OPEN LETTER

To live and age as who we really are: Perspectives from older LGBT+ people in Ireland [version 2; peer review: 3 approved]

Previously titled: To live and age as who we really are

Lorna Roe\textsuperscript{1,3}, Miriam Galvin\textsuperscript{1,4}, Laura Booi\textsuperscript{1,5}, Lenisa Brandao\textsuperscript{1,6}, Jorge Leon Salas\textsuperscript{1}, Eimear McGlinchey\textsuperscript{1,7}, Dana Walrath\textsuperscript{1}

\textsuperscript{1}Global Brain Health Institute, Trinity College Dublin, the University of Dublin, Dublin, Ireland
\textsuperscript{2}Centre for Health Policy and Management, Trinity College Dublin, the University of Dublin, Dublin, Ireland
\textsuperscript{3}The Irish Longitudinal Study on Ageing, Trinity College Dublin, the University of Dublin, Dublin, Ireland
\textsuperscript{4}Academic Unit of Neurology, School of Medicine, Trinity College Dublin, the University of Dublin, Dublin, Ireland
\textsuperscript{5}Discipline of Clinical Medicine, School of Medicine, Trinity College Dublin, the University of Dublin, Dublin, Ireland
\textsuperscript{6}Department of Health and Human Communication, Psychology Institute, Federal University of Rio Grande do Sul, Porte Alegre, Brazil
\textsuperscript{7}School of Nursing and Midwifery, Trinity College Dublin, the University of Dublin, Dublin, Ireland

\textbf{Abstract}

This Open Letter discusses the theme of ‘diversity in brain health’ in research, practice and policy for older LGBT+ people. It is written by a multidisciplinary group of Atlantic Fellows for Equity in Brain Health at the Global Brain Health Institute in Trinity College Dublin (TCD), from a variety of disciplines (health economics, human geography, anthropology, psychology, gerontology) and professions (researcher, clinicians, writers, practicing artists). The group developed a workshop to explore the theme of ‘Diversity and Brain Health’ through the lens of lesbian, gay, bisexual, transgender/transsexual plus (LGBT+). Guided by two advisors (Prof Agnes Higgins, TCD; Mr Ciaran McKinney, Age and Opportunity), we invited older LGBT+ people and those interested in the topic of LGBT+ and ageing, healthcare providers, policy makers and interested members of the research community. We partnered with colleagues in the School of Law to include socio-legal perspectives. Following the workshop, Roe and Walrath wrote an opinion editorial, published in the \textit{Irish Times} during the 2019 PRIDE festival, and were subsequently invited by HRB Open Research to provide a more detailed expansion of that work. In this Open Letter we describe the theme of ‘diversity and brain health’ and some of the lessons we learned from listening to the lived experience of older LGBT+ people in Ireland today. We illustrate why it’s important to understand the lived experience of older LGBT+ people and highlight the failure of the State to evaluate the experience of
LGBT+ people in policy implementation. We call on researchers, clinicians, service planners and policy makers, to recognize and address diversity as an important way to address health inequities in Ireland.

**Keywords**
Ageing, diversity, brain health, LGBT+, health inequity

This article is included in the *Ageing Populations* collection.
Dis­mis­sion
The views expressed in this article are those of the author(s).
Publica­tion in HRB Open Research does not imply endorsement by the Health Research Board of Ireland.

In­tro­duc­tion
Brain health is des­cribed as the abil­ity to re­mem­ber, learn, plan, con­cen­trate and main­tain a clear, active mind by being able to draw on the strengths of your brain such as in­for­ma­tion man­age­ment, logic, judg­ment, per­spec­tive and wis­dom1. A healthy brain func­tions quick­ly and auto­mat­i­cally. But when prob­lems oc­cur, the re­sults can be de­vas­tat­ing. Some of the main­types of dis­or­ders af­fect­ing brain health in­clude: ne­u­ro­ge­netic dis­or­ders (e.g. Hun­t­ington’s dis­ease), de­gen­er­a­tive dis­or­ders of adult life (e.g. Parkin­son’s dis­ease and Alzhei­mer’s dis­ease), me­tabolic dis­or­ders (e.g. Gaucher’s dis­ease), cere­bro­va­scu­lar dis­or­ders (e.g. stroke and va­scu­lar demen­tia), tra­u­ma (e.g. spi­nal cord and head in­jury), con­vol­u­tive dis­or­ders (e.g. epi­lepsy), in­fec­tious dis­or­ders (e.g. AIDS demen­tia), and brain tu­mors2.

