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Prejudice against the older LGBTQIA+ population in Long-Term Care Facilities (LTC): a scoping review

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Abstract *Among older people, LGBTQIA+ persons represent one of the groups most likely to depend on formal care services because of socio-economic vulnerability. However, the prejudice rooted in society, including health and social care professionals, result in a cis-heteronormative model of care delivery in Long-Term Care Facilities for older persons (LTC). The aim of this article is to investigate, describe and analyse the scientific production on prejudice against the older LGBTQIA+ population in LTC. Scoping review based on searches in the following databases: AgeLine, Portal de Periódicos CAPES, SciELO, Portal USP and HeinOnline. No time limit was set. Of the initial 642 articles, 31 were selected to comprise the sample. Four categories and 11 subcategories were identified. These covered agents, causes, effects, and solutions found in the research. The lack of preparation of the LTC staff and the history of prejudice during life leads the LGBTQIA+ community to fear institutionalisation, when the desire is to have a friendly or exclusive environment. Training of LTC staff is essential, in addition to the need to create legislation to protect this population based on local surveys.*

Key words *Homes for the Aged, Sexual and Gender Minorities, Prejudice*

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Introduction

Although an aging population generates various challenges to public policies[1], older persons still suffer from social invisibility[2], a factor aggravated by economic inequalities, difficulty in accessing health services, and a lack of implementation of human rights[3]. In old age, there are even more invisible, marginalised groups, including older lesbians, gays, bisexuals, transsexuals, queers, intersex and asexuals (LGBTQIA+).

It is considered by Article 5 of the Interamerican Convention of Human Rights of Older Persons (2005) that the older LGBTQIA+ population are victims of multiple discrimination, on the one hand, for simply being older persons, related to the stigma of vulnerability; on the other, because they clash with cis or heteronormative attitudes, suffer homophobic or gender identity threats, which implies a lonelier and constantly invisible way of life[4].

In some countries, non-heteronormative sexual orientation or non-binary gender identity is seen as a crime[5]. Even in countries where there are human rights conquests and establishment of institutional organisations aimed at defence of LGBTQIA+ communities, as in the United States, the United Kingdom, Canada and Australia, the statistics regarding old LGBTQIA+ are not accurate[6,7].

Structural discrimination and prejudice make many older LGBTQIA+ people not be upfront about their gender identity or sexual orientation, this being expressed among LGBTQIA+ as "return or stay in the closet"[7]. Exemplifying, regarding gays and lesbians, homophobia on the part of society and internalisation (denial of one's own identification with this sexual minority[8]) are aggravated by the accumulation of stigmas according to the situation of the person (income, race, etc.), resulting in a discriminatory intersectionality, with the concomitant expression of, for example, ageism, racism and misogyny[7,9,10].

The fear on the part of older persons to reveal an LGBTQIA+ identity spans different generations, such as the silent generation[11] and the baby boomers, born respectively before World War II and between 1940 and 1960. These generations experienced criminalisation of homosexuality and pathologisation of gender identities and sexual orientations that clash with heteronormativity (classified until 1990 as mental disorder by the International Statistical Classification of Diseases and Health-related Problems[12]). Another factor that contributed to the stigmatisation of the baby boomer gay generation was the advent of AIDS (acquired immunodeficiency syndrome). The correlation of the disease with the gay population at the time caused it to be characterised as "gay cancer" or "gay plague"[13].

This is the history of how society formed deeply rooted prejudice, a legacy causing the LGBTQIA+ population to experience discrimination till today, and be afraid of cis-heteronormative care in the most diverse services. This situation has led the LGBTQIA+ to avoid or delay health care, and hide their gender identities or sexual orientation from care providers, the direct impact of which has been a lack of health information and assistance[2,6,14].

In Brazil, among the assistance services offered to older persons, there are Long-term Care Institutions (LTC), which are collective homes, governmental or not, where people over 60 reside, supported or not by their families, and have freedom to come and go[15].

LTC is one of the services that generate most fear in older LGBTQIA+ people[16], due to being afraid of receiving poor quality care, as well as suffering discrimination, isolation, verbal or physical violence from other residents and their relatives[2,17,18]. At the same time, among older adults, LGBTQIA+ represent one of the groups with the highest probability of depending on these services, since some lose contact with their biological families early in life due to non-acceptance of their sexual orientation or gender identity, they tend not to have children (who could provide support in this phase of life), or may be in a situation of economic vulnerability caused by social marginalisation, making it impossible to achieve a good educational level and obtain employment.

