interviewees work at the moment, but 1 of the participants believes that one woman in her residential home is lesbian;
- All interviewees report having had no training on the subject, both in academic and professional settings, but acknowledge the importance of such training;
- All participants have interest to know more about the topic, but never went into deep on the subject, because they never had to deal with LGBTQI+ people on their work setting;
- All participants refer that the knowledge they have acquired is in part from what they see on TV, in pride month, on social media, information they search on internet;
- All interviewees feel capable to take care of a LGBTQI+ older person and state that they would care for them the same way as they do with all the others; most of them refer that, like everyone else, LGBTQI+ people would have specific treatment if they have a specific condition, for instance, diabetes or depression;
- All interviewees believe that LGBTQI+ people don't have the need of physical and psychological care, however some participants consider that in some cases it could be relevant some kind of psychological care;
- Some interviewees point that one of the specificities in caring of older LGBTQI+ people are related with language, how we address people;
- All interviewees mention that if an old person revealed to be LGBTQI+ they would respect the will of the person, however P1 refers that would advise to seek professional help in some cases (e.g. a 80 year old person wanting to change sex); and all interviewees agreed that would reveal this information to the technical team (and only to technical team), if justified.
- There are no guidelines regarding the needs of LGBTQI+ people in any of the institutions where interviewees work.

Knowledge about the LGBTQI+ designation; sexual orientation and gender identity

P1 - That part of IQ+, honestly no. I only knew LGBTI and I don't remember what the "I" was about anymore, but I remember it being talked about on TV and being more the LGBTI.

P3 - Yes, I already know what means the letters, maybe I haven't memorised well but i understand what they mean;

P4 - Nowadays we listen systematically with the acronym and the designation but I can't say that I know.

P5 - Well, maybe i can not say everything (all the letters)

P1- Gender identity is how we feel. Whether we feel female or male or neither of these genders. Sexual orientation is how we relate to the other, on a sexual level, I don't know!

P2- Sexual orientation is when, ok, we like someone of the same or different sex, and gender is what we identify with, for example, I was born female, but I can identify more with the male gender.

P3 - sexual orientation is the sex which I feel atracted to, men or women, gender identity is about what I feel as a person, if I feel a man or a woman.

P5 - Sexual orientation is the predisposition to intimacy or relationship with another person. Gender identity has to do with who we are, if we are women, men, if we are not defined.

Experience with LGBTQI+ people

P2- Yes, yes. I had a colleague who we think could be [LGBTQI+], but she never assumed it, never talked about it and I never questioned it either.

P1- I heard later that in a Nursing Home where I worked, one of the users was [LGBTQI+], but this user didn't happen to be very participative...

P2- I think yes [that there are LGBTQI+ older people]. Because I believe that there might be some older people who have another... who are homosexual or are bisexual, or whatever. I believe that there are, but there is no opening for this, because this is never spoken about, much less in the third age, nowadays. (...) In fact, it's the first time I'm hearing about this subject [LGBTQI+ older people]. (...) One hears a lot about it, but one doesn't hear about it in the third age.

P3 - I have experience with old people who I think identify in this way but have never assumed [their sexual orientation].

P4 - I haven't quite sure. At one point, in home support... But it was a long time ago.

P5 - To my knowledge, in the professional sphere, that someone has asked for help or that I have indications that there could actually be a different situation there than we usually deal with, no.

Physical and Psychological needs of older LGBTQI+ people

P1- In terms of speaking, I know that those gender issues... they might want to be treated differently, right? If we treat in the feminine, in the masculine, I don't know. I know there are these issues now, the very approach of how you talk to people. But in terms of the physical, the treatment, I think that's like any older person. I think. There are limits, always explaining what we are going to do and understanding what you like and what you don't like.

P1- I don't think the treatment was going to be different. [on what would do differently if she cared for an LGBTQI+ older person] It was respecting how the person also likes to be treated, but that regardless here, anyone.

P1- These clear definitions, it's more that question. I think so [it is important to have training on the subject]. At this moment I think so, because one notices that these differentiations are increasing and maybe it makes sense because people are there and like it to be known how they like to be treated and these specificities. Although I think that for me it is indifferent in the sense that I will always respect how the person wants to be treated and I don't really care if the person likes men, women, you know? For me it is the person. (...) It may be that I don't know whether there are certain rules or certain differentiated care. If there are, I think it is important to understand these differences so that we can be prepared, if these specificities really exist!

P2- Physical (specific care), I don't think so. Psychological, I think this should be a topics that should be considered normal, because people are free to choose who they like, and to have the sexual orientation that they want, as long as they are happy. (...) Maybe, speaking more about this topic in old age (being old and LGBTQI+), going to residential care, or to have projects like this, I think it could help these people.

P4 - if I understand that they have to be different [about specific physical and psychological care for LGBTQI+ people]? I don't think so.

P5 - these people are people like all others, like us, as those who do not identify as being heterosexual, is equal. They're people. They have the same needs, they are certainly the same health problems, they are sure the same economic, psychological problems, whatever.

Training about older LGBTQI+ people

P1- I don't remember talking [about LGBTQI+ issues during academic years], honestly.

P3 - Sometimes it is something that is discussed informally with the employees, but training, in what concerns to me, never had.

P4 - Even in gerontology. Now, it's been a long time since I've been to training because they are no longer presential, are online... But any congress on the elderly is always the same thing, it's aging, losses...