The Global Brain Health Institute (GBHI) was es­tab­lished to pro­mo­te equi­ty in brain health, specif­i­cally to address the risk and im­pact of demen­tia glo­bally. Dementia - an un­bram­a­lla­term for a va­ri­ety of dis­or­ders of the brain which cause cog­ni­tive de­cline and loss of func­tion - is in­cur­able, but, a ran­ge of non/phar­ma­co­log­i­cal ther­a­pies ex­ist to man­age the con­di­tion3. Dementia is de­ter­mined by a com­plex ran­ge of risk fac­tors in­clud­ing genet­ic (e.g. ApoE e4 gene), lifesty­le (e.g. smok­ing, ex­er­cise), health (e.g. car­di­ovas­cu­lar risks, de­pres­sion, hear­ing loss), so­cial (e.g. lon­el­li­ness, iso­la­tion) and en­vi­ron­ment (e.g. pol­lu­tants)4. It’s been es­ti­mated that 1 in 3 demen­tia cases could po­ten­tially be pre­vented by ad­dress­ing risk fac­tors5.

Diver­sity and brain health
Dif­feren­tial ex­po­sure to so­cial, eco­nomic, and en­vi­ron­men­tal risks fac­tors be­tween in­di­vid­uals lead to health inequal­i­ties, which are de­fined as dif­fer­ences in health which are sys­tem­ic, so­cially pro­duced (and there­fore mod­i­fi­able), and un­fair6. Such inequal­i­ties are not oc­ca­sional or ran­dom, rather they are sig­nif­i­cant, fre­quent, or per­sis­tent as­so­ci­a­tions7. For ex­am­ple, in Ireland an ad­di­tion­al 10.2 in­fant de­aths per 1,000 live births are found in the Irish Trav­eller com­mu­ni­ty (an Irish eth­nic mi­nor­ity group) com­pared to the gen­er­al popu­la­tion8; 30 year dif­fer­ences in mor­tality are found in ad­ults who are home­less in Dublin com­pared to the gen­er­al popu­la­tion9, and a 2.80 beats per min­ute higher rest­ing heart rate (a risk factor for car­di­ovas­cu­lar dis­ease in older adults) are found in older adults in the low­est com­pared to the high­est in­come quint­ile10. System­atic dif­fer­ences in brain health have also been found. For ex­am­ple, a high­er pre­va­lence of cog­ni­tive im­pair­ment has been found among ad­ults who are home­less in Cal­i­for­nia com­pared to the gen­er­al popu­la­tion11.

In seek­ing to ad­dress health inequal­i­ties, epi­dem­i­olo­gist Sir Michael Marmot, Chair of the Com­mis­sion on the So­cial De­ter­min­ants of Health (SDH), urged us to ad­dress the ‘causes of causes’ by tackling the con­di­tions of life for peo­ple as they are born, live, work and age12.

In 2018, Sir Marmot presiding over the Pan Amer­i­can Health Or­ga­ni­za­tion’s (PAHO) Com­mis­sion on Equity and Health In­equal­i­ties in the Amer­i­cas re­port, ex­panded the SDH frame­work to in­clude struc­tural driv­ers (e.g. insti­tu­tion­al rac­ism) and the in­ter­sec­tion of vari­ous driv­ers as fac­tors which ad­versely in­crease the ex­pe­ri­ence of the so­cial de­ter­minants of health, see Fig­ure 112.

