



# **Aging and Living Well Among LGBTQI Older Adults in Canada: Findings from a National Study**



**August 2023**



# Land Acknowledgement

We would like to begin by acknowledging that Egale is based on the traditional shared territories of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. The territory is protected by the Dish With One Spoon Wampum Belt Covenant, an agreement between the Haudenosaunee, Anishinaabe and allied nations to peaceably share and care for the resources around the Great Lakes. The concepts of gender, sexuality, and oppression that we often rely on in 2SLGBTQI advocacy work are largely based in White, Western, colonial systems of thought and do not represent the multitude of understandings of identity that exist outside of this viewpoint. Colonial violence created the foundations for the landscape of gender-based violence that we understand today. Indigenous communities and Two Spirit activists, scholars, writers, and artists have gifted us with ample tools to work with as we move toward the collective liberation of gender and sexuality minority people. We are grateful to carry these with us here and in our work beyond. The violence of colonialism is ongoing. So too are movements toward resisting this violence.

# Acknowledgements

## About Egale

Egale is Canada's national 2SLGBTQI organization. Egale works to improve the lives of 2SLGBTQI people in Canada and to enhance the global response to 2SLGBTQI issues. Egale achieves this by informing public policy, inspiring cultural change, and promoting human rights and inclusion through research, education, awareness, and legal advocacy. Our vision is a Canada, and ultimately a world, without homophobia, biphobia, transphobia and all other forms of oppression so that every person can achieve their full potential, free from hatred and bias.

## Authors

Dr. Celeste Pang, Egale Canada, Mount Royal University

Ellie MacLennan, Egale Canada

## Contributors

Nina Hallal, Fondation Émergence

Curtis Larade, Alzheimer Society of Toronto

Daniel MacKay, ElderBerries

Julien Rougerie, Fondation Émergence

Norval Collins, Nova Scotia Rainbow Action Project

Rocky Wallbaum, Rainbow Elders Calgary

Cheryl Loadman, Queer Seniors of Saskatchewan

Josephine Agudo

Bruce Cameron

Lawrence Friesen

Linda Furlought

Rupert Raj

Shirin Gerami, Egale Canada

Dr. Brittany Jakubiec, Egale Canada

Dr. Félix Desmeules-Trudel, Egale Canada

Kimberly Seida, Egale Canada

We are grateful to all participants who so generously shared their time, experiences, and insights.

This research was funded by the Slight Family Foundation.

ISBN: 978-1-7389331-1-2

© Egale Canada 2023

# Table of Contents

Introduction .....	6
Methodology & Orientations .....	8
Collaborative Approach .....	8
Orientations .....	8
Participant Engagement .....	8
Semi-Structured Interviews .....	9
Overall Demographics .....	9
Findings .....	14
Employment .....	15
Housing .....	28
Social Connection and Disconnection .....	46
Healthcare Access .....	68
Death and End-of-Life Wellbeing .....	88
Conclusions and Next Steps .....	98
Appendix I: More on Research Orientations .....	99
Appendix II: More on Recruitment .....	101
References .....	103

# Introduction


What does “aging and living well” look like for lesbian, gay, bisexual, trans, queer, and intersex (LGBTQI)<sup>1</sup> older adults in Canada? What could it look like? And what social changes are needed to better enable LGBTQI older adults to live and age well, on their terms?

Most research on aging in LGBTQI communities in Canada to date has focused on health and healthcare access related issues. Researchers have documented a range of barriers to care access for LGBTQI older adults, including experiences and fears of erasure and discrimination in home care and long-term care settings (e.g., Grigorovich, 2015; Furlotte et al., 2016; Kortess-Miller et al., 2018), and systemic barriers that negatively impact the care that care workers can provide (e.g., Daley et al., 2016; Pang, 2022). Research has also highlighted concerns related to accessing social services (e.g., Brotman et al., 2007; Flanagan & Pang, 2022) end-of-life care and advanced care planning (e.g., Wilson et al., 2018; de Vries et al., 2019; Dube et al., 2022), and housing inequities (Redden et al., 2021), while research on a broader range of social determinants of health and wellbeing is lacking.

The purpose of this national interview-based study was to expand and deepen our understanding of how LGBTQI older adults themselves conceptualize “wellbeing”, and what is needed for our communities to live well into old age. By asking about “aging and living well” we aimed to delve into the complex social realities and intersectional experiences that LGBTQI older adults in Canada have, and to identify areas for action and social change. To do so, in the summer of 2021 we conducted interviews with 48 LGBTQI older adults living in cities, towns, and rural areas across Canada. We asked them about their current living situations and material concerns (such as housing and finances), their experiences accessing healthcare and services, their thoughts on end-of-life, and about what wellbeing and aging well looks like, or could look like, for them.

---

<sup>1</sup> See full 2SLGBTQI Glossary of Terms at: <https://egale.ca/awareness/glossary-of-terms/>



This report provides a high-level summary of the research findings and recommendations. It has three main parts. [Methodology & Orientations](#) describes the research approach and process. [Findings](#) discusses five overarching themes: [Employment](#); [Housing](#); [Social Connection and Disconnection](#); [Healthcare Access](#); and [Death and End-of-Life Wellbeing](#). Each of these sections can be read as stand-alone sections, and we welcome you to navigate to those that interest you. In the final part, we provide summary [Conclusions and Next Steps](#).

Aging is far from a universal experience. Social and systemic inequities affect different groups in different ways. The issues that older adults face can be very different, as can their priorities and ideas about what aging and living well mean. We hope that this report can deepen understanding of some of the key issues facing LGBTQI older adults in Canada today, and spark connections and conversation with other social issues, efforts, and imaginings about what aging can be.

# Methodology & Orientations

## Collaborative Approach

The research was led by Dr. Celeste Pang, and supported by Shirin Gerami (literature review, interviewing, and transcription), Ellie MacLennan (transcription, analysis, writing), the Egale Research Department, and Fondation Émergence (French-language components). In addition, two advisory committees were established to provide expertise and input on the study. This included a community advisory committee made up of five LGBTQ older adults from across Canada and one LGBTQ service provider, and a second advisory committee made up of five community organization and service provider representatives. These committee members provided valuable input to the research, including providing feedback on the interview questions and assisting with study recruitment.

## Orientations

We approached this research with a specific set of analytical orientations. Along with knowledge of existing research literature and key gaps, these orientations informed how we designed this study, the questions we asked, our interpretation and presentation of data, and the recommendations we made. These analytical orientations included (a) examining dynamics of power and privilege, (b) taking a queer life course perspective, and (c) focusing on wellbeing instead of ideas about health and “healthy aging”. We describe these orientations further in [Appendix I: More on Research Orientations](#).

## Participant Engagement

We invited participants who self-identified as 2SLGBTQI, were over 65 years old, currently lived in Canada, and who could participate remotely (via phone or online) in English or French. Participants were recruited through a range of methods, including by sharing recruitment materials through the advisory committees and existing networks, direct emails to community groups, and through Egale’s social media platforms. Ultimately there were no participants



who identified as Two Spirit. For this reason, when using a general acronym to describe findings in this report we use the acronym “LGBTQI”. In the recommendations we use “2SLGBTQI” to signal the relevance of these to sexual and gender minority groups more generally.

Due to the COVID-19 pandemic and associated safety concerns and restrictions, all engagement with participants or potential participants was done virtually. Each participant received a \$50 gift card in thanks. To read more about the recruitment process and participant selection see [Appendix II: More on Recruitment](#).

## **Semi-Structured Interviews**

In total, we interviewed 48 participants. Interviews lasted between 25 minutes and 90 minutes and were guided by a semi-structured interview guide. Interview questions were grouped to focus on material considerations (e.g., housing, finances) and family relation, social life, care and support, and end-of-life considerations. Overarchingly, the interview questions were designed to elicit perspectives on aging and wellbeing, including how participants defined these ideas.

As interviewers, we let participants guide the conversation. We listened and probed for particularities in rural aging experiences, for reflections on impacts of race and racism, and regional specificities and differences, among other cues. We also listened for their ideas about actions that could be taken to improve their situations, and to meet unmet needs. Each interview was audio-recorded and later transcribed.

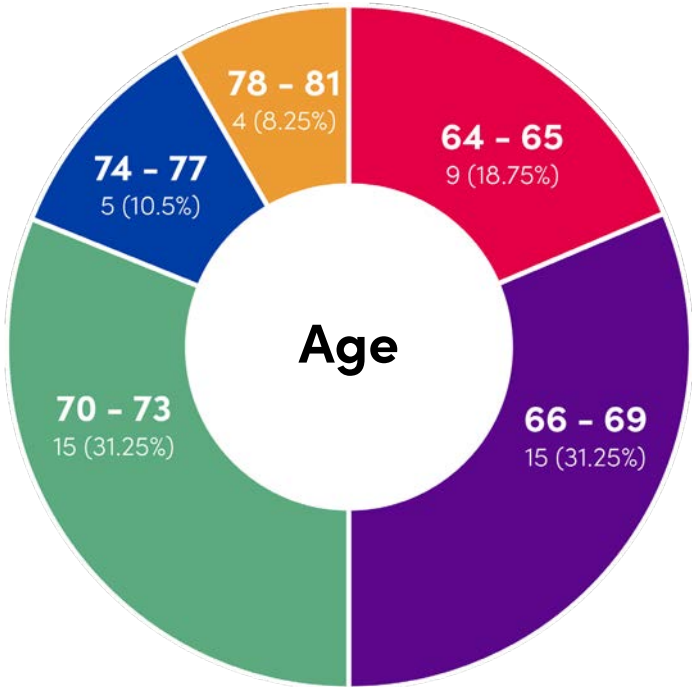
## **Overall Demographics**

We interviewed participants from eight different provinces who were between 64 to 81 years old. The average age of participants was 70 years old. Overall, study participants reflected a wide range of subject positions with regards to gender identity, sexual orientation, housing situation, income level, and area of Canada in which they were living, among other characteristics and life circumstances. Below (Tables 1-7) we provide a snapshot of the overall self-

reported demographic profiles of the 48 participants. Additional tables within the report show highest level of education completed, annual household income, and working status (in [Employment](#)); housing composition and housing type (in [Housing](#)), and partnership status (in [Social Connection and Disconnection](#)).

Table 1: Age

Age <sup>2</sup>	
64-65	9 (18.75%)
66-69	15 (31.25%)
70-73	15 (31.25%)
74-77	5 (10.5%)
78-81	4 (8.25%)



### Location

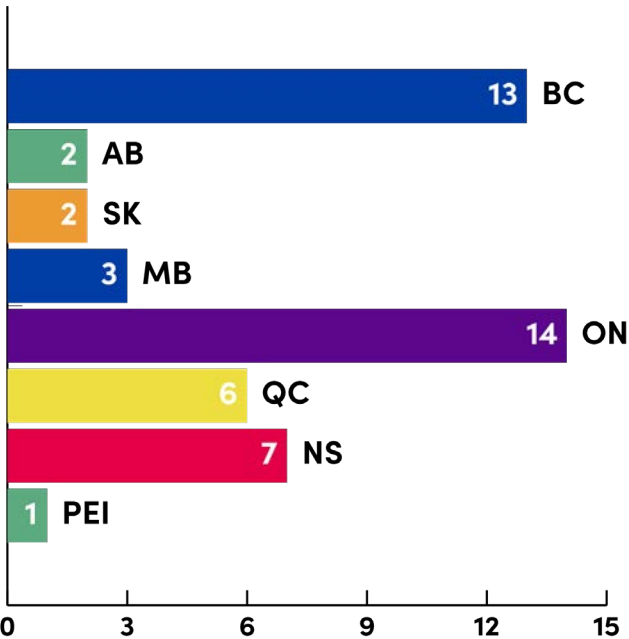


Table 2: Location (by province)

Location (by province)	
British Columbia	13 (27%)
Alberta	2 (4.25%)
Saskatchewan	2 (4.25%)
Manitoba	3 (6.25%)
Ontario	14 (29.25%)
Quebec	6 (12.5%)
Nova Scotia	7 (14.5%)
Prince Edward Island	1 (2%)

2 The original inclusion criteria for participants were age 65 and above. Exceptionally, we included one person who expressed interest in participating who was 64 to increase representation in a western province and increase reflections on living with multiple chronic conditions.

Table 3 Location (urban or rural)

Urban or Rural	
Urban	36 (75%)
Rural	12 (25%)

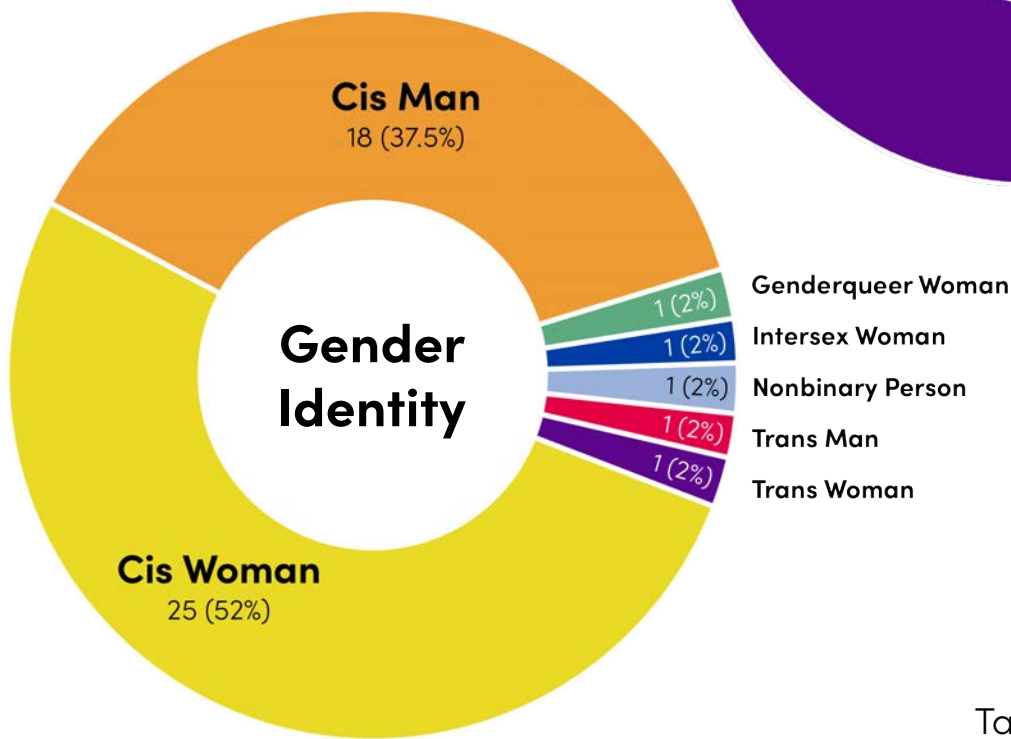
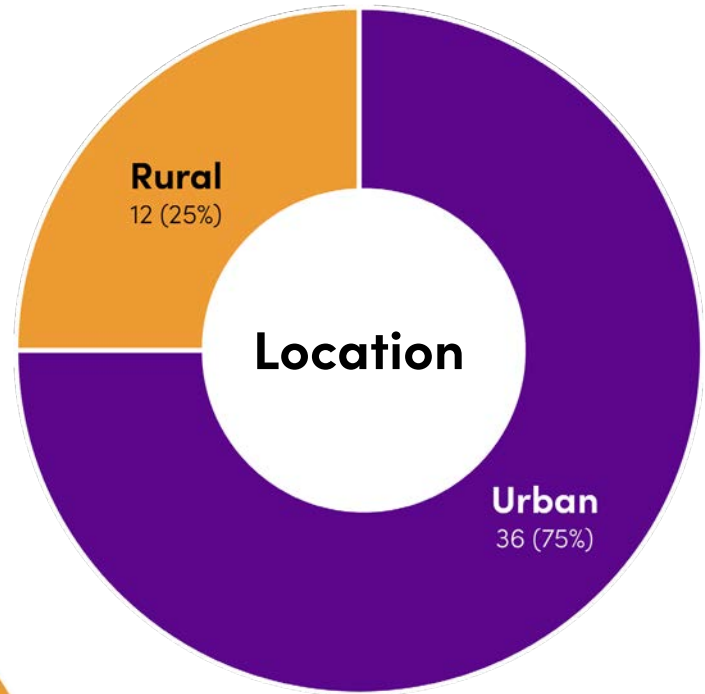


Table 4: Gender Identity

Gender Identity	
Cis woman (Including self-identification as female, cisgender woman)	25 (52%)
Cis man (Including self-identification as male)	18 (37.5%)
Genderqueer woman	1 (2%)
Intersex woman	1 (2%)
Nonbinary person	1 (2%)
Trans man	1 (2%)
Trans woman	1 (2%)

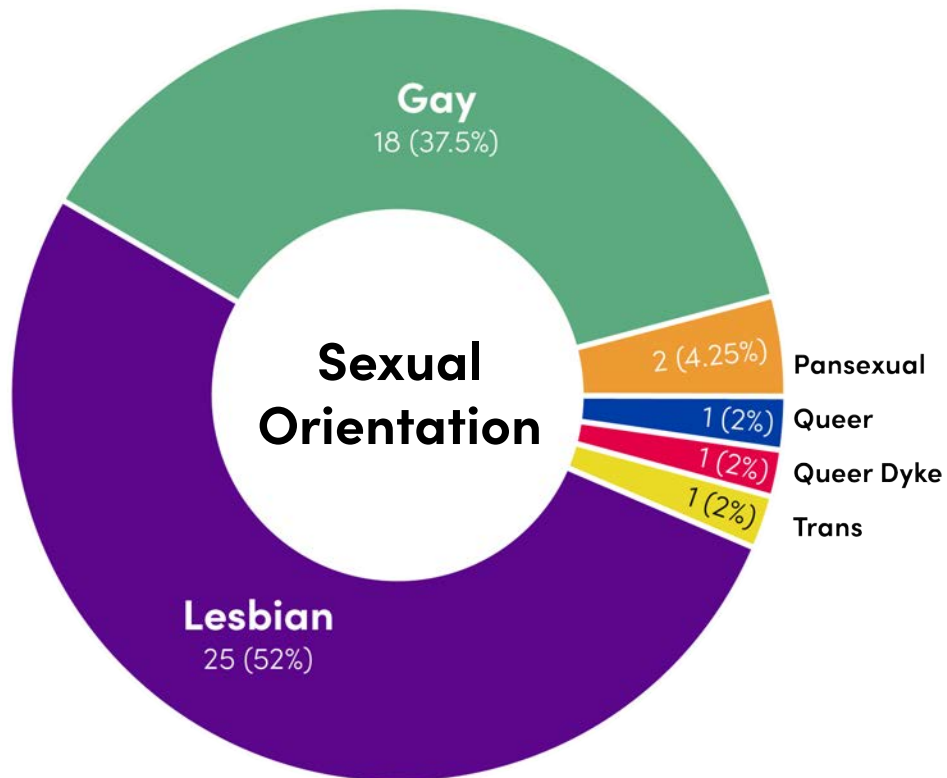


Table 5: Sexual Orientation

Sexual Orientation	
Lesbian (Including self-identification as lesbian, lesbian/bisexual, lesbian/dyke, lesbian/gay, and lesbian and queer)	25 (52%)
Gay (Including self-identification as gay, gay/queer, homosexual)	18 (37.5%)
Pansexual	2 (4.25%)
Queer	1 (2%)
Queer Dyke	1 (2%)
Trans	1 (2%)

Table 6: Ethno-racial Identity

Ethno-Racial Identity <sup>3</sup>	
White/ Caucasian	41 (85.5%)
Person of Colour	4 (8.25%)
Black	2 (4.25%)
Indigenous to Turtle Island	1 (2%)

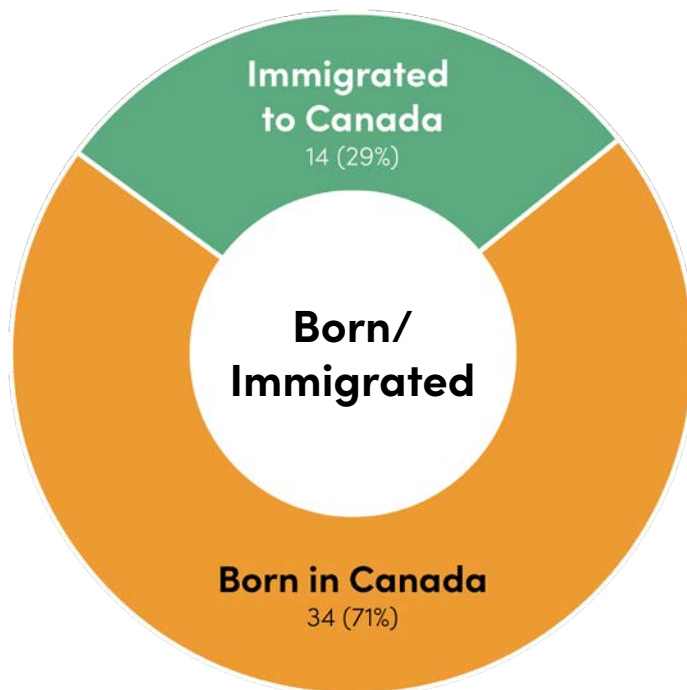
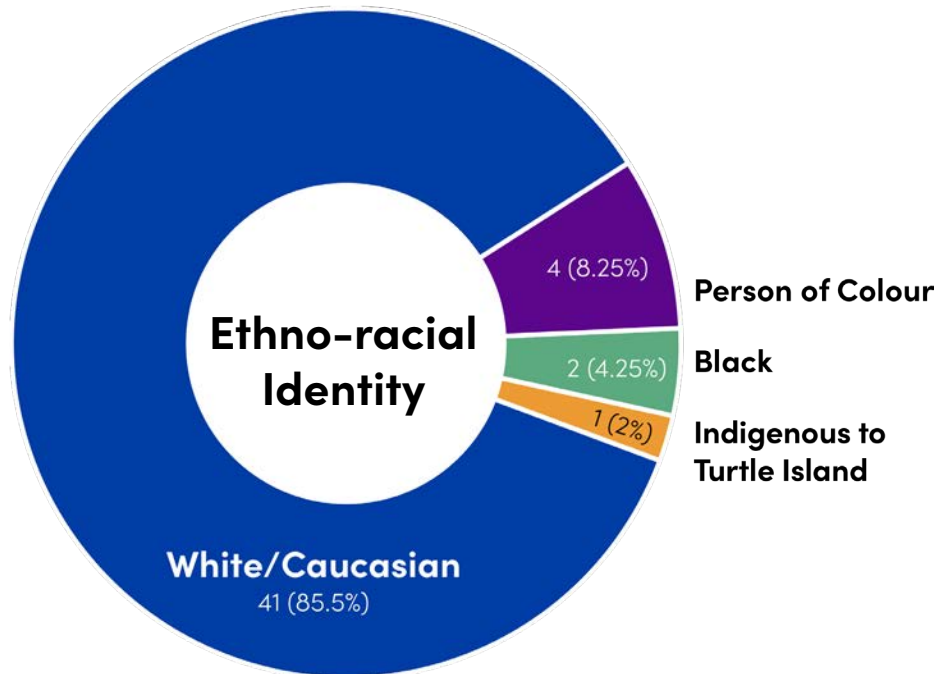


Table 7: Born in Canada/  
Immigrated to Canada

Born in Canada/ Immigrated	
Born in Canada	34 (71%)
Immigrated to Canada	14 (29%)

<sup>3</sup> Regarding categorization of self-reported ethno-racial identities: We have used the general grouping of "White/Caucasian" to capture participants who explicitly identified as "White" or "Caucasian", or with a closely related category. "Person of colour" refers to a range of ethno-racial identities & expressions that are racialized as persons of colour in Canada. "Black" includes participants from various diasporas, including of mixed descent and Indigenous to the countries they immigrated from. Any attempt at grouping or categorizing people is imperfect, as these categories are themselves socially made and contingent; this is only one way to present the data.