What would happen if a user revealed their sexual orientation

P1- would try to understand with that information what he wanted and it was respected his decision. Now, if I was told "I want to change my sex", an 80-year-old person (...) maybe I would advise a psychologist.

P1- People deserve to be well cared for regardless of whether they are a minority or not.

P2- I would first talk to the person and ask if they felt comfortable to talk more openly with people about it. It could be an example and there could even be other people who after hearing that testimony, would feel more open.

P2- I would say that there is someone here [LGBTQI+] who has a different sexual orientation, who is part of this group and that we have to be careful with some types of behaviour, sometimes conversations, even corridor conversations (...) but if the person was open to talking, I would use that testimony to raise awareness among the other users.

P2- Yes, I think that, on the part of other users, there may be some discrimination, some less pleasant thoughts, due to their age, due to the experience they had, the dictatorship they went through (...)

P3 - In front of me they wouldn't do anything. They would talk to each other, draw their conclusions but directly they wouldn't say anything.

P4 - I think we would have a little bit of everything [reactions]. I'm not saying that from time to time things wouldn't come out that shouldn't... judgments.

P5 - *Quite frankly. I don't see why not to say it or to hide it. It is a person's own decision. I don't know afterwards, and then I don't even know how to answer, how others will cope. When I say others, I mean those who will deal with it as professionals.*

Making the facility LGBTQI+ friendly

- All intervewees don't agree with having residential care exclusively for LGBTQI+ older people, saying that it is a way of discrimination;
- All interviewees consider that training and information about the topic is very relevant and needed, both at professionals and users' level; moreover, they all consider that the it is necessary to talk about the topic in residentials home everyday life, in order to avoid the unknown effect and normalise LGBTQI+ issues;
- P1 considers that younger people (professionals) may deal better with cases of LGBTQI+ people in residential care, but maybe the other residents may have more difficulty with that and could question or comment;
- P2 and P3 even says that training and information should exist everywhere, even since early age;
- P3 mentions that training and information should include sexually transmitted infections, pointing that this is one of the problems of sexuality in old age in general and in residential care being a tabu;
- Some other suggestions: address the issue at admission, amend the admission forms and other documents to reflect this; be careful with the questions/ language we use (e.g. instead of asking if the man is married with a woman, aks if the person as a partner); have training in the institutions; intervene on a day-to-day basis, in the sense of having a normalization discourse; have reference in internal regulations about the inclusive and non-discriminatory nature of the institutions;
- Interviewees consider that reactions to the disclosure of someone being LGBTQI+ would differ greatly, depending on the people. They consider that there would be both people who would respect privacy and people who would behave inappropriately, such as gossiping
- P2 thinks that if someone in the institutions reveal as LGBTQI+, it would be more difficult to talk about this with other residents;
- P2 feels it would not be easy for an LGBTQI+ person to talk about themselves in an institution, because other residentials could discriminate;
- All interviewees consider that since residential homes in Portugal are very close to religious institutions these can be an obstacle or create barriers to the evolution of attitudes towards LGBTQI+ people and their acceptance, and therefore LGBTQI+ older people may be worried about their old age because of this.

Suggestions to make residential care more friendly for older LGBTQI+ people

P1 - There we are differentiating [about residential care exclusively for LGBTQI+]. I am against these distinctions. For me, they are part of society and we all have to live in community.

P2- That would discriminate even more [homes exclusively for LGBTQI+ people].

P1- I think they have the same constraint they have in society in general [LGBTQI+ Older people in residential care]. Everything has to be worked on.

P1- Maybe our generation (...), we have another type of vision and another type of information. It's all about information.

P1- It's not that they don't know. They know. I think what they should know is... that behavioural issue, how to react, how to speak. (...) They know that it exists, they just don't know how to respect it.

P1- Starting with our admission forms, we don't even broach this subject. (...) I don't know if it would make sense to ask [about LGBTQI+ issues]. It's also a good question. If you think it's pertinent to know this kind of information in an admission form.

P2- We are right there saying that he is heterosexual [when we ask a man if he has a man] and that he has to have a woman or a man. (...) It restricts a little bit the person's freedom to talk and to assume himself.

P2- I think that there should be training to explain to people that, we should understand that there are people who identify with another gender, there are people who like people of the same sex, there are people who like both sexes. And I think that there should be training to really explain to people that this exists, that it is a reality, and that it is okay as long as people are happy and feel good about themselves.

P2- It starts at a very early age, in our academic training and so on, and then even in the institutions themselves, for the professionals, because, well, I'm young and I'm more... I deal more with this issue, but we have employees here who are almost retired and perhaps this issue is very embarrassing for them. You should really start with the employees, because we are the ones who welcome the elderly and we are the ones who are going to determine whether or not they are open to talking about their situation.

P2- I think that it's in the day-to-day, in the conversations. To be open and normalise what should have been normal for a long time.

P3 - instil in all professionals, regardless of the hierarchical position, on this topic (...) I would talk to them and I would tell them that lesbians and gay men age. They will show up, sooner or later. They will be there and they don't have to lie or hide what they are.

P4 - I think there is a lot to be done, we are not prepared, that is, the technicians in the areas of different social responses that do not deal with this reality, as the structures are made. Imagine that in a structure there could be individual rooms, for example, it is easy for the person to have the space just for herself, and the work we would have to do is with the team that would provide care.

Should LGBTQI+ people be concerned about integration in residential care?

P2- I believe that those residential homes that are related with the church, the social and parochial centres, I believe that it could be an obstacle when they tell the priest that they are going to talk about this subject, there could be one or two who accept, but I think it would be much more complicated.