St­ruc­tural driv­ers, or struc­tural vi­olence, is a term coined by an­thropol­o­gists, which de­scribes how op­pres­sive so­cial struc­tures or in­sti­tu­tions can re­sult in death, in­jury, ill­ness, subjug­a­tion, stigmat­i­za­tion, and even psy­cho­log­i­cal terror for spe­cific so­cial groups or pop­u­la­tions13. Struc­tural fac­tors are borne out as de­ter­minants in the brain health lit­er­a­ture, such as lev­el of ed­u­ca­tion at­tai­nment, which is im­pacted by many fac­tors, in­clud­ing the qual­ity of ed­u­ca­tion. For ex­am­ple, in the United States, schools in the South were ra­cially seg­reg­ated up to 1954, with schools for Af­rican Amer­i­can stu­dents on aver­age re­ceiv­ing fe­wer re­sources (e.g. short­er school term length, high­er pupil-teacher ra­tio) than schools for white stu­dents14. Attend­ance at schools in so­lu­nor­al states was sub­se­quently found to be as­soci­ated with years of com­pleted ed­u­ca­tion and late-life cog­ni­tive de­cline14. Struc­tural fac­tors are also im­por­tant in the con­text of health­care sys­tems which can also in­fluence health out­comes. For ex­am­ple, long wait­ing times in the Em­er­gency De­part­ment can be a bar­rier for in­di­vid­u­als with ad­diction is­sues or at­ten­tion de­ficit hy­per­ac­tiv­ity dis­or­der, com­mon with­in the home­less popu­la­tion15. Access to health care is de­fined as the op­por­tu­nity to reach and ob­tain ap­propri­ate health care serv­ices in sit­ua­tions of per­ceived need for care16. Com­ponents of access in­clude ‘ap­proach­abil­ity’ (peo­ple can iden­tify their health needs and the serv­ices needed to meet these needs) ‘ac­cep­t­abil­ity’ (peo­ple ac­cept the socio-cul­tu­ral as­pects of the serv­ice); ‘avai­labil­ity’ (an ade­quate sup­ply of serv­ices re­la­tive to needs); ‘ac­com­moda­tion’ (health serv­ices can be re­ached both phy­si­cal­ly

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and in a timely manner); ‘affordability’ (the in/direct cost implications to the person in relation to need); and ‘appropriateness’ (fit between services and person’s needs), see Figure 2.

Intersectionality refers to the complexities of how people experience disadvantage based on a broad array of social group memberships (e.g. race, class, religion, sexual orientation, ability and gender). Cultural and political processes produce each of these aspects of identity. Each person has a social location where their identities overlap, which determines their existence in the social and political world, their relationship to others and to dominant cultures, and the kinds of power and privilege they have access to and can exercise. Across the world, identity is used to influence the distribution of power and privilege and both sub/conscious oppressive actions maintain the status quo. Oppressive actions are expressed by individuals (e.g. attitudes and behaviours), institutions (e.g. policies, practices and norms), and society/culture (e.g. values, beliefs and customs). These actions do not ‘just happen’, rather they are reproduced in a process of normalization and reinforced in a cycle of ‘business as usual’. It’s possible to interrupt oppressive cycles by calling into question the truth of what is learned about the power relationships among different social groups and our own social position.

Diversity and brain health: Perspectives from older LGBT+ people

In this context, the workshop was developed by a group of Fellows who were aware that lesbian, gay, bisexual, transgender/transsexual plus (LGBT+) people were and are not always accepted both within and across countries. In 2019 being LGBT+ was illegal in 68 countries worldwide and punishable by death in 12 countries. Furthermore, researchers have reported experiencing barriers to publication with an LGBT focus with severe risk of harm to themselves, their colleagues, and their families.

We were also aware these identities can go unseen in healthcare settings. Through our clinical rotations (as part of the Fellowship programme), we were cognizant that for some people, changes in cognition associated with dementia (affecting an estimated 55,000 older Irish adults), could result in a disclosure of their true gender or sexuality for the first time. We agreed that the older LGBT+ community would be a valuable lens through which to look at diversity and to learn about how diverse identities impact the experience of ageing, interactions with healthcare services, and the ability to ‘age in place’. Ireland provided an interesting case example having transitioned recently and rapidly from a State in which homosexuality was a crime, to one which welcomed marriage equality and gender recognition legislation. Together with two advisors and with partners in the School of Law at TCD, we developed a workshop held on June 4th at TCD, to examine diversity and

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1 Advisors: Prof Agnes Higgins, Professor in Mental Health, School of Nursing & Midwifery at TCD and the author of Visible Lives report (Higgins et al., 2011), Ciaran McKinney, Engage Programme Manager (Promoting active citizenship and lifelong learning) at Age & Opportunity, formerly Director of Gay HIV Strategies at Gay and Lesbian Equality Network.