There is less research related to the needs of older LGBTQIA+ people than that focused on gender, class or ethnicity in old age[2]. Until now, there are no records of studies with primary data collection regarding this population in Brazilian LTC. Therefore, this research aimed at surveying, describing and analysing the scientific production about the prejudice against older LGBTQIA+ persons in LTC.

Method

It is a qualitative, bibliographic, exploratory, descriptive scoping review. For the research question, the strategy of the acronym PCC[19] was used for the population (older LGBTQIA+ people),

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concept (prejudice) and context (LTC or similar institutions in other countries). The question was formulated: What is there in the scientific literature on prejudice in relation to LGBTQIA older persons in LTC? The scoping review protocol was published on the OSF Registry Platform in August 2022.

The databases accessed were: AgeLine, Portal of Periodicals CAPES, SciELO, the USP Portal and HeinOnline. There was no temporal limit on publications, and the following English descriptors and keywords: "prejudice", "nursing home", "sexual and gender minorities", "LGBT*", "homes for the aged" and "long-term care" were used in six different combinations. The Portuguese terms used were: "*minorias sexuais e de gênero*", "LGBT*", "*instituição de longa permanência para idosos*", and "*preconceito*", in four different combinations.

The inclusion criteria were: to address prejudice against LGBTQIA+ in LTC (or similar institutions in other countries) and older LGBTQIA+ persons concomitantly; and make the full text available online. Studies in the project phase and letters to the editor were excluded. A PRISMA[20] flowchart was used with the scoping review steps (Figure 1), and, for data analysis, qualitative content procedures[21].

Searches were conducted on 6th September and 6th December, 2021, and on 25th February, 2022. 1,531 articles were found; of these, 811 were duplicates and 78 without full access. After superficial reading (pre-analysis) of the titles and summaries, 642 articles remained. After reading the summary and application of the inclusion/exclusion criteria, 73 articles were selected for reading in full. Of these, 31 were selected to compose the review's final sample (Chart 1). The entire selection and evaluation process was carried out by two independent reviewers, and a third reviewer dealt with cases of disagreement.

Results

The 31 articles selected for the review were published between 2006 and 2021, 16 of these in the last five years, which suggests an increase in interest and urgency in the debate on the theme. The research originated in 10 countries, mostly the United States (n=19, four literature reviews). Among the others there were: the United Kingdom (n=4), Canada (n=2), South Africa (n=1), Germany (n=1), Australia (n=1), Brazil (n=1), Belgium (n=1) and Spain (n=1).

The articles were published in 22 different journals, covering studies of a qualitative and quantitative nature, bibliographic research and documentary analysis. Nine researches had LTC professionals as participants, and most of the studies about the LGBTQIA+ population did not have the participation of bisexual, transgender and non-binary persons.

From the content analysis, four thematic categories emerged: characteristics, causes, effects and solutions, which were divided into 11 subcategories (Chart 2).

Discussion

The definition of ageism adopted in international documents distinguishes stereotypes (how it is thought), prejudice (as it is felt) and discrimination (as it is acted)[39,40]. In the sample of this literature review, in relation to prejudice against older LGBTQIA+ persons, there was no clear distinction between prejudice and discrimination. No article presented a definition for the term prejudice. The works addressed characteristics, causes, effects and solutions of prejudice as well as discrimination against the older LGBTQIA+ population in LTC as interrelated phenomena.

Characteristics

Targets of Prejudice

Decades of marginalisation and oppression in relation to the LGBTQIA+ population are reflected in a community, now older, loaded with intersecting stigmas, such as the highest level of poverty (compared to the situation of the heterosexual population in the same age range), the race/ethnicity, the lowest access to education, lack of housing and the insecurity linked to the break from the family of origin[12]. However, the profile of participants and targets of prejudice in the sample involved those aged 50 or older, the majority gay men and lesbians[22,24,26-28], white[24], residents of urban areas[26], members of the middle or upper class[27,28], and holding a university degree[27].