P3 - *I don't think any person will be mistreated, at least from the residential care I know, because they assume their sexual orientation. Treatment will be guaranteed in any case. Now, it will not be given to everyone in the same way because there are women who think that a woman who is a lesbian will try to seduce all women.*

Conclusions

- Intimacy and sexuality remain taboo topics with regard to the elderly and in residential care. This fact brings to question the need of an open policy about sexuality and health protection.
- All interviews revealed to be very similar;
- Professionals have heard about the LGBTQI+ topic/issues, but consider not to have enough knowledge;
- There are very few professionals with experience with LGBTQI+ older people in their professional life;
- All professional emphazise that LGBTQI+ people are the same as all other older persons, and as such should be treated equally, with no discrimination and with no need for differentiate treatment, although recognizing tha some of them may have some psychological needs regarding their life history or emotional difficulties related with discrimination of being LGBTQI+;
- For those reasons, professionals consider themselves as capable of taking care of all people, including LGBTQI+ people, but acknowledge that they would benefit with knowledge (training and information) about the issue;
- Training, information and making the topic visible and present in everyday life are strategies to make institutions more inclusive, as well as clear indications in official documents that institutions are inclusive, LGBTQI+ friendly and do not tolerate discrimination;
- All people (professionals, senior technicians, staff, administrators, users) should be involved and targeted by these strategies;
- Religious guardianship of old age institutions can present itself as a barrier and a factor that slows down the normalisation of LGBTQI+ issues in old age and nursing homes;
- Residential homes exclusively targeted to LGBTQI+ people are not a solution, on the contrary, it would be another form of discrimination and segregation for the LGBTQI+ community.

Porto, 8th of September, 2022
Hélder Ferraz & Maria João Azevedo

Demographic information

[Please describe here your participants: age-gender-sexual orientation – educational and professional background... any information you deem relevant to provide some context. Please do not exceed six lines per person.]

IDI 1 (she/her)

She is 54 years old, works in management and provides consultancy services on topics such as diversity and inclusion, tries to give back as much as possible to the LGBT community. Is an ambassador of the Romanian Diversity Charter. She says she always knew who she was but didn't have the courage to tell someone until she was 35. Got married with her partner in 2017, in Iceland, as it was one of the countries this was possible in without being a citizen (besides Denmark). In 2017 she also found out she had breast cancer and started treatment, which ended successfully in her overcoming the illness.

IDI 2 (she/her)

She is 51 years old, moved in 2020 to the UK to live with her partner, who she married. In Romania, before leaving, she had a dog accommodation business in her home, was also an activist in MozaiQ, a Romanian NGO fighting for LGBTQI+ rights. She lost contact with the community 7 years ago. Says that most lesbians are not out because they are afraid losing their jobs. She has experience with residential care, as her partner's father and her grandmother received care in a residential care centre (in UK, respectively Romania – situations which she can compare.)

IDI 3 (he/him)

He is 54 years old, an activist, member of an NGO working for LGBTQI+ rights, he participated in multiple prides in Bucharest since the start of the movement in Romania. He is generally encouraging many others in the community, especially towards self-acceptance and coming out, against internalised homophobia. He came out in college, at work – he speaks out whenever he feels there is prejudice.

Experience with care

[Please make a summary of the replies collected from the group of interviewed persons. Please use bullet points and underline commonalities and differences of replies among respondents. Please do not exceed one page]

Common or shared aspects

Respondents do not have direct experience with residential care facilities, as moving to such a care centre is associated with not being able to function on their own, which is not the case. However, they have indirect experience with a parent of their own, or a parent of their partner's – with both public and private sectors.

- Private sector seems to be generally preferred for providing better care services than the state, which has a quite bad, even scary reputation for being unable to properly care for patients.

- Current care services are perceived as lacking in social and emotional skills, lacking sufficient personnel to properly care for all patients.
- Current care services are not yet focused on the psychological well being of the patients, but rather on the medical/physical.

Differences of replies

IDI 1 – She doesn't need support in her daily activities nor has personal experience with receiving care in a residential care service – however, her partner's mother lives in such a settlement, and her experience has been mainly positive: there is an elevator to help older people move between floors, support bars for every steps, people have rooms of their own, if they choose to live alone, with their own bathroom, they benefit from counselling, medical services, etc.

She would not intentionally disclose that she is part of the LGBT community, if receiving care, but not out of fear or other negative reactions, but because she believes is not relevant to how she is supposed to receive care – as heterosexual people are not purposefully questioned about this nor feel the need to disclose their sexual orientation or gender identity.

In terms of her experience with receiving medical care, she also had a positive experience, but also took preventive measures as to avoid getting in unpleasant situations – she purposefully asked around about doctors and their personality – because she believes that a big part of healing and care is emotional connection – and that is what she believes will differentiate a good service.

> *"I always knew who I was".*
>
> *„I don't believe in segregating LGBT members from the others. We just need clear anti-discrimination policies and education provided to employees of care centers."*
>
> *"There is no group or community to not reflect the whole society – so wherever you go, it will be the same."*

IDI 2 – She doesn't currently need support in her daily activities and doesn't have personal experience with receiving care in a residential care service, but her partner's father and grandmother did, so she has indirect experience, in both Romania and UK.

She thinks that it is important to disclose whether an elder is part of the LGBTQI+ community or not, as an employee who is also part of the community can be assigned to the person and therefore offer a more empathetic care and offer some psychological support through engaging in conversations and sharing their experiences.