2 Partners: From the School of Law in TCD, Prof Mark Bell and Prof Mary Rogan contributed to workshop planning, while Prof Ivana Bacik presented during the workshop.
brain health through the lens of the LGBT+ community. Following the workshop, Roe and Walrath wrote an opinion editorial, published in the Irish Times during the 2019 PRIDE festival and were subsequently invited by HRB Open Research to provide a more detailed expansion of that work.

Below, we outline 10 things we learned about diversity and brain health, by listening to the lived experience of older LGBT+ people and their advocates.

1. The ‘LGBT+’ experience: It’s easy to think there is a common ‘LGBT+ experience’, when we view this identity through a heteronormative lens. In reality, variation exists between different sexualities and gender identities, which intersect with other factors, such as social class. For example, some attendees spoke about the psychological stress of needing to hide their identities in their workplaces. For some, their identity would have led to expulsion due to the explicit rules of the organization, while others felt the stigma would have serious repercussions for their jobs or businesses. By contrast, other participants spoke with pride about being part of a community which supported one another and a social movement which brought about positive change. It became clear that LGBT+ specific protective factors (e.g. increased resilience) and risk factors (e.g. internalized stigma or disenfranchised grief) to general health and brain health, were not experienced universally within this community. Therefore; while we need to examine the experiences and outcomes of LGBT+ people as a social group within the general population, it is important to examine the

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1 85 people registered for the workshop on June 4th 2019 from organisations representing the LGBT+ community e.g Gay and Lesbian Equality Network, Older Women Lesbians and Transgender Equality Network, Running Amach, and LGBT Ireland. Delegates also came from the Department of Health, charities representing older adults and academia. Research Ast. Prof Roe and Dr Walrath led the workshop with contributions invited from: Senator Davis Norris, Marianne McGiffin (Older Wiser Lesbians), Claire Farrell (Transgender Equality Network Ireland), Ciaran McKinney (Age and Opportunity), Prof Agnes Higgins (School of Nursing, TCD), Prof Victor Valcour (GBHI- UCSF), Prof Brian Lawlor (GBHI- TCD), Prof Mark Bell (School of Law, TCD), Prof Ivana Bacik (School of Law, TCD), Amanda Dunsmore (Limerick School of Art & Design, LIT ), Karl Duff (Department of Health, Ireland). During the workshop, Dr Laura Booi (GBHI-TCD) and Ast. Prof Eimear McGlinchey (GBHI-TCD) took written feedback from attendees on post-its and Prof Mary Rogan (School of Law, TCD) and Prof Miriam Galvin (GBHI-TCD) took notes on the workshop themes and provided a synthesizing wrap up.
within-group variation with respect to the nature and distribution of protective and risk factors.

2. Dissonant identities: Some LGBT+ people experienced dissonance between their LGBT+ identity and other identities. For example, an attendee described coming under pressure to ‘drop’ her LGBT+ identity to be accepted as grandmother to her new grandchild. Sociologists describe this as a ‘psychological colonization’ where oppressed group members knowingly, but not necessarily voluntarily, go along with their own mis-treatment to survive or to maintain some status, livelihood, or other benefit\(^7\). Her narrative of hidden identity, resonates with a story recently published in the *Irish Times*, of a closed gay man who internalized stigma, and kept secret from his family his (required) love for another man until his death\(^22\).

3. The attitudes of healthcare providers: We learned how healthcare services can be ill prepared to accommodate LGBT+ people. For example, a transgender woman described receiving a single room in hospital, although she didn’t have private health insurance, something she felt was because health care staff felt she did not fit into the ‘male’ or ‘female’ wards. This could be seen as an example of a subconscious (i.e. implicit) bias if organisations such as hospitals fail to develop policies to guide staff. For others, issues of discrimination at the societal level and lack of adequate training for health care professionals may lead to negative experiences which colour future interactions with healthcare practitioners. Attendees noted a particular strain regarding homecare workers whose personal beliefs interfered with providing respectful compassionate care to members of the LGBT+ community. This could be seen as an example of conscious (i.e. explicit) bias, where a staff member knowingly commented in a stigmatising or derogatory way to a service user. Workshop attendees also called for the presence of LGBT+ individuals as well as allies at every level of health services.