In a considerable part of the studies, participants were sought through LGBTQIA+ communities via letters, phone calls or emails, which may have limited access to low-income older people, those with less education, residents of rural areas, and members of other ethnic groups[22,24,26,29]. Groups, such as the transgender[29,46] – transsexuals, transvestites – and bisexuals showed low or no presence in the studies.

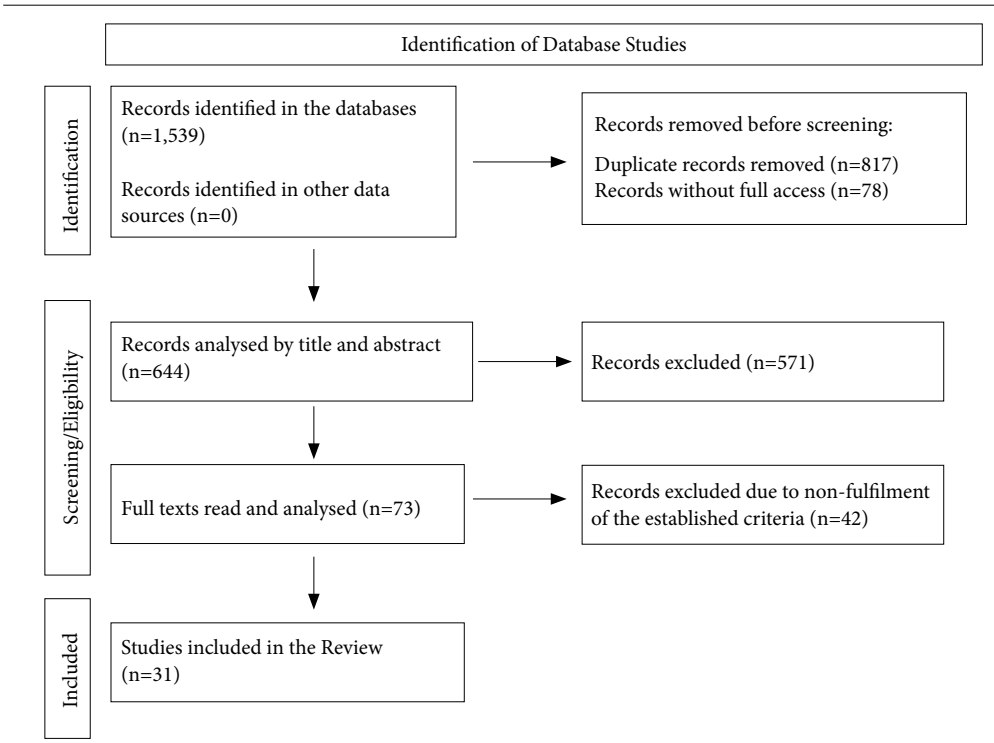

Figure 1. PRISMA Fluxogram (flow diagram) of the selection of the articles.

Source: Page *et al.*[20].

Prejudice agents

The family[24,27], the professionals[3,28,29] and LTC residents themselves[32,33] emerge as the main agents of prejudice, discrimination, intolerant and hostile actions.

Regarding the family, matters such as distancing after "coming out of the closet", parental rejection, financial interests and conflicts involving relatives of their partners were the main indications of discrimination[24,27].

LTC themselves are perceived as agents of prejudice by allowing and instigating discriminatory practices, disrespecting (and even separating) long-term partners, imposing barriers to fulfil health decisions presented by the family of choice, and, more cruelly, creating ghettos, by allocating/hiding old LGBTQIA+ with dementia out of sight to prevent other residents from complaining about their presence[3].

The LTC residents interviewed in the articles of the review and who are agents of prejudice follow the profile of residents in general, most of them composed of white heterosexuals, educated, over 60, and believe that LGBTQIA+ fellow residents must not have revealed their sexual orientation to be admitted to the LTC[32]. In contrast, some residents were favourable to coexistence with LGBTQIA+ residents, corroborated in an American study[33], according to which this change in attitude can be the result of increased cultural acceptance of LGB sexual activity in all age groups.