> *"I left Romania in October 2020, but not necessarily from the point of view of gay rights, although it is equally important, but because Brexit."*
>
> *"When the law making the gay community illegal came down in 2001, I was already 30 years old. Being out as a gay person for my generation doesn't exist, or for those of close ages. 2008-2009 I started to show my true colors, people were asking me why I don't have children."*

"It would be good to have people who talk to people with dementia or Alzheimer's, to distract them from the crisis, to be able to express themselves."

"I hope I don't end up falling into the hands of medical professionals."

IDI 3 – Also does not have any direct experience with residential care centers but has heard from friends and from extended family about bad experiences that they encountered in residential care centers. He associates them with inhumane treatment and unhygienic conditions, and he would hope not to live in one – he was mostly talking about state/public residential care centers, as he does not have any information about private ones, besides asking for prices that he perceives as unaffordable, especially for a single paying person.

"Many in the LGBTQI+ community are hidden. I have friends who don't want to respond to the census, so they don't see themselves staying illegally with their boyfriend."

"What about the right to live in truth? It is essential for the human nature to be free, not to be like a dog in chains."

"Realistically – when you get to a center – you stay for a few months, if you're alone no one hospitalizes you."

"There are inhumane conditions in the nursing homes as well."

"I hope I'll stay strong (as in, not needing care)."

"It matters little to what extent those in the LGBTQI+ community are discriminated against, rather the Roma are discriminated."

"Overall it's a somewhat good trend. In recent years - there have been no more public acts of violence."

Ideal care home

[Please make a summary of the replies collected from the group of interviewed persons. Please use bullet points and underline commonalities and differences of replies among respondents. Please do not exceed one page]

Common or shared aspects

When it comes to the ideal residential care home for the LGBTQI+ community, respondents did share some common views:

The LGBTQI+ community does not need special or dedicated care, outside from psychological support (which is generally needed and recommended).

Ideally, people part of the community should benefit from care from carers that are also part of the community, in order to better connect and resonate. This would imply for the patients to be out, and this is where opinions are split.

There is no need for a dedicated LGBTQI+ care centre, as this is perceived as only heightening the separation of the community from society.

There is a need for a standard/quality framework for residential care centres, they need to

be evaluated, as there is often lack of information or even consequence, if unpleasant situations occur.

There is a strong need for education in terms of soft skills, communication skills, empathy, overall emotional intelligence and knowledge with regards to the LGBTQI+ community among medical personnel and carers, so they know how to approach their patients in a more humane and validating way.

Differences of replies

[Please include at least one verbatim statement from each interviewed person which in your opinion is relevant to "tell the story" of the respondent in relation to the topic. Please do not exceed half a page per respondent.]

IDI 1 – An ideal care home would not be fundamentally different from what she found is provided:

- emotional connection is key for caring services – that is, is essential for the personnel to be empathetic and to show it to residents, show positivity, smile, answering questions or requests, validating older people's perspectives – for them to know the significance and importance of the work they are doing.
- in terms of functionalities and infrastructure, it is important for a care home to offer accessibility to essential rooms, to outside and public spaces, have support bars,
- to include medical services (having a progressive price offer, depending on offered services),
- to include psychological counselling as well.
- use thorough communication seems to be a desired characteristic as well, for personnel to tell older people why they need to do certain actions, what is happening, what is next ("like at the dentist"), to provide plenty of explanations and communicate thoroughly with the residents.

For the LGBT community members, she thinks it is important for personnel to be educated on the matter, to be able to ask questions such as "how would you like me to refer to you?" or "how would you like to be addressed?", in order to avoid tensions or misunderstandings. The education of the personnel would also be relevant when offering care to transgender people, to help in administering hormonal treatments.

She suggested that care homes or residencies to be classified, for a standard to be available, such as in hospitality industry (one, two, three stars, depending on facilities) – so one would know what they would get in return: the value for money ("Like they do abroad, in Italy").

> *"There should be no plan to approach sexuality and intimacy – is there one for heterosexual people? It should work like in your home or any home for that matter."*
>
> *"It is important that a standard exists, and that someone can verify the quality of the services offered."*

IDI 2 - Ideal care home for her would be closer to what she directly and indirectly experiences in terms of medical and residential care in UK. Here are some aspects that she mentioned:

- at registration,
  - to ask how that person wants to be addressed (he/she/they, etc.),
  - also if they are part of the LGBTQI+ community, in order to be assigned a carer from the community, if available, or to declare partner/family who has visiting rights.
  - to declare dietary restrictions (if the person is vegetarian or has an intolerance)
  - to make sure that the centre has access to the pacient's medical record
- for the medical personnel to use simple language, and not a technically abundant language, for the centre to include a pre-assessment period (such as a trial, to see if the older person can integrate),
- for the medical and care personnel to ask permission/knock every time they enter the room, or ask permission before touching the patient, before applying a treatment.
- For the care personnel to offer conversation hours for people who are intellectually degrading or in a crisis.
- Reviews to be available, so one can read other's impressions with the offered care services.