4. Source of social support and caregiving: For some attendees a ‘chosen family’ comprising emotional and social ties, is as important as a biological or legal family. This was especially the case before the legal recognition of same sex marriage, as networks of peers, friends and non-relatives are a major source of support and, importantly, know the person’s care and the end of life preferences. These individuals or chosen families need to be recognized and included by clinicians and care providers in decision-making discussions. This could be done for example, by asking in a clinical encounter “Is there anyone important to you that you would like involved now?” instead of assuming that the biological family is the only or most appropriate source.

5. History and healthy ageing: For some workshop attendees, previous negative experiences in society, or simply their preference to be with people from the LGBT+ community, makes services such as day centres or even care homes which have a predominantly heteronormative culture, an uncomfortable space. This is important, as by failing to appreciate the effects of historical stigma and discrimination, we are in danger of ‘seeing the puddles, but not the rainstorms and certainly not the gathering thunderclouds’\(^19\), and running the risk of creating barriers to care which will perpetuate health inequities\(^20\). By this we mean failing to address how older LGBT+ people may not feel accepted in these spaces due to fear or stigma.

6. Access to homecare: In Ireland, homecare is wedded to the nuclear family, particularly the role of women who make up the majority of our informal or family carers. The State’s role in homecare is defined by the principle of subsidiarity in care and social matters - family first and State second - a legacy of our socially conservative history\(^24\). Consequently, State provided homecare often only supplements informal care, offering enough hours to support an older adult, only if informal care can cover the remainder hours\(^24, 25\). All this means those with non-traditional family arrangements, typical within the LGBT+ community, are less likely to receive homecare and the only option becomes costly residential care.

7. Ageing and health policy: To address health inequities and social exclusion, strategic commitments must be supported by mechanisms such as target setting, monitoring and evaluation underpinned by adequate data collection to measure progress. However, in Ireland, though the Government identifies older LGBT+ people as a group at risk of social exclusion, it has yet to monitor their experiences or develop bespoke policy solutions which support their inclusion. For example, while LGBT+ people are identified as a group vulnerable to social exclusion in the National Positive Ageing Strategy\(^28\), their experiences are not captured by the national indicators to monitor the strategies’ implementation\(^25, 24\).

8. Social inclusion and LGBT+ communities: We learned how activities designed for geographically-based communities fail to address the needs of dispersed communities without spatial boundaries. For example, geographically-based initiatives such as Men’s Sheds have been enormously successful in supporting healthy ageing among men. However, older lesbians across the country who historically met-up to support each other, are now at risk of isolation and loneliness in old age as they cannot secure physical spaces in urban areas because of the competition for those resources.

9. Harnessing the strength of diverse social groups: The successful fight for social recognition of diverse gender and sexual identities highlights the skills, knowledge, and vocabulary that this community can bring to the identity politics of ageing. This community knows how to support one another through the formation of community groups such as OWLS, GOLD, Running Amach, and Outhouse, how to fight for services that do not exist, how to coin terms for concepts society only knows subconsciously.

10. Being inclusive: Attendees remarked the needs of older LGBT+ people will change over time. The experience of being LGBT+ people today is different to what it was
historically, with shifts in social attitudes, legal rights and the language. Thus, the solutions to create an inclusive society are not neat interventions. Rather inclusivity needs to be a value, and ‘being inclusive’ recognized as a process which focuses on what is meaningful to people, what facilitates people to be themselves in the world, to age as they are and to leave it as who they are. For LGBT+ people this means being able to maintain their identity through ageing and end of life. Learning how to be inclusive to LGBT+ people will teach us how to be inclusive to all forms of diversity, including those living with diseases of the brain.

**Conclusion**

We learned the older LGBT+ community experience healthcare services and ageing in place in different ways. This community comprises several sub-communities which play an important role in the lives of its members by providing social outlet and support; containing a rich reservoir of history and identity; and being highly resourced in advocacy and self-expression. As older LGBT+ people age, they are finding ways to harness the opportunities which ageing brings, while learning to adapt to their changing personal circumstances. Some of the challenges faced by this community can include negative interactions with healthcare workers and the design of societal structures and policies which fail to address their specific needs. These factors can negatively affect older LGBT+ people in terms of a heightened risk of loneliness and discrimination in old age, their ability to access inclusive person-centred care where they feel safe and accepted, and their ability to continue to fully participate in society while maintaining their identity.