LTC professionals were pointed out by both LGBTQIA+ residents and by co-workers as agents of prejudice. The staff that responded were composed mainly of women[30,31,33,37] (in more than 80% of all samples surveyed, reflecting the worldwide reality that few men work in the care area), lie in the age range 34-44[31,33,34,37], and are heterosexual[30,33,34], white[30,33,35,37], with more than five years work experience in the care sector[30,31,33,36,37], and have secondary school education or higher[31,34,37].

As for LTC staff, many believe that their history of homophobia is now a thing of the past[46], although they claim not to have "many older LGBTQIA+ people at the moment" in their facil-

Chart 1. Mapping of the literature in the Review (n=31).

Year	Reference	Publication	Country	Method	Participants
2006	Tolley and Ranzijn[34]	Australasian Journal on Ageing	Australia	Data collection	113 staff members of 13 LTCES, aged 18-65
2009	Concannon[45]	British Journal of Social Work	UK	Review and documental analysis	-
2010	Bell *et al.*[35]	Social Work in Health Care	USA	Descriptive Analysis	1,071 managers of LTCES, aged 35-54
	Ritter[51]	Texas Law Review	USA	Review and theoretical argumentation	-
	Stein *et al.*[26]	Journal of Gerontological Social Work	USA	Focus groups	16 gays and lesbians aged 60-84
2011	Gabrielson[27]	Advances in Nursing Science	USA	Case study	10 lesbians aged 55-65
	Knauer[3]	Elder Law Journal	USA	Review and theoretical argumentation	-
	Redman[12]	Temple Political & Civil Rights Law Review	USA	Review and theoretical argumentation	-
2012	McIntyre and McDonald[25]	Advances in Nursing Science	Canada	Explanatory research	-
2013	Johnson[50]	Journal of Gender, Race & Justice	USA	Review and theoretical argumentation	-
2014	Donaldson *et al.*[32]	Clinical Gerontologist	USA	Interpretative phenomenological analysis	13 heterosexuals aged 62-90
2015	Henning-Smith *et al.*[23]	American Journal of Public Health	USA	Database analysis	297 LGB persons (lesbians, gays and bisexuals) and 13,120 heterosexuals aged 40-65
	Schwinn and Dinkel[42]	Online Journal of Issues in Nursing	USA	Literature review	-
2016	Czaja *et al.*[24]	Aging & Mental Health	USA	Focus groups and data collection	124 gays and lesbians aged 50-89
	Donaldson *et al.*[46]	Clinical Gerontologist	USA	*Grounded theory*	22 staff members of 3 LTCEs aged 22-72
	Porter *et al.*[29]	Clinical Gerontologist	USA	Literature review	-

it continues

ities[30], which indicates the invisibility of this population. In some studies, professionals believe "they treat everyone in the same way"[37], with open, tolerant attitudes[31], confident that the quality of the treatment of older persons is, in general, the same for all[30]. However, even if they do not report negative attitudes towards these residents, some professionals perceive these in their co-workers[38]. In accordance with a study, the younger the professional, the greater the likelihood of having supportive reactions and positive attitudes towards older LGBTQIA+ persons[31]. Professionals reported that they should receive training specific to the needs and stressors of older LGBTQIA+ people[30] with a view to providing less insensitive, less heteronormative care[37].

Object of the prejudice

Most of the results focus more on prejudice and discrimination against sexual orientation than gender identity. In the case of sexual orientation, the prejudice and discrimination are

Chart 1. Mapping of the literature in the Review (n=31).