# Findings

Findings presents select high-level findings of the study. Overall, we respond to the three overarching questions that the study sought to address: *What does “aging and living well” look like for LGBTQI older adults in Canada? What could it look like? And what social changes are needed to better enable LGBTQI older adults to live and age well, on their terms?*

Direct quotations have been de-identified to better ensure participants’ confidentiality. We have generally specified the rough age of participants (e.g., “70s”), gender identity and/or sexual orientation, and if they were living in an urban or rural area. Most study participants were White, cisgender, and living in urban areas. In selecting which direct quotes to use in this report, we aimed to include a range of experiences and perspectives, and to address under-representation of specific groups in this study and in LGBTQI aging research more broadly, including Indigenous, Black, and other racialized groups and people based in rural areas. No experience is reducible to a single identity category, and these categories themselves are dynamic and being constantly being contested and transformed.

Each thematic section concludes with recommendations for policy and practice change and collective organizing. Beyond this report we will continue to mobilize research findings in different ways, including in educational resources, journal publications, and materials targeting policymakers and useful for specific community mobilization efforts.

## Employment

In this section we take a life course approach to interpreting participants' employment trajectories and what these trajectories tell us about broader social conditions of employment and employment discrimination. This includes dynamics of homophobia and transphobia, as well as sexism, ageism, and ableism.<sup>4</sup>

Participants' past employment trajectories were shaped by historical conditions of pathologization and criminalization of LGBTQI identities. The history of overt state-sponsored discrimination is recent, emblemized in the systemic discrimination, harassment, and firing of LGBTQ federal public servants and military personnel through the 1950s to mid-1990s (see Kinsman & Gentile, 2010). Even while sexual orientation and gender identity and expression have been added as protected grounds under the Canadian Human Rights Act (as of 1996, and 2017), gender and sexual orientation-based discrimination in the workplace and in hiring practices persist (e.g., see Bauer et al., 2011; Brennan et al., 2022).

Given the age range of participants—64–81 years old, with an average age of 70 years old—many had directly experienced the effects of legal discrimination in their workplaces or were keenly aware of them and negotiated their working lives accordingly. A range of past workplace experiences continued to emotionally resonate with participants, while job and career trajectories also impacted their financial security in old age.

### **Educational and Economic Possibilities**

#### **Education, economic situation, and employment were dynamically intertwined.**

For some, their economic situation was a key factor in shaping the education they pursued, and in turn the types of employment they had access to.

Educational pathways were also mediated by gender-based discrimination, and norms about the kinds of work men and women could and should do.

Table 8 shows the highest level of formal education completed by participants.

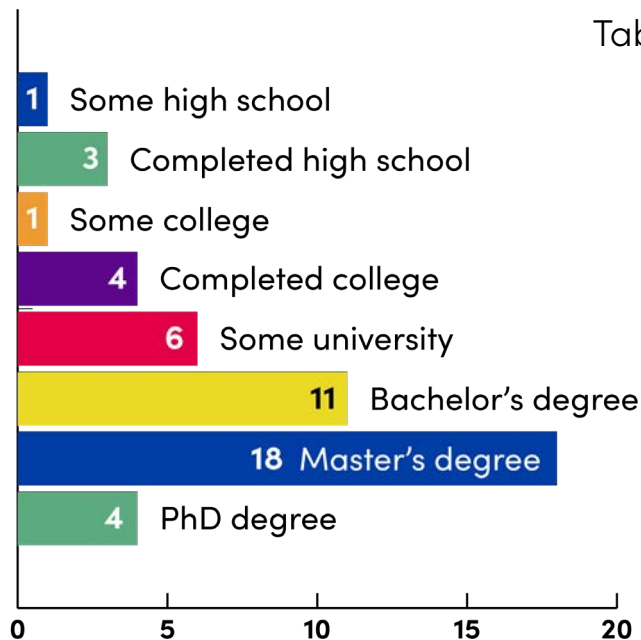
---

<sup>4</sup> See <https://egale.ca/awareness/systems-of-oppression-and-privilege-terms/> for a quick reference guide on common terms and concepts related to systems of oppression and privilege.



## Education

Table 8: Highest Level of Education Completed



Highest Level of Education Completed	
Some high school	1 (2%)
Completed high school	3 (6.25%)
Some college	1 (2%)
Completed college	4 (8.25%)
Some university	6 (12.5%)
Bachelor's degree	11 (22.75%)
Master's degree	18 (37.5%)
PhD degree	4 (8.25%)

While the participant sample overall can be considered “highly educated” participants had mixed educational trajectories and discussed multiple barriers to achieving the levels of education they wanted. For some, attending school and accessing higher education meant overcoming multiple hurdles, barriers that had direct impacts on their employment options and economic security later in life. Homophobic and transphobic bullying and credentialism—or the reliance on formal qualifications as the best measure of a person’s ability, intelligence, and status (OED Online, 2022) — were among these barriers.

Participants’ trajectories also highlighted a lack of straightforward relationship between education and employment. Notably, multiple participants had pursued and completed formal higher education beyond high school. This included cis women participants who pursued graduate degrees in fields traditionally reserved for men, notable due to the significant barriers that women have faced in entering certain professional fields (e.g., the sciences). In these cases, educational attainment did lead to securing employment in fields of study and more secure economic situations later in life. Overarchingly, however, completing college or university degrees did not necessarily correlate with securing related employment. Nor did it necessarily lead to financial wealth or economic security.



**Importantly, ageism and ableism in the workplace also emerged as a reason for re-training later in life.** Clear across narratives was the keen awareness that participants had about the multiple systemic challenges they faced. While many participants persevered despite barriers shifting over time, the very need for perseverance highlights just how stringent these systemic challenges were.

One participant, an intersex woman in her 70s described how experiences of homophobic bullying and homelessness in high school negatively impacted her educational trajectory. She eventually enrolled in a technical college program and then a university program with the encouragement and some financial support from community member mentors:

I went there [to adult education institution] and I got my grade 12. And then I took a [technical course], got a technician's license. It was not really ringing my bell, you know, but I was handy...

She later certified in a non-manual labour profession, a skill which she used later in her career. She reflected on its utility, and ageism in the technical industry in which she worked:

[The new training] proved to be invaluable as my working technician days came to a close because the body fails. A lot of ageism in that industry. If you look like you're old or they actually know your birthday, you're in trouble. Because of the group insurance, health costs, body fails, you know that kind of thing, and I'd already had some accidents with injuries. Heavy equipment is like that.

Another participant, a trans man in his 60s, also discussed higher education and the challenges he faced in accessing the degree that he needed to pursue his desired profession:

I was working minimum wage as a security guard while I was going to university, because no one would hire me for social work or psychology or counseling because you had to have a master's degree, and I didn't have

one. [...] I even tried to get back into school...they wouldn't take me, because my grade point average (GPA) was too low. Then I finally got into the [program at a college] and my average went up to an A-minus. So, because of that I got into a school finally, because of my grade point average [...] I struggled all my because they only want that stupid GPA. So, I wasted all those years, and I wasted all that money that I could have been making a decent salary, and I could've bought a house back then. Instead, I'm 30 years behind [...] I lost 30 years of building up an economic base.

One participant, a lesbian woman in her 60s, described her educational journey from completing an undergraduate degree to pursuing graduate studies in mathematics and science. While she became recognized in her field, she also experiences institutionalized sexism in the workplace. This discrimination impacted her financial situation, while she could still live comfortably as a retired professor:

Well, surely there was [sexism]. Just being a woman in an academic environment, it was really clear to us that we weren't getting paid at the same standard that the guys were. And I think for many reasons, not necessarily just the institutional reasons, but just for my own sense of belonging, and the drive I had to have academically, was affected by being a woman.

Participants' experiences highlight the multiple factors that can shape what types of jobs and careers people have, and in turn the complex ways that socio-economic situations and educational trajectories can shape—but not determine—employment trajectories. Sexism, homophobia, and transphobia all shaped participants' trajectories, while ableism and age-based discrimination emerged as key barriers to securing and keeping employment later in life, despite human rights protections.<sup>5</sup>

---

5 To learn more about wage gaps and employment discrimination related to gender identity, expression, and/or sexual orientation in Canada see Denier & Waite, 2017; Waite, 2020.

## Navigating Identity and Being Out at Work

Participants had a range of educational and employment trajectories and formal job roles, ranging from work in the healthcare and social service sector (e.g., nursing, social work), to business, education, trades, and the arts. Regardless of profession or work history, being out at work was an issue of concern for most participants. **For most participants finding and keeping employment and getting along within workplaces involved complex negotiations and careful consideration about what to disclose about their identities, to whom, and how to do so.**

**Fears of being outed and of discrimination informed how people navigated their workplaces and their career paths.** Participants who were mainly or partially closeted in the workplace described their careful day-to-day navigations in dealing with colleagues, clients, and workplace superiors. They also described career shifts they had made to minimize the potential of them being targeted or falsely accused of inappropriate behaviour. Furthermore, for those who continued to work, or wanted to work, potential discrimination against them as LGBTQI people remained on their radars.

**Some participants described positive workplace experiences, and intentional moves to work in queer environments.** For example, participants discussed how they had found jobs in queer areas of big cities where there was a critical mass of LGBTQI people in their workplace, recounting the sense of belonging and relative safety that characterized these experiences. Others related how they were comfortably out to colleagues at work, but that navigating disclosure to clients in healthcare and social service fields had distinct considerations.

One participant, a lesbian woman in her 60s, described her experience as a young person working in a queer area of a big city, and the relative ease that this allowed her:

When I was living in [city] I was a cook, and a lot of those places that I worked at were gay owned. And all the staff was gay. It was like, Pride Day every day, you know? And so there was no discrimination there. You kind of looked forward to going into work.


Now working in social services, this participant is out to her co-workers, but discrete about what she shares with her clients, connecting it with efforts to be “professional” and not talk about her home life.

Another participant, a gay man in his 70s who had also worked in social services, described his discretion in working with clients, how he navigated sharing information with his supervisors and colleagues, and his pain in having to hide aspects of himself:

My supervisors always knew that I was gay. I thought of being wise, that I get in front of it. But it was kind of irrelevant. [But] of course it is not, when you're working with families. A typical question will be from parents, “Well do you have children?” Of course, I learned to say, “We're here to talk about your family not mine.” I kind of ducked out of that. So I was out to coworkers and bosses, yes. It doesn't mean that they knew anything, anything beyond that. It is not like I shared my personal life with everybody. But I didn't have to stay hidden. And I guess it would have been against my principles to stay hidden. That's why it was very painful for me to feel like I had to hide that aspect of myself.

One gay man in his 60s who had worked in temp labour described how he stopped wearing a Pride button and how this helped him financially:

I sat in that office from 5:30 in the morning until 9 and not have my name called. And, you know, so [much] that I stopped wearing a Pride button and started going to a different temp agency...It helped me financially, not necessarily physically, in the long run, but financially it helped.



These reflections highlight the complex navigations that LGBTQI people can face in their careers, negotiating identities and stances with the realities of discriminatory workplaces and their own material needs and career goals. While in some ways the experiences participants shared were particular to their workplaces and past socio-legal landscape, navigation around disclosure (if an LGBTQI person has a choice) and the potential for employment discrimination are still very much current issues (e.g., see Bauer et al., 2011; Sasso & Ellard-Gray, 2015; Sears, 2021; Brennan et al., 2022). **Continued efforts to combat workplace discrimination and critical attention to the long-term and compounding consequences of employment discrimination and un- and under-employment among LGBTQI people over the life course are both needed.** Ongoing efforts to combat discrimination and to improve workplace safety can learn from LGBTQI older adults, including from how they have navigated challenging workplace circumstances and led efforts to press for change. At the same time, ongoing imagining about and possibilities for enhanced forms of social support and solidarity that do not depend on lifetime workforce participation is critical.

## Financial Security and Working Later in Life

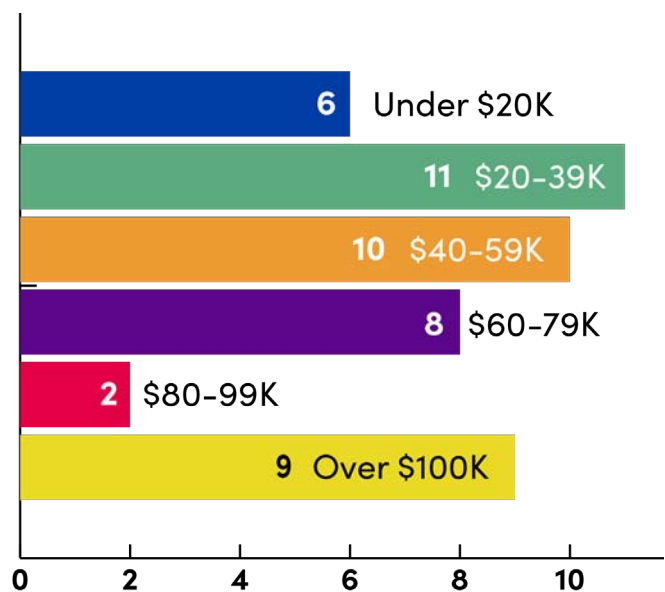
Finally, participants spoke to us about their current economic circumstances, including how their paid employment histories impacted their financial security later in life.

The financial resources that participants had were from a range of streams, including pensions, savings, and other resources such as partner's incomes. Table 9 shows annual household income. Notably, among those with an annual household income of under \$40,000, more than two-thirds (13/17) were living alone.

Table 9: Annual Household Income

Annual Household Income <sup>6</sup>	
Under \$20K	6 (13%)
\$20-39K	11 (24%)
\$40-59K	10 (21.75%)
\$60-79K	8 (17.5%)
\$80-99K	2 (4.25%)
Over \$100K	9 (19.5%)

### Income



### Pensions were an important

**source of income for most participants.** Some participants relied heavily on their entitlements through the Canadian Pension Plan (CPP) and Old Age Security (OAS)<sup>7</sup>. Others had additional pensions from their workplaces or relied upon the pensions of their partners and pooling income. Regardless, pensions were a significant part of most participants' financial planning and their projections about how they could provide for themselves at present and into the future.

<sup>6</sup> Two participants chose not to respond to this question. We originally asked participants for their rough annual household income; some participants living with others (including partners/spouses) may have chosen to report individual incomes.

<sup>7</sup> One Statistics Canada publication reporting on 2005 data found that CPP and OAS made up roughly 44% of seniors' total incomes. Older adults who were "unattached" had the highest incidence of low income; 11 times higher than couples (National Seniors Council, 2007).

When asked about any concerns about his current or future financial situation and if he expected to be able to meet his basic needs in the next ten years, one participant, a gay man in his 60s who had been a taxi driver shared:

That's a big question, since we never know what will happen to us. I've tried putting some money aside, but I haven't been doing it for long since it'll be eleven years this November since I've stopped using cocaine, which was very expensive. Up until now, I've managed pretty well. But I don't know if it'll last, since no one is safe from bad times. Sometimes, things just come out of nowhere and there's no way to predict them. I really don't have much saved up at all, it's basically pennies, but at the same time, I calculated that what I'll get from my pension and the guaranteed income supplement won't make me rich, but I didn't want to be rich anyways.

Another participant, a lesbian woman in her 60s who lived with her wife, described their joint planning:

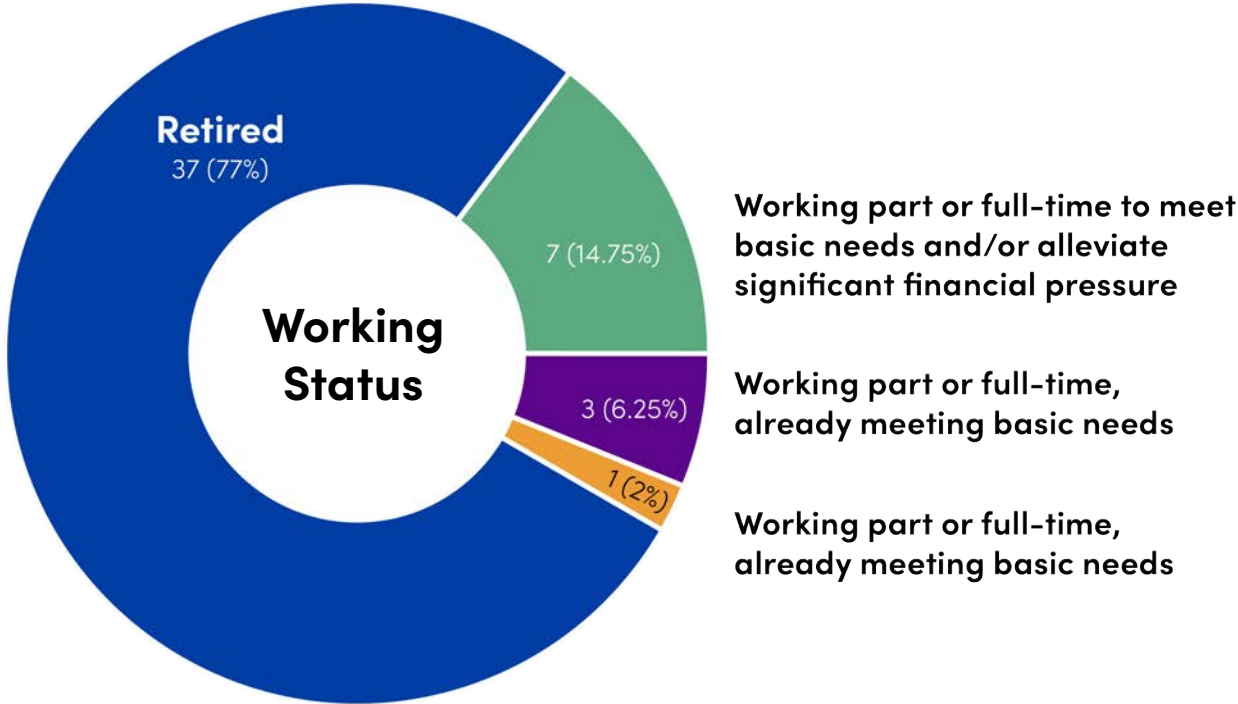
Well, we're planning it carefully, let's say that. My partner's figuring on picking up contracts [...] She doesn't get a pension from her work. I do. We've got the Canadian pensions. I mean, it's really, well...how much are the pensions? Very little. So we've been saving, so that we've got something to draw on when things start looking grim.

**Multiple participants continued to work and look for work past the age of 65, including due to financial necessity.** As shown in Table 10, of the 48 participants, 37 were retired and 10 were working full- or part-time. Seven of 10 participants who continued to work did so to meet basic needs or alleviate significant financial pressure. Half of the participants who were working had an annual household income of under \$49,000. One participant who had experienced homelessness and at the time of the interview survived on an income of under \$10,000 a year wanted part-time work but did not feel comfortable being an out queer man in the workplaces that were potentially available to him.

While this was a qualitative study and these findings do not have statistical significance, they resonate with broader patterns of older adults' working and needing to work in later life. As one Statistics Canada report highlights, in 2017 close to one-third of people over aged 60 had worked or wanted to work; and of these, half did so out of necessity (Hazel, 2018, p.4). More than one-quarter (28.4%) of people over age 70 continued to work due to necessity (Hazel, 2018, p.6).

Table 10: Working Status

Working Status	
Retired	37 (77%)
Working part or full-time to meet basic needs and/or alleviate significant financial pressure	7 (14.75%)
Working part or full-time, already meeting basic needs	3 (6.25%)
Wanting part-time work to meet basic needs, but currently not working	1 (2%)





One participant, a lesbian woman in her 60s who was self-employed at the time of our interview described her current financial difficulty, impacted by her work history, familial responsibilities, living with a chronic disability, and the precarity caused by COVID-19. Her reflections tie together how people with chronic conditions and disabilities often face added barriers to being financially secure and meeting basic needs:

I did work half time for the government for many years [...] I burned out and kind of got PTSD. I retired a bit early [...] I have a little pension from them which is great, and when I turned 65 I applied to OAS so I get a little bit from that. So I have enough to pay the mortgage and my bills [but] there's not a lot left over. And my daughter, I buy all her groceries and stuff because she has special needs and not much income.

Due to COVID-19, one lesbian woman in her 70s had begun to tutor children online. She discussed her need to work, and the challenges of finding and keeping work at her age, a point speaking to ageism and ableism in workplace cultures:

I absolutely have to work, and that's hanging over my head. [...] It's not easy because my age is working against me and has been for a long time. I've been putting in applications, because that's what I think I want to do. Anyways, I was on medical leave when my doctor told me I couldn't pursue my other work anymore. Then I wasn't able to do it. "Respect yourself and respect your age." So he told me to "Find something else," and that's that. As a tutor, I could work from home, that would work for me, but because of my age, I'm not protected from a lot of things that could happen.