> *"The person who would care for me would have to ask me how I would like to be addressed. It is essential. When I'm in bed and you visit me, to ask for consent every time before you touch me, i.e. to give me treatment. It's important the security of data processing. May I see? May I palpate the area? Because I may be suffering from anxiety or some other condition."*
>
> *"No one should enter the room directly, they should knock on the door and wait for an answer."*
>
> *"People are afraid in the absence of information. I would read about the place I would check into, if I read reviews where I saw that patients weren't being treated properly, I would go ahead and spread the word."*
>
> *"There should be a trial period to see if the place fits the principles you are looking for."*
>
> *"There should be a designated chef, patients should be asked if they have a certain diet, if they are vegetarian, intolerant, etc."*
>
> *"It makes sense to ask you, ideally at the beginning, gender, sexuality, whether you want to declare or not, how to address. That's if it's a dedicated LGBT centre. Community employees could take care of older people in the community, because they can understand the social and psychological needs much better. To understand you have to be part of the community."*
>
> *"We don't need different treatment; we want to be treated the same as everyone else."*

IDI 3 – An ideal care home is not characterized by many factors – and when it comes to an ideal care home for LGBTQI+ people, there is no perceived difference in needs: it would need to offer

- equal and humane care,
- treat patients with empathy,
- offer socializing activities and opportunities,
- provide outdoors hours,
- have a system of quality control.

> *"To have the right to go out, 2-3 times a week to take a walk, not to be in detention, to be able to have therapeutic animals. To be able to bring your dog."*
>
> *"It should be about humanity. Decent conditions. Diet food for the elderly, but enough to satiate them, to be helped with medication, to be able to do medical tests."*
>
> *"It should offer social interaction methods. Music and dance groups to make them feel useful, not to be in a place where they wait to die. They should have social security and employees paid properly."*
>
> *"A centre should have cameras, surveillance, to catch irregularities."*
>
> *"It depends on the situation, whether I declare or not being part of the community. If there are precarious conditions, if I'm afraid they'll let me die, then I wouldn't declare that I'm part of the community."*
>
> *"You have to make sure they listen to you, that they have your best interest at heart, and that they like it. They have to show that you're important, that you deserve care and are appreciated like everyone else."*

Demographic information

[Please describe here your participants: age-gender-sexual orientation – educational and professional background... any information you deem relevant to provide some context. Please do not exceed six lines per person.]

IDI P1

F is 42 years old and is the administrator of the senior care centre in a small to medium city, inspired by centres in Sweden and Italy. He is originally trained in stomatology and provides these services to the residents. The centre hosts up to 20 seniors and has around 10 employees, medical nurses, and assistants. The seniors who come to the centre are not usually able to take care of themselves or take decisions, have mobility or psychological issues, so they need permanent care. The social workers visits periodically, but not enough, as F declared.

IDI P2

G is 29-year-old, president and programme coordinator at an association with the mission to create activities for independent seniors (who are retiring or retired, who can take care of themselves and their home, they live at home): social activities, recreational, cognitive, playing boardgames, going on walks, engaging in sport activities, interacting with younger generations (children and teenagers) - to prevent Alzheimer and dementia. Most of seniors are lonely and need help with chores and other activities. Activities take place in public spaces, outside or in senior centres.

IDI P3

She is the 34-year-old coordinator of the Elderly Line (RO: „Telefonul Vârstnicului"), the only confidential and free phone line for seniors and caregivers in Romania. She coordinates a team of social workers who offers social and general information and moral support, from Monday to Friday from 8 AM to 8 PM and Saturday from 8 AM to 4 PM. The foundation also organizes other activities, going to art galleries, concerts, theatre, social events, restaurants, excursions for seniors. She also has 3 years' experience as a social assistant for older people, in a residential care centre for people with dementia, providing occupational therapy.

IDI P4

He is 25 years old, has a master's in the management of social services and currently is a social assistant in a residential centre in Bucharest. He also makes home visits and keeps in contact with the tutors of the older people, if they are not able to care for themselves. He feels content with the latest developments in terms of public policies for the elderly, especially at the European level. Some challenges that he faces: bureaucracy, lack of personnel, which makes his job more difficult and leaves less time for him to spend more quality time with his patients.

IDI P5

She is a 28-year-old social assistant in a hospital and has direct experience with caring for older people. She offers support for social cases with medical problems. She keeps in touch with multiple institutions, NGOs and private care providers and social services providers – her main goal is to find solutions so that the patient is safe. She has experience with older LGBTQI+

people, she believes that a big problem for them is social isolation, which leads to a domino effect in their lives, leading to degradation and further isolation.

IDI P6*

She is 59 years old, the director of the Red Cross Branch Sector 5 Bucharest and the coordinator of the socio-medical services for elderly people – she didn't disclose whether she has met elderly people who are part of the LGBTQI+ community but is open to the topic and discussion.

*Note: This respondent did not manage to participate in a live discussion and chose to answer the questions in writing. The input was rather brief, but underlined similar topics/issues as the other respondents.

Knowledge and experience about LGBTQI+ people

[Please make a summary of the replies collected from the group of interviewed persons. Please use bullet points and underline commonalities and differences of replies among respondents. Please do not exceed one page]

Professionals are somehow familiarized with the meaning of the LGBTQI+ term, but there are still some details that seem confusing – they seem to be more familiar with the first letters (lesbian, gay, etc.). Younger professionals seem to be more knowledgeable about the topic, having also personal acquaintances who are part of the LGBTQI+ community. They generally feel that the care system is not properly adapted to take care of the elderly, regardless of them being part of the LGBTQI+ community or not, because of the perceived lacking emotional, social and communication skills.

[Please include at least one verbatim statement from each interviewed person which in your opinion is relevant to "tell the story" of the respondent in relation to the topic. Please do not exceed half a page per respondent.]

IDI P1

F is quite familiar with the term and meaning of LGBTQI+. F declared he is part of the LGBTQI+ community, also having employees who are part of the community, but has not met older LGBTQI+.