Year	Reference	Publication	Country	Method	Participants
2017	Ahrendt *et al.*[33]	Journal of Homosexuality	USA	Data collection	153 staff members of 2 LTCEs, aged 20-80
	Pelts and Galambos[36]	Journal of Gerontological Social Work	USA	Field research	60 staff members of 3 LTCEs (average age 38)
2018	Hafford-Letchfield *et al.*[52]	Health & Social Care in the Community	UK	Action research	6 managers of LTCEs and 8 LGBTQIA+ volunteers
	Nhamo-Murire and Macleod[47]	International Journal of Nursing Practice	South Africa	Integrative review	-
	Putney *et al.*[22]	Journal of Gerontological Social Work	USA	Focus groups	50 LGBTQIA+ aged 55-87
	Simpson *et al.*[30]	Ageing & Society	UK	Data collection	187 staff members of an LTCE (average age de 42)
2019	Mahieu *et al.*[43]	Aging & Mental Health	Belgium	Systematic review	-
	Villar *et al.*[31]	Journal of Homosexuality	Spain	Data collection	2,254 staff members of 96 LTCEs (average age 39)
	Wilson *et al.*[48]	The Canadian Journal of Human Sexuality	Canada	Descriptive analysis	-
2020	Holman *et al.*[37]	Journal of Gerontological Social Work	USA	Field research	43 staff members of an LTCE (average age 34)
	Caceres *et al.*[38]	The Gerontologist	USA	Systematic review	-
2021	Buczak-Stec *et al.*[49]	Age and Ageing	Germany	Database analysis	4,268 heterosexuals and 337 LGBT aged 43-90
	Kneale *et al.*[41]	Ageing & Society	UK	Scoping review	-
	Silva Junior *et al.*[44]	Revista Brasileira de Enfermagem	Brazil	Scoping review	-
	Ryan and Peralta-Catipon[28]	Journal of Occupational Therapy	USA	Photo-elicitation and Focus groups	4 residents of an LGBTQIA+ LTCE, aged 64-82

Source: Authors, 2022.

referred to by the terms homophobia/biphobia and heteronormativity/heterosexism, while, in relation to gender identity, transphobia and cisgenderism are used[30].

Homophobia is characterised as feelings or actions driven by hatred, fear or rejection of homosexuals[32], and biphobia (referring to bisexuals) feeds hostility, prejudice and discrimination[30]. There is also internalised homophobia[39] – denial or fear of revealing sexual orientation to avoid situations of embarrassment or discrimination. So, aware of this, many health professionals[41] change their attitudes as of the revelation of sexual orientation or divergent gender identity[26,33,42]. Homophobic discrimination on the part of health professionals shapes the expectations of long-term care provision, making the LGBTQIA+, especially the trans population[12], not seek health or care services any longer.

Heteronormativity is a form of discourse that assumes heterosexuality as the norm; cisgenderism believes that people should correspond to the gender with which they were born/were socialised[30]. Heterosexism is viewed as a mechanism of institutional, systemic and cultural oppression, since it denies non-heterosexual expression[33,35,42]. It is substantially experienced in heteronormative policies and presumptions in LTC, which, although not always presenting openly discriminatory behaviour, discriminatory postures are adopted in admission, such as not welcoming older LGBTQIA+ persons[31], or culminating in oppressive attitudes, such as verbal and even physical harassment on the part of staff

Chart 2. Analysis categories and subcategories.

Category (Definition)	Subcategory (Definition)		
Characteristics Main traces of identification of the situations of prejudice against older LGBTQIA+ persons in LTC	**Targets of prejudice** Profile of the persons who suffer the prejudice	**Agents of the prejudice** Profile of the agents of prejudice	**Aim of the prejudice** Content of the prejudice
Causes Origins or motivations behind the feelings (prejudice), prone to result in violations (discrimination)	**Lack of knowledge?** Lack of familiarity with the theme on the part of the agents of aggression	**Moral and religious beliefs** Values on which rejection of the group are based	**Gaps and violations of rights** Absence of laws and guarantees of protection for the institutionalised LGBTQIA+ population
Effects Impacts or consequences of the prejudice	**Fear of institutionalisation** LGBTQIA+ fear of becoming institutionalised in old age	**"Return to the closet"** Tendency to hide or cease to manifest gender identity and/or sexual orientation	
Solutions Definition: Possible measures to provide secure, welcoming atmosphere for LGBTQIA+ in LTC	**"Staff like us"** Existence of LGBTQIA+ professionals in LTC	**Within the "Rainbow"** LTC friendly or exclusively for LGBTQIA+	**Training for a new look** Staff training and sensitisation to welcome and provide adequate treatment for older LGBTQIA+ people in LTC

Source: Authors, 2022.

and residents. Such attitudes are perpetrated by veiled discrimination[34] and lack of perception of privilege enjoyed by heterosexuals[43].

Causes

Lack of knowledge

Lack of knowledge seems to be one of the causes of prejudice against the older LGBTQIA+ population, given that 23 of the 31 articles draw attention to the need for sensitisation training.