Another participant, a queer man in his 70s living alone in a rural area had worked in the arts. With an annual income of \$25,000 a year, he described the necessity of continuing to work part time to meet present and future basic needs:



Well, because I work in the arts, and a lot of times I worked under the table. I wasn't really thinking about my old age or putting away money for my old age or any of that kind of thing. And I don't have a pension I can live on. So I have to supplement it by having part time work.

Financial security in the present and in the future was a significant concern for many participants. While some had steady streams of income including savings to draw on, others depended significantly on CPP and OAS, and workplace pensions if they had them. Even with pension income, multiple participants had to continue to work to meet basic needs or to alleviate significant financial pressure. **Importantly, the necessity of finding work in older age highlights a range of social inequities including class and gender-based inequity. It also brings issues of ageism and ableism to the forefront,** including in hiring practices and in how value is placed on different bodies and minds in capitalist Canadian society.

## Recommendations

### Workplace policies & culture:

- Continue to strengthen anti-discrimination policies in workplaces and implement measures to promote inclusive and equitable workplace cultures for 2SLGBTQI people.
- Learn to recognize, and address, ageist and ableist hiring practices and workplace cultures.
- Learn to recognize, and address, intersections of ageism, ableism, racism, transphobia, homophobia, and other forms of discrimination in employment practices.

### Education & mentorship:

- Continue to challenge gendered ideas about professional prospects, and encourage students of all sexualities and genders to pursue education and careers of interest to them.
- Support students from under-represented groups in pursuing desired higher education, including guidance for first generation college and university applicants.
- Create and/or maintain funding for 2SLGBTQI groups, centers, and other supports from elementary school through to high-school and postsecondary settings.

### Labour, pension, & social support reform:

- Increase greater protections for non-unionized and precarious workers (e.g., workers in the “gig economy”) who are more vulnerable to labour exploitation and discrimination.
- Maintain and improve coverage provided through Old Age Security and other pension and support programs, eliminating ableist and gendered measures that directly penalize people who cannot work or have taken time away from work for caregiving and other responsibilities.
- Increase financial supports for older adults living in poverty and on minimal fixed incomes.

## Housing

Housing and access to affordable and secure housing is a national issue that crosses generational and geographic boundaries. Costs of home prices and rents affect people of all ages living in Canada, and increasing numbers of people live in unaffordable housing and are in core housing need,<sup>8</sup> including nearly 17% of people over 65 years old, and nearly 40% of older adult renters (Statistics Canada, 2022a). Across Canada, LGBTQ2+ households spend more of their total household income on shelter than non-LGBTQ2+ households, and more were in core housing need (Randle et al., 2021). While there has been research and advocacy has focused on housing and homeless among LGBTQ+ youth in Canada (e.g., see Abramovich 2012, 2017; Munro et al., 2019; Abramovich & Kimura, 2021; Friends of Ruby, 2023), with recent exceptions (e.g., Redden et al., 2021) much less attention has been paid to the housing situations and needs of LGBTQI adults or older adults. This, while both older adults and LGBTQ+ groups have been identified as among those in greatest housing need (Canadian Mortgage and Housing Corporation, 2018).

Given this gap and the prominence of housing issues in Canada today, housing was one key focus of this study. We interviewed people who lived alone, with spouses and partners, and with others (see Table 11), and who lived in a range of housing types (see Table 12), and asked about their housing situations, concerns, and what might be desirable housing arrangements in the future.

---

8 In Canada, households defined as in “core housing need” live in dwellings that are considered unaffordable (more than 30% of income on shelter cost), inadequate (needs major repairs), or unsuitable (not enough bedrooms for household composition, per National Occupancy Standard), and would have to spend more than 30% of total before-tax income for alternative local housing that is affordable, adequate, and suitable (Statistics Canada, 2021).

Table 11: Housing Composition

Housing Composition	
Living alone	27 (56.25%)
Living with a partner/spouse	16 (33.25%)
Living with roommates	3 (6.25%)
Living with others (Including with an adult child, an ex-partner)	2 (4.25%)

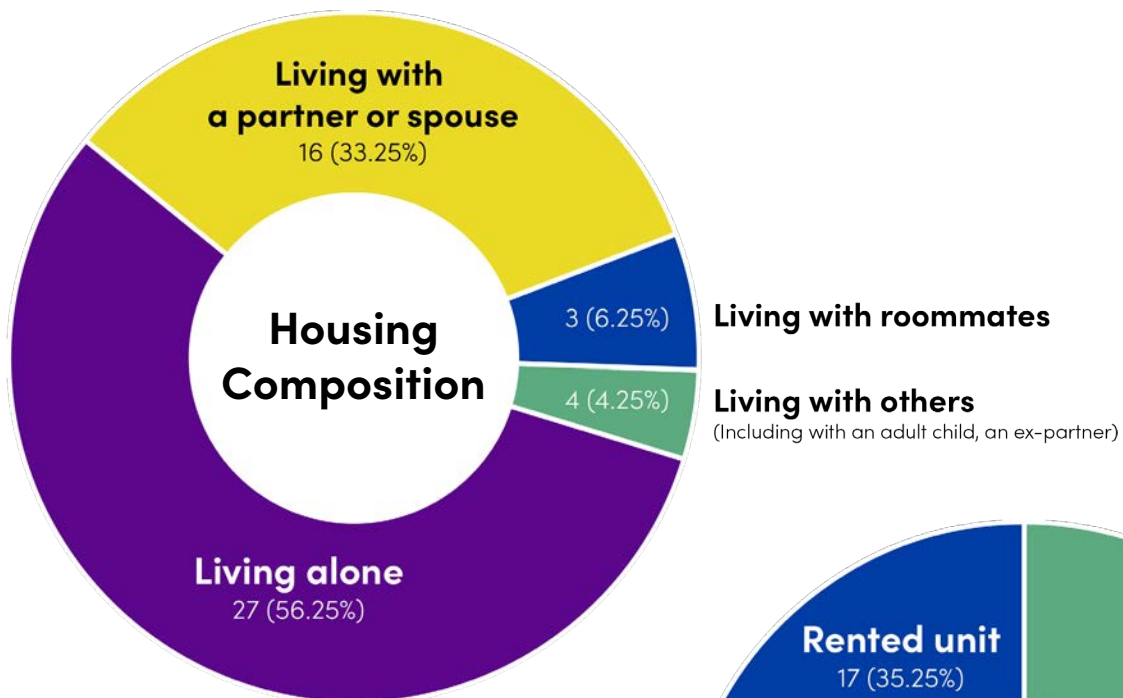
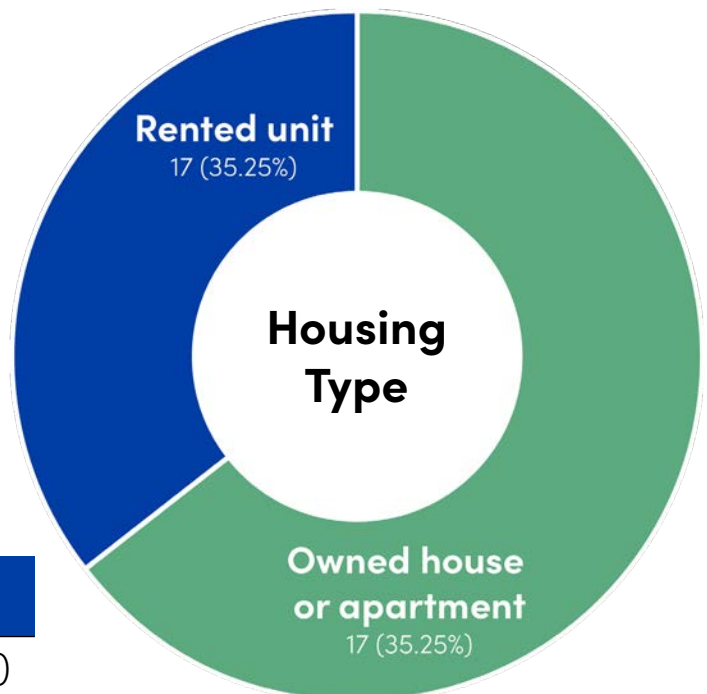


Table 12: Housing Type

Housing Type	
Owned house or apartment	31 (64.5%)
Rented unit (Including one co-op unit)	17 (35.5%)



## Housing (In)Security and Cost

Concerns over costs of housing were mediated by income (especially from pensions), accumulated wealth (e.g., savings), anticipation of future housing costs (e.g., for accessibility), as well as geographic location and local costs of renting and buying. Some felt secure in their current housing, while others faced significant insecurity about their shorter and longer-term housing situations.

**Homeowners and renters alike expressed concerns about rising housing costs, including their financial ability to meet rent and other living expenses.** Many participants described their income and finances as tight or limiting in their respective housing markets, which increased fears surrounding their future housing options. Others described the challenges of being house-rich but cash-poor, meaning that while they had equity in their homes meeting day-to-day needs was still challenging. Multiple participants described this as a reason for selling their homes and renting instead.

One participant, a lesbian woman in her 70s living alone in an urban area of Nova Scotia discussed how her options for housing were related to her pension and the “middle zone” she fell into with her monthly income:

I just finished selling my house, right before COVID [...] Now I'm living in an apartment, a very tiny one, but I'm just happy right here for now. It costs me about \$1275 a month. My house was costing me probably \$1800 a month. Too much for me. My income is only around \$3800 a month. And that puts you in that crazy middle zone everywhere.

Another participant, a lesbian woman in her 60s living with her partner in urban British Columbia reflected on their new rental situation:

We feel quite stable but if they ever sell this building, we probably won't be able to stay here, which will be a problem. [...] But together we're quite comfortable, given how we've chosen to live. We could be seriously house poor, if we insisted on ownership.

Participants also spoke about fears of developers buying up rental properties and driving up housing costs in the areas where they lived. Discussions about private development and the impact of large-scale developments on the security and affordability of housing also led to discussions about public housing projects. A shared concern for the LGBTQI older adults we interviewed was that governments had not been putting resources into affordable housing for many years, while big developers bought older buildings to be developed into unaffordable condominiums.<sup>9</sup>

One participant, a lesbian woman in her 60s spoke of her and her partner's experience moving to a new city. She described how although they currently felt secure in their rental housing, there was always the prospect that their building could be bought:

We decided that we would move to Vancouver, and we were very, very lucky to find a rental building with a great older large apartment at a decent price. The prices are insane here [...] We feel quite stable but if they ever sell this building, we probably won't be able to stay here, which will be a problem.

Another participant, a lesbian woman in her 70s living alone in an apartment discussed the lack of affordable housing in her province, Prince Edward Island. She saw integrating affordable housing into multi-generational housing projects as the way of the future:

The province isn't building anymore [affordable housing] units, per se. They're usually tagging units onto complexes that are being built just generally. The builders are supposed to have a certain percentage of units available to low income. Or subsidized housing. I think that's the way of the future, rather than having seniors all congregated into one unit, one building.

**Housing rental costs were so great for some participants that they described needing to work to meet their basic needs.** This was particularly the case for

---

<sup>9</sup> To learn more about the impact of real estate investment and financialization on housing supply and affordability see the documentary PUSH (Gertten, 2019); Sassen, 2009, 2019. For more on realizing the right to housing in Canada see Schwan & Perucca, 2022.

people without private pensions and low government pensions, reflecting broader dynamics of privilege and economic precarity related to workforce participation and informal versus formal paid work. Others described sharing housing with roommates or renting parts of their home to offset housing costs.

One participant, a gay man in his 70s living alone in a rural area of British Columbia, described his need to continue to work part time:

I rent. I did own a home in Vancouver, but I no longer do. [...] Because I work in the arts, and a lot of times I worked under the table. I wasn't really thinking about my old age or putting away money for my old age or any of that kind of thing. And I don't have a pension I can live on. So I have to supplement it by having part-time work.

Another participant, a queer man in his 70s living in Toronto spoke about the benefits of his central location and rent control but continued burden of re-development and rising housing costs:


Literally every building I can see is being torn down, literally every month. And I considered moving to [another location] although this is so central and good [...] I am concerned because my housing costs, even though my rent's controlled, go up every year. So I'm grateful to be getting this part time job, because I can make a little money.

One participant, a retired gay man in his 70s living in Winnipeg described his rental situation with a part-time roommate:

I live basically on my own. I do have a, quote, unquote, part-time roommate. He works up north [...] He wanted a place where he could hang his hat when he comes to Winnipeg, so he's there about three months out of the year.

**Finally, we found significant differences in housing security among people who were living on a single income as compared to those who lived with partners or spouses.** Participants who lived with spouses and partners pooled their income,





providing increased financial stability and allowing them to share the burden of housing costs. Some had stable pension incomes and younger partners who were still working full-time. Conversely, participants who were single and/or living alone did not have this safety net.

The situation of one participant who was amid a separation from her spouse exemplified these differences. Separated but still living in the same apartment as her spouse, she discussed her precarious situation and worries about where she could end up:

I'm scared to death. I will not be able to carry this mortgage. If she goes on her merry way, she's going to have to sell this place, and I'm going to be out on the street. And I'm already providing for myself and my meals. I don't make enough money; I don't have enough money left over for groceries and I do use the food bank for myself [...] I am very worried. I'm scared to death. I don't know how I'm going to end up.

Importantly, these findings confirm the realities of housing insecurity among many LGBTQI older adults, and the distinct measures—from continuing to work, to selling homes, to finding roommates—that many must take to stay in their homes and meet basic needs. Participants' situations highlight the need to address high and rising housing costs and cost-of-living across Canada. Our findings also highlight the need to recognize the distinct insecurities that people who live alone on single incomes face, and the varied housing realities and dynamics beyond the nuclear family model.

## Housing (In)Security and Safety

Experiences and/or sense of safety and security related to gender and sexuality was another key theme that emerged, especially among people who were renting and/or living in apartment or condominium buildings. Some participants, especially those living in houses that they owned, felt relatively safe and secure. Others described experiences of discrimination in buildings where they lived. Anti-LGBTQI discrimination also emerged as an area of concern in seeking rental housing, a concern shared by younger and older LGBTQI people alike (see Levy et al., 2017; Migdal, 2019).

**Participants described mixed experiences of being “out” when living in apartment or condominium buildings.** Some described positive experiences of connecting with their neighbours, and of having a critical mass of fellow LGBTQI people nearby, especially when living in or near queer neighbourhoods. Others described more negative experiences, including overt homophobia.

One gay man in his 60s living in an urban area spoke about his experience living with his partner in their small condominium building:

Everybody knew that we were the gay couple on the first floor. There was never any attempt at hiding that. We only had one real negative thing happen to us, but one year in Pride we hung up the rainbow flag and a neighbor, she didn't like it... she complained to us directly, and then she complained to the building council, and she was told, “You know, there's nothing, nothing wrong with it. They're not breaking any rules, regulations or bylaws.” So there we are.

Another participant, a lesbian woman in her 60s, described the community she has in her apartment building, and how she and her neighbours support one another. This including forming a “bubble” during the pandemic, a practice that increased their collective sense of safety:

There are quite a few queer people in our building. We also had our bubble during COVID. That was kind of nice, too. So that's our little community within the building. [...] We checked on each other because there's the older folks involved, and our other neighbour has back issues, and so on and so forth. But we keep a constant check on each other and meet for dinner, or hockey games.

Experiences and fears of discrimination were of particular concern among trans and intersex participants, who had faced or anticipated facing gender-based harassment and discrimination. **This included in the buildings where they lived, and in anticipated encounters with landlords.**

A trans woman in her 60s renting alone in a rural area, for example, contrasted her current and past housing situations:

It's good because other places I was living at I was having trouble with some of the tenants. Like the fact that me being trans, and then harassing me and calling me names and all that. It got to a point of, you know I need to find a place where I don't have any problems. Here it's nice and peaceful, I don't run into a problem.

Another participant, an intersex woman in her 70s spoke of her concerns about finding a new place to live. She emphasized how difficult it can be to seek protections from rental discrimination, as landlords can provide more palatable excuses to refuse housing:

When I go out looking for a place to live, I can just imagine the time I'm going to have. It's just going to be, "Oh sorry, it's rented." I'm just imagining the excuses I'm going to get when I won't be able to find a place to live. That needs to be corrected. It needs to be a situation whereby, yes, this is a senior citizen. She is intersex. Or she is transgender, or she is whatever. We need to be assured and really well advised that there are legal means in place to protect this person.

**Concerns about safety, belonging, and being LGBTQI were also major considerations for participants when moving.** This included moving to new rental housing, as in the instance above, and among participants who were moving from larger cities to small urban or more rural areas. For some, these concerns were realized. For others, their concerns were based on beliefs and biases that smaller communities would not be welcoming to LGBTQI people and did not materialize.

One participant, a dyke in her 60s, spoke about her experience being “out” in a rural community in western Canada:

I moved down to [partner’s town]. That was interesting because she is more butch looking, and she calls herself a tomboy. And having her with me outed me in this small town...When I didn't have a partner there really wasn't an opportunity to say, “I'm a lesbian”. It kind of didn't come up, but I've never not said it when it's appropriate. But then walking down the streets with her, suddenly I'm out. I was interested to observe my own reactions because it's very different than living in downtown Toronto where you're pretty anonymous. You are not anonymous in a town of 900 people.

Conversely, a gay man in his 60s who was recently retired and facing an aggressive cancer described the benefits of the comparatively close-knit community in his current town, as opposed to the estrangement of living in a big city:

I like it here very much. The people are terrific...they're real people. I think I was sent to a small town at the last stage of my life in order to understand what it's like [...] There's a grassroots thing here that's happening that I've never been aware of, because, well frankly, you get onto [public transportation in the city] and you have a newspaper, and you've finished it by the time you get to your stop, and you leave it on the bus, and that's it. You see pages of obituaries and you don't know anybody, and you leave it on the bus for the next person.

In thinking about housing security, questions of safety are critical. Not only must housing be affordable, adequate, and suitable, LGBTQI people must also have access to housing where they do not experience discrimination or violence. As we describe further below, this need and participants' mixed experiences can also inform ideas about aging in place, and about different types of housing models.

## **Aging in Place**

Thinking about the future, participants reflected on what they would need to age in their homes and communities. Some participants had very specific plans for what they wanted their housing situations to be as they aged, while others had not yet given this much thought. Regardless, all participants expressed a desire to remain in their homes or communities as long as possible. With this came explicit calls for support and action.

**Many participants noted how being able to access community-based support would allow them to stay in their homes for longer.** This included help with household chores and other care-related support. Indeed, participants shared several suggestions and innovative ideas about what could enable them, and others like them, to remain in their homes and chosen communities longer.

One lesbian woman in her 70s living alone in an urban area described what she would need to age in her community:

As long as my health enables me, I would like to stay in an apartment and maybe have someone come in two or three mornings a week or something [...] My kids, I could call them if I really needed to. But them [kids], to rely on more for my social fun and happiness. So [help] to get things done like grocery shopping, or cleaning house and stuff and helping me to maintain it.

Another lesbian woman in her 60s shared the novel idea of a “dyke-run homecare company”, a service that, with humour and realism, she suggested she and many others would benefit from:

I think in order that people stay in their homes, what we're really dreaming for is that some dykes should start a PSW [personal support work] company, like for a personal PSW visiting your house...We need to put the word out there, we need those young women, or older women, whatever. Because we'd prefer to stay where we're at.

**Access to healthcare and social services, as well as transportation and walkable neighbourhoods, also impacted where some participants chose to stay or to move to later in life.** This included decisions about remaining in unaffordable urban areas that had a higher density of services nearby. We discuss healthcare access and homecare further in the [Healthcare Access](#) section.

One participant, a lesbian woman in her 60s living with her partner spoke of her strategic decision to remain living in a big city due to the proximity to resources it could provide:

We've got every possible resource here. And I mean though it's a matter of choice, right. It'd be nice to live in the country, it'd be so pretty, but why the hell would I do that? When I can just walk across the street and get my vegetables and stuff. I think it's about choices, and that's why I live here. And I was born in Toronto, but I've chosen to stay here.

Another participant, a lesbian woman in her 70s, summed up this trade-off in explained her thinking surrounding the costs-resources trade-off:

If help was easily available and accessible, you'd be able to stay in your community and not have to move, because the moment you move to somewhere that's more affordable, you're further away from everything. It becomes a Catch-22 situation. You move way to where it's cheaper, but have less access to stuff, or do you stay where you have more access, but it costs more. So, that is the problem.

## Making home structures more accessible was a related topic of discussion.

Many participants who owned houses discussed emerging and progressing mobility limitations, and their prospects of modifying their homes to make them accessible or having to move. However, like accessing community-based support, this posed challenges, especially due to cost.

One participant, a pansexual woman in her 70s and living alone spoke about the challenges in the layout of her current home, and the high cost of modifications:

I have a two-story home. Now that's a problem now because I've got bone-on-bone arthritis in my left knee. And I'm on a long waiting list for surgery for knee replacement. And then my foot has to be operated on [...] I have to go up and down stairs because I only have one bathroom, which is upstairs. Bedrooms upstairs, kitchen down here, living room and dining room down here. And there's not enough room to build another bathroom down here. Unless I destroy my beautiful garden and have contractors and everything coming in to put on an extension off the back, which would cost me sixty thousand dollars. And I don't have it. So I know I have to move eventually.

Another participant, a lesbian woman living with her partner also discussed the financial strain of staying in their home, the challenge of stairs with arthritis, and the emotional toll of imagining what could be next:

We're both in our 70s. And who knows what the future holds. We have talked about the possibility of selling our home, because we might just move into an apartment [...] We worry about finances constantly [...] The biggest worry is about if something happens to one of us. Now she has rheumatoid arthritis and I have osteoarthritis. We both have artificial knees. I think we do very well for our age, and we attempt to eat properly and to stay strong. It's a battle every day. It's hard climbing the stairs. And it's a worry because we might end up being forced to sell the house. It's not possible to do all the packing and all that sort of thing. If I think about it, I get overwhelmed.