The issues raised by the workshop participants challenge our societal responsiveness on a number of levels. At the level of the healthcare system, issues such as these speak to the appropriateness of healthcare services and delivery, rather than simply to the availability of services, often the most commonly spoken about barrier to accessing care in the Irish context. At the level of social policies, these issues speak to the need for the design of policies for the population, not blind to the specific needs of sub-groups, such as older LGBT+ people. At the individual level, these issues speak to the lack of skills and language which would make everyday interactions more accommodating, inclusive and welcoming for older LGBT+ people.

In conclusion, by learning how to become more inclusive of the LGBT+ community and their needs, we learn the skill of being an accepting and inclusive society to all forms of diversity. And if we can be respectful of differences of whatever kind and develop inclusive services and policies, we can address structural and intersectional factors that impact on healthy ageing. We call on researchers, clinicians, service planners and policy makers to recognize the importance of knowing their own ‘social location’ and how it might blind them to the needs and experiences of diverse groups in their work.

**Recommendations**

We call specifically for the research, policy and health care community to:

- Collect data to identify LGBT+ people in quantitative studies on ageing and consider how this identity intersects with other factors to create health inequities in old age. Undertake qualitative research to understand the ways in which discrimination and stigma affects older LGBT+ people at individual, institutional, societal and cultural levels.

- Provide diversity-awareness training programmes which gives healthcare professionals the language and skills to identify and support older LGBT+ people in clinical practice; including the identification and inclusion of an individuals’ ‘chosen family’ in medical and social decisions.

- Develop policies which harness the existing strengths and skills (i.e. intrinsic capacity) of diverse groups, which are socially rather than geographically defined, in the promotion of healthy ageing.

- Evaluate strategies designed to improve access to healthcare and to address social exclusion by monitoring the experiences and outcomes of diverse social groups, such as older LGBT+ people.

- Consider how best to support older LGBT+ people with homecare where no informal care is available.

- Recognise that ‘inclusivity’ is not a standalone intervention, but an ongoing process, allowing people to live, age and die as who they wish to be.

**Data availability**

**Underlying data**

No data are associated with this article

**Acknowledgements**

The authors acknowledge the contribution made by colleagues to the running of this workshop including Prof Victor Valcour and Prof Brian Lawlor, Executive Director and Deputy Executive Director, at the Global Brain Health Institute; Prof Mark Bell and Prof Mary Rogan in the School of Law at Trinity College Dublin; and Prof Agnes Higgins from the School of Nursing at Trinity College Dublin and Ciaran McKinney from Age and Opportunity. Finally, we are grateful to our colleague Sarah D’Alessio, an Atlantic Fellow at GBHI, for her comments on an earlier draft of this Letter.

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4 (Note: Since the workshop, LGBT Ireland have been awarded funding from the Slaintecare Integration Fund Project for their training programme for health and social care professionals working in older age services.)


7. All Ireland Traveller Health Study Team: All Ireland Traveller Health Study Summary of Findings. 2010. Reference Source


Open Peer Review

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Version 2

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Jessica Marsack
Department of Health Behavior and Biological Sciences, School of Nursing, University of Michigan, Ann Arbor, MI, USA

No additional comments.

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Health disparities, Sexual and gender minority health, Internal medicine, Kidney failure & dialysis, End of life care.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Reviewer Report 28 May 2020

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Caroline Dorsen
Rory Meyers College of Nursing, New York University, New York, NY, USA

I have no further comments. Thank you again for the opportunity to review this manuscript. Looking forward to future collaborations.

Competing Interests: No competing interests were disclosed.
**Reviewer Expertise:** LGBTQ health disparities with a focus on stigmatizing and affirming care from healthcare providers and how they impact sexual risk and substance use behaviors among sexual and gender minority persons.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

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Gloria Gutman
Gerontology Department, Simon Fraser University, Vancouver, Canada

No further comments.

**Competing Interests:** I have no financial conflict of interest and have not published with any of the authors nor have I had any prior contact with any except L. Booi. During the years she was studying for her PhD at Simon Fraser University and held a fellowship from the Canadian Frailty Network, while not a member of her dissertation committee I did serve as an academic mentor. I do not believe this affected my ability to review impartially.