The mechanisms of prejudice and discrimination are perpetuated in both society[26] and in its institutional facilities (LTC)[36,44] catering for older LGBTQIA+ people, which may be of a public nature, private, philanthropic or religious[3,43]. The demonstrations of prejudice, discrimination or aversion practiced sometimes by professionals and staff[31,43], and sometimes by other LTC residents[36], are manifested in various ways. Residents may demonstrate prejudice, discrimination or aversion through radical and aggressive attitudes, such as insults, moral harassment and physical violence[22,31,42]. Some results suggest that it is possible that the agents of prejudice and discrimination are unaware of the reasons why they discriminate[32].

In this social and care context, empathy is fundamental and appears with greater frequency in professionals when they have had previous contact with LGBTQIA+, through relatives, friends, patients or during training[34,38]. They contribute most to engagement in defence of this group's rights in the institutional environment[30]. The scarce literature on barriers to this group and their demands, as well as the scarcity of technical courses or curricular disciplines in higher education[27,29], may contribute to the perpetuation of prejudice against this minority.

Moral and religious beliefs

More than two thirds of the articles referred to dictates and moral norms influencing LTC residents and staff attitudes in their lives alongside an LGBTQIA+ population. Heterosexism[28,34,45-47] appears in the majority of the articles, followed by homophobia[23,26,43], both being present, for example, in LTC contexts catering for military veterans[24]. As illustrations of this prejudice, one can point to aversion to demonstrations of intimacy by same sex partners in public[22,46,49], to the existence of a bedroom for a homo-affective couple, or to the possibility of a heterosexual resident sharing a bedroom with a LGBTQIA+

person[32]. Divergent sexual orientation is regarded as a threat to patriarchal family dogmas[29,43]. As for transgender people, prejudice manifests itself by cisgenderism, through, for example, the adoption of forms and treatments on the part of professionals of pronouns that are not ones the persons recognise for themselves[25].

The LGBTQIA+ representing a threat was inherited from the time when even state security was taken as a justification for oppression. There was silencing and invisibility regarding divergent sexual behaviour, such as in the 1950s to the 1970s, in which homosexual sexual orientation was combated as a risk to the stability of political institutions, equated with communism[50].

One of the stereotypes of ageism is that older persons become asexual[43]. Ageism focuses on the LGBTQIA+ community itself, hindering intergenerational solidarity within the group[3,33,43].

In 14 studies, religious beliefs, sometimes related to the philanthropic nature of the LTC[12,50], were influential as much on the resident population[32] as on the staff[3,38], this being concentrated in North America and Europe. Religious influence on LTC only began to be reported in the articles published as of 2009. Two of these studies were carried out only with managers and staff, and the remaining 12 with residents, both heterosexual and homosexual. None of the 14 studies dealt with the religious issue focused on the divergence of gender identity, leading to the hypothesis that the possible lack of coexistence makes the non-binary invisible in the eyes of people with binary religious rigour, or even that the rejection is so great the subject is avoided. Also there may be difficulties regarding divergent sexual orientation. In one emblematic case, a resident of an LTC with a religious base whose heterosexual sexuality was discovered, had his money returned and was removed; even an ensuing legal claim was lost, revealing the justice system's tolerance of this kind of discrimination in the case of religious institutions[24].

Gaps and rights violations

The Defence of Marriage Act (DOMA), sanctioned in 1996 in the United States, but judged unconstitutional by the Supreme Court much later, in December 2022, introduced a definition of marriage as a legal union between a man and a woman and defined spouse as a person of the opposite sex, thus preventing same sex couples from receiving conjugal benefits at the Federal level, such as social security, benefits for veterans' surviving spouses, tax relief and pensions[3,35].

According to research conducted in the United States and Europe, older LGBTQIA+ persons are more afraid of violations that can be covered up, such as the invisibility of their partners in health decisions, and the prohibition of visitors who do not have what the institution considers a "family bond"[42] than more visible violations, such as physical violence, already protected by law[43]. Researches in countries such as Spain[31] and Canada[46] have some laws designed to protect LGBTQIA+ from discriminatory practices.

As for transgender and non-binary people, there are still few policies that protect their gender identity in LTC, which officially have no established criteria, such as room sharing[29].

Effects

Reported in several studies covered by this review, discrimination, violence and invisibility are attitudinal manifestations related to prejudice against older LGBTQIA+ people in LTC. Prejudice added to these manifestations result in two main effects that are highlighted in these studies.