Aging in their own homes and communities was a clear priority among participants. The comfort and familiarity of their own homes as well as access to community and to nearby resources were among the reasons that participants hoped to not have to move. **However, accessibility and cost emerged as major barriers that must be addressed.** Enabling LGBTQI older adults to age in the “right place” – or the most appropriate setting based on their personal preferences, circumstances, and care needs (National Institute on Ageing, 2022, p.8)—must recognize and address these major barriers.

### **Shared Housing Models**

**Finally, in describing potential future housing scenarios many participants shared ideas about seniors’ residences and shared housing models.** Some described a desire to live among other LGBTQI people in shared housing arrangements, while others expressed a desire to be near community, such as in a building or neighbourhood, but not to live communally. Throughout these conversations, participants described wanting independence, respect, and choice in where and how they would live, as well as assurance they would not face exclusion or maltreatment for being LGBTQI.

**Ideas surrounding shared housing models were often fueled by a desire to live in a caring and supportive community.** This included feeling connected to LGBTQI community and living in LGBTQI-focused housing arrangements. It also included a desire to live in mixed-demographic housing among like-minded people, a sentiment that has also been documented in other LGBTQ older adult housing research (Redden et al., 2021, p. 13-14).

One participant, a lesbian woman in her 70s living on the east coast, shared:

I think there could be sort of cooperative living, buildings more geared to LGBTQ people in a community environment. More like a massive sort of complex, as opposed to a nursing home type of thing. More individual units in more cooperative, inclusive, sort of living. People could depend on each other, as opposed to totally on the government. Interdependent.



Another lesbian woman in her 70s living in rural Quebec her hopes for living collectively among friends and like-minded others:

There's always the dream that we had... friends, because most friends my age aren't lesbians, they're either widows or alone. We always thought of having aging centers constructed, places we could live the way we want. Not institutions, like... sharing tasks, coming together... we have friends of all ages, from all kinds of fields, there are some who are managers, doctors, artists. Everyone has something to contribute. And that was the dream, to build ourselves a place where we could continue to live with the most autonomy and the most sharing of different things, like food, chores, laundry, all that.

**While some participants welcomed the idea of living in LGBTQI-specific or LGBTQI-friendly shared housing, others expressed strong hesitations.** This ambivalence reflects broader patterns of perspectives on the issue among LGBTQ older adults (e.g., Redden et al., 2021; Rosenberg et al., 2018). Some participants simply did not find the idea appealing, preferring to continue to live alone or with their partner. Others expressed significant concerns about being targeted. These were concerns borne of lived experience and ongoing histories of violence against LGBTQI, and that can be related to recent increases in Canada of hate crimes targeting sexual orientations (Statistics Canada, 2022b) and the rise in “anti-gender” movements.<sup>10</sup> Others expressed concern about being lumped together as a singular group and not having unique needs considered.

One lesbian woman in her 60s described how collective living did not appeal to her:

I know that people talk about, you know, ‘purple acres’, a gay guest home, or retirement communities. That's the last thing on earth that I'd want, to have to face people every day. I'd rather be at home with my partner. Some people

<sup>10</sup> To learn more about anti-gender movements see Equal Rights Coalition, 2022: <https://equalrightscoalition.org/documents/anti-gender-movement-background-paper/>. For more on police-reported crimes statistics on hate crimes targeting sexual orientation see Egale, 2021: <https://egale.ca/awareness/brief-on-police-reported-hate-crimes-2021/>.

really will not want gay retirement homes. And palliative care, it could be in the home.

Another participant, a lesbian woman in her 70s expressed safety concerns about LGBTQI-specific or “gay friendly” seniors’ homes. She noted that while there has been progress regarding LGBTQI inclusion, public opinion of the LGBTQI community varies and has recently shifted backwards:

A number of people have expressed in our different groups, “Oh, I want to live in a gay-friendly senior's home.” I immediately thought, I don't, because I don't want to be targeted. I would like to see it as sort of a place where they had gay-friendly people, and maybe on one floor you could have lesbians that didn't want to be with men, and don't want to be with straight people, you know... so that it's not like standing out with a pink triangle. Today, things are more up and down. We went through phases of feeling very afraid, and then we felt sort of safe, and now it's not as safe anymore...The environment is changing on us.

One trans woman in her 60s described her hesitancy towards LGBTQI seniors’ homes because of the unique differences and needs within LGBTQI communities. She worried the creation of LGBTQI-specific housing could lead to seeing the LGBTQI community as homogenous and an inability to recognize important differences:

I would still have a little bit of hesitancy. Because if I do want a situation like that, I'd rather have somebody that knows care of a transgender person than a gay person or lesbian or nonbinary person. Everybody has different needs and different ways of being looked after.

**Participants also discussed the challenges of successfully creating LGBTQI seniors’ homes or shared housing for older adults.** Notably, multiple participants from across Canada discussed how promises of the development of LGBTQI-specific housing for older adults rarely, if ever, seemed to come to fruition despite community efforts. Cost concerns were noted as the primary

barrier, along with political will, organizing capacity, and administrative hurdles. Property prices were also cited as a core barrier, and an explanation why so many queer housing projects have failed in the past. This problem was coupled with participants' concerns about making LGBTQI seniors' housing affordable and to avoid further marginalizing people who are not wealthy.

One participant, a lesbian woman living in Quebec, described her dream of creating home-based care, and the challenges she had faced in getting this idea off the ground:

I bought this house myself, I wanted to make it into a boarding house. I wanted to host people who don't have a home. I wanted to look out for them, to cook for them, to go with them to get government support. Home-based care. But you need papers for this, papers for that. There's always something wrong, the size, the height, a ton of things, and you have to arrange everything with the government [...] It's not easy, no matter how much I want to do it, but in some way, I need support to do it.

Another participant living in British Columbia discussed how given the failure of past initiatives, different alternative living models and home-based supports might be more viable despite current gaps:

None of the queer residential homes that we were promised [happened]. It was all a big thing, wasn't it, 10 years ago. We had Plum Living, Rainbow Coalition. [...] And they all got overtaken by property prices, at least here in BC. They couldn't afford to go through with it, so in the absence of queer residential care, aging in place becomes the more comfortable option. Alternative living models, co-ops, I think we need to be looking at that. I hope somebody is. And in-home support. Where are the queer organizations that are organizing, that I could call maybe when I'm 84 and I need help? Who can I call who's going to say here's the medical support, here's food delivery? It seems to me that it should be a growth industry.

Overall participants were in favour of expanded shared housing options, whether they saw shared housing or collective living as ideal options for themselves. Community, affordability, and ongoing autonomy were all positive associations that participants made. The idea of LGBTQI-friendly or specific seniors' homes elicited more mixed responses, highlighting an ongoing need to address anti-LGBTQI movements and discrimination in society at large.

## Recommendations

### Housing Policy:

- Recognize housing as a basic human right; prioritize housing for people to live in.
- Implement policy measures that restrict the purchase of housing as a form of investment, and that combat the financialization of real estate.
- Implement rent controls.
- Create more not-for-profit rental housing and expand units and eligibility for rent-geared-to-income options.
- Increase funding and eligibility for home modifications and retrofitting to increase accessibility, including ensuring 2SLGBTQI and diverse family and household units are recognized.

### Practice:

- Implement universal design principles in new housing designs.
- Rent to older people; rent to people with disabilities; rent to 2SLGBTQI people.
- Listen to 2SLGBTQI people's concerns about discrimination and harassment in the places where they live and implement measures that will address the roots of the problem.

### Collective Organizing:

- Find common cause—including intergenerational—in housing issues. Housing insecurity affects 2SLGBTQI people of all ages; it is critical to come together to advocate for measures and solutions to increase access to safe and affordable housing.
- Continue to explore and experiment with alternative housing models.

## Social Connection and Disconnection

Social connection emerged as an important theme in participants' lives. Participants had a wide range of social networks, from "family-centered" to "friend-centered" and "diverse" networks with extensive ties multiple communities (Antonucci et al., 2014; Kim et al., 2016). Many maintained ties to families of origin (or those families they were born into or raised as children), chosen families, and mixtures of the two. Friends and community emerged as important sources of social connections and support, as did participation in different activist and volunteer efforts, faith groups, and recreational activities.

The LGBTQI older adults we interviewed had also lost connections with family, friends, and community throughout their lives, including due to family members' rejection of their identities. Some described themselves as introverted and were content with less social time or fewer connections, while others wished they had greater social interactions and close ties. Unsurprisingly, the COVID-19 pandemic significantly impacted participants' social lives and surfaced underlying social dynamics and challenges. **In this section we focus on the connections and disconnections that participants shared were significant in their lives, and explore conversations related to dependability and support networks.**

### Connection: Friends and Family

We asked participants about their current social lives, what a fulfilling social life looked like for them, and what, if anything, they would change. Overall, having meaningful social connections with friends or family, a sense of community, and people to depend on proved to be important to participants' wellbeing. **Categorical lines between friends and families of "origin" or "choice" were blurred, with elements of relationships such as care, support, and companionship taking precedence.**

**Importantly, participants came out at different ages and stages in their lives, shaping their relationships with families, friends, and communities in distinct ways. In discussing their social and family lives, participants reflected on**

**coming out as a continuing process.** Participants also spoke about long-time friends they had made before they initially came out, who continued to be there for them.

For example, one lesbian now in her 60s described coming out again in her mid-50s:

It was really funny [...] all these people had only known me as either a married woman or a single mom, because I really had no social life at all...it's like having to come out with them it was really weird because I had already done that in my 20s and I had to do it all over again to a whole new bunch of people.

One lesbian woman in her 70s spoke about her two long-time friends who she had known prior to her coming out who, while no longer living nearby, remained important people in her life:

I have my friend who I met in high school in Jamaica. She lives in the States, she's still my closest friend. And [friend's name] who I met when I first came here, is still my closest friend. So they have seen me transition and go through, and they still remain my closest friends.

**The importance of friends and families of choice was reinforced by discussions of who was around and showing up in times of need.** Throughout their lives many participants had faced losses, health issues, and crises, including the loss of partners and spouses. These experiences showed them who they could depend on and illuminated the power of having close others around.<sup>11</sup> In discussing who they had to count on, participants also described the impact of aging on their close social networks.

One participant, a nonbinary lesbian in her 70s discussed her diagnosis with cancer and the support she has received:

---

<sup>11</sup> For more on the importance of social support networks and non-kin caregiving see Croghan et al., 2014; Ismail et al., 2019; Flanagan & Pang, 2022; Kittle et al., 2022).

I have some very good friends that have particularly been very, very supportive over the last [little while]. And I realize that having a really good social support system is so key. So even though I say to people, I get sick and tired of listening to myself talk, let alone answer myself, during the pandemic, I'm not isolated. I have lots of really nice friends, [I'm] so very fortunate.

One lesbian woman in her 60s discussed significant losses throughout her life, including of her late spouse. She spoke about the ways that people in her life showed up when her spouse was dying:

I'm very blessed with the friends that I have. I'm an only child. So I have always been of the feeling that my friends are my family [...] When [my spouse] got sick, it blew us away the number of people that came to us. She felt that most of these people were my friends, and when she ended up in the hospital towards the end, I put the call out because we really thought we were losing her that weekend, and she was absolutely blown away by the number of people. It was just a constant stream.

One participant in her 70s living alone in an urban area described that for her, being an older lesbian woman meant she felt more alone. In contrast to narratives focused on LGBTQI communities depending more heavily on families of choice and friends, in her eyes, being lesbian led to her leaning more on her family of origin, in this case her children:

It's a lot lonelier [aging as a lesbian woman]. You have fewer friends. Everybody disperses like gas... My basic living, my needs are met. But there's not been connectedness for me. My family is probably my biggest connection. One of my daughters I'm closest to and my other daughters are very good. And we see each other quite a bit, so I'm more connected [to them]. Maybe that's because I do have family, right? But if I didn't, I'd be all alone.

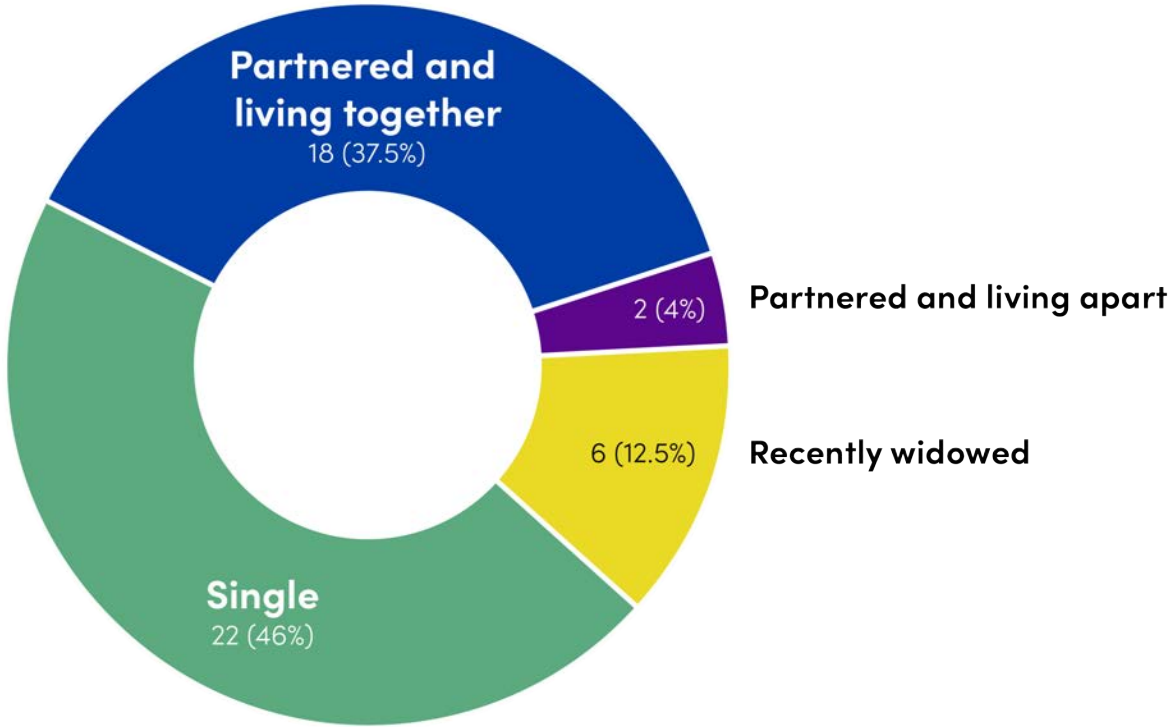
**Alongside friend and family connections, participants varied widely in their partnerships and romantic relationships.** As shown in Table 13, we spoke with



participants who were single, partnered and living together, partnered and living apart, and who were recently widowed.

Table 13: Partnership status

Partnership Status	
Single	22 (46%)
Partnered and living together	18 (37.5%)
Partnered and living apart	2 (4%)
Recently widowed	6 (12.5%)



A few participants were actively dating at the time of the interview, while others who were currently single discussed their thoughts about meeting someone again. Some were looking for long-term relationships, while others were content with casual dating. Alongside the possibilities for fun and companionship, participants also spoke explicitly about getting older and their concerns about being alone.

One participant, a widower in his 60s living in an urban area, spoke about his experience with dating:

I have a very special friend, who unfortunately doesn't live in [city] but he lives in [another city], and we go back and forth all the time. He is a widower as well [...] And I also have what I would call my sexual network. I don't have one person in particular right now that I'm involved with. But I do enjoy people coming over, we go for a walk, we have coffee. You know, and you're just talking about what's going on for you.

Another participant, a lesbian woman in her 70s, discussed the challenges of trying to find another partner post-divorce and in older age:

It was one of the hardest things [getting divorced] because I was then in my 60s. And it's not like I could start all over again and gain everything that I had gained to that point. That taught me one lesson. I haven't really had anyone permanent in my life again. I've lost a little trust, and I'm getting older [...] I find that a lot of people like myself who are single and older, I don't know, we just can't be bothered getting back into it again. It's just not the same.

Overall, care, support, and companionship were important aspects of relationships that participants described as significant to them, regardless of the specific type of relationship, or frequency of seeing one another. The relationships that participants had were diverse, and categorical markers of “family” or “friend” mattered much less than how people showed up for one another and were a source of connection familiarity.

### **Connection: Community and Organized Activities**

**In addition to close friends and family ties, connections to community and through organized activities were critical.** This included social connections related to LGBTQI identities, to other cultural and religious affiliations, and to activist, volunteer, and recreation interests.

**Involvement in community activism and volunteering were important for several participants.** Being activists and supporting activist efforts had been, and for some continued to be, personally and politically meaningful. This involvement led to connections with others who shared significant aspects of

their identities and experiences. Among those we spoke to, volunteer activities included working with older adults, being involved in research projects, and volunteering at their church, all contributions that provided participants a sense of purpose and community. Especially for participants who were more isolated, volunteering provided an important avenue to connect with other people, a fact highlighted when volunteer activities were suspended during the COVID-19 pandemic.

As one participant, a Black lesbian woman in her 70s, described:

Through my community activism I also made friends with a lot of younger, particularly in this case, Black folks, and a large number of them are gay. So my social life is made up of a range of age groups, a fair number of those are gay men and gay women who are all out and acting. In that sense I have a world that's fairly safe.

One widowed gay man who was living alone described the sense of purpose and connection he got from his volunteer work:

I don't have any living family around, and I'm pretty isolated. I'm retired from work. Prior to COVID, I filled some of my time with volunteer work, which I found very gratifying, but of course, with COVID now, that has been suspended for the time being. [...] I'm [volunteering] at the nursing home, I am pretty good at what I do, so I know that I'm helpful, and I know that I relate well with clients. And it's also an area where I meet other people like myself, because people like myself do tend to gravitate there. I can relate to people better within that structure, and then take it from there, possibly into a social situation.

**Participants also found social connection in organized activities and described the benefits of being able to access free or low-cost recreational activities and social groups.** This included groups organized around games, physical activity, and senior or LGBTQI social groups. Here, community centers were highlighted

as especially important hubs, as were online social groups that emerged during the pandemic.

One participant, a lesbian woman in her 70s, discussed her and her partner's engagement with a local seniors' center. She talked about how the activities they ran were important sources of social interaction for them both:

My partner plays cards. Right now, she plays cards every morning online so that's very good for her and she needs that, she has been doing that through the pandemic [...] I do other things. I'm a writer and do that sort of thing. And I'm also affiliated with the senior center. I attend there at least once a week, when everything is good, I belong to a scene. And that seems essential, absolutely essential, in both our lives. It's no charge, and we can be a part of [a scene]. If there was more of that, that would be wonderful.

One gay man in his 60s described his enjoyment in connecting with others over shared interests via a Pride-related community social media group:

There is a [social media] group which is run by a programmer in one of the local community centers [...] And I can relate to them better than I can to what they're doing at the community center. Because there's somebody for example who is an avid gardener, so we get to see lots of gardening, we talk about gay issues, and mainly in Canada in the US but also internationally. People reminisce about, you know, my favorite song from the disco era, there's all different kinds of topics going on.

**Finally, spirituality and religion were significant parts of some participants' lives and social connections.** While many participants told us that they had left religious communities or institutions earlier in their life, citing homophobia and other harmful experiences, some continued to take part in organized religious activities while navigating their multiple identities. Others found spiritual or religious communities for the first time later in life, communities which in terms of social life they described as supportive and a source of intergenerational connection.

One participant in his 80s spoke about navigating his life as a gay and Jewish man:

I do have two major [communities]. The gay network and the Jewish network. I'm lucky that way. And I think community in both senses are very important... Mind you I have to tell you something a bit strange, when I'm with the synagogue, I feel gay. With my gay friends, I feel Jewish [laughs] [...] I always feel a bit the odd one out. [...] I do feel comfortable with both of them, I'm just conscious of the point of difference.

One lesbian woman in her 70s described her church community as a main support, but also her caution and careful navigation of church spaces:

Right now, my supports are my church. I'm very involved in [my church] [...] For a long time up until a year ago nobody ever really knew me, and so suddenly, I decided, well—I actually met a woman who was there, she was older, and she says, “I don't care. I was corporate all my life. I'm going to be open right now” — and I said, well, gosh, we're friends. What am I gonna do? [laughs] I guess maybe I could be a bit open. And that's where I'm at now. I don't run around advertising it because I still have that internal fear. It'll never leave me, it was so deep. But I do work around that...

Another lesbian woman in her 70s spoke of her Buddhist community as one where she found intergenerational connection as well as a spiritual home:

For me, I began practicing Buddhism a few decades ago, with [an international organization]. And through that, there's people across Canada and several million around the world. And I consider that a very active social community for me. [...] I'm the really reaching out, socially connected person within the organization, and I would say it's through that group that I have many more intergenerational connections.

In sum, participants found connections in a variety of ways. Community centers and the seniors' and LGBTQI programming they offered emerged as

especially important. The structure of volunteering and connections created through organized community and spiritual and religious groups were also important for many, as they found purpose and support from others with common interests. While the COVID-19 pandemic closed off many opportunities for socializing, it also highlighted the importance of different social activities to participants and opened the doors to new online opportunities.

## **Finding People to Depend On**

**Participants also discussed who they could count on for intensive care and support, beyond more casual social connection.** They discussed who they could depend on, and for which type of support they required, experiences that varied greatly and were shaped by a range of interpersonal, social, and structural factors. They also discussed the challenges in finding people to receive support from and depend on with age. Importantly, having acquaintances or people to socialize with was an entirely different matter from identifying others who could be called on in times of need (see also Pang et al., 2019).

**Friends and family members were among the close others who showed up for some participants in times of need and who, conversely, were missed when they were not around.** This included for emotional support, and practical matters such as transportation to and from appointments, an issue especially for people who lived alone and/or in rural areas. When close others were not available, participants had to seek other sources of support.

One lesbian woman in her 60s living alone in a rural area described the difficulties she faced post-surgery:

I had dental surgery. And they are specialists because it was an implant [...] And I said, just get an anesthesiologist to put me out. So they did, but I needed to have someone to pick me up. And again, that becomes a struggle, especially because my best friend who was in [nearby city], couldn't come over. And my other friend was limited in her circle. Finally, somebody did come forward, so I stayed at his place.