**Reviewer Expertise:** Health promotion and aging, LGBT aging, gerontechnology, aging and the built environment, disasters and aging, elder abuse prevention and mitigation.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

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Gerontology Department, Simon Fraser University, Vancouver, Canada

I agree with reviewer 1 that if this open letter is directed to an international readership it would be helpful if terms known mainly to the Irish population were explained. I needed to go to Google to determine that Travellers were an ethic minority and to learn that “rough sleepers” were what I believe elsewhere are referred to as the homeless population. My main recommendation however is that consideration be given to modifying the title, which is a bit misleading. The main argument of the letter, which is an important one, is the need for inclusivity in research, practice and policy related to brain health. We need the voices of marginalized groups such as the LGBT population to be heard, and their lived experiences to be recognized but also we need hard data i.e. numbers with respect to incidence and prevalence of neurodegenerative diseases such as dementia affecting this population – which is what at first I thought I might find in the article. We also need to recognize the “diversity within diversity” reflected in learnings #1 and #10. In the case of research, this requires data collection and analysis to explore and to “slice and dice” the LGBT population. Although not stated in the letter, to date the preponderance of research is on gay men. Services and service providers need to be reminded, as the letter suggests, that this is not a homogeneous group. In general, the learnings part of the letter are excellent and concordant with research from elsewhere. They could be tied back a bit more to the theme and to dementia and other of the conditions the research group specializes in but otherwise, the authors are to be congratulated for conducting the workshop and sharing their findings via the open letter.

Is the rationale for the Open Letter provided in sufficient detail?
Partly

Does the article adequately reference differing views and opinions?
Yes

Are all factual statements correct, and are statements and arguments made adequately supported by citations?
Yes

Is the Open Letter written in accessible language?
Partly

Where applicable, are recommendations and next steps explained clearly for others to follow?
Yes

Competing Interests: I have no financial conflict of interest and have not published with any of the authors nor have I had any prior contact with any except L. Booi. During the years she was studying for her PhD at Simon Fraser University and held a fellowship from the Canadian Frailty Network, while not a member of her dissertation committee I did serve as an academic mentor. I do not believe this affected my ability to review impartially.

Reviewer Expertise: Health promotion and aging, LGBT aging, gerontechnology, aging and the built environment, disasters and aging, elder abuse prevention and mitigation.
I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 15 May 2020

Lorna Roe, Trinity College Dublin, the University of Dublin, Dublin, Ireland

Thank you for your time in reviewing our article. We recognize that the term ‘travellers’ needs to be described for an international audience and have amended the text with reference to the meaning of the term in the Irish context. We are grateful for your suggestion to change the title to reflect the article content more clearly, the revised title is ‘To live and age as who we really are: Perspectives from older LGBT+ people in Ireland’. It was beyond the scope of the workshop to collect any self-reported or objective measures of brain health from those attending. However, we intend to pursue this in our future work on diversity and brain health. Finally, we added a section examining the higher level learnings from this workshop in relation to the theme of brain health and diversity. And we intend to continue to contribute to this area, given the gaps in knowledge you have outlined.

Competing Interests: No competing interests were disclosed.

Reviewer Report 31 March 2020

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Caroline Dorsen
Rory Meyers College of Nursing, New York University, New York, NY, USA

Thank you for the opportunity to review your paper "To live and age as who we really are". This is a very timely and important topic as we face the global ageing of the population, with relatively little understanding of the unique culture and special health and social needs of older LGBTQ+ persons. I hope my comments below are helpful as you prepare your manuscript.

Please note that as this is not a research report, my review does not follow the usual protocol.

1. Overall, I liked the paper content and structure very much, and found it was informative and written in a useful way for both health and social care providers. Well done. Most of my revision suggestions are small.

2. I found the writing clear, although there are a few places that the authors use language that is perhaps not understood by non-Irish readers. For example, 'rough sleepers' is not a term we use in the US. I raise this issue to make sure that you are understood by the maximum number of readers, especially because you give examples from the US, specifically making
the paper of interest to North Americans.

3. Similarly, you use a number of terms in the paper that would not be acceptable to readers from the US. The clearest example of this is describing LGBTQ+ persons as 'non-normative.' This is reflective of a very heteronormative view of sexual orientation and edgier identity and would be quite offensive to some LGBTQ+ people and allies.