Fear of Institutionalisation

For older LGBTQIA+ persons, residing in an LTC corresponds to living in an environment in which heterosexuality is presupposed, that is, an environment that does not offer security to live with friends and life partners without situations of vulnerability and violence[25].

Anticipation of the effects of homophobia are manifested by the old LGBTQIA+'s feeling of uncertainty about who will look after them when they cannot live independently anymore[26]. Resorting to an LTC is not always a matter of choice. In an American study[23], while 75% of the heterosexual participants said they would resort to a family member if they needed care, only 53% of LGBTQIA+ participants reported they would do the same.

There is also the history of negative experiences when visiting LGBTQIA+ partners and friends in LTC, which culminate in fear of institutionalisation and unwelcomeness due to sexual orientation or gender identity[26,49]. In the LTC, professionals and staff can have attitudes such as micro aggression[33], inferior quality of service, abuse[23], blackmail to reveal the condition of LGBTQIA+[51], and even refusal of contact with people identified as LGBTQIA+[50]. Homophobia and heterosexism in LTC involved, among other fears, those of social isolation, abuse, ostracism[26], insecurity[22] and concerns related to care in case

of being unable to disguise their sexual orientations due to some cognitive impairment[43,49].

The return to the closet

In the LTC reception, there is reluctance to ask about sexual orientation and gender identity, the justification being they are personal, private matters, assuming that a heterosexual individual may be offended[35,52]. This omission reinforces the vulnerability of LGBTQIA+ people by aggravating the lack of staff awareness and sensitivity[12,46,52]. Even those who had chosen to live openly, end up hiding or denying their gender identity or sexual orientation, that is, they return to the closet in search of more security and protection[3,12,22,26,41,43,44,50]. The return to the closet forces the person to be constantly attentive to avoid behaviour and speech that could reveal their identities[51]. This can be especially devastating for transgender and non-binary people, forced to return to gender expressions that do not match their own, a plan for suicide being one of the possibilities raised by these populations to escape prejudice and discrimination in LTC[29]. However, a Belgian systematic review[43] indicated that some people expressed resistance to the idea of hiding their identity, even in the face of the risk of discrimination.

Solutions

Staff as our equals

The existence of LGBTQIA+ staff or supporters of the group was pointed out by three researches as a possible solution for combating prejudice in LTC. In this regard, older LGBTQIA+ persons, especially lesbians, pointed out that having LGBTQIA+ staff in LTC would be a guarantee of not being discriminated or suffering abuse[26,38].

Inside the rainbow

The preference for LTC exclusively aimed at the LGBTQIA+ was found in almost half of the selected articles. This perspective only appears in the articles since 2009, in European and North America countries. Only one of these studies had professionals[46] as participants, and six studies had LGBTQIA+ aged over 55. Five researches pointed out the desire of middle-aged participants to have exclusive environments for this minority in old age[26-28,46,49].

One of the advantages of these facilities would be the reception of affective families[28], since, in conventional institutions, there is a preference for decisions taken by biological families, even though many of these have no affective link with the respective older LGBTQIA+ individual due to religious or moral incompatibility[28]. In the traditional institutions, partners or lifelong partners are denied a bedroom in common or privacy for internal reasons (philanthropic and religious) of the institutions, unprepared to deal with homo-affective couples[45].

The existence of an exclusive LTC revives the Stonewall solidarity of diverse categories of the LGBTQIA+ community[28], allowing interaction in the same space along with the freedom to express themselves, in addition to promoting the expansion of networks, visits by affective families and joint work with associations and communities defending the rights of these populations[28].

In contrast, in a systematic review[44], with studies from Spain, Belgium, Australia and the United Kingdom, there was no consensus among the older LGBTQIA+ persons on the alternative to live in an exclusive environment, since these spaces can reproduce the reality of ghettos or exclude the possibility of cohabitation with sympathisers. In addition, the existing specific institutions are mostly for people with high purchasing power, and they do not cater for much of the population of these communities[50,51].

Another suggestion from participants in four surveys was that there should be more publications for older LGBTQIA+ people in these facilities, such as films and signs pointing out that the place is friendly to this group[22,25,42,43]. Inclusive procedures were suggested, such as specific medical care – STDs/AIDS, hormonisation[51], use of the appropriate pronouns in the treatment language that includes the transgender[38,46], and sensitisation regarding the history of prejudice[36,45].