One participant, a gay/queer man in his 60s described his experience with determining who he could and could not depend on:

Family ties are no longer as strong after your parents are gone. That's a bit sad but I accept it. Because my family is also here in [this city] [...] My found family: good friends, people who you can talk to about real things, who you can open up to...So that's comforting to see. And it's never a problem because I'm very active in the Francophone community, the LGBTQ community and all sorts of festivals where you see the same volunteers from one festival to the next. So making friends isn't a problem. But there are friends and there are acquaintances, and when I use the word "friends," I mean friends you can confide in and trust – if you have a problem, you know who you can reach out to, who'll come to your rescue.

**Participants discussed how asking for help from friends and family was difficult, especially when they wished to maintain autonomy and not trouble others.**

One lesbian woman in her 70s who described counting on her younger partner but not wanting to burden her:

I count on her more, but it bothers me to count on her. I'd like to find other ways to make it easier for her... it's her who does the gardening, shovels snow in the winter, brings the wood in, all those chores. And so finding someone, because we could pay someone to help do those things, that's what I'm always looking for.

Another participant, a lesbian woman in her 70s, reflected on appreciating her daughter's presence in her life but not wanting to depend on her too much for care and support:

I don't want to be always asking her to be there. [...] This is really important: it's one thing as a senior lesbian to access various health care services, various mobility services, that's all well and good. But so often senior people

are put in the position of asking their family for this, their family for that. And it really chips away at your sense of self, it chips away at your pride as a parent, as a grandparent. It is demeaning to always be the one asking, so if there is a service that can do things for us it gives us a sense of pride. Dignity is something that's hard to come by. That's hard.

**Participants also pointed to the challenges of relying on friends and family who were similar in age, due to them having similar care needs and ability limitations. These concerns illuminated the importance of intergenerational connections and wide support networks.** Participants discussed the need for access to more professional support. They also stressed the importance of having relationships with younger people. Importantly, relationships between older and younger generations are not unidirectional, pointing to the mutual benefits and opportunities fostering intergenerational connections can provide in communities.<sup>12</sup>

One lesbian woman in her 70s reflected on the situations of her aging peers and the supports, or lack thereof, available in her rural community:

Our friends, we're all aging at the same time, so everyone needs their circle of resource people. But here in the country, I don't think there's much. We have a municipality that isn't very rich. There are organizations for the elderly that do several things, but I don't think it'll be in the community that I'll find [support]. Close by we have a couple that we've known since we've been here that help us, a friend comes to clean every two weeks [...] But the others are aging too.

One lesbian woman in her 60s emphasized the importance of having a network of people of different ages, and, implicitly, abilities:

---

12 For recent examples of LGBTQI+ intergenerational community-building programs in Canada see Robson et al., 2018 (on raising awareness and addressing elder abuse through community-based participatory arts); Bain et al., 2021 (The Youth/Elder Podcast: <https://buddiesinbadtimes.com/show/the-youth-elders-podcast/>).



Amongst my circle of friends there's quite an age range, and so I think that it's important to know younger people well [...] You can't do it with a bunch of eighty-year-olds, there's got to be a cross section.

Another lesbian woman in her 60s living in an urban area the intentional intergenerational she had built, and how it was important for her to be there for younger community members:

Ever since I came out, unconsciously and now, consciously, I've been building a foundation of having younger people around me who will support me as I'm aging. For me it's reciprocal because I want to be there for them. And I keep pointing out to queer seniors who say "Oh, they don't know how easy they have it, we went through all of this" and I'm saying to them, every single one of my queer young friends is working at least three jobs. They are all sharing housing with at least three roommates, they're all living on contracts, they will never have full time jobs, they will never be able to own a home, none of them were born in [the city] they all come from outside of [the province or city] because they had to flee their families and their provinces to find safety. So, for me it's important that I'm there for them.

In all, participants pointed to a range of issues regarding having dependable support. The distinctions between a close friend and an acquaintance, and between having friends and then having people who were able to help at a moment's notice emerged as especially significant, illustrating how having friends, family, or close community is not necessarily the same thing as having consistent support. Similarly, while family, friends, and intergenerational connections were also described as important, access to professional support was also described as critical.

## Disconnection: Rejection and Loss

Participants also shared experiences of feeling isolated and disconnected from others around them. Some of these experiences stemmed from rejection from families of origin and other significant others, as well as from loss.

**Participants shared stories of coming out to their families and loved ones early and later in life, and the rejection that they faced.** These experiences varied widely and were also influenced by the age at which participants initially came out. While not all coming out experiences were negative, many did face rejection or backlash in ways that continued to affect them.

One lesbian woman in her 70s who was living alone described the rejection she faced from her family, and how she learned to depend on herself:

I don't have any family to speak of. None at all. I can only count on me, myself, and I. So that's some of what I'm going through. I've always made do alone. Since age 11, I knew that I couldn't count on my family. They were never there for me, even less since they found out I had a different orientation [...] But I'm happy I did it, because that's what I went through and I've been successful at it, and I still manage to be happy today.

Another lesbian woman in her 70s who had been in a heterosexual marriage before meeting her current long-term partner she spoke about the mixed reaction she received when she came out. She described the social rejection from friends and family, including her children:

My daughter, in the initial stages [of finding out her mother had fallen in love with another woman], refused to let me see my grandchildren. [...] They were just, they were embarrassed, and there were all sorts of negative things. They were very angry.

**Long-standing experiences of homophobia, transphobia, and related discrimination impacted many participants' trust and distrust of others, and how they navigated their social lives and relationships.** Many participants

spoke about how public attitudes towards LGBTQI today are largely different than before, but also noted that discrimination against LGBTQI people continues.

One participant was a lesbian woman in her 70s who came out in her 30s. She described the homophobia she had faced from people at her work and church, and how these experiences and consequent need to hide her identity continued to affect her in the present day:

It's why I sort of grew into a person that has a great big shield over me. And it's very hard to get rid of...You see I came from the older time of coming out, right? When it wasn't safe. People would yell at you on the street, if they even thought you were a lesbian. And so you often found your home when you were with your lesbian friends, that was the only time you felt safe.

Another participant, a lesbian bi woman in her 60s spoke about wanting to feel free to be herself without the need to hide parts of her identity:

Eventually I'd like to live in a supportive community where there's more gay people. For the majority of my life, since I was 16 years of age, I had to hide. When I was with my partner I finally said, you know what, I'm not hiding anymore. That's it, I've had enough. But I have to still be very careful, because who knows what kind of crazies there are out there. Maybe that's my mindset from you know when I grew up.

**Some participants also discussed the impact the HIV/AIDS epidemic on the LGBTQI community, and the losses they experienced.** This generation of LGBTQI people particularly had experienced a great collective loss, with mass deaths due to HIV/AIDS and lack of response to the crisis. This loss impacted who people had around in older age, as many of the friends and partners they may have grown old with had died.<sup>13</sup>

---

13 To learn more about the histories and legacies of the HIV/AIDS and activism in Canada see Hindmarch & Orsini, 2018; CATIE, 2020; and the work of the AIDS Activist History Project: <https://aidsactivisthistory.ca/> including Kinsman, 2020. For more on social aspects of HIV/AIDS and aging see Roger et al., 2013; Solomon et al., 2013. See also the work of realize on HIV and aging: <https://www.realizecanada.org/our-work/hiv-and-aging/> and The Pan-Canadian Research Agenda on HIV, Aging & Older Adulthood (Murzin et al., 2022).

In speaking about housing plans one gay/queer man in his 60s reflected on the height of the crisis, and the distinction of living into old age:

We lost a lot of people who are braver than me and could have contributed a lot more. That's important to remember during Pride too that, there's all sorts of people that aren't here, that should be here. That could be here.

Another participant also in his 60s shared:

In the 70s I would have known 200 guys as friends, casually, or as better friends. Now maybe six. They're gone, they're dead because of AIDS. A huge number of people died in Vancouver. I don't think they will ever tell us the truth, never, nobody knows the tens of thousands....

As participants' experiences made clear, rejection from loved ones had a lasting impact. So too did experiences of discrimination, and the distrust and feelings of unsafety that continued to resonate. The impacts of loss varied by participant, but often posed challenges for older adults in managing grief, change, and finding people to depend on. We further discuss loss and grief support in the [Healthcare Access](#) section.

### **Disconnection: Social Exclusion**

Participants also faced social exclusion from those around and from communities they were part of. **Here we highlight what participants articulated about social exclusion as it relates to ageism, ableism, and racist discrimination within LGBTQI communities, as well as experiences trying to integrate into new communities.**

**Ageism and ableism emerged as key reasons why some participants did not feel welcome in LGBTQI communities.** Some participants described how they felt they were often overlooked because ageism leads people to believe older LGBTQI people do not “count” and that older adults are no longer “sexual beings” and therefore count less. Others described a sense of community abandonment and not being valued. The greater public visibility given to youth,

a lack of measures to make social spaces more physically accessible, and patronizing in older adult social programming were all cited as manifestation of ageism and ableism that participants encountered.

One lesbian woman in her 60s, for example, shared:

I think there's a lot of ageism even within the LGBT community, so it's difficult. I often think of the little saying, "If a tree falls in the forest, and there's no one there to hear it, did it make any sound?" And that's kind of the way I feel about my life. I guess it doesn't really matter. And my personal history doesn't really matter [...] There are not many pushy, older gay people, and we run out of steam. And there's a lot of ageism. So you're kind of pushed out, because you're not cool anymore.

One lesbian and genderqueer person in her 70s discussed patronizing attitudes in the community, and the greater focus on youth:

We need more respect for the wisdom of queer elders and the history of queer elders. And by respect, it pisses me off that when there is respect it's done in such a cheesy way [...] Even [community center with queer programming], I support their work but the activities they put on for seniors, it's like quiz night, trivia night. I mean, come on. And the same with youth. I have to say that a lot of queer youth groups, it's like eat pizza, doesn't matter if you show up, and when you do show up, reinscribe your stories of oppression. [...] I think another thing is better visibility within the queer community for elders, because we don't have a great track record. We've been traditionally dominated by the white 25- to 35-year-old guys.

### **Participants also described the challenges of integrating into existing social networks upon moving to new areas.**

One participant, a gay man in his 70s, moved to a new province in his 60s. He described that while there were several gay groups in the city, he found it challenging to make connections:

It takes a while....and especially when you come into it later in life where people have already formed their small groups. It's a little bit more difficult [...] Having come here relatively recently, I was meeting with a group this morning, and in fact there were two of us out of 12 who did not grow up in the area.

Another participant, a lesbian woman in her 60s described the challenges she and her partner faced finding new friends while navigating changes mobility limitations:

We've had a little bit of trouble making close friends, but we also find that people's dance cards are full. People have these long-standing relationships already, there are strong chosen family circles here in this town [...] It's been challenging because we've had multiple surgeries between us since we've arrived here: hip, knee, knee and two broken wrists. So we've been a little less able-bodied than is "normal" for us. There's also a whole crowd of women who go hiking, but we can't keep up. They're more like 45 to 55, and they're more active and more able bodied than we are so we're kind of stuck in between, in terms of social circles.

**Finally, past and present experiences of racism significantly impacted senses of safety and belonging among racialized participants.** Multiple participants discussed racism in LGBTQI communities and spoke about general racial inequities that could be seen in socio-economic status, level of financial security, and past experiences in workplaces. Participants also related the impact of racism on their lives, including racial "Othering" that they first experienced upon migrating to Canada.

One participant, a queer dyke of mixed descent, reflected on being brought to Canada from the Caribbean as a teenager. She described the challenges of this experience, including culture shock and racism she experienced:

Moving to this country where everybody was white, and back in the 1970s, if you were not white you were Black. It was that simple. So being called names that I wasn't used to, I didn't even know what racism meant, because coming from [Caribbean country], which was the most cosmopolitan, that was the word that was used back then. [Caribbean country] was and still is probably the most racially diverse country in the world. So I was used to being around people who are multiracial. Coming here was really difficult.

Another participant in her 60s described the racism she faced on the basis of her name:

There's a lot of racism in gay communities. We know this. Right? And for example, in Vancouver, it was very bad. I don't have an English name, so... I wasn't included in a lot of lesbian things [...] We have to talk about exclusion and racism in the gay community.

While LGBTQI community was important for many participants, the exclusions that participants faced, especially among people of colour and living with different disabilities, were significant. Ageism, ableism, racism, and other intersecting and compounding forms of discrimination must continue to be challenged and addressed in any efforts to create safer community spaces.

## **COVID-19 Pandemic**

**The COVID-19 pandemic had a clear impact on the social lives and wellbeing of the LGBTQI older adults we interviewed.** Interviews with participants illustrated the harsh impact COVID-19 had on many, including loss of social connections and mental and emotional challenges, findings resonant with other research and commentaries on the impact of the pandemic on older adults (e.g., Savage et al., 2021; Sepúlveda-Loyola et al., 2020; Wister et al., 2021), and on 2SLGBTQI+ communities (e.g., Egale & Innovative Research Group, 2020; Egale et al., 2020; Fields et al., 2021; Kia et al., 2022). At the time of the interviews (summer 2021) participants had been through months of fluctuating pandemic lockdown and social distancing safety measures, and the impacts of being separated from close others and from social activities were keenly felt. Here we

highlight some of these impacts, as well as forms of connection via technology that benefited older adults during this time.

**Participants with active and less busy social lives alike described feeling alone during the pandemic.** The temporary cancellation of organized social activities affected many participants, as did the inability to be close to friends and family.

One participant, a gay man in his 70s, described:

I'm retired from work. Prior to COVID, I filled some of my time with volunteer work, which I found very gratifying, but of course, with COVID now, that has been suspended for the time being. I think in the past year, or a little more since COVID, I really feel age coming on.

One participant, a gay man in his 60s who lived with a partner expressed simply:

I have a wide circle of friends and stuff and then COVID hit, and there's nobody.

Another man in his 60s who lived alone put it similarly bluntly:

I'm alone. And during COVID, it's kind of a different quality of alone-ness.

**The pandemic posed additional challenges for those grieving, as people were largely isolated during a time that often calls for increased social support.**

One participant, a queer lesbian participant in her 70s had recently lost her partner. Though she had a strong social support network in her city, the isolation COVID-19 caused made her grieving more difficult:

My partner died of cancer a year and a half ago, so I'm calling myself a COVID widow. I think for those of us who lost a long-term partner, we were together [over three decades], and it's brutal, I mean, taking care of somebody with terminal cancer ain't a walk in the park. And to go straight from her death pretty much into the isolation of being a single woman during COVID. It's been an education.



**In light of the difficulties the pandemic posed, participants also described a host of ways in which they coped.** This included the community support networks that people maintained and created, and the “bubbles” that they formed with close others.

One lesbian woman in her 70s who had lost her partner several years ago discussed how her friends looked after each other throughout the pandemic, and the importance of maintaining social connection especially as someone who was single and living alone:

We support each other. During COVID, with phone calls [...] At least with a couple they had each other. And of course, on many days that could be good or bad, but nevertheless, they did have somebody. One couple were really good to me. They really understood how lonely I could have been without my partner with me during COVID. Lots of my friends kept in touch.

One lesbian woman in her 60s described forming a bubble with neighbours in the building where she lived, an example of community solidarity as well as intricate navigating of collective health and wellbeing during the pandemic:

There are quite a few queer people in our building. We also had our bubble during COVID. So that's our little community within the building. [...] We checked on each other because there's the older folks involved, and our other neighbour has back issues, and so on and so forth. But we keep a constant check on each other and meet for dinner, or hockey games [laughs].

**Finally, technology came up as a key topic of discussion regarding the pandemic and social dis/connection.** For many, technology (the Internet, computer access, and cell phones) helped them to maintain social connection and support during the pandemic (as described in the [Social Connection: Community and Organized Activities](#) section above). Others expressed reservations about reliance on technology, arguing that technology could never replace in-person connections and expressing their preference for in-person meetings and real physical contact. They also noted the issue of accessibility,

and how relying on technology could ease access for some but be a limitation for others.<sup>14</sup>

One gay man in his 60s living alone shared his concerns about technology and the divide between users in ability to adopt new technologies:

My biggest, biggest concern is that everything is getting pushed over to technology now. And there are lots of people who do not use technology, who are not comfortable using technology. And I think there are still lots who don't use it at all [...] I know that [local group] has been having business meetings and they're using Zoom, and they had to have a whole barrage of workshops on how to use Zoom because people might have a laptop, but they don't know how it works, they don't know how to install the application, they don't know what buttons to push and all that kind of thing. And it's really part of the whole issue about the divide between the people who are aware of it and who use it comfortably to those who have no idea, and who are totally like inept. I think it's getting wider and wider, and I find it very concerning.

One lesbian woman in her 60s described her use of online platforms during the pandemic, but her preference for being physically close to others:

We did a bunch of Zoom calls. I didn't see anybody for months, physically. It was, for me, I'm a hugger, and this has been the hardest 16 months of my life, not being able to physically hug my friends and my family. That was the hardest, was the separation.

The COVID-19 pandemic caused widespread change and disruptions with stark impacts on the social lives of older adults. Separations from close others, communities, and regular activities impacted their wellbeing, and highlighted the importance of these connections and pursuits. While technology emerged as a way for people to stay in touch, it was largely seen as supplementary to participant's lives, rather than a replacement for in-person contact.

<sup>14</sup> For more on older adults' use of digital technology during the COVID-19 pandemic, its benefits, and digital exclusion, see, e.g., Seifert et al., 2020; Hasse et al., 2021; Sixsmith et al., 2022).

## Recommendations

### Create safer, more welcoming, and more accessible community spaces:

- Direct resources to 2SLGBTQI-led community groups to create social programming that is accessible and inclusive of older adults, including intergenerational programming.
- In designing 2SLGBTQI older adult specific social programming ask participants what they would like to do and how they would like to engage; be mindful of using infantilizing or paternalistic language or approaches.
- Prioritize making events and event venues accessible, including measures to increase physical accessibility.
- When exploring online programming options, consider how online options will increase accessibility for some (e.g., reducing costs of transportation, dependent care) while reducing accessibility for others (e.g., people without access to the Internet, needed technologies, digital literacy) and strategize around the best ways to reduce barriers and serve diverse communities.

### Combat discrimination and social exclusion:

- Continue and increase efforts to combat racism and other forms of discrimination that impact 2SLGBTQI people, including within 2SLGBTQI communities.
- Continue and increase efforts to recognize and address ageism and ableism as they directly affect LGBTQI older adults and people of all ages.

### Provide needed community-based supports:

- Increase funding and eligibility for community-based supports, including personal support work and transportation programs.
- Increase funding and eligibility for shorter-term and long-term services that can assist older adults and people living with disabilities with tasks such as grocery shopping and housework.

## Healthcare Access

The LGBTQI older adults we interviewed described a host of experiences related to accessing, or trying to access, healthcare services. They described their struggles in finding care providers and navigating healthcare systems, disclosure-related decisions, and healthcare encounters that had gone well or could be significantly improved. Participants' reflections spanned experiences with primary care, mental healthcare, and specialist care, while they also related concerns about home care and living in long-term care institutions (an area more commonly documented in existing research, e.g., Grigorovich, 2015; Furlotte et al., 2016; Kortés-Miller et al., 2018; Pang, 2022).

Participants had varying healthcare needs and lived with a range of chronic conditions including arthritis, cancer, depression, HIV, and respiratory illnesses for which they sought care. They also had a range of perspectives on health and wellbeing, and what they needed to live well including and beyond health-related considerations. We begin by exploring these perspectives, and then discuss healthcare access and navigation issues across care domains.

### Perspectives on Health and Wellbeing

In the interviews we asked participants to define what “wellbeing” was for them. In response, participants shared a range of reflections, connecting wellbeing to being able to meet a range of basic needs and finding self-acceptance, a sense of purpose, and fulfilling social connections.

**Notably, while some participants linked wellbeing to health-related considerations, most conceptualized wellbeing without health considerations as the central factor.**

For instance, one lesbian woman in her 60s spoke about a sense of peace, and how good health and wellbeing are not necessarily related:

I would say a sense of peace [...] you can still have wellbeing, even if you don't have good health. I mean, ideally, being out, being active. I was a marathoner and stuff. Can't do that so much anymore but I can still get out. I think wellbeing [is] having balance in all the areas of your life, social, emotional, spiritual, mental.

Also separating health and wellbeing, one gay man in his 60s reflected on managing multiple chronic health conditions, as well his perspective that wellbeing is “more of a mental construct” that is influenced by factors such as access to social connections.

**Participants also emphasized the impact of cost-of-living on wellbeing and discussed dynamics of privilege and disadvantage.** For some, wellbeing was closely tied to housing affordability and food security, while others extended their reflections to discussions of class and privilege.

As one Black lesbian woman in her 70s shared:

Wellbeing for me, it starts with the basic Maslow's hierarchical needs [...] My housing is secure, my income is secure. If you're old and don't have that, then I think you become more insecure because then you are dependent [...] If you're white, middle, upper-class, you have a different life experience. And I think that continues right into old age. If you're lesbian or gay, and you're white, and highly educated, that's one experience. If you're a poor immigrant visible minority gay and lesbian that's a different experience. So for me, class makes a difference in aging. Colour makes a difference, but class particularly makes a difference.

These points about race, class, and privilege are critical to understanding how differently positioned LGBTQI older adults experience and navigate aging. This includes how people may or may not have access to the resources to “live well”, as they define it.

## Finding and Accessing Good Care: Disclosure and Seeking Affirming Care

**Participants spoke at length about seeking affirming care,<sup>15</sup> and about their disclosure practices when seeking healthcare.** Their experiences with healthcare were shaped by a host of factors, including gender identity and expression, past experiences, and regional practitioner shortages. Depending on their situation, privileges, and sense of empowerment, participants also adopted numerous strategies to negotiate care encounters. The idea of “good care” captures participants’ sentiment that given so many barriers, attaining “good enough” care was still a major focus for them.

**Participants described many negative experiences with providers, and the great importance they placed on receiving affirming care.** Negative experiences ranged from providers refusing to recognize their relationships or to touch them, and general silence around the topic of sexuality or relationships even when relevant to care. The importance of recognizing partners and significant others, of being comfortable talking about sexuality, gender, and relationships where relevant to clinical care, and of being generally open and explicitly LGBTQI-friendly were all stressed as important traits and practices that healthcare providers should have.