> *"I'm from the community, I've even had employees from the community. Some were even open, towards them, there were no such problems (as there are with abused women in Romania). Romania is not what it was 20 or 30 years ago. They (young employees) are much younger and more open than me, who is 40-something years old... They said from the beginning (from the time they were hired) who I am and how I am... There was someone else, but being older, I didn't talk about it. That's how I noticed I'm up to 30 years old, neither had any problems with integration or homophobia. Neither did mine in the centre. Things came up without me intervening or saying anything. I've never publicly said that stuff about myself."*
>
> *"It comes down to positive discrimination. I'd like it not to be exaggerated, to be seen as normal people, but also not to be protected, to be the same equality that it was before knowing. To appreciate a person's qualities for being human and that's it."*

„I don't think there would be a problem anywhere in Romania if an elderly person disclosed in the home that they were part of the LGBTQI+ community."

IDI P2

She has mixed feelings about how people would react to an elder person coming out – she feels that there have been some recent developments in terms of awareness and tolerance of the LGBTQI+ community, but there is always the risk for discrimination and reluctance. She hasn't met any, explains that this is due to the fact that most elderly have repressed this part of their lives or learned not to talk about it.

"To a small extent I am familiar. Personally, I'm familiar, I know what's going on or what's happened in Europe or America, but I don't know how things work in our country, especially as we move quite slowly."

"I know it's an acronym, I don't remember exactly what each letter stands for, but I know what it is."

"I know there's a gender neutral and then we use the plural - and on the sexual identity side, I kind of get confused on those."

"I know people from the LGBT community in my private life – I'm trying to figure out if I know people who are out of the closet or in the closet. Most of them are not out, one is. And they're not open precisely for that reason, because of society, family, etc."

IDI P3

She shares the common opinion that elder people do not regularly talk about LGBTQI+ issues, and that there is a continuous need for education and awareness. She believes that interaction with younger people (who are part of the community, respectively) would help in opening the conversation. She herself is open to the topic, but is worried about how other elderly or professionals would react – so a first step would be to start the conversation, as currently the topic seems to be avoided.

"What the acronyms mean, I don't know all what they mean, I know that in the last few years a lot of them have appeared. I consider myself open-minded, I also have friends who are gay, but I don't know all the terminology, I try to catch up, for example when I find something on Netflix, because Netflix promotes almost every show. I generally know the subject."

"[The difference between sexual orientation and gender identity] I think it's pretty clear to me, as I did a bit of research a while ago, anyway, it started from a discussion with some friends. But I can't say I have a very good grasp of it."

"[If she met older people from the LGBTQI+ community] As a foundation, we're accepting, we don't put labels, we had young people on a project who were gay, but older people...I don't know. I don't even know if I knew them or not, maybe they were, and I didn't recognize them... as long as it wasn't being assumed..."

"Our elders are open... but they don't necessarily talk to us about such sensitive subjects. They go on the idea that it's their business, that if they love each other, I'm not interested. Apart from the fact that they're churchy, they seem pretty open."

IDI P4

As other young respondents, he shares a good knowledge of the acronym and general issues concerning the LGBTQI+ community or know persons who are part of the community. As a professional, he hasn't met any elderly who are part of the community but does not exclude it – he suspects that older people who are part of the community are even more socially isolated.

> *"Once I studied social work, I also had a subject in college on this subject, I know the subject itself well. I wanted to go to Pride, but I didn't make it. I'll try to explain each letter, there are many letters: L stands for lesbian, G for gay, B for bisexual, T for trans, Q for queer, + probably to include them all, genderfluid, binary, non-binary."*
>
> *"Sexual orientation is about sexual drive, gender orientation is about how you feel, male, female, both, neither. You can be a trans woman and be gay/lesbian or straight. Intersex is not clear to me what it refers to."*
>
> *"I know people who are part of the community. Most of them are my age, or from college."*
>
> *"I haven't met any seniors in the community, but I suspect. Not that I'm a traditionalist, but when you see certain people who have had no luck in love, are lonely and withdrawn, there's usually a repressed sexuality lurking there. You can see it in the behaviour - it may or may not be, you wouldn't know."*
>
> *"If you're talking about the elderly, they don't even know there's such a thing, they've repressed any form of sexuality or questioning. They get aggressive when they hear the word."*

IDI P5

As a professional, she also has experience with the medical system, which is also very relevant and informs the behaviours and practices in social care – moreover as they are strongly connected in old age. She talked about the medical perspective, that always or often excludes the emotional and social context of the patients, focusing only on the medical/biological - which is perceived as somehow necessary in order to be able to do one's job properly and not be overwhelmed by emotions. In relation to the LGBT community as patients, this is not viewed as discrimination.

> *"From a professional point of view - just on the medical side, yes, professionals are adapted to take care of people in the community. Not with regard to their psychological, emotional or social needs. I think the professional environment cannot and will not differentiate between a non and LGBT elderly person."*
>
> *"(Doctors) are more inclined to ignore than to discriminate, to minimize. They're used to ignoring that side of emotions, that's what they do, that's what it sometimes means to them. For them it means non-discrimination. To ignore gender identity, residency background."*
>
> *"They need a lifestyle that is closer to the community. Most (older LGBT people) have families, they have children, grandchildren, they are towards their third age. There are people who chose not to do that (start a family) or couldn't."*
>
> *"I knew someone who had been through a powerful trauma and had no support after losing their partner. So all the time he had to hide, the trauma transferred into the rest of his life. Because no one was there for him, he started losing his apartment, his whole lifestyle, he lost his health. He was very, very lonely. He lost his physical integrity and independence."*

IDI P6

She acknowledges the need for psychological care and education for older people, regardless of being part of the community or not.