Training for a different look

Twenty three articles encompassed the suggestion of staff training in LTC to care for LGBTQIA+: seven devised with technical staff, eight made with LGBTQIA+ populations aged 50 and over, and the others were legal articles and literature reviews. The studies were representative of countries from all continents except Asia.

Combating heterosexism was the principal motivation for the LTC staff training, which consider that contact with LGBTQIA+ and the inclusion of specific LGBTQIA+ health content in vocational training curricula can contribute to mitigation of heteronormativity among the professionals[34,35,43,45,46,52].

It has been pointed out that training helps to reduce the distrust of professionals when an

LGBTQIA+ resident considers the decision to reveal his/her identity[47], and increases sensitisation of the specific needs of the group[22,26,52]. The professional category indicated for this training was that of nurses[27], LTC managers[51], psychologists[29] and social workers.

The training gap in care is so great that a national inquiry into discrimination against transgender people in the United States[53] revealed cases in which transgender people themselves needed to teach professionals how to proceed in their service[29]. Two U.S. studies[38,42] pointed out the low number of class hours and discontinuity of care courses about LGBTQIA+ for health and social assistance professionals[27]. Another gap was the absence of this discipline in the curriculum grid of higher education[27,29,48], even in advanced countries where LGBTQIA+ rights have been achieved, such as Canada and the United States.

Studies highlight the need for involvement and guidance from family members and visitors[25,30] about older LGBTQIA+ persons rights and respect through content and consulting of entities upholding these[37,46]. It is necessary to extend this training beyond the metropolitan regions, since, in rural regions, this can be essential to mitigate conservative customs in the community[30].

Limitations

This study had limitations due to the profile, size and type of samples found, which were not aimed at ensuring representative sampling in relation to the LGBTQIA+ population. The scarcity of research in Latin American countries makes discussion difficult, as it is based on local realities.

Final considerations

Although publication on this matter is increasing in international scope, in the whole of Latin America only one article was found, that referring to Brazil, which suggests that, in this region, the theme is little explored. This emphasises the need for Latin American research to consider the growing demand for long-term care services due to accelerating longevity and cultural specificities in European and North American countries.

Although the searches in the databases were directed by words like "prejudice/harm", the articles presented data regarding both prejudice and discrimination. No definition was found for the term prejudice in the sample analysed, which indicates that there is no precision or rigour in the conceptual distinction in the treatment of this theme. Homophobia and heterosexism were defined by some authors. It was seen that most of the studies deal more with prejudice in relation to homosexuals than prejudice against the gender identity of bisexuals and other LGBTQIA+ minorities.

The religious and moral beliefs of residents and their families, plus the lack of knowledge on the part of professionals about old age among the LGBTQIA+, are the predominant causes of prejudice in the LTC against this group. The evidence of this review shows that the effects of this prejudice happened before, during and after institutionalisation.

The solutions identified involve empathy: hiring of staff who themselves are LGBTQIA+, which is a request presented by the group to contribute to the feeling of security and confidence; permanent training of LTC staff, a solution pointed out by older persons and the LTC professionals themselves; and equity and security, with the existence of specific LTC or ones friendly to LGBTQIA+, in order to expand their networks and welcome decisions from their families of choice.

This study is expected to shed light on the long-term care debate regarding this older population, leading to future research that could take into account the specificities of several groups of the LGBTQIA+ community, and seek to define prejudice and discrimination more precisely to achieve a better understanding of the distinction and relationship of these concepts.

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Collaborations

WRN Torelli contributed substantially to the conception and elaboration of the protocol to be used, to the selection of studies, extraction and interpretation of data from the work, he also contributed to writing the work and has direct responsibility for the manuscript. TA Bessa contributed substantially to the selection of studies, extraction and interpretation of data and writing of the manuscript. B Graeff contributed substantially to the design and elaboration of the protocol to be used, to the extraction and interpretation of work data, to the writing and critical review of the relevant intellectual content, not only as an advisor to the holder but also as Minerva's vote in the event of non-agreement by the two first authors in decisions regarding the choice of articles participating in the review as other demands.

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