One participant, a genderqueer woman in her 70s described a specific instance of cis-heterosexism and hostility she and her partner faced:

We encountered it before my partner's surgery, a nurse was actually quite hostile. She was actually okay when she thought I was a man. She was fine. I got really good service when she thought I was male, and then when she realized I was female, she was hostile. She was rude, dismissive, abrupt, unpleasant.

One woman in her 70s contrasted her experience of having a gay-friendly doctor with a doctor who would not physically touch her:

---

<sup>15</sup> By “affirming care” we mean care that recognizes and respects people’s gender identities, gender expressions, sexual orientations, and relationships.

The doctor I go to now? We don't know if she's gay-friendly or not. She's never touched my body and I've been with her like three or four years. [...] It's scary. She sits over there with her computer, and I'm over here. I haven't told her I'm gay, because I'm afraid she'd run out the door [...] I had a doctor before that for about 20 or so years. She was wonderful. She wasn't gay, but she was gay-friendly. And we would talk about everything about health[...] with this other doctor, I keep everything to myself. And I just hate it if I have to go see her.

Importantly, participants could not always point to a specific instance of discrimination but described the “sense” that something was off or that the relational dynamic had become more judgmental after, for example, disclosing one’s identity. **Navigating covert homophobia proved difficult to address because of the inability to point to anything explicit and the knowledge that providers “knew better” than to outright say something homophobic.**

**In light of this, participants described how they sought out care providers who seemed comfortable or experienced working with LGBTQI clients, including LGBTQI-identified professionals where possible.** Many described trying to find a new care provider through informal or formal networks via LGBTQI friends and/or LGBTQI-specific services. Others also described strategies to assess whether a health professional or practice would be LGBTQI-friendly prior to going to their services. Losing trusted care providers was a blow.

One participant, a lesbian woman in her 60s, shared:

I always research. I don't put myself in that kind of position, so I knew who I was going to go to. Having a gay flag is, you know, it's a good move [but] I mean, I don't trust the gay flags; [they] are just everywhere. And that's nice and everything, but I'm not too sure about what kind of sensitivity training people have been given in mainstream health.

Another participant, a racialized trans man in his 60s lost his trusted doctor when he moved, a significant loss especially because he was both gay and knowledgeable and affirming in trans healthcare:

I miss my doctor in [province], he was a gay [immigrant and racialized] man...He is very trans friendly, he has a lot of trans clients... he's a lovely guy. Anyway, I miss him because I had him for 17 years as my doctor. I have a family physician. He's not LGBT but he knows I'm trans because I told him, he has no problem with that. But it's not the same when your doctor is not LGBT. It's okay, but it's not the same.

**Closely related to seeking affirming care, disclosure—or what to share with healthcare providers about one’s sexuality and/or gender identity—emerged as a weighty topic across interviews.** Disclosure practices were complex and blunt. Many participants were selective in disclosure, only addressing their identity when they viewed it as relevant to their care. Some treaded carefully, afraid from experience that they would be treated badly because of their expression, identity, or relationships. Several participants told us that the topic of sexual and/or gender identity often “just didn’t come up.” Others, regardless of past negative experiences, had decided to be immediately forthcoming about their identities, citing that they were at a stage and place in life where they had been through adversity and that at least some level of recognition and acceptance was non-negotiable.

One participant in her 70s described how she does not discuss her lesbian identity with her doctor, despite her doctor knowing she lives with another woman.

I didn't actually say the words, we've never actually discussed it. He knows that I live with her and she lives me...It's something that we don't talk about [...] I'm sorry that he's uncomfortable. I'm not okay with that. But it's not for me to change him.



Another participant, a trans woman in her 60s, described her approach to disclosure as direct and emphasized the respect she should be accorded:

If I tell somebody I'm trans, I'm just letting them know I'm trans, and I expect to be treated a certain way. Now if you're going to treat me like a male, then the conversation just ended. So goodbye, I'm leaving the office, or I'm ending the Zoom call, or I'm ending the telephone call, and if you're asking me why, I'm ending it. [...] I expect this kind of response to where I am as a senior, to be treated this way, not that way.

Finally, as one participant, a lesbian queer woman in her 70s, summed up:

You spend your life battling for gay rights and battling sexism and battling homophobia and transphobia, and when you get older, you just want a break. It would be nice just not to have to do it, and I think that's what most of my elderly friends who've been through the healthcare system will say. We're done with having to educate everybody. We're used to it, and we're good at it, but it would be nice if it stopped at some point. [...] It's a lot of emotional work at a time when you don't really need it.

**Importantly, always alongside descriptions of positive and negative experiences was participants' knowledge that, regardless of the reception they got, there may not be alternatives in their region given shortages of medical professionals, including primary care physicians.** Participants described long wait times to get a family doctor and region-specific shortages. These were issues that transcended identity but were also compounded by concerns about facing homophobia, transphobia, and other prejudices, and the anticipatory exhaustion of having to navigate disclosure and safety in accessing healthcare.

One participant, a gay man who had moved from Ontario to rural Nova Scotia described his situation finding a new doctor and psychiatrist:

Well, Nova Scotia is in worse condition than Ontario. We did get a doctor. There was a five to six year wait, but I managed to pull some strings and get

it. We both try very hard to access mental health support, but there isn't a lot. I did the paperwork before I left Ontario. I had a psychiatrist there, and she sent it over here, and I am just now getting an initial interview tomorrow with a psychiatrist, so it's been four years, but it was due to my digging and my work.

Another participant, a lesbian woman in her 70s living in rural Quebec reflected on inter-provincial differences in pay and working conditions for care providers and the shortages this caused:

The obstacle I have is that I live in the Ottawa River area... Because we're on the other side of the river, and our nurses go to work in Ontario because it pays better. Doctors don't want to come here because resources are lacking. We're really an abandoned region of Quebec and Ottawa, in every way. When I had my knee problem, it took two years for them to find me a doctor.

While affirming care was a priority across participants, questions about whether to disclose, what to disclose, and how to do so were common conundrums. Especially with shortages in primary care physicians, most participants took who they could get. The toll this constant navigation had was not lost on them, nor was the irony that after a lifetime of negotiating systems and fighting for change, these challenges continued.

### **Finding and Accessing Good Care: Rural Access and Cost**

**Access to care in rural areas and out-of-pocket costs for a range of healthcare services emerged as two additional barriers, evidencing how Canada's "universal" healthcare is currently insufficient in meeting the needs of LGBTQI older adults.** Participants highlighted an urgent need for more comprehensive coverage of services currently not fully covered under provincial healthcare, and increased access to services in rural areas.

**Transportation, primary care physician shortages, and access to specialists were top among the specific healthcare access challenge described by those living in rural areas.** These were all entangled issues, as having to drive

long distances to access specialist care that was not available in smaller communities, for example, was a major point of concern. Here, access to a private vehicle and the ability to drive long distances emerged as a key point of privilege as well as concern. Notably, concerns surrounding transportation were also shared by participants living in urban areas, highlighting the overarching need to address transportation as a key accessibility priority.<sup>16</sup>

For instance, one participant, a lesbian woman in her 60s living in rural Ontario discussed her ability to drive as critical to accessing primary and specialist care:

I have to be able to drive, that's one of the most important things for me. If I lose that ability then I have to move to the city, which I won't be happy about. [...] Right now, I'm going to physiotherapy, because I have a knee that has no cushioning in it. So I'm trying to build that up and avoid surgery. If I had my knee done, who's going to take care of me? Who's going to help me in my house? Those are the issues that are really important for me. I have to travel 49 kilometers to my doctor, so I have to go to Toronto. I have to go to a mammogram; I have to come to Toronto. Today, I had to go to physiotherapy. That program is not offered anywhere in my community, so I have to come up to Toronto.

Another participant, a lesbian woman in her 70s living in rural Ontario highlighted the range of challenges that people living in rural areas face in accessing a range of specialists, and believed her small community would benefit from more mental health services for the elderly provided by specialists who remained in the area rather than doing locums.

**Cost was another major barrier associated with access to care, cutting across rural and urban divisions and concerning participants across income brackets.**

Dental care, mental health care, physiotherapy, vision care, dermatology, and prescription drugs were all listed as high-cost areas in need of more comprehensive coverage. Many participants further noted that aging is often associated with increased healthcare needs and subsequently costs.

<sup>16</sup> For more on transportation and care access in Canada see, e.g., Young et al., 2019; Alhassan et al., 2021; Mirza & Hulko, 2022.

Participants explained cost was a prohibitive factor in accessing necessary care and treatment, impacting their health and wellbeing in various ways.

One participant, a queer dyke of mixed descent, described losing her disability-related supports when she turned 65 and the nearly un-meetable cost of a \$3000 root canal:

When you turn 65, we call it “the miracle of 65”, your disability just disappears [...] So I lost my private disability income, and I lost my CPP disability and then you move on to regular CPP and OAS. I went from living on \$2,000 a month to \$1500 a month. So now I'm barely surviving. I have had to vamp up my private work for that shortfall of \$6,000 a year. So, I'm living precariously. [...] I had an emergency root canal [earlier this year] that was \$3,000, and I'm thinking ‘where am I going to get \$3,000’? And a friend stepped in and said I'll help you with half, and then [company] gave me a short contract, and there was the other \$1500.

Another participant, a lesbian dyke in her 60s, described trying to access physiotherapy and massage services after sustaining injuries, and how she was fortunate to be able to pay for the associated costs through savings and private insurance:

I broke my dominant wrist a year and a half ago [...] I also broke my shoulder and got a rotator cuff injury, and I developed an unexpected immune response to the trauma, and I'm still recovering. So, I have paid a lot of money, which would have been a real problem if I didn't have the money to spend on a particular specialty within physiotherapy [...] But I also fell off a stepladder, and I tore a ligament in my knee, and after six years of it worsening and becoming more unstable [...] [I finally found a surgeon] but I had to wait, because everyone has to wait, this wasn't a joint replacement, it was a reconstruction of a ligament. Then I had to have physio. I pay \$200 a month for Greenshield health insurance, but they only pay \$300 a year for these various services. [Y]ou need money for all those services, and if you

don't have money to pay for them, then you don't get them, wherever you live.

Across the board, access to primary and specialist care was much more limited for participants living in rural areas. Accessing needed healthcare could mean having to travel to the nearest city, introducing transportation barriers and additional costs. Besides this, participants living in rural and urban areas across the country described the major impact that out-of-pocket healthcare expenses had on their health and wellbeing. Having to pay for services—either fully, or in part— meant that participants without adequate financial resources had to compromise on their care. Whether primary care or specialist services, cost-related barriers impacted not only physical and mental health but also participants' sense of being recognized, supported, and secure in older age, and highlighted the major inequities that privatization of care can create and exacerbate.

### **Mental Healthcare & Grief Support**

The need for improved access to mental healthcare and addictions support was a clear theme among participants. **Reflections highlighted the need for greater access to mental healthcare services for older adults generally, while also illuminating specific mental healthcare needs of older LGBTQI community members.**

**Cost-related barriers to accessing mental healthcare services were significant and discussed by many participants.** Cost determined if someone could access mental health care and determined the types of mental health professional one could see. Some participants talked about how they had found a professional they connected with but had to stop seeing them because their coverage had run out. This was especially frustrating given the challenges in finding LGBTQI-friendly providers to begin with.

One participant, a racialized trans man in his 60s spoke about the difficulty he had in finding a mental healthcare provider whose services were covered

under provincial healthcare, and the gaps in free or low-cost mental health care, particularly for men and for longer-term needs:

There's no free therapy for men, help for adult men as far as I know. There is free therapy for women, and there's free therapy for children and teenagers, but as far as I know, unless you're like a special medical condition or psychological condition, I don't think there is anything for men, which is sad. They do have group therapy, you know, in hospitals and prisons for men, other than that no free therapy as far I know. Now they do have cost effective therapy, \$60 an hour, at other agencies. So I could afford it if I really want to, but I couldn't afford to go every week, like I did before. That's why I look for an MD psychotherapist, because it is all covered. There is no way I could afford 20 years of therapy, if I had to pay out of my pocket.

Another participant, a lesbian gay woman in her 60s described the difficulty of finding an affirming provider following the passing of her late spouse. After trying several providers who lacked an understanding of her grief, she found a mental health care worker with whom she was affirming but whom she had to stop seeing due to insurance coverage limitations:

[S]he was registered social worker... she was gay, and I started seeing her, at the very, very beginning [after spouse died]. And she was amazing, and she totally understood, and it was my safe spot, and I could just bawl, and she got it. And then my insurance company for long term disability said, she's not some[one] that you can see, we don't support that. And I had to stop seeing her. And it was the worst thing that could ever happen. She was a clinical counselor, and I'm like, she's helping me. She gets it. She's understanding my feelings and everything that I'm doing and saying, and she's giving me the safe place to let it out. And I had to stop seeing her. And it was the dumbest thing I'd ever heard. Because it's very difficult when you're gay to find clinical people who understand, unless they themselves are gay, or they have a family member who is gay, and they accept it. It's hard to find somebody who doesn't bring their own beliefs into the situation.

**In addition to cost-related barriers, system navigation to get mental healthcare within the public system was a major access barrier.**

One participant, a queer man in his 70s spoke about his difficulties accessing addiction support, which led him to sporadically seek out private addiction professionals. He also noted that in his experience, many medical professionals seemed to be unprepared and untrained to adequately care for people with addictions:

When I started on my journey, I went to [addiction center], and there I got referred to a GP [general practitioner] who was an addiction specialist. With respect to seniors or anyone though, [addiction center] is a fortress, it is impossible to get to it... It's very difficult to go through all the hoops that they put in front of people who need help. And I have been an advocate for others to break down those barriers [...] There is a crisis, a frigging crisis in the medical profession, they are not trained, they don't know anything about substance use disorder.

**Participants also identified grief-related support as a specific mental health care need.** This was expressed especially by participants who had lost a partner or spouse, but whose losses were not fully recognized. Participants described how the loss of a same-sex partner seemed to be treated as less legitimate than the losses experienced by people in heterosexual partnerships.

A genderqueer woman in her 70s who had lost her partner, for instance, explained her experience with a grief support group:

I went to a grief group after [partner] died. I felt definitely that my grief didn't rate quite as highly as "real" grief, you know, when you lose a "real" partner. I never went back. I reported that to the organizers.

Another participant, a gay man in his 60s who had lost his husband, found that there was a lack of support both for him in his rural area as a gay man:

As far as social services, the only thing I tried to get was grief counselling after my husband died. And I mean, I was concerned what that might be like, I knew if anything I would be the only gay man in that group. And this was before the pandemic still. And it turns out there was nothing. It didn't matter that I was gay or straight, there was just nothing in our area in the way of grief counseling.

**The COVID-19 pandemic further impacted participants' mental health and illuminated that while there were some crisis supports available, long-term support was much harder to find.** For example, one participant, a gay man in his 60s, noted that during the pandemic only crisis services were available, leaving him without access to counselling services for ongoing challenges. By contrast, for an intersex woman in her 70s, crisis lines were the only ongoing source of mental health support. Depending on the 311-crisis line and the wellness calls she received every two weeks, she emphasized the need for more ongoing attention to trauma.

**Mental healthcare and grief support was a patchwork at best,** as participants described uncertain access and the great lengths they took to try to find services that they could afford and that were affirming of them as LGBTQI people. Participants' experiences point to the multiple layers of what "access" to care means, and how the out-of-pocket cost and privatization of mental healthcare severely limited their access to care and to LGBTQI-affirming providers. In highlighting the experiences of LGBTQI older adults in Canada these findings contribute to predominantly US-based research literature showing the significant mental healthcare access barriers faced LGBTQI older adults (e.g., Gendron et al., 2016; Burton et al., 2019; Marshall & Cahill, 2022), and enhances understanding of LGBTQI people's mental healthcare navigation practices across provincial systems (e.g., Ferlatte et al., 2021; see Jakubiec et al., forthcoming; Seida, et al., forthcoming). We outline several recommendations that stem from these findings below.



## Long-Term Care

Finally, participants shared their thoughts on long-term care, including experiences and perspectives related to homecare and long-term care homes.

**Participants emphasized the importance of reliable and affirming homecare personal support services.** As shared in the [Housing](#) section, many participants noted how being able to access community-based assistance with age and care needs would allow them to stay in their homes for longer and provided suggestions to this effect. Multiple participants had previously worked in healthcare and social service sectors themselves and provided insight into structural challenges related to homecare and homecare work, highlighting the critical link between the situations of care workers and care recipients or clients.

One lesbian woman in her 60s shared the novel idea of a “dyke-run homecare company”, a service that she suggested she and many others would benefit from:

I think in order that people stay in their homes, what we're really dreaming for is that some dykes should start a PSW company, like for a personal PSW visiting your house...We need to put the word out there, we need those young women, or older women, whatever. Because we'd prefer to stay where we're at.

Another lesbian woman who had worked in healthcare spoke passionately about the need for home care, and for treating homecare workers well:

I would fund the home support and homecare system ten times more than it currently is. And really help people stay at home. Number one is pay community health workers a salary and not by the hour. And number two, recognize all the practical and emotional work that they do, and not just quantify it by how many gowns or many needles or how many pills, but how well the whole person is supported to continue living at home. And I would [make] housing that is similar to housing co-ops, or other kinds of housing,

where the people are really neighbors, and they can really help each other, as a group.

**In addition to personal support work, participants highlighted how various professionals can be part of a community-based care team.** With this came ideas about enhancing support, but also concern about the cost of care.

One participant, a lesbian woman in her 70s, reflected on her experience of supporting a tenant who lived in her home when he became ill. She brought up the importance of having a care team and the specific role of the community pharmacist:

We have a community pharmacist. In this case, not from the community health center, but [who was willing] to deliver medications daily to my tenant. Because he could not remember to take his properly, which meant that I didn't have to do it several times every day. And just because there was always somebody visiting him, was just exceptionally great [...] It was because he was able to have a combination of those kinds of supports from the pharmacy, his family doctor, and workers, that I wasn't exhausted by his care. That's why he was able to not have to go to a care facility, which was his primary goal in life. It made a huge difference.

Another participant, a lesbian woman in her 70s, described being fearful of her and her partner's care situations in the future, as well as the financial costs of homecare:

I'm scared to think of it. We continue to say that one of us can take care of the other if one of us has a stroke [but] with the assistance of daily help, and we'd have to have someone come in and we don't have money for this [...] There used to be much more help, socially, than there is today. And today it is astronomical. To have someone like that comes to the house we are looking at \$50 an hour. And if one of us is really ill and needs saving, I mean obviously we can't live without. It's tremendously expensive so that would have to be what we do if we have to sell the house to get the money to pay

for that. We're hoping very much that we can just die at home, and then we've decided too, if things are too bad, we just let the other one, we just go, we just die. Seriously, just die. What's the point of lingering on and on for years and years.

**Although no participants were living in long-term care homes at the time of the interviews, many had thoughts to share about long-term care homes and similar institutional care settings.** This included perspectives informed by caring for significant others who had lived in long-term care homes, as well as second and third-hand accounts from their communities and the news. These forms of knowledge, as well as general experiences accessing healthcare, shaped how the participants conceptualized long-term care homes and what they thought about the potential of coming to live in one themselves.

**Central to participants' discussions were what it could be like to be LGBTQI in a long-term care home environment, and the potential of having LGBTQI-friendly or LGBTQI-specific long-term care homes.** Concerns of structural and interpersonal homophobia towards older 2SLGBTQI adults were common, including fears of being separated from partners and fears of encountering homophobia among staff and fellow long-term care home residents. This included concerns about facing verbal abuse, to erasure, and physical mistreatment.

One lesbian woman living in rural Quebec whose mother had lived in a long-term care home related:

The only major concern I have now as a 79-year-old lesbian is what will happen to me when I can't be autonomous anymore, when I need to go live in an institution, or if I find myself alone in a generation that isn't necessarily very open to homosexual relationships... I don't want to find myself in a place like that. I don't want to find myself somewhere, whether we're together [with my spouse], if we're both still alive and need to go to an institution...I don't have any idea now where I'd go or what it would mean for us.

Another participant, a single gay man in his 70s shared his thoughts on potential erasure:

There are no facilities that I know of that are specific to our community. So then you just feel very much below the game, because people with very good intentions, the care aides, the nurses, the volunteers, want to know about your life. And “where's your wife?” “What did she do?” You know, “do your grandchildren ever come and visit?” And I don't have any of that. And, so, then you just retreat even more, and I really want to find a way out of that.

One lesbian woman in her 60s who had lived in collective housing and worked with LGBTQ older adult clients in the past shared her safety concerns:

Getting old as a lesbian, it's very stressful. I wonder what will happen to me... I have a lot of fears. If something happens to me and I end up in a CHSLD... I don't know. I don't have the patience for that kind of intolerance [...] anymore. And what happens to seniors who fight against it? We give them drugs to shut them up.

As in recollections of their housing situations (see [Housing](#) section), **participants also shared concerns about LGBTQI-specific long-term care.**

One participant, a lesbian woman in her 70s shared her reservations regarding queer-specific long-term care and voiced her strong support for improved publicly funded facilities, while acknowledging the many systemic challenges:

We have had so many discussions about having some kind of queer long-term care type of thing. And there are so many challenges with that, because it seems like it would end up being private, and then that would be extremely expensive and exclusive to very few people. I have no interest in that. I worked in the public health care system. And I'm committed to that. Some of my previous colleagues worked, and community, has worked very hard to try to make the existing publicly funded long-term care facilities queer-friendly, queer-supportive, queer-competent. I've been at some of those trainings, I

think we're making progress, but all of the challenges of COVID have shown how many challenges there are in the whole system...

This participant's reflection on the structural change that is needed to create viable long-term housing and care support for LGBTQI older adults gets to the heart of the matter that concerned many. Common concerns among the LGBTQI older adults we interviewed included being mistreated, ignored, and targeted in long-term care settings and other healthcare encounters; the cost of care; and encountering discrimination. Their experiences and perspectives provide strong evidence that transformations in healthcare and long-term care delivery are needed.