> *"Gender identity refers to the gender with which a person identifies: masculine, feminine, or pangen (i.e., it is neither exclusively feminine nor masculine, but a combination of these. It is not always identical to the person's biological sex (transgender/cisgender). Sexual orientation is a person's preference in relation to others. Gender identity - it's about the self."*

Making the facility LGBTQI+ friendly

[Please make a summary of the replies collected from the group of interviewed persons. Please use bullet points and underline commonalities and differences of replies among respondents. Please do not exceed one page]

Overall, a LGBQTI+ friendly facility would be characterized by:

- **Trained or educated employees:**
  - On the topic of LGBTQI+, what constitutes discrimination and what not, best practices
  - On emotional intelligence, empathy and communication skills that are essential when caring for a vulnerable person (whether being a senior or part of the community or both)
- **Communication on the topic**: a friendly residential care centre would communicate clearly about its openness, in order to set an example for others and open the conversation.

Please take note that professionals who accepted to talk with us can already be considered as LGBTQI+ friendly, as they were open to talk on the topic – as they also mentioned, the topic is often overlooked and ignored and is especially difficult to bring up in conversations with older generations, for whom the topic was hidden, ignored or vilified (a law making LGBTQI+ relationships illegal has been annulled in 2001, they have been sanctioned a long time and especially during the communist period in Romania, when the current 50+ generations grew up).

[Please include at least one verbatim statement from each interviewed person which in your opinion is relevant to "tell the story" of the respondent in relation to the topic. Please do not exceed half a page per respondent.]

IDI P1

F declared his dissatisfaction with the lack of appropriate communication skills of the nurses and assistants, saying that they have difficulties in addressing correctly the emotional and social needs of older people/residents. Moreover, his dissatisfaction is also related to the lack of digital skills of the personnel, with multiple employees not being able to comfortably use a computer, send an email, search or book online services, etc.

He claims that he would not need different services or care as a member of the community – there is only a general need for education with regards to good practices, social assistance,

communication skills and digital literacy. In the centre he is administering, he did not employ psychologists because he finds them difficult to motivate to come visit the patients, as is the case with other services as well: kinesiotherapy, massage.

An ideal care centre would have better educated employees in terms of emotional intelligence and digital skills.

> *"The social worker we have hired only because we have to. As a clinician, if you ask me, I don't think there's any use, as I don't think he has the training to do things he should be doing, to interact not only with LGBTQI+, but with more..."*
>
> *"They're pretty stories...the welfare forms aren't useful either, we do them to get accreditation. It's not the fault of the caregiver, it's the state not being prepared and not preparing people for this, it's preparing them for getting a certificate and walking around with 3 papers. Not to talk to the elderly, communicate with them, ask them about their lives. She (the nurse) tries hard, but she doesn't have it, just like I don't have the training."*
>
> *"I've had the care home for 7 years now and we've learnt everything as we went along - when we opened the home, for example we bought normal beds, then we realised they were too low for an elderly person. Then we realised we needed bumpers, then we bought medical beds, then we ended up designing new beds."*
>
> *"There are many nursing schools here in the city, but they still don't have the training to care for the elderly. They're taught a whole other thing. They're not taught what it means to literally feed an elderly person, use a crane to lift an elderly person, or how to talk to an elderly person. They're old standards by old books."*

IDI P2

She does not see the relevance for a dedicated LGBTQI+ centre, as she feels that would be segregation. In terms of what would make a care centre LGBTQI+ friendly, that would be:

- Better trained professionals: who would be informed with regards to the LGBTQI+ topic, with better communication skills, being open to discussion and challenges, being able to see other perspectives and with a perceived better work ethic (able to express dissatisfaction or report inappropriate behaviours, to request improvements, etc.)

> *"[Centres] are not [prepared to manage situations where an elder would be part of the LGBT community]. There are a lot of minuses in terms of mentality. The people who work in such centres are people 40-50 years old or more, who are in charge, then later comes the team which is 30-40, most of the nurses are from rural areas or places near Bucharest, because the salaries are very low. Then they don't have such openness. It would be interesting for me too to see how they would react...it also depends on what situation the senior is in. If he is very cognitively degraded, then it might be easier to manage things, because he doesn't remember...if not and the partner/partner comes, it would be quite strange for the staff, because of the mentality."*
>
> *"I think they should convey [that the elder is part of the LGBTQI+ community], because otherwise there would be no change. Of course, they should talk to him/her, if he/she can talk, if he/she will say yes, then they should declare. If he/she is degraded and can't communicate, I think he/she should at least communicate with either a nurse, or rather the psychologist would be the best person to convey this to and he/she should decide how he/she will manage this situation with the staff."*

"I don't think they would need different care than an elderly person who is not part of the community - or other special services."

"To have a younger, and better trained team, and I mean everyone who works in that centre, a team that can have workshops, trainings, feel comfortable at work and free, in the sense that they can express their opinion and come up with all kinds of ideas. I think that's where it all starts from, the organisational environment. If it is healthy and allows employees and always tries to bring something fresh and allows them to come with an input, then it would be much more friendly. But for that you of course need the financial side. Because people will come to you, they would like it, but you also have to motivate them."