4. There is a sentence fragment 'While a lesbian...'

5. I would like to see you differentiate between subconscious bias (or implicit) and conscious (or explicit) bias in the attitudes section. This is essential for understanding the nuances of the barriers to access to and utilization of care among LGBTQ+ persons.

6. I am glad that you mentioned the historical moment and subsequent shifts in social and legal norms. I think it is important to say something here about the fact that we experience significant controversies around the globe about LGBTQ rights, and that patients and families may have had a huge variation of experiences previously, and sense of safety currently. There are over 70 countries in the world where it is still illegal to be LGBTQ, in about 15 of them LGBTQ is a crime punishable by death.

7. Excellent recommendations for the future.

**Is the rationale for the Open Letter provided in sufficient detail?**
Yes

**Does the article adequately reference differing views and opinions?**
Yes

**Are all factual statements correct, and are statements and arguments made adequately supported by citations?**
Partly

**Is the Open Letter written in accessible language?**
Partly

**Where applicable, are recommendations and next steps explained clearly for others to follow?**
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** LGBTQ health disparities with a focus on stigmatizing and affirming care from healthcare providers and how they impact sexual risk and substance use behaviors among sexual and gender minority persons.

I confirm that I have read this submission and believe that I have an appropriate level of
expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 15 May 2020

Lorna Roe, Trinity College Dublin, the University of Dublin, Dublin, Ireland

Thank you for your time in reviewing our article. We have addressed the issues you have raised and amended the original text. The term ‘rough sleepers’ is changed to ‘adults who are homeless’; we have deleted ‘non-normative’. We have addressed the sentence fragment identified in the text. We illustrated where there may be examples of subconscious and conscious bias in some of the issues described by workshop participants. However this requires further work exploring the attitudes and behaviours of people towards older LGBT+ people to fully understand sub/conscious bias. We recognise that being LGBT+ is unsafe in many countries around the world and have included additional text to explicitly refer to this issue. The authors appreciate your contribution and feel that the article is stronger because of the points that you raised and the amendments in the text.

Competing Interests: No competing interests were disclosed.

Reviewer Report 16 March 2020

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Jessica Marsack

Department of Health Behavior and Biological Sciences, School of Nursing, University of Michigan, Ann Arbor, MI, USA

This open letter is a wonderful expanded discussion of an opinion piece published in the Irish Times. The open letter as a whole discusses the authors' "lessons learned" from a workshop held around the aging LGBT+ community. The rationale for this article is clearly stated with good background information and relevant citations, so the factual statements made in the article are covered. However, the criteria "does the article adequately reference differing views and opinions?" is only partly covered. While the article does mention some opposing opinions, e.g. under #3 where the attitudes of healthcare providers are described, the majority of the article is about one viewpoint. Obviously the article is going to focus on this viewpoint because it is discussing a workshop around a singular viewpoint, but it may be worthwhile to lend some citations to the opposition rather than just case evidence. My only comment about language being "accessible" is really in relation to description of transgender individuals - for example, the use of the phrase "trans-woman" in #3. Wording such as "transfeminine person" might be more inclusive, or "transgender woman" more formal. The next steps and recommendations are clearly...
Is the rationale for the Open Letter provided in sufficient detail?
Yes

Does the article adequately reference differing views and opinions?
Partly

Are all factual statements correct, and are statements and arguments made adequately supported by citations?
Yes

Is the Open Letter written in accessible language?
Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Health disparities, Sexual and gender minority health, Internal medicine, Kidney failure & dialysis, End of life care.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

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Author Response 15 May 2020

**Lorna Roe,** Trinity College Dublin, the University of Dublin, Dublin, Ireland

Thank you for your time in reviewing our article. We reviewed some of the language used to describe LGBT+ people in keeping with international norms and your suggestion regarding the accessibility of the term ‘trans-woman’. This has been changed to ‘transgender woman’ in the text.

In relation to including opposing perspectives and arguments in this article, we feel that the article as currently constructed reports on the workshop proceedings and views expressed therein. We agree that alternative perspectives are important in order to get a more comprehensive view of LGBT communities and brain health. This was beyond the scope of this particular piece of work, but we aim to conduct a systematic literature review in our future work in this topic area which will capture divergent views and alternative perspectives.

**Competing Interests:** No competing interests were disclosed.