## Recommendations

### Increase availability of affirming primary and specialist care:

- Take immediate measures to increase the supply of primary care physicians, such as enabling internationally trained medical professionals to certify and practice in Canada.
- Implement mandatory curriculum on 2SLGBTQI healthcare issues for all care providers in training, including mental healthcare professionals, personal support workers, doctors, nurses, and other specialists.
- Implement ongoing education opportunities for healthcare professionals at all levels to stay up to date on 2SLGBTQI healthcare access issues, promising practices, and relevant new treatments (e.g., regarding transition-related care).
- Continue to fund mental health crisis supports (e.g., helplines) while taking immediate measures to increase access to long-term care mental healthcare.

### Eliminate prohibitive out-of-pocket costs for care services:

- Fund comprehensive dental care, vision care, and physiotherapy coverage.
- Fund public transportation and care transfer programs to enable older adults, people living with disabilities, and others to get to healthcare appointments.
- Increasing coverage for different types of mental healthcare professionals.
- Reduce reliance on short-term crisis-oriented mental healthcare solutions, while maintaining.

### Long-term care:

- Provide funding to increase access to more and more reliable homecare supports.

- Implement immediate measures to better support long-term care home staff and increase staff to resident ratios, allowing for greater person-centered care.
- Continue efforts to reimagine and fund long-term care options that are humane, focus on wellbeing, and can better address and respect the diverse needs of care recipients.

## Death and End-of-Life Wellbeing

While death and dying are sometimes framed as taboo subjects, participants had much to share regarding their experiences, perspectives, fears, and wishes about death and end of life. This section highlights the range of ways in which participants approached death, dying, and end-of-life, from social, interpersonal, spiritual, and ethical standpoints. It also examines the points of reference that participants drew on in their approaches, and areas they identified for increased support.

### Witnessing and Wellbeing

Participants expressed a range of attitudes and approaches to death and end-of-life. They reflected on questions of care, faith, and change, and discussed death and end-of-life with different combinations of pragmatism, gratitude, concern, and surrender to what will pass. Participants also shared their general philosophies, and how these extended to thinking about death and end-of-life. **Significantly, their philosophies and approaches were often connected to their ideas of wellbeing and the values by which they had tried to live their lives.**

**Some participants expressed a sense of fatalism, as well as focus on the present.** For instance, in speaking about end-of-life care, one participant, a lesbian woman in her 70s, shared:

I tend to be a fatalist, so what will be, will be. I don't really dwell on what's going to happen. I pretty much take one day at a time. If you think too far ahead, you could get very depressed, and I'm not a depressed kind of person, so I don't even go there.

Another participant, a gay man in his 60s, expressed his views on this being his last life on Earth, and his sense of gratitude that informed his focus on the present:

I'm not coming back, this is my last life, at least on Earth. I'm not interested in coming back. [My partner] and I have built everything that you see around



us. We are very happy and comfortable with our lives, and we want for nothing. We are full of gratitude, and there's nothing really to want for.

**Approaches to death and end-of-life were also deeply informed by witnessing the lives of others, including significant others and fellow community members.**

Participants spoke about the end-of-life experiences of their loved ones, including spouses and parents. They also spoke about the impact of the HIV/AIDS epidemic on LGBTQI communities and how this shaped their views on death and dying.

One participant, a lesbian woman in her 60s, spoke about the passing of her spouse, and the quality of life she would prefer to sustain until the end:

My thoughts on end-of-life are, I don't want to be kept alive. I have always had an attitude with humans and animals that if you really love somebody, you let them go. And I have told [current spouse], I do not want undue measures used to keep me alive...I was very fortunate with [previous spouse] because she was good, up until the end. It wasn't until two or three days before she passed that she was not herself. She was the person that I knew [...] And that's what I want.

Another participant, a lesbian woman in their 70s, described the loss of friends and community members during the height of the HIV/AIDS crisis, and how this impacted their views:

I'm not afraid of aging and dying. I really appreciate my experience. I've worked with many people who had AIDS, who passed away. By the time I was doing that, those [individuals] were younger than myself. And it felt so tragic to be sometimes with people who have lived less life than I had already. But I learned from that, that in some ways, the value of life is not how long it is. And so I can accept that too [...] The process of end of life is hard, but it doesn't have to be horrible. Dying is really challenging, but in our biggest view isn't the end. It's a recipe for a new beginning. And the quality of it is something that we do have some control over, some influence over.

## Finally, being closer to end-of-life also shaped perspectives on death and life.

For one participant, a gay man in his 70s living with an aggressive cancer, this meant a changing relationship to faith and focus on life on earth:

I've certainly changed my view on that over the years. When I was younger, when I was doing hospice work, I saw people die. That really held on to that aspect of spirituality. And I nourish that. For me, my thoughts have changed. I don't believe in a higher being. I'm not sure what's going to happen, but I don't feel in my heart that there is a God and that there's another life... my belief is that my life is on earth. And I will enjoy the last days of my life knowing that I did everything I could, in a manner that helps others and myself. So, that's where I'm at now.

Participants' varying perspectives illuminated how approaches to living include death and dying, and how death and dying also drive contemplations about life and life well-lived. Across reflections what stood out clearly was that death, while in many ways individual or personal, was for those we spoke to deeply interpersonal and informed by shared experiences.

### **Death Rites & Rituals**

#### **Participants also shared thoughts about rites and rituals surrounding death.**

This included funerary and burial or cremation arrangements. Considerations related to death rituals included concern for loved ones and others who would outlive them. They also included fears and wishes around the “death event”, such as where and how death would happen and what rites occurring in the wake of death would take place. Often, these considerations all came together.

For instance, one gay man in his 60s discussed his relationship with a younger husband, his wishes for cremation and his relationship with his family and community where he was born:

Because of the age difference between [my husband] and I, probably I will be the first to go, but not necessarily. I feel very strongly that I do not want any artificial means to keep me alive. When I die, I said to him, I want to be cremated and my remains taken back up where I grew up and buried with my mother. I don't want a service, because I've been away from that community for 50 years [...] So I said to [my husband], if you can do this, I'd like you to take my urn up and just deposit it. And if you can't, then you know, we joke, I said, "Ship me on FedEx" [laughs].

Another participant, a lesbian woman in her 70s, discussed her dog and her daughter in her reflections on burial and post-death rituals:

I'm just going to be cremated and I'm going to be put in the grave where my parents are. I've made arrangements for that. They just have to dig a little hole, put my little urn in there. They're going mix my dog, after, in my ashes [...] I said to my daughter, "Gee, I think I'm just going to have my ashes thrown out in the old farm area that my family used to have, and we still have a grave site there." And my daughter said, "Oh, Mom, where will I go to know you were there?" [laughing]. And she wasn't a baby, she was like 40 years old! So, I said, "You know what? We'll do whatever you want. Because you're the one here, left... I will not care; I will no longer exist." You have to think about the people that you're leaving. What will I care? No, I won't. But will she care? Yes. So it's more important that I leave with her needs being met than mine.

**Relationships with family and place, broadly conceived, were a salient part of participants' reflections on what they wanted to happen upon their passing.**

The reflections above highlight the salience of concerns for close others, as well as ongoing connections to loved ones who have already passed away, and to significant places. Notably, relationships with family and place also informed participants' thoughts about where they would prefer to spend their final days and be laid to rest.

One participant described her and her partner's wish to age and die in their home, a preference that other participants also expressed. She described how her dad's positive end-of-life experience informed this desire:

I'd prefer to be here. We both would, and to have people come in. My dad had a stroke in his late 80s, and he was in the hospital, and then we just said, we're bailing him out. And we brought him home and we found palliative doctors, and they came in and it was all cool, and we played jazz 24 hours a day, and bagpipe music. And one day, he said, he whispered, that's all we could do. He says, "Get the big box ready?" I'd go, "Okay, cool." He knew it was cool, and we played the bagpipe honor songs for him...and so he had his tunes on as he left. And I think that's a good way to go.

For another participant the death of his husband made him think about the possibility of dying alone and to reflect on where he would prefer to spend his last days. He had family members and a planned burial spot in another province, both factors shaping his decision to move:

As far as end-of-life, I've thought that I'll probably go back to [city in another province] where I do have family. I know what I want done with myself, I have [my husband's] ashes, they are going to go together. There's a spot up in the mountain that we want to be. But what scares me the most is dying alone. And that's why I want to go back to [other province], was that I realized I didn't want to die alone. You know, I sat with [my husband] for three days and held his hand so that he wouldn't die alone. And I was there when he died. And right now, I would probably have to die alone. And, you know, it's unfortunate that so many people right now are dying alone. So I guess it wouldn't be that big a deal, but I always dreamed of having somebody there.

Others had also planned their burial sites in advance, naming places that were convenient for loved ones who visit, where their remains could be among family, and places that were significant to them. **Together, these reflections**

again illuminate how death and prospect of death brought together social relationships with philosophical and spiritual orientations. Salient across perspectives were desires for specific conditions of dying, be that with others or at home, and the meaning that people attributed to these conditions and the places where they would be laid to rest.

## **Wills & Advanced Care Planning**

Our interview question about thoughts on death and end-of-life elicited more philosophical thoughts and reflections on place, family, and community. We also asked participants about end-of-life planning. Given previous research focused on end-of-life care planning among LGBT older adults (e.g., Hughes & Cartwright, 2014; de Vries et al., 2019; Pang et al., 2019) we were curious how our research might surface similar or different findings, and how much advance care planning was on the radar for our participants.

**The most common form of planning that participant described was writing wills.** Experience caring for aging parents, having any degree of wealth to distribute, and rocky relationships with relatives were among the key drivers for estate planning.

One participant, a single gay man in his 70s, described how writing a will and estate planning was a way to make sure his assets were distributed to charities instead of estranged relatives:

Because I was dealing with my elderly parents, I was aware of all that kind of stuff, so I have my will, I have my executor, I have my plot at the cemetery. Everything's kind of in place. I don't have anybody really to give things to. I have only a couple of things that I have earmarked for individuals, and the rest I have designated to certain charities. Although only because—this sounds terrible—but only because if I were to die without a will or without designating something, things would, by law, go to relatives [...] If for over 10 years nobody has even [been around or been in touch], why should my meager amount be divided between siblings who don't pay any attention to me whatsoever?

Another participant, a lesbian bi woman in her 60s who had considerable assets discussed how she had a will on her to-do list, but also how she imagined she would spend her money on friends and her partner while she was still alive:

I will end up giving money to my friends, while I'm alive...I will spend my money on these people while they're alive, while I'm alive, because there will be taxes you are leaving the government. And even with my partner. My partner is significantly younger than me...and she loves me for what it is.

**Participants also discussed naming powers of attorney and making financial plans.** Having plans in a place was a source of comfort or security for some, who compared their circumstances to others who may not have the same degree of planning in place and have more fears or anxieties about end-of-life matters. It also brought up questions about relationships and what care and support could be like.

One queer woman in her 60s described appointing attorneys for personal care and finance, as well as her financial plan based on her property ownership:

I have my POAs [powers of attorney] and I have my will, and I have a sibling in [another city]. I know that's far away but it's a short flight. And I have a very close friend, she is now my POA, and we have talked about this and it's in my will also, I've made it very clear how I want to be taken care of. So I have that in place [...] And I have the arrangement with the bank that I can live here based on what I'm making...When I die, everything will be paid off, so I don't have that hanging over me.

Another participant, a pansexual woman in her 70s, discussed seeking out a new attorney. Reflecting on needing someone new, she ran through a list of possibilities and why they may or may not work out.

I'm starting to have some issues with my health, and some more severe stuff recently. I have two gay friends who are my executors. Younger than me. My power of attorney first was a young woman [...] but we've drifted apart, and

I don't find her reliable. And my nieces, they're very fond of me but they're not around. And they don't know my life...I do have some friends there who, like one guy, he and I knew each other years ago. We got along really well... But he's older than me. So he can't be my power of attorney. So that's been playing on my mind.

This participant's reflections highlight how even for a person with family and strong social connections, identifying someone to be an attorney can be challenging. Reliability, knowledge of one's life and preferences, and ability to be around are among the factors that can be considered.

Despite such challenges, another participant, a lesbian woman in her 70s, summed up benefits of advance care planning:

I have my power of attorney, I have my will done, I have even paid for my own funeral. It's done. My wishes are articulated, as set out, because I have seen that happen to too many people. I don't want it to happen to me [...] I'm not leaving it up to guesswork, or emotion or whatever. But it's not just the end of life so I want to be careful about, it's about aging, and caring. Because if you're sick, and in hospital, you also want whoever is doing your care to know your gay friends are going to come, because that's another time that they can just step in and isolate you. I just think a lot of aging gay people aren't putting enough of that stuff in place for themselves.

Like existing Canadian research, the LGBTQI participants in our study had differing levels of knowledge about wills and advance care planning and had taken different steps towards having conversations and putting documentation in place. Several participants had named "powers of attorney", or attorneys for personal care and/or finance who could represent their wishes and act on their behalf when needed. Creating a will and advance care planning document prompted reflection on interpersonal relations, and considerations about who was not only familiar and available but would also show up and be supportive. Notably, most participants who had put advance care planning measures were single at the time of the interview. This could suggest that not having a "built-in" person there in the form of a partner or spouse could spur on such thinking.

## Recommendations

### For individuals:

- Consider who you can approach to be your power(s) of attorney for personal care and for finance, and prepare advance care planning documents.
- Be open to learning about your loved ones' later and end-of-life care wishes, and discussing these with them.

### For healthcare and social service practitioners:

- Encourage clients to have advance care planning conversations and provide them educational material.
- Validate people's concerns about death and end-of-life, and support the approaches they wish to take while presenting a full range of options.

### For future research:

- Further examination of palliative and hospice care experiences, what is working, and what could be improved.
- Further research into the significance of ideas about "home" and "place" in end-of-life preparations.



# Conclusions and Next Steps

Aging is far from a universal experience, and the issues LGBTQI older adults face can be very different, as can their priorities and ideas about what aging and living well means. For participants in this study, wellbeing meant being able to meet a range of basic needs, to being able to access needed care, and to finding fulfillment and sense of purpose in their pursuits and social lives. Our findings highlight the range of factors that can shape LGBTQI older adults' abilities to age well on their own terms. Access to safe, secure, and affordable housing, to affirming and low to no-cost healthcare, and to social activities and community spaces all emerged as key needs and priorities. Importantly, participants' priorities and their abilities to lead the lives they wanted in older age were significantly mediated by financial situation and employment histories, by class, race, and age-based discrimination, and by compounding effects of facing homophobia and transphobia over a lifetime. Enabling LGBTQI older adults to age and "live well" requires addressing broad-based systemic inequities, maintaining and increasing commitments to publicly funded services, and building cities and communities that are meant to be enjoyed by a great diversity of people.

Each section of this report provides specific recommendations to these ends. We will continue to work to mobilize study findings in a variety of ways, including through the creation of free educational resources, and publications that delve into key themes in greater depth. We hope that this report has sparked, and can continue to spark, conversations and imaginings about what could be.

# Appendix I: More on Research Orientations

**Analysis of Power and Privilege:** In designing this study and our research questions we explicitly considered the social inequities that may impact LGBTQI older adults, as well the dynamics of power and privilege that operate through race, class, gender, sexuality, age, and other social markers. This approach guided our efforts to explicitly welcome participants from under-represented groups and guided our analysis of interview transcripts. In our analysis we paid particular attention to how broader social inequities and intersecting social dynamics seemed to be shaping participants' possibilities for aging and living well, and how participants' experiences were informed by multiple, overlapping, and sometimes conflicting identities and social positions. Together with a queer life course perspective (described below) this focus on power and privilege helped us to examine how past and present-day social and structural dynamics were shaping LGBTQI older adults' living conditions, and their experiences and understandings of age. This focus also informed how we chose to present data and recommendations in this report and will continue to inform future publications

**Queer Life Course Perspective:** In social gerontology, a life course perspective recognizes that “the physical, psychological, and social aspects of individual ageing are often not dictated by chronological age per se, but instead shaped by a host of factors that cumulate in individuals over decades of living” (Dannefer & Settersten, Jr., 2010, p. 3). This approach recognizes that aging is an “experientially contingent reality” (Danner & Settersten Jr., 2010, p. 4), a phenomenon shaped over time by many different social dynamics and forces. In this research we adopted a life course perspective to consider how social and material conditions that older adults face later in life can be understood considering social and material conditions earlier in life. At the same time, we took and will continue to take a critical approach to the life course, an idea that has been critiqued for its linear understanding of life stages based on heteronormative notions and values. Queer theorists have pointed out, for

example, that the linear life course model commonly hinges on key productive and reproductive events, such as marriage and childrearing (e.g., see Freeman, 2007; Halberstam, 2003, 2005). Also critical of this, we paid attention to how participants themselves conceptualized aging as a process and what they identified as significant life events.


**Asking About Wellbeing:** In this study, we chose to focus on “aging and living well” to learn more about a range of considerations related to wellbeing, including but not limited to health and healthcare access related issues. In addition to building on existing research focused on healthcare access issues among LGBTQI people over the life course, we specifically aimed to re-orient away from risk-based frameworks and from paradigms of “healthy” or “successful aging”. These paradigms associate “success” with independence, high physical functioning, and the avoidance of dependence (Rowe & Kahn, 1997), and are not only deeply ableist and heterosexist but with a focus on the individual draw attention away from structural inequalities (Katz & Calasanti, 2015). Further, “health” itself can be understood as a category that involves morality and judgement and is both a privilege and an ideological position (Metzl, 2010). Normative ideas about what constitute a healthy body or healthy behaviours reflect broader systems of social power and privilege, and can directly negatively people who are disabled, fat, neurodivergent, and 2SLGBTQI, among others (e.g., see Kim, 2011, 2017; McPhail & Bombak, 2015; Meera et al., 2016; Richie, 2019; Jakubiec et al., forthcoming, for select intersectional analyses). By focusing on wellbeing, we wanted to understand how participants themselves defined “living well” and what is needed for them to age well on their own terms.

## Appendix II: More on Recruitment

As observed by many researchers and readers, a core limitation of research focused on LGBTQI aging is that it has predominantly engaged older adult participants who are gay or lesbian, white, cisgender, have formal higher education, and/or live in urban areas. In some respects, this tide is shifting, with recent research in Canada focusing specifically on the situations of trans older adults and aging issues (e.g., Baril & Silverman, 2019; Pang et al., 2019; Flanagan, 2020; Silverman & Baril, 2023), examining intersections of aging and intersexualization and the experiences of intersex older adults (Latham & Barrett, 2015; Latham & Holmes, 2018), and accounting for dynamics of power and privilege as they operate through race, class, and migration trajectories (Pino, 2018, 2019). But much more work needs to be done. To our knowledge, there is currently no published research focused on rural aging among LGBTQI people in Canada, nor on the impact of settler colonialism on the possibilities for aging and living well among Two Spirit and Indigenous LGBTQ people. Much more can be learned of different communities' priorities, and about the daily disparities that shape different individuals' and groups' possibilities to age and live well.

Recognizing this gap, we sought to address under-representation by specifically welcoming older adults who were Indigenous, Black, and people of colour, and those living in rural areas, to share their perspectives by joining the community advisory committee and by participating in interviews. For the community advisory committee, we posted an open call, and in selecting members intentionally selected for a diversity of experience and explicit critical reflections on racism and colonialism. Ultimately, two of the six community advisory committee members were people of colour. All advisory committee members received an \$800 honorarium. We received no expressions of interest from people self-identified as Indigenous or Black.

In recruiting for interview participants, we explicitly stated on the recruitment material that we “especially welcome the participation of 2SLGBTQI older adults who are Black, Indigenous, people of colour, and who live in rural areas”.



We shared recruitment materials through Egale’s social media platforms, with community and social service agencies, and with other existing networks and individual connections. As we began interviews with the first set of participants, we also asked participants to share information about the study within their networks (a sampling method known as “snowball sampling”).

In total, we received 118 submissions for participation in the study. Of these, nine were ineligible, six declined to participate, 34 did not respond to follow-up emails or phone calls, and 21 were not selected to participate. In the interests of representation and addressing key gaps in the literature, selection was based on including up to one-third of participants who were rurally based and up to one-third of participants who were racialized. These selection criteria were made clear in recruitment materials. Ultimately all eligible people who lived in rural areas or identified as racialized were invited to participate for a total of twelve rurally based and seven racialized participants. From there, we included all eligible Francophones who expressed interest (five), and then selected for regional breadth. Exceptionally, we included one participant who was 64 to increase representation in a western province and reflections on living with multiple chronic conditions.

# References

- Abramovich, I. A. (2012). No safe place to go – LGBTQ youth homelessness in Canada: Reviewing the literature. *Canadian Journal of Family and Youth*, 4(1), 29–51. <https://doi.org/10.29173/cjfy16579>
- Abramovich, A. (2017). Understanding how policy and culture create oppressive conditions for LGBTQ2S youth in the shelter system. *Journal of Homosexuality*, 64(11), 1484–1501. <https://doi.org/10.1080/00918369.2016.1244449>
- Abramovich, A., & Kimura, L. (2021). Outcomes for youth living in Canada’s first LGBTQ2S transitional housing program. *Journal of Homosexuality*, 68(8), 1242–1259. <https://doi.org/10.1080/00918369.2019.1696102>
- Alhassan, J. A. K., Abonyi, S., Neudorf, C., & Hanson, L. (2021). “It feels like somebody cut my legs off”: Austerity, transportation and the “web of dispossession” in Saskatchewan, Canada. *Social Science & Medicine*, 282(114147). <https://doi.org/10.1016/j.socscimed.2021.114147>
- Antonucci, T. C., Ajrouch, K. J., & Birditt, K. S. (2014). The Convoy Model: Explaining social relations from a multidisciplinary perspective. *The Gerontologist*, 54(1), 82–92. <https://doi.org/10.1093/geront/gnt118>
- Bain, N., Bergman, S. B., Lee Kam, leZlie, Sloane, T., & Spencer, R. (2021). *The Youth / Elders Podcast* [Audio podcast]. <https://buddiesinbadtimes.com/show/the-youth-elders-podcast/>
- Baril, A., & Silverman, M. (2019). Forgotten lives: Trans older adults living with dementia at the intersection of cisgenderism, ableism/cogniticism and ageism. *Sexualities*, 25(1–2), 117–131. <https://doi.org/10.1177/1363460719876835>
- Bauer, G., Nussbaum, N., Travers, R., Munro, L., Pyne, J., & Redman, N. (2011). We’ve got work to do: Workplace discrimination and employment challenges for trans people in Ontario. *Trans PULSE E-Bulletin*, 2. <https://www.transpulseproject.ca>.