"[You need] communication skills, social skills, minimal psychological knowledge, very good grooming skills, of course on the equipment side, to have good quality pampers, good sockets, starting from practical things."

"[There is a need] for themes, training on topics, where staff are always learning and actualizing."

"I would not opt for a centre dedicated to the LGBT community, because we want inclusion and normality. A special centre would be positive discrimination, we don't want to separate you, but we are separating you."

IDI P3

In terms of what would make a care centre LGBTQI+ friendly, she mentioned:

- More empathetic employees, following training or workshops on emotional intelligence
- Specialized psychological care – to address the specific problems that could occur as a victim of discrimination or isolation
- Info-materials and events organized on the topic
- Regular assessments from a regulating institution, to check for inappropriate behaviours

"It's not enough for caregivers to feed them, give them their medication and change them, they need to talk to them, understand them, be empathetic, adapt to the specifics of the elderly."

"It matters everywhere to bring in people with a new spirit, to stop transmitting outdated preconceptions. Because it's not the fault of the specialists who are now 50-60 years old, because that's how the information has been passed on to them."

"In the nursing homes, there could be psychologists talking to the nurses about how to behave, of course. There should be foundations that hold occasional courses for specialists in the field. The owner or the director could call on these organisations, talk to them about old age diseases, about dementia, how to talk, how to behave, and touch on subjects like that, about the elderly in the community. Some are not necessarily bad intentioned, they just haven't had the good fortune to interact with people who tell them about LGBTQI+, they don't even know what it means and if you go to church, most of them hear all kinds of opinions from church or from TV, from shows that should be banned in my view. Some people can't be changed, but some people you can work with, to tell them that it's not going to do anything to them, that (LGBTQI+ elders) are no different from other elders."

"If there was a manual or flyer on awareness, I think it would be a great help. That would talk about the fact that even the elderly can be part of the community. A lot of people think

that only young people can be in the community. And they need the same affection, the same services as other seniors. We don't talk about that, coming from communism where it was even more complicated..."

"When an assessment is made in the provision of care, there should be a team of specialists, in addition to the social assessment, and a social worker to come more often, to make reassessments, to see how the condition changes, a psychologist to talk to him, to listen to him in confidence, depending on the needs of each elderly person. Not just to fill in some documents."

"When hiring, the employer should talk to the caregiver, and whether or not they have seniors in the community, there should be a standard procedure. They should be told up front that they could work with people from the community, not to approach the elderly differently, to have training."

IDI P4

He imagines a care centre that treats equally both LGBTQI+ and non-LGBTQI+ persons, and this would be possible through:

- Communication on the topic of LGBTQI+ in care centres and general media: offering information, organizing workshops, trainings, signalling when a centre is LGBTQI+ friendly.
- Setting clear instructions and rules on what constitutes discrimination, setting sanctions for inappropriate behaviour – having a standard for evaluating care centres.

"I dream of a Scandinavian-style society, like in Sweden - why should there be clubs or special things for that, when they (LGBTQI+) are normal people, and they can do this stuff anywhere? Well, in Romanian society, you start step by step, you don't do it all at once."

"You shouldn't have to declare your sexual orientation when entering a centre. It's like asking me my favourite colour. You can talk to the person separately, make him/her feel appreciated. But I wouldn't see that (declaring) as a standard."

"I would force social workers to accept it, I would introduce sanctions if they discriminated - there has to be an ethics, we are not here to judge people."

"One training wouldn't work, but more would. We need to expose society a little bit to the LGBT topic."

"Exposure could be increased in the centres through information sessions with different specialists, tightening up staff, explaining the needs of the elderly and about this stuff, opening their minds, introducing sanctions, the elderly need to know that they can complain, the employees that they can be held accountable. The media would play an important role, TV commercials would be made."

"It takes empathy, tolerance, self-acceptance and acceptance of others, critical thinking skills are important, that's what makes you accept others."

"We should put up flags, things that highlight that we are LGBT-friendly. We have a beneficiary charter and rights, put this in the charter, organised LGBT-friendly activities, marketing: I'm LGBT elderly and I've stayed at the X centre. It takes a lot of communication."

"Easiest to do: promotion. A guide to their rights needs to be drawn up, so they know where they can turn if they feel discriminated against. Then workshops held by the psychologist and with the other beneficiaries and assistants, explaining the concept and everything."

IDI P5

For this respondent, a LGBTQI+ friendly centre would:

- Partner up with other LGBTQI+ supporting associations
- Invite members of the community to speak and educate on the topic
- Provide information on the topic, as well as materials and resources, such as: list of LGBTQI+ friendly services, whether medical or not, LGBTQI+ friendly associations, websites, books, or magazines on the topic, help or support lines/resources, etc.

> *"An LGBTQ+ friendly care centre would have a partnership with LGBTQ+ associations, it would be connected, because it's generally hard to identify other LGBT people to provide access to the community. They could invite young LGBT people to visit and speak on the topic."*
>
> *"It could have medical services or a list of medical specialists who have expertise in providing medical care to trans people."*
>
> *"It would be helpful to have a psychologist or counsellor who has experience with LGBT people."*
>
> *"There should be a degree of confidentiality, to have all these services without being exposed to other residents. They should have the freedom to choose whether they want to talk about it or not."*

IDI P6

> *"The physical needs may be identical in the standard care protocol; the psychological ones are those that increase self-confidence and eliminate the pre-concepts of discrimination phenomenon."*
>
> *"I don't know (how centres could be more friendly). I don't think this problem is identified at the level of care institutions."*