- Brennan, K., Halpenny, C., & Pakula, B. (2022). LGBTQ2S+ voices in employment: Labour market experiences of sexual and gender minorities in Canada. *Social Research and Demonstration Corporation*. <https://doi.org/10.13140/RG.2.2.23298.15042>
- Brotman, S., Ryan, B., Collins, S., Chamberland, L., Cormier, R., Julien, D., Meyer, E., Peterkin, A., & Richard, B. (2007). Coming out to care: Caregivers of gay and lesbian seniors in Canada. *The Gerontologist*, 47(4), 490–503. <https://doi.org/10.1093/geront/47.4.490>
- Burton, C. W., Lee, J.-A., Waalen, A., & Gibbs, L. M. (2019). “Things are different now but”: Older LGBT adults’ experiences and unmet needs in health care. *Journal of Transcultural Nursing*, 31(5), 492–501. <https://doi.org/10.1177/1043659619895099>
- Canada Mortgage and Housing Corporation. (2018). *What is the strategy?* <https://www.cmhc-schl.gc.ca/en/nhs/guidepage-strategy>
- CATIE. (2020). *A history of HIV/AIDS*. CATIE. <https://www.catie.ca/a-history-of-hiv-aids>
- Croghan, C. F., Moone, R. P., & Olson, A. M. (2014). Friends, family, and caregiving among midlife and older lesbian, gay, bisexual, and transgender adults. *Journal of Homosexuality*, 61(1), 79–102. <https://doi.org/10.1080/00918369.2013.835238>
- Daley, A., MacDonnell, J. A., & St. Pierre, M. (2016). *LGBTQI communities and home care in Ontario: Project report*. York University. <https://yorkspace.library.yorku.ca/xmlui/handle/10315/32817>
- Dannefer, D., & Settersten, R. A. (2010). The study of the life course: Implications for Social Gerontology. In *The SAGE Handbook of Social Gerontology*. SAGE Publications Ltd. <https://doi.org/10.4135/9781446200933.n1>
- de Vries, B., Gutman, G., Humble, Á., Gahagan, J., Chamberland, L., Aubert, P., Fast, J., & Mock, S. (2019). End-of-life preparations among LGBT older Canadian adults: The missing conversations. *International Journal of Aging & Human Development*, 88(4), 358–379. <https://doi.org/10.1177/0091415019836738>
- Denier, N., & Waite, S. (2017). Sexual orientation wage gaps across local labour market contexts: Evidence from Canada. *Relations Industrielles / Industrial Relations*, 72(4), 734–762. <https://doi.org/10.7202/1043174ar>

- Dube, D., Sussman, T., Brotman, S., de Vries, B., & Gutman, G. (2022). Advance care planning among older gay men living with HIV in Montreal, Canada: Challenges to thinking and talking about future care. *Journal of Homosexuality*, 69(4), 756–772. <https://doi.org/10.1080/00918369.2020.1855029>
- Egale Canada. (2021). *Brief on police-reported crime statistics in Canada, 2021: Hate crimes targeting sexual orientation*. <https://egale.ca/awareness/brief-on-police-reported-hate-crimes-2021/>
- Egale Canada, African Canadian Civic Engagement Council, & Innovative Research Group. (2020). *Impact of COVID-19 on the LGBTQI2S community: Second national report*. <https://egale.ca/awareness/covid19-impact-second-national-report/>
- Egale Canada, & Innovative Research Group. (2020). *National survey results: The impact of COVID-19 on the 2SLGBTQI community*. <https://egale.ca/awareness/covid19-impact-report/>
- Equal Rights Coalition. (2022). *Research on and responses to contemporary anti-gender movements: Briefing note to the Equal Rights Coalition Conference, Buenos Aires, Argentina, 8-9 September 2022*. <https://equalrightscoalition.org/documents/anti-gender-movement-background-paper/>
- Ferlatte, O., Gaudette, M., & Pang, C. (2021). *2SLGBTQI Suicide prevention research in Canada: Evidence, gaps, and priorities*. Egale Canada & L'École de Santé Publique de l'Université de Montréal. <https://egale.ca/awareness/2slgbtqi-suicide-prevention-research-in-canada-evidence-gaps-and-priorities/>
- Fields, J., Gibb, J. K., & Williams, S. A. (2021). Queer people's experiences during the pandemic include new possibilities and connections. *The Conversation*. <http://theconversation.com/queer-peoples-experiences-during-the-pandemic-include-new-possibilities-and-connections-162747>
- Flanagan, A. K. (2020). *Do we really get to choose our own story? (Re)imagining community support with transgender and non-binary older adults* [Doctoral Thesis, University of Waterloo]. <https://uwspace.uwaterloo.ca/handle/10012/16404>



- Flanagan, A., & Pang, C. (2022). *Coming out and coming in to living with dementia: Enhancing support for 2SLGBTQI People Living with Dementia and their primary unpaid carers*. National Institute on Ageing, Toronto Metropolitan University, & Egale Canada. <https://egale.ca/awareness/coming-out-and-coming-in-to-living-with-dementia-enhancing-support-for-2slgbtqi-people-living-with-dementia-and-their-primary-unpaid-carers/>
- Freeman, E. (2007). Queer belongings: Kinship Theory and Queer Theory. In G.E. Haggerty, & M. McGarry (Eds.), *A companion to lesbian, gay, bisexual, transgender, and queer studies* (pp. 293–314). John Wiley & Sons, Ltd. <https://doi.org/10.1002/9780470690864.ch15>
- Friends of Ruby. (2023). *About*. Friends of Ruby. <https://www.friendsofruby.ca/about/>
- Furlotte, C., Gladstone, J. W., Cosby, R. F., & Fitzgerald, K.A. (2016). “Could we hold hands?” Older lesbian and gay couples’ perceptions of long-term care homes and home care. *Canadian Journal on Aging*, 35(4), 432–446. <https://doi.org/10.1017/S0714980816000489>
- Gendron, T. L., Pendleton, T., & White, J. T. (2016). Mental health counseling of LGBT elders. In D. A. Harley & P. B. Teaster (Eds.), *Handbook of LGBT elders: An interdisciplinary approach to principles, practices, and policies* (pp. 455–471). Springer International Publishing. <https://books-scholarsportal-info.myaccess.library.utoronto.ca/en/read?id=/ebooks/ebooks3/springer/2017-08-17/1/9783319036236>
- Gertten, F. (Director). (2019). *PUSH* [Documentary].
- Grigorovich, A. (2015). Older lesbian and bisexual women’s experiences with home care services. *Research on Aging*, 37(7), 763–783. <https://doi.org/10.1177/0164027514562650>
- Haase, K. R., Cosco, T., Kervin, L., Riadi, I., & O’Connell, M. E. (2021). Older adults’ experiences with using technology for socialization during the COVID-19 pandemic: Cross-sectional survey study. *JMIR Aging*, 4(2), e28010. <https://doi.org/10.2196/28010>

- Halberstam, J. (2003). What's that smell? Queer temporalities and subcultural lives. *International Journal of Cultural Studies*, 6(3), 313–333. <https://doi.org/10.1177/13678779030063005>
- Halberstam, J. (2005). *In a queer time and place: Transgender bodies, subcultural lives*. New York University Press.
- Hazel, M. (2018). *Reasons for working at 60 and beyond*. Statistics Canada. <https://www150.statcan.gc.ca/n1/en/catalogue/71-222-X2018003>
- Hindmarch, S., & Orsini, M. (2018). *Seeing red: HIV/AIDS and public policy in Canada*. University of Toronto Press. <https://www.jstor.org/stable/10.3138/j.ctv2fjwxtk>
- Hughes, M., & Cartwright, C. (2014). LGBT people's knowledge of and preparedness to discuss end-of-life care planning options. *Health & Social Care in the Community*, 22(5), 545–552. <https://doi.org/10.1111/hsc.12113>
- Iciaszczyk, N., Arulnamby, A., Brydges, M., Marshall, M., Cheng, S. M., Feil, C., & Sinha, S. (2022). *Ageing in the right place: Supporting older Canadians to live where they want*. <https://www.nia-ryerson.ca/airp>
- Ismail, M., Hammond, N. G., Wilson, K., & Stinchcombe, A. (2019). Canadians who care: Social networks and informal caregiving among lesbian, gay, and bisexual older adults in the Canadian Longitudinal Study on Aging. *The International Journal of Aging and Human Development*, 91(3), 299–316. <https://doi.org/10.1177/0091415019864603>
- Jakubiec, B. A. E., Pang, C., & Seida, K. (2023). "We need healthcare to be anti-misogynistic": Healthcare access experiences and needs among LBQ women, trans, and nonbinary people in Canada. Egale Canada. Forthcoming report.
- Katz, S., & Calasanti, T. (2015). Critical perspectives on successful aging: Does it "appeal more than it illuminates"? *The Gerontologist*, 55(1), 26–33. <https://doi.org/10.1093/geront/gnu027>

- Kia, H., Rutherford, L., Jackson, R., Grigorovich, A., Ricote, C. L., Scheim, A. I., & Bauer, G. R. (2022). Impacts of COVID-19 on trans and non-binary people in Canada: A qualitative analysis of responses to a national survey. *BMC Public Health*, 22(1), 1284. <https://doi.org/10.1186/s12889-022-13684-x>
- Kim, E. (2011). Asexuality in disability narratives. *Sexualities*, 14(4), 479–493. <https://doi.org/10.1177/1363460711406463>
- Kim, E. (2016). *Curative violence: Rehabilitating disability, gender, and sexuality in modern Korea*. Duke University Press.
- Kinsman, G. (2020). Some notes on learning from AIDS activism for our responses to the Coronavirus (COVID-19) pandemic. *AIDS Activist History Project*. <https://aidsactivisthistory.ca/aahp-blog/>
- Kinsman, G., & Gentile, P. (2010). *The Canadian war on queers: National security as sexual regulation*. UBC Press.
- Kittle, K. R., Boerner, K., Kim, K., & Fredriksen-Goldsen, K. I. (2022). Social resource variations among LGBT middle-aged and older adults: The intersections of sociodemographic characteristics. *The Gerontologist*, 62(9), 1324–1335. <https://doi.org/10.1093/geront/gnac021>
- Kortes-Miller, K., Boulé, J., Wilson, K., & Stinchcombe, A. (2018). Dying in long-term care: Perspectives from sexual and gender minority older adults about their fears and hopes for end of life. *Journal of Social Work in End-of-Life & Palliative Care*, 14(2–3), 209–224. <https://doi.org/10.1080/15524256.2018.1487364>
- Latham, J., & Barrett, C. (2015). Appropriate bodies and other damn lies: Intersex ageing and aged care. *Australasian Journal on Ageing*, 34(S2), 19–20. <https://doi.org/10.1111/ajag.12275>
- Latham, J. R., & Holmes, M. M. (2018). Intersex ageing and (sexual) rights. In *Addressing the sexual rights of older people* (1st ed., pp. 84–96). Routledge. <https://doi.org/10.4324/9781315641751-7>

- Levy, D. K., Wissoker, D., Aranda, C., Howell, B., Pitingolo, R., Sewell, S. H., & Santos, R. (2017). *A paired-testing pilot study of housing discrimination against same-sex couples and transgender individuals*. Urban Institute. <https://www.urban.org/research/publication/paired-testing-pilot-study-housing-discrimination-against-same-sex-couples-and-transgender-individuals>
- Marshall, A., & Cahill, S. (2022). Barriers and opportunities for the mental health of LGBT older adults and older people living with HIV: A systematic literature review. *Aging & Mental Health*, 26(9), 1845–1854. <https://doi.org/10.1080/13607863.2021.2003300>
- McPhail, D., & Bombak, A. E. (2015). Fat, queer and sick? A critical analysis of ‘lesbian obesity’ in public health discourse. *Critical Public Health*, 25(5), 539–553. <https://doi.org/10.1080/09581596.2014.992391>
- Meeraj, S., Abdillahi, I., & Poole, J. (2016). An introduction to anti-Black sanism. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, 5(3), 18–35. <https://journals.library.mun.ca/ojs/index.php/IJ/article/view/1682>
- Metzl, J. (2010). Introduction: Why “against health”? In *Against health: How health became the new morality*. NYU Press. <https://doi.org/10.18574/nyu/9780814759639.003.0004>
- Migdal, A. (2019, July 20). How LGBT renters in Vancouver are finding safe living spaces. *CBC News*. <https://www.cbc.ca/news/canada/british-columbia/lgbt-renters-vancouver-1.5217493>
- Mirza, N. A., & Hulko, W. (2022). The complex nature of transportation as a key determinant of health in primary and community care restructuring initiatives in rural Canada. *Journal of Aging Studies*, 60, 101002. <https://doi.org/10.1016/j.jaging.2022.101002>
- Munro, A., Reynolds, V., & Townsend, M. (2017). Youth wisdom, harm reduction & housing first: RainCity housing’s queer & trans youth housing project. In A. Abramovich & J. Shelton (Eds.), *Where Am I Going to Go? Intersectional Approaches to Ending LGBTQ2S Youth Homelessness in Canada & the U.S.* Canadian Observatory on Homelessness. <https://www.homelesshub.ca/resource/51-youth-wisdom-harm-reduction-housing-first-raincity-housing%E2%80%99s-queer-trans-youth-housing>

- Murzin, K., Ahluwalia, P., & Wang, S. (2022, March). *The Pan-Canadian research agenda on HIV, aging & older adulthood*. <https://www.realizecanada.org/wp-content/uploads/Research-Agenda-on-HIV-Aging-and-Older-Adulthood-EN-July-14-2022.pdf>
- Oxford English Dictionary. Credentialism. (2022). In *OED Online*. Oxford University Press. <http://www.oed.com/view/Entry/400083>
- Pang, C., Gutman, G., & de Vries, B. (2019). Later life care planning and concerns of transgender older adults in Canada. *The International Journal of Aging and Human Development*, 89(1), 39–56. <https://doi.org/10.1177/0091415019843520>
- Pang, N. C. (2022). *Reorienting Response: An Ethnography of Old Age, Disability, and Queer Lives in Canada*. [Doctoral dissertation, University of Toronto].
- Pino, F. L. (2018). Older Filipino gay men in Canada: Bridging Queer Theory and Gerontology in Filipinx Canadian studies. In R. Diaz, M. Largo, & F. Pino (Eds.), *Diasporic Intimacies: Queer Filipinos and Canadian Imaginaries* (pp. 163–182). Northwestern University Press. <https://doi.org/10.2307/j.ctv47wd88.17>
- Pino, F. L. (2019). *A different shade of grey: Intimacies of older Filipino gay men in Canada* [Doctoral Thesis, University of Toronto]. <https://tspace.library.utoronto.ca/handle/1807/106798>
- Randle, J., Hu, Z., & Thurston, Z. (2021, November 22). *Housing experiences in Canada: LGBTQ2+ people in 2018* [Fact Sheet]. Statistics Canada. <https://www150.statcan.gc.ca/n1/pub/46-28-0001/2021001/article/00004-eng.htm>
- Redden, M., Gahagan, J., Kia, H., Humble, Á. M., Stinchcombe, A., Manning, E., Ecker, J., de Vries, B., Gambold, L. L., Oliver, B., & Thomas, R. (2021). Housing as a determinant of health for older LGBT Canadians: Focus group findings from a national housing study. *Housing and Society*, 0(0), 1–25. <https://doi.org/10.1080/08882746.2021.1905996>
- Richie, C. S. (2019). Not sick: Liberal, trans, and crip feminist critiques of medicalization. *Journal of Bioethical Inquiry*, 16, 375–387. <https://doi.org/10.1007/s11673-019-09922-4>

- Robson, C., Gutman, G., Marchbank, J., & Blair, K. (2018). Raising awareness and addressing elder abuse in the LGBT community: An intergenerational arts project. *Language and Literacy*, 20(3), Article 3. <https://doi.org/10.20360/langandlit29408>
- Roger, K. S., Mignone, J., & Kirkland, S. (2013). Social aspects of HIV/AIDS and aging: A thematic review. *Canadian Journal on Aging*, 32(3), 298–306. <https://doi.org/10.1017/S0714980813000330>
- Rosenberg, L., Kottorp, A., & Johansson, K. (2018). LGBTQ-specific elderly housing as a “sparkling sanctuary”: Boundary work on LGBTQ identity and community in relationship to potential LGBTQ-specific elderly housing in Sweden. *Journal of Homosexuality*, 65(11), 1484–1506. <https://doi.org/10.1080/00918369.2017.1377487>
- Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, 37(4), 433–440. <https://doi.org/10.1093/geront/37.4.433>
- Sassen, S. (2009). When local housing becomes an electronic instrument: The global circulation of mortgages – A research note. *International Journal of Urban and Regional Research*, 33(2), 411–426. <https://doi.org/10.1111/j.1468-2427.2009.00868.x>
- Sassen, S. (2019). *Saskia Sassen—The process of “financialisation” of real estate assets* [Video]. <https://www.youtube.com/watch?v=7Vz2LZYU5c8>
- Sasso, T., & Ellard-Gray. (2015). *In & Out: Diverging perspectives on LGBT inclusion in the workplace*. Canadian Centre for Diversity and Inclusion. [20150528-report-lgbt-inclusion-in-the-workplace-en.pdf \(ccdi.ca\)](https://www.ccdi.ca/20150528-report-lgbt-inclusion-in-the-workplace-en.pdf)
- Savage, R. D., Wu, W., Li, J., Lawson, A., Bronskill, S. E., Chamberlain, S. A., Grieve, J., Gruneir, A., Reppas-Rindlisbacher, C., Stall, N. M., & Rochon, P. A. (2021). Loneliness among older adults in the community during COVID-19: A cross-sectional survey in Canada. *BMJ Open*, 11(4), e044517. <https://doi.org/10.1136/bmjopen-2020-044517>
- Schwan, K., & Perucca, J. (2022, March). *Realizing the right to housing in Canadian municipalities: Where do we go from here?* The Shift. <https://make-the-shift.org/wp-content/uploads/2022/04/Canadian-Municipal-Policy-Scan.pdf>

- Sears, B., Mallory, C., Flores, A. R., & Conron, K. J. (2021). *LGBT people's experiences of workplace discrimination and harassment*. Williams Institute, UCLA School of Law. [LGBT People's Experiences of Workplace Discrimination and Harassment - Williams Institute \(ucla.edu\)](https://www.williamsinstitute.org/lgbt-people-experiences-workplace-discrimination-harassment)
- Seida, K., Desmeules-Trudel, F., & Jakubiec, B. A. E. (2023). Queering mental health supports in Canada: Integrating lived experiences into 2SLGBTQI affirming mental health and social service approaches. Egale Canada. <https://egale.ca/awareness/queering-mental-health-supports-in-canada-a-research-report/>
- Seifert, A., Cotten, S. R., & Xie, B. (2020). A double burden of exclusion? Digital and social exclusion of older adults in times of COVID-19. *The Journals of Gerontology: Series B*, 76(3), e99–e103. <https://doi.org/10.1093/geronb/gbaa098>
- Sepúlveda-Loyola, W., Rodríguez-Sánchez, I., Pérez-Rodríguez, P., Ganz, F., Torralba, R., Oliveira, D. V., & Rodríguez-Mañas, L. (2020). Impact of social isolation due to COVID-19 on health in older people: Mental and physical effects and recommendations. *The Journal of Nutrition, Health & Aging*, 24(9), 938–947. <https://doi.org/10.1007/s12603-020-1500-7>
- Silverman, M., & Baril, A. (2023). “We have to advocate so hard for ourselves and our people”: Caring for a trans or non-binary older adult with dementia. *LGBTQ+ Family: An Interdisciplinary Journal*, 1-24.
- Sixsmith, A., Horst, B. R., Simeonov, D., & Mihailidis, A. (2022). Older people's use of digital technology during the COVID-19 pandemic. *Bulletin of Science, Technology & Society*, 42(1-2), 19–24. <https://doi.org/10.1177/02704676221094731>
- Solomon, P., O'Brien, K., Wilkins, S., & Gervais, N. (2013). Aging with HIV and disability: The role of uncertainty. *AIDS Care*, 26(2), 240–245. <https://doi.org/10.1080/09540121.2013.811209>
- Statistics Canada. (2021). *A statistical portrait of Canada's diverse LGBTQ2+ communities*. The Daily. <https://www150.statcan.gc.ca/n1/daily-quotidien/210615/dq210615a-eng.htm>
- Statistics Canada. (2022a). *Housing indicators, 2021 Census*. <https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/dv-vd/housing-logement/index-en.cfm>

Statistics Canada. (2022b). *Police-reported crime statistics in Canada, 2021*. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2022001/article/00013-eng.htm>

The National Seniors Council. (2009). *Report of the National Seniors Council on low income among seniors*. <https://www.canada.ca/en/national-seniors-council/programs/publications-reports/2009/low-income-seniors.html>

Waite, S. (2020). Should I stay or should I go? Employment discrimination and workplace harassment against transgender and other minority employees in Canada's federal public service. *Journal of Homosexuality*, 68(11), 1833–1859. <https://doi.org/10.1080/00918369.2020.1712140>

Wilson, K., Kortés-Miller, K., & Stinchcombe, A. (2018). Staying out of the closet: LGBT older adults' hopes and fears in considering end-of-life. *Canadian Journal on Aging*, 37(1), 22–31. <https://doi.org/10.1017/S0714980817000514>

Wister, A. V., & Kadowaki, L. (2021). *Social isolation among older adults during the pandemic*. Federal, Provincial and Territorial Forum of Ministers responsible for Seniors. <https://www.canada.ca/en/employment-social-development/corporate/seniors/forum/reports/covid19-social-isolation.html>

Young, T. K., Tabish, T., Young, S. K., & Healey, G. (2019). Patient transportation in Canada's northern territories: Patterns, costs and providers' perspectives. *Rural and Remote Health*, 19(2), 1–7. <https://doi.org/10.3316/informit.143529796228367>



# Egale



Suite 217-120 Carlton Street,  
Toronto, ON. M5A 4K2



(416) 964-7887



[research@egale.ca](mailto:research@egale.ca)



[egale.ca](http://egale.